Legislative Commission on Primary Care Workforce Issues

September 26, 2019 2:00-4:00pm at the NH Hospital Association –Conference Room 1, 125 Airport Road, Concord

Call in information:

(267) 930-4000

Participant Code: 564-395-475

Agenda

2:00 - 2:05	**Welcome and Introductions**
2:05 – 2:25	**Future of the Commission survey results & legislative language, Endowment for Health/JUA update, State Budget Update, New Commission website**
2:25 – 3:05	**Patients as Partners in Transformation in the Rural Setting** – Mary Reeves, MD, Transforming Clinical Practice Initiative National Faculty
3:05 – 4:00	**From Consolidation to MCOs- the Ever-Changing Health Care Landscape: Impact on primary care practice** - Lucy Hodder, JD, Director of Health Law and Policy, Institute for Health Policy and Practice

Next meeting: Thursday October 24, 2:00-4:00pm

State of New Hampshire
COMMISSION ON PRIMARY CARE WORKFORCE ISSUES

DATE: September 26, 2019

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Hospital Association (Rm 1)

Meeting Notes

TO: **Members of the Commission and Guests**

FROM: Danielle Weiss

MEETING DATE: September 26, 2019

Members of the Commission:
Rep. Polly Campion, NH House of Representatives
Laurie Harding – Chair
Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair
Mike Auerbach, New Hampshire Dental Society
Mary Bidgood-Wilson, ARNP, NH Nurse Practitioner Association
Donald Kollisch, MD, Dartmouth-Hitchcock Medical Center
Kristina Fjeld-Sparks, Director, NH AHEC
Jeanne Ryer, NH Citizens Health Initiative
Mike Ferrara, Dean, UNH College of Health and Human Services
Trinidad Tellez, M.D., Office of Health Equity
Scott Shipman, MD, Director, Primary Care Affairs and Workforce Analysis, AAMC
Tyler Brannen, Dept. of Insurance
Pamela Dinapoli, NH Nurses Association
Diane Castrucci, NH Alcohol & Drug Abuse Counselors Association

Guests:
Danielle Weiss, Health Professions Data Center Manager, Rural Health and Primary Care
Paula Smith, SNH AHEC
Anne Marie Mercuri, QI Nurse – Maternal and Child Health Section, DPHS
Barbara Mahar, New London Hospital
Phil Heywood, Executive Director, Northeast Osteopathic Medical Education Network, UNE
Jan Thomas, UNH, Health Policy & Practice
Geoff Vercauteren, Director of Workforce Development, Catholic Medical Center
Ann Turner, Integrated Healthcare, CMC
Vanessa Stafford, NHHA
Lucy Hodder, JD, Director of Health Law and Policy, Institute for Health Policy and Practice
Mary Reeves, MD, Transforming Clinical Practice Initiative National Faculty

Meeting Discussion:

2:00 - 2:10 **Welcome and Introductions** – Laurie Harding – Chair, NH Commission on Primary Care Workforce Issues

Mary Reeves is visiting from CO
- Presented at JSI/CHI yesterday on patient and family advisory committees
- Is presenting today on Patient Family Advisory Councils (PFACs)

- Suggests having a patient advocate as a Commission member

2:05 – 2:25 **Future of the Commission survey results & legislative language, Endowment for Health/JUA Update, State Budget Update, New Commission Site –** Laurie, Alisa

- Survey results to determine the future of the Commission are posted: https://public.tableau.com/profile/danielle.weiss#!/vizhome/Results_15694414079790/FutureoftheCommission?publish=yes

- The NH General Court Commission page (http://www.gencourt.state.nh.us/statstudcomm/committees/152/default.html) now contains the link to the new Commission site on the NH DHHS site (https://www.dhhs.nh.gov/dphs/bchs/rhpc/leg-comm/index.htm)
  - A Committee on Commissions has been legislatively established to review Commission activities
    - The new site will better document the Commission's activities throughout the years
  - Posting materials on the GenCourt site proved too difficult
    - Required a request from a legislator
    - The site was not user friendly
      - Difficult for the public to navigate and find all meeting materials posted
    - Only posted four years' worth of materials
  - New site has easy-to-read tables with meeting topics listed
    - Currently 2018 and 2017 is posted but all years will be up by the end of the year
      - 2019 is scheduled to be up within the month of October

