

# Episodes of Care: Building on the Successes of Centers of Excellence

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2:00 pm – 3:00 pm



# Our Speakers



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# Early Centers of Excellence (COE) – 1980s, 1990s

Environment – Staff/Group model with developing IPAs

Problem: Address wide variation of cost and quality of high cost, high risk, relatively uncommon procedures (organ transplants)

Requirements for COE

- Quality measures
  - Process: dedicated staff, dedicated units, stable staff, comprehensive pre-procedure evaluation, comprehensive post procedure care (required long questionnaire and site visits)
  - Outcome measures: mortality, organ survival, public sources of data (UNOS)
  - Well defined selection criteria
- Cost (usually corridors of fixed price to allow for variation)
  - Pre-transplant evaluation
  - Transplant
  - Post transplant with specification of treatments, especially immuno-suppressive drugs, and duration

# COE Benefit design

- Often “buy up” or additional benefit
- Selective or exclusive networks
- Incentives for members
- Small network (<50) concentrated in major centers often required travel
- Travel and care-giver support
- Active case management starting when potential for transplant was identified
- Communication with the self-insured employer about a potential case

# Expansion

- Academic publications in 1970s showed relationships between volume and outcome
- Multiple publications in 1990s highlighted volume and cardiac surgery outcome links
- COE encouraged and supported by measures from Leapfrog, NCQA, NQF
- As more quality measures became available and pathways/clinical guidelines became more accepted, plan expanded COE to include larger numbers of conditions and specialties.

# Where else might this approach work?

- Criteria
  - Appropriateness criteria
  - Quality measures
  - Care path, guideline, or equivalent
  - Variation in care or cost
  - Steps to improvement are known
  - Payment method to support improvement
- COE approach could be used for more common conditions in an EOC



# Healthcare Value Strategy



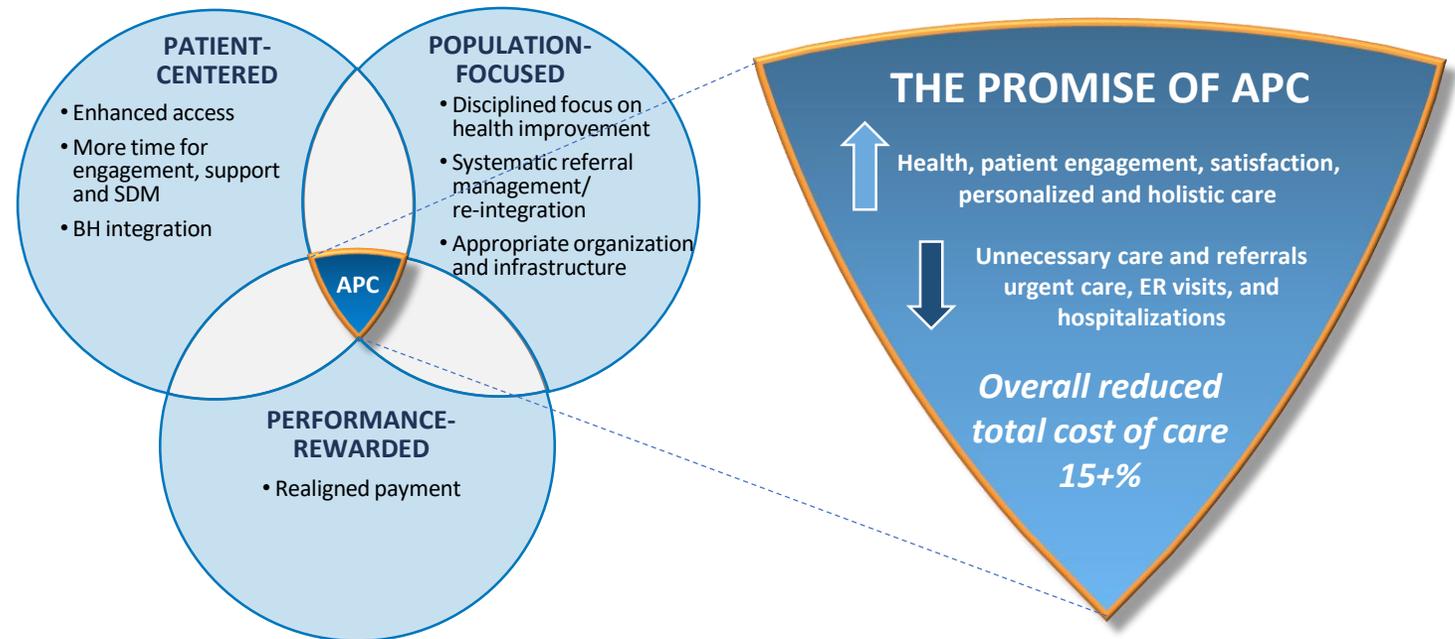
# Front End strategy - Advanced Primary Care (APC)