- Endowment for Health hosted symposium to discuss re: JUA funds at Manchester Country Club
  - Commission members participated
  - $100k in perpetuity
  - Concern in bottleneck
    - Increasing number of students in site without residencies to place them
  - Using funds to establish sites for clinical placements
  - Many of the ideas raised echoed what is communicated at Commission meetings
    - The right people are at the table

- The budget was voted on yesterday and passed
- $3.25m for State Loan Repayment Program (SLRP), including a position for the program and a position for the Health Professions Data Center
  - Funds will be non-lapsing, meaning the funds will carry over to the next fiscal year
    - This will allow the program to move money around and use it
    - Providers that default, can put money back and fund someone else
  - Funding is likely for 40-something that are on waitlist
    - Applicants will be asked to apply to National Health Service Corps (NHSC) first before SLRP
    - A recent Health Professional Shortage Area rescore makes more areas competitive for federal repayment programs

2:25-3:05 **Patients as Partners in Transformation in the Rural Setting** - Mary Reeves, MD, Transforming Clinical Practice Initiative National Faculty

Refer to presentation "Patients as Partners in Transformation in the Rural Setting."

3:05-4:00 **From Consolidation to MCOs – the Ever-Changing Health Care Landscape: Impact on Primary Care Practice** – Lucy Hodder, JD, Dir. Of Health Law and Policy, Institute for Health Policy and Practice

Refer to presentation "The Changing Healthcare Landscape."

Next meeting: Thursday October 24, 2:00-4:00pm

PATIENTS AS PARTNERS

IN TRANSFORMATION IN THE RURAL SETTING

MARY REEVES MD

TCPI NATIONAL FACULTY

Citizen's Health Initiative Symposium

September 25, 2019

Concord, NH

OBJECTIVES

1. Discuss applying principles of practice transformation to the unique characteristics of a rural practice.

2. Learn how patient family advisory councils (PFACs) can be implemented in health care settings.

First Street Family Health (FSFH)

http://www.firststfamilyhealth.com

- Rural 4 doctor, 2 PA physician-owned Family Medicine Clinic in Salida, Colorado (84 years old)
- We have 8400 empanelled, risk stratified patients.
- Transformation since 2012 with CPCi (Comprehensive Primary Care initiative) – now, thriving in comprehensive primary care – advanved quality care model so you don't have to do MPS (CPC+ track 2-risk)
- PFAC started August 2014
- Case study for AHRQ - *Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families*

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/partnering-1.pdf

And me…

- I practiced full spectrum Family Medicine at FSFH from 1993 – 2015 (now retired)
- Physician lead for CPCi 2012 – 2015 –> realized value of PFAC for our practice
- National Faculty for TCPI since December 2015 -> realized value of PFE as a national strategy for transformation

https://edhub.ama-assn.org/steps-forward/module/2702611?resultClick=1&bypassSolrId=J_270

PFAC: HOW WE GOT STARTED

- National Partnership for Women and Families provided us with the foundation and structure to begin.
- Identified practice members for the council including 1 physician, 1 RN care coordinator, one member from front office, back office and MA staff.
- Recruit patient/family members with focus to fairly represent populations in regards to payer source, age, gender, ethnicity, etc.
- Create ground rules re: confidentiality and meeting protocol, etc.

RESOURCES – AMA

STEPS FORWARD MODULE

Forming a Patient Family Advisory Council (PFAC)

CME modules:

https://edhub.ama-assn.org/steps-forward/module/2702594?resultClick=1&bypassSolrId=J_2702594

3 MONTHS LATER, THE FIRST PFAC MEETING

- The PFAC identified issues that were important to patients & the practice and worked together to solve them. The first project will set the tone and build confidence and trust.

- Some topics were generated by the patients and some by the practice

- Now— anytime an issue comes up in the practice, we start by "running it by the PFAC" for input.

FSFH PFAC: HOW IT WORKS

- We met monthly at the beginning to get off to a good start, now we meet quarterly.
- Meeting - 5:30-7 pm in a community space provided by one of the members
- Food! Best chance of participation if you feed us!
- Daycare provisions help

5 YEARS LATER…OUR PFAC IS A VALUABLE PARTNER AT FSFH

- Started by solving a persistent front desk phone reception problem
- Re-vamped new patient forms
- Performed regular clinic walk-throughs
- Re-designed our website
- Currently working on Diabetes QI projects

NEXT…?

WHY PARTNER W/ PATIENTS AND FAMILIES?

- Bring important perspectives
- Teach how systems really work
- Keep staff grounded in reality
- Provide timely feedback and ideas
- Inspire and energize staff
- Lessen the burden on staff to fix the problems… staff do not have to have all the answers
- Bring connections with the community
- Offer an opportunity to “give back”
- **Prioritize precious resources**

MORE REASONS TO PARTNER…

- By definition – the patient perspective on your practice
- Partnership is superior to hiring consultants
- Putting patients first is always the most practical investment providers can make to transform their practices. (Best ROI)
- Accelerates Practice Transformation
- Best way to increase patient or family member's health literacy and engagement
- Prevent burn-out

“Patients and their families are an abundant source of wisdom as we navigate the stormy seas of health care delivery. To go it alone without their partnership is foolish and unwise. With patients as equal partners in the journey of health care transformation, our work together is more fulfilling, more meaningful, and more likely to help them reach their health goals.”

Dr. Joseph Bianco, MD, FAAFP, Director of Primary Care for Essentia Health

Patient-Centered
Primary Care
COLLABORATIVE

PARTNERING TRANSFORMS EVERYTHING

- My transformation from skeptic to spokesperson
- Improved operational performance
- Low cost – high value
- Engaged patients have better outcomes
- Patients take the transformation out of the practice
- This new normal is transforming U.S. healthcare system

SO, LET'S CHANGE THE ASSUMPTIONS

Assume *patients* are the *experts* on their own experience & that they have information *you need to hear and act on.*

Understand that families are primary partners in a patient's experience and health.

OPPORTUNITIES TO PARTNER W/ PATIENTS

Opportunity	Examples
1. At the Point of Care	Shared decision-making Safe medication use, “med” management Patient “activation” Patient Portal
2. In the Community	Wellness programs Support groups Community partnerships

MORE OPPORTUNITIES TO PARTNER W/ PATIENTS

Opportunity	Examples
3. At the Organizational Level	PFACs, patient surveys Serving on the Board of Directors Care process mapping Clinical QI teams, oversight, strategy Informing best practices
4. Contributing to Public Policy	Partnering with advocacy groups, public health & government affairs, publishing

THE VALUE OF A PFAC

- Adds a “department” to a practice totally devoted to improving the practice.
- Provides the infrastructure to bring patients into partnership for transformation – assuring patient centered efforts and accelerating transformation.
- PFAC started 8/2014 has generated operational process improvements totaling > $100,000

RESOURCES – PCPCC

PATIENT CENTERED PRIMARY CARE COLLABORATIVE

6 Steps to Creating a Culture of Person and Family Engagement in Health Care – a Toolkit for Practices

https://www.pcpcc.org/sites/default/files/resources/PCPCC-%20Planetree%20PFE%20Culture%20Change%20Toolkit%20050517.pdf