What Makes Primary Care **ADVANCED** Primary Care (APC)? National Alliance Identified **SEVEN** Key Attributes



## “Advanced Primary Care”

- Better engagement and health of patients
- Improved value and productivity for employers
- Integral to referral management to COE/EOC



# Episodes of Care – Getting it right while moving forward

## Procedures

- **Cardiology:** PCIs, Pacemaker-Defibrillator, Cardiac Valve, CABG
- **GI:** Bariatric, Gall Bladder, Colonoscopy, Upper GI Endoscopy, Colorectal Resection
- **Ortho:** Hip Replacement/Revision, Knee Replacement/Revision, Knee Arthroscopy, Shoulder Replacement, Lumbar Laminectomy, Lumbar Spine Fusion
- **Maternity:** Pregnancy/Delivery, Newborn
- **Other:** Tonsillectomy, Lung Resection, Prostatectomy, Cataract Surgery

## STANDARDIZATION PRINCIPLES

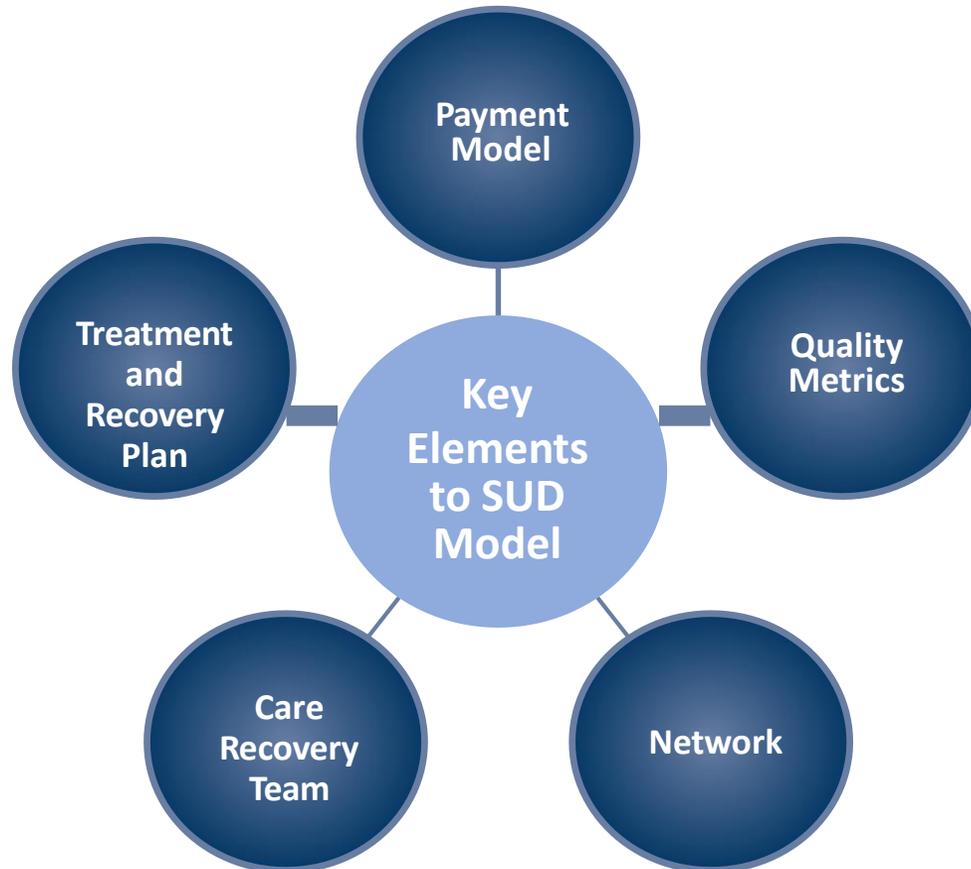
- Common episode definitions
- Quality & appropriateness of care
- Double-sided risk alignment
- Warranted performance
- Relevance for patients, purchasers and providers