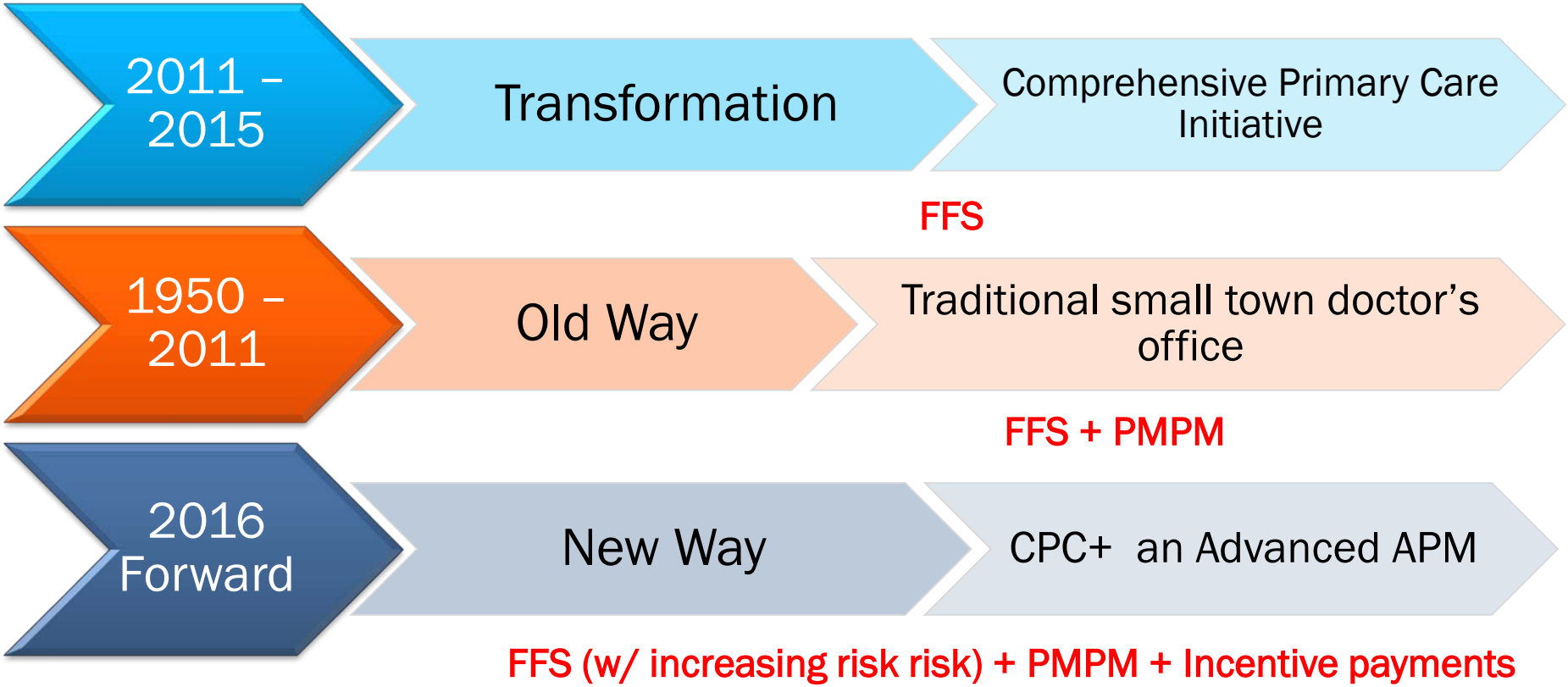
HOW IT WORKED

INVEST in people and infrastructure with CPCI funds – an additional 13% of budget.

IMPROVED PERFORMANCE through care management, population health, care team redesign.

Partnering w/ Patients strategies are a low tech/low cost way to accelerate the process of transformation.

TIMELINE OF TRANSFORMATION



Exemplar Practice: What FSFH looks like now

- Teams are key – Clinical teams and Practice teams are a new way to care for patients and run a practice
- Payment is complex – Care Management Fee is risk adjusted PMPM payment, Performance Based Incentives linked to pt. exp., CQMs and utilization, and FFS w/ a portion at risk
- Data drives everything - > 85% benchmark on all measures qualify for higher payment levels, access data reviewed in huddles weekly, falls
- Access – multiple care paths allow the practice to remain open to new patients
- Patient Voice – PFAC meets quarterly and is an integral part of the practice

SUSTAINABILITY=PAYMENT REFORM+JOY IN WORK

Payment Reform because it's not possible to transform practice to a patient centered culture on the current "hamster wheel" of FFS.

and

Joy in Work because it's not possible to sustain the work if the workforce if burned out.

WE NEED TOOLS FOR BOTH

PARTNERING WITH PATIENTS IS SUCH A TOOL

- Partnering with patients accelerates practice transformation
- Partnering with patients promotes joy in work
- Partnering with patients both relies on and improves their Health Literacy

Patient & Family Engagement:

Central to QPP Success

yment Program—
uality Measures (60% of MIPS score)
- Patient experience
- Medication management
- Functional status
- Advanced Care Plan

dvancing Care Information (25% of MIPS score)
- Patient portals, Summary of Care, e-Prescribing, patient-specific health education

provement Activities (15% of score)
- Engage patients and families to guide improvement in the system of care
- Regularly assess the patient experience through surveys, advisory councils and/or other mechanisms
- Shared decision making

ntered
Care
RATIVE

X4 HEALTH

QPP is a **mechanism** to pay YOU for value.

WHAT IS THE RETURN ON INVESTMENT?

- Increased patient engagement and satisfaction
- Reduced ER visits
- Reduced re-admissions
- Better screening and care of chronic diseases
- Decreased medication errors

ALL IMPORTANT METRICS IN APMs

THANK YOU!

Contact Information

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Twitter: @MarySalida

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The Changing Healthcare Landscape

Primary Care Workforce Commission
September 26, 2019

By Lucy C. Hodder

Lucy.hodder@unh.edu

Professor of Law, UNH School of Law

Institute for Health Policy and Practice

Today

- NH News
  - Budget
  - New MCO contracts
  - Hospital happenings
  - Latest with Payment Reform
- US Landscape

A VISION FOR PATIENT-CENTERED PRIMARY CARE:

Taken From: Policies to Transform Primary Care: The Gateway to Better Health and Health Care; Center for Consumer Engagement in Health Innovation; Garrett, Hwang, Miller, Howitt, and Maass; December 2018

"A transformed health system that meets the health needs of all people must start with a re-envisioning of how we deliver and pay for primary care in the United States. Primary care serves as the gateway to the health system for many people and their source of consistent health system contact. If we can utilize primary care to catch chronic health issues or social needs early and address those needs in a coordinated and comprehensive way, it is possible to lower health care costs, improve health outcomes and patient satisfaction, and begin to tackle health disparities.

Patient Centered Primary Care Collaborative Recommendations

In August 2018, the Patient Centered Primary Care Collaborative (PCPCC) published its "Consensus Recommendations on Increasing Primary Care Investments". One of the recommendations was that "primary care investment should be tracked and reported through a standardized measure." They noted that "long-term, systemic change demands a system that ensures a standardized measurement at the health plan level across all payers to track and publicly report primary care investment. This data is essential to demonstrate that increases in investment lead to improved quality."