## Conditions

- **Major Chronic Conditions:** Asthma, COPD, Diabetes, CAD, Hypertension, CHF, GERD, Arrhythmias, Heart Block, Crohn's Disease, Diverticulitis
- **Behavioral/ Mental Health:** Depression, Bipolar, ADHD, Schizophrenia, Substance Use Disorders
- **Ortho:** Low Back Pain, Osteoarthritis, Rheumatoid Arthritis
- **ENT:** Chronic Rhinitis; Sinusitis
- **Oncology:** Breast Cancer, Prostate Cancer, Lung Cancer

# Episode of Care Redesign: *Substance Abuse Disorder*

## KEY ELEMENTS OF “Addiction Recovery Medical Home”



### Phase 1

Pre-Recovery and Stabilization

### Phase 2

Recovery Initiation and Active Treatment

### Phase 3

Community-Based Recovery Management



**CONNECTICUT'S**  
**HEALTH**  
**ENHANCEMENT**  
**PROGRAM (HEP)**  
*State Comptroller's Office*



**National Alliance**  
**of Healthcare Purchaser Coalitions**  
Driving Innovation, Health and Value

# HEALTH ENHANCEMENT PROGRAM

- **Targets preventive care and chronic disease through:**
  - » Voluntary enrollment for employees
  - » Required age appropriate preventive screenings and care
  - » Lower co-pays for medication/care associated with five chronic diseases and conditions
  - » Chronic disease management education program
- **Lowers costs for participating/compliant employees by:**
  - » Waiving co-pays for preventive care and chronic disease management
  - » Reducing monthly premium share (\$100 per month)
  - » Waiving annual deductible (\$350 individual, \$1,400 family)



# CHRONIC DISEASE MANAGEMENT

- Targets five chronic diseases: Asthma, COPD, diabetes, hypertension, hyperlipidimia
- Lower co-pays for medications used for target chronic conditions

	<u>HEP Chronic Condition Drugs</u>	<u>Standard Drugs</u>	
Generic	\$0	\$5	*All Diabetes drugs have a \$0 co-pay
Preferred	\$5	\$20	
Non-Preferred	\$12.50	\$35	

- No co-pays for office visits related to chronic conditions
- Chronic Disease Education Program:
  - » Administered by third party vendor with dedicated staff of RNs
  - » Participant engagement monitored
    - Compliance with HEP program contingent upon minimum level of engagement
    - Engaged members eligible for \$100 annual bonus payment



# HEP 2.0

## October 2017 Go-Live

- Tiered PCP Networks
- Tiered Specialty Network
- Site of Service: Imaging and Labs
- Smart Shopper



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# VALUE BASED HEALTHCARE

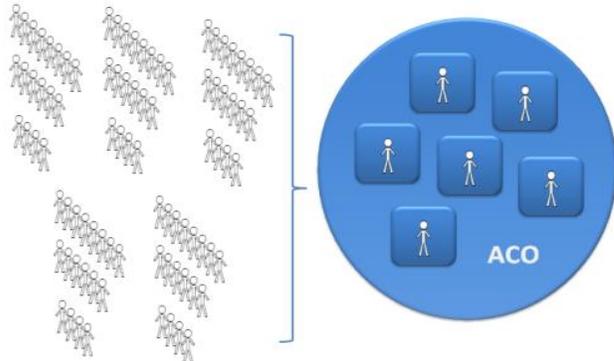
## System Delivery Reform

### Value-based Payment



## Demand-side Reform

### Value-based Insurance Design (VBID)



*Using incentives in benefits to encourage employees to be more value-conscious in their health behaviors and treatment choices*

Quality Performance Scorecard		30%	40%	50%	60%	70%	80%	90%
<b>Care Experience</b>								
	PCMH CAHPS							
<b>Care Coordination</b>								
	All-cause Readmissions							
<b>Prevention</b>								
	Breast Cancer Screening							
	Colorectal Cancer Screening							
	Health Equity Gap							
<b>Chronic &amp; Acute Care</b>								
	Diabetes A1C Poor Control							
	Health Equity Gap							
	Hypertension Control							
	Health Equity Gap							



# HEP 3.0

## New PBM Contract

- Utilized on-line Reverse Auction
  - Three Price and Specification-based Cycles
  - Accomplished Acquisition Cost and Best Price Guarantees
- Drug-specific Point of Sale Pass-through of Rebates/Revenue
- Prescribers to see Net Price to the Plan of Drugs
  - At time of prescribing
  - As a CDS Alert when Alternative Available at Significantly Lower Price



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# HEP 3.0

## Direct Episodes of Care/COE Contracting

- Will Attempt to Cover Much of our Spend Under Episodes of Care Contracts with Quality Improvement
- Highest Quality Will Be Designated COE
- Concierge Service w/ Incentives
  - Small Incentives for Above Average Provider Groups
  - Large Incentives for COEs
- Direct FFS Contracts with Hospitals for Remaining Services

## Primary Care Modernization Effort



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# USING TECHNOLOGY TO SUPPORT INITIATIVES

## Clinical Decision Support (CDS) Alerts

- Choosing Wisely
- Medicare Advantage Star
- E-Prescribing Transparency Tool

## HIE Real Time Link

- All Provider Groups Engaged in Bundles/COE
- Two-way Flow of Data/Analytics with Providers



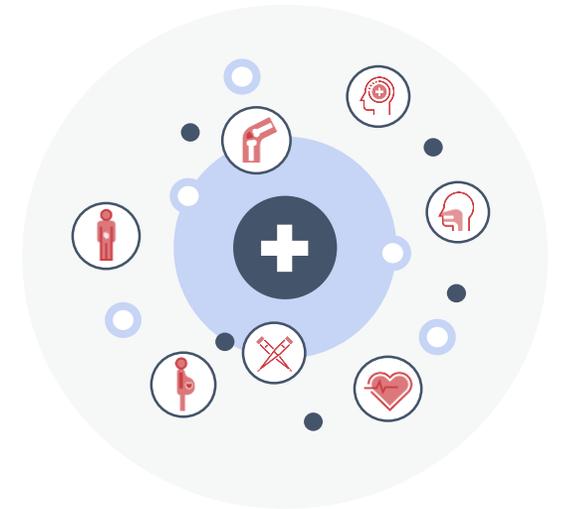
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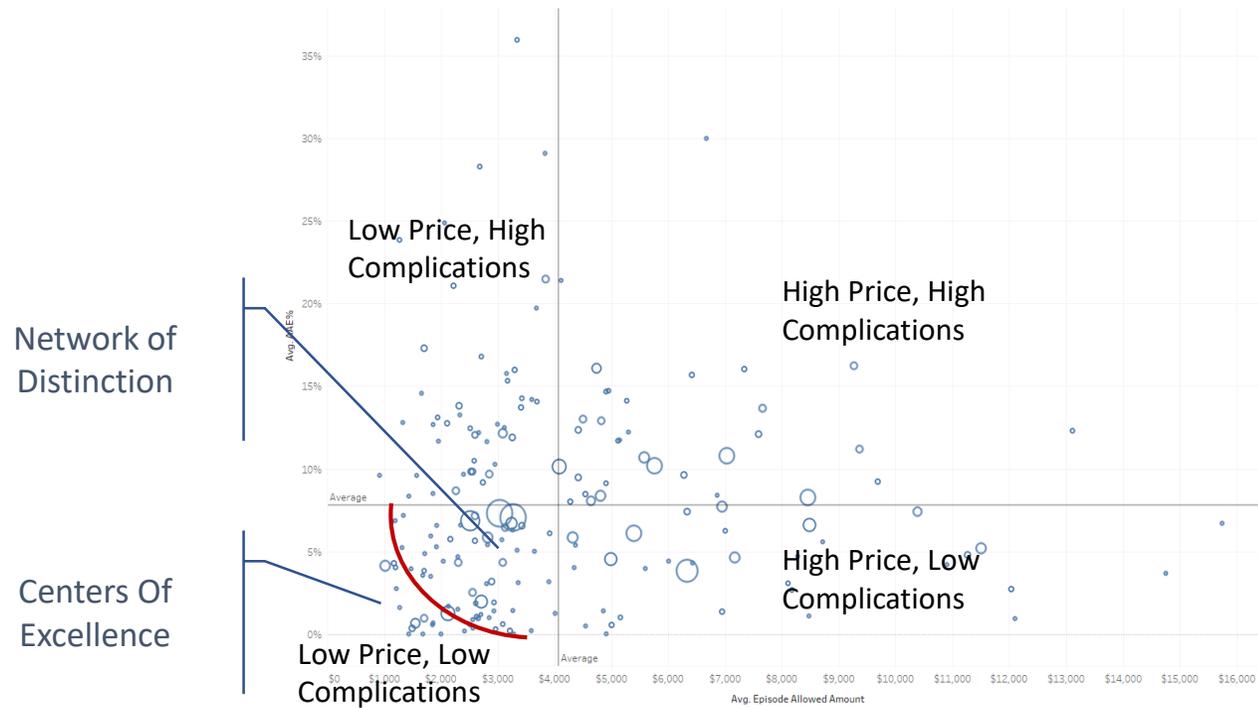
# Broad Program Scope Covering > 50% Of Spend

## Procedures & Conditions

- Orthopedic – from low back pain to joint replacements
- Cardiology – from diabetes to bypass surgery
- Gastroenterology – from Crohn’s disease to gastric bypass
- Behavioral and mental health – from depression to substance use disorders
- OB/Gynecology – from deliveries to hysterectomies

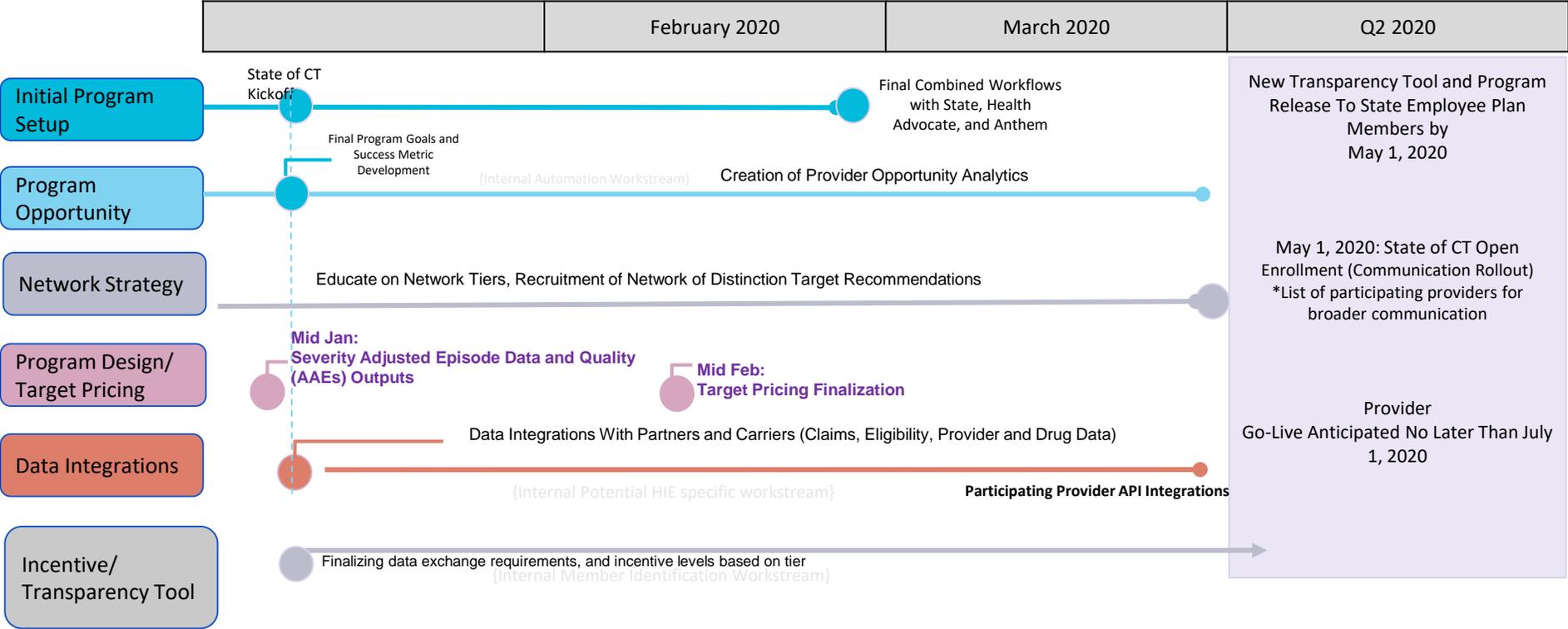


# Providers Will Be Tiered Based On Quality First

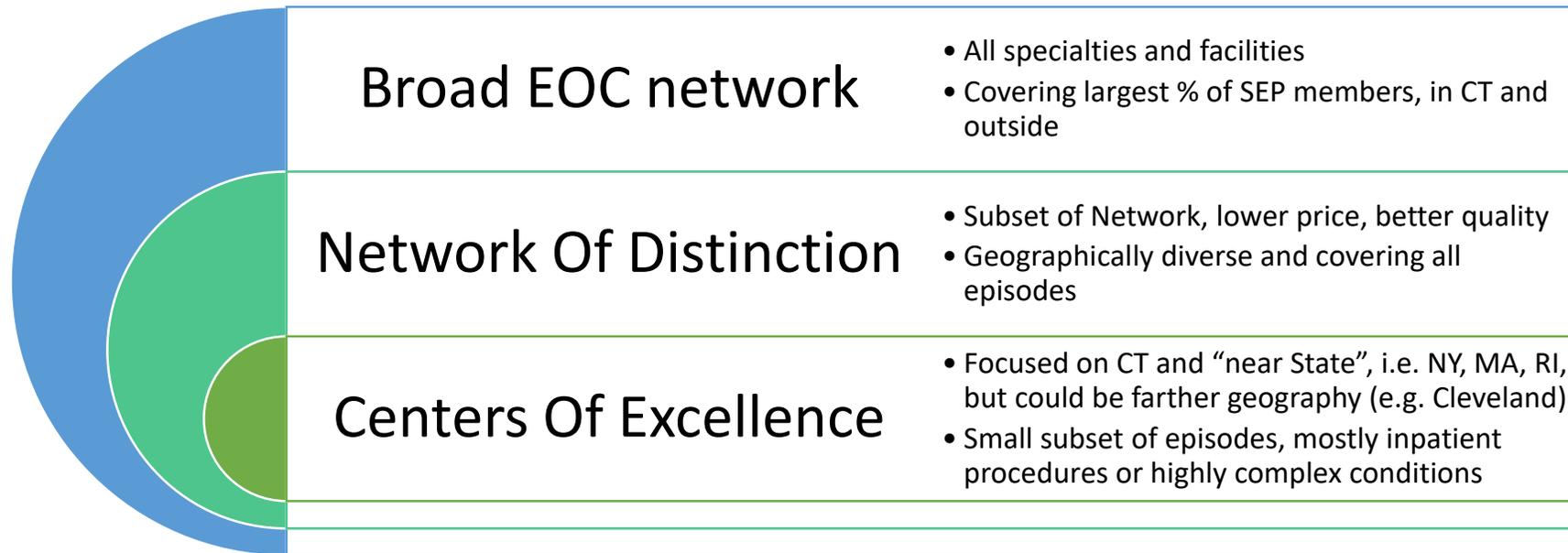


For any given condition or procedure there are high-value providers. Episode-of care contracted high-value providers will be in the Network of Distinction. Plan members will have cash incentives to get care from NOD providers.

# Timelines and Milestones *Actively Driving towards Launch*



# Network Tiering



# “QUESTIONS?”



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