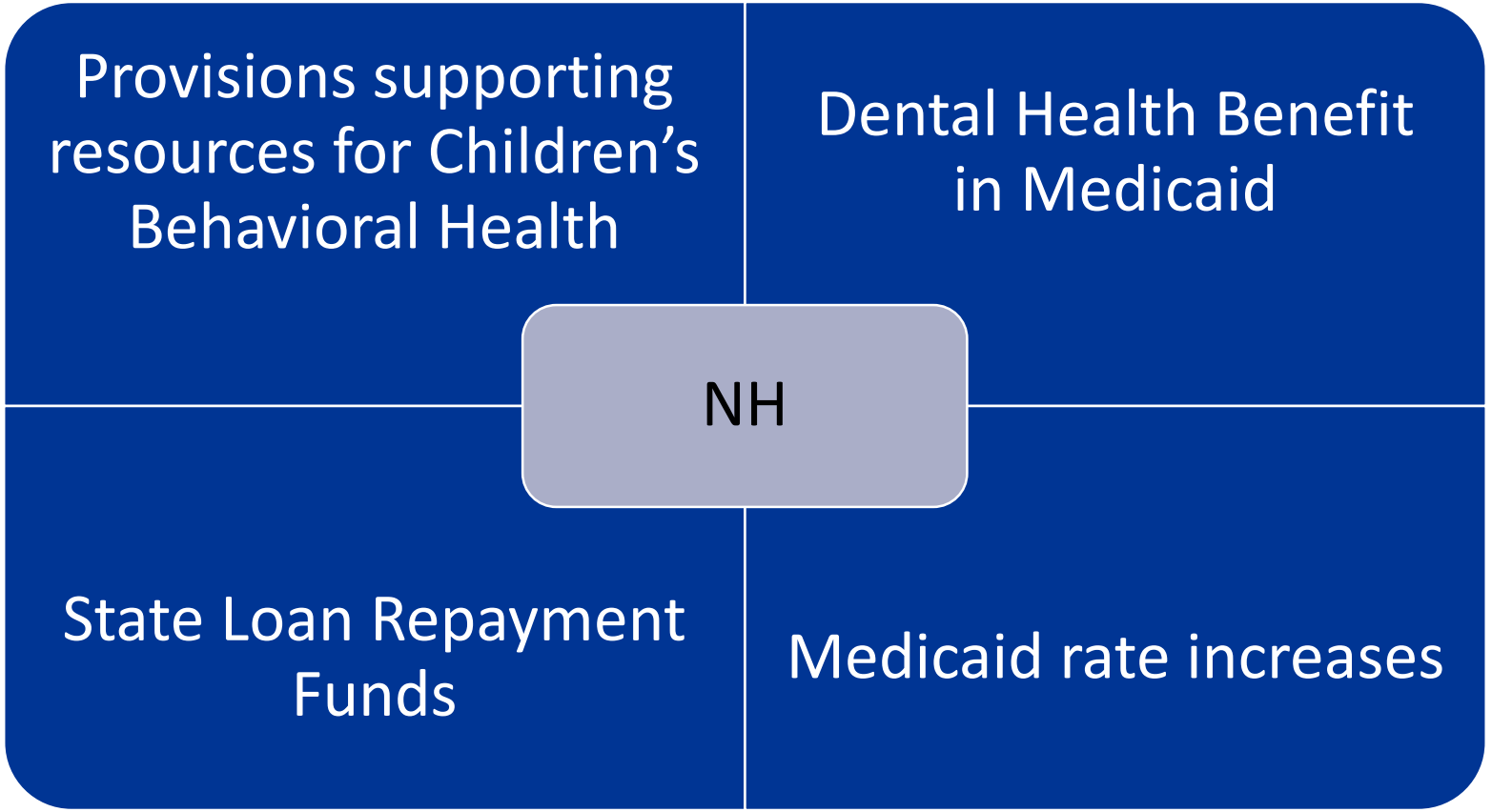
What are the Sustainability Goals of the US Centers for Medicare and Medicaid? *Value and transparency*

- "Americans enjoy the benefits of the best healthcare providers and innovators in the world. Yet while the volume of care consumed by American patients has not increased dramatically compared to similar economies, the cost of care in the United States has accelerated at an alarming pace."
- "Healthcare costs are growing faster than the U.S. GDP, making it more difficult with each passing year for CMS to ensure healthcare for generations to come. The status quo is simply unsustainable."
- "The 15 percent of beneficiaries with 6 or more chronic conditions accounted for 51 percent of spending in 2015".
- "CMS's Central mission is to transform the health care delivery system to one that moves away from delivering volume of services to one that delivers value for patients – **one that provides high quality accessible care, at the lowest cost."**

Relative Value?

- PCPs salary increases (3.4%) v. SPS salary increases (4.4%) in 2017-2018 (Medscape)
- Biggest increases were in ER, cardiology and urology
- Top paid:
  - Orthopedics
  - Plastic surgery
  - Otolaryngology
  - Cardiology
  - Dermatology
- Primary care physicians generate almost as much revenue for hospital systems as specialists

NH State Law Developments – Budget Finally!



"ER visits and hospital admissions should be considered failures of the healthcare system until proven otherwise."

Atul Gawande, Hotspotters, 2011

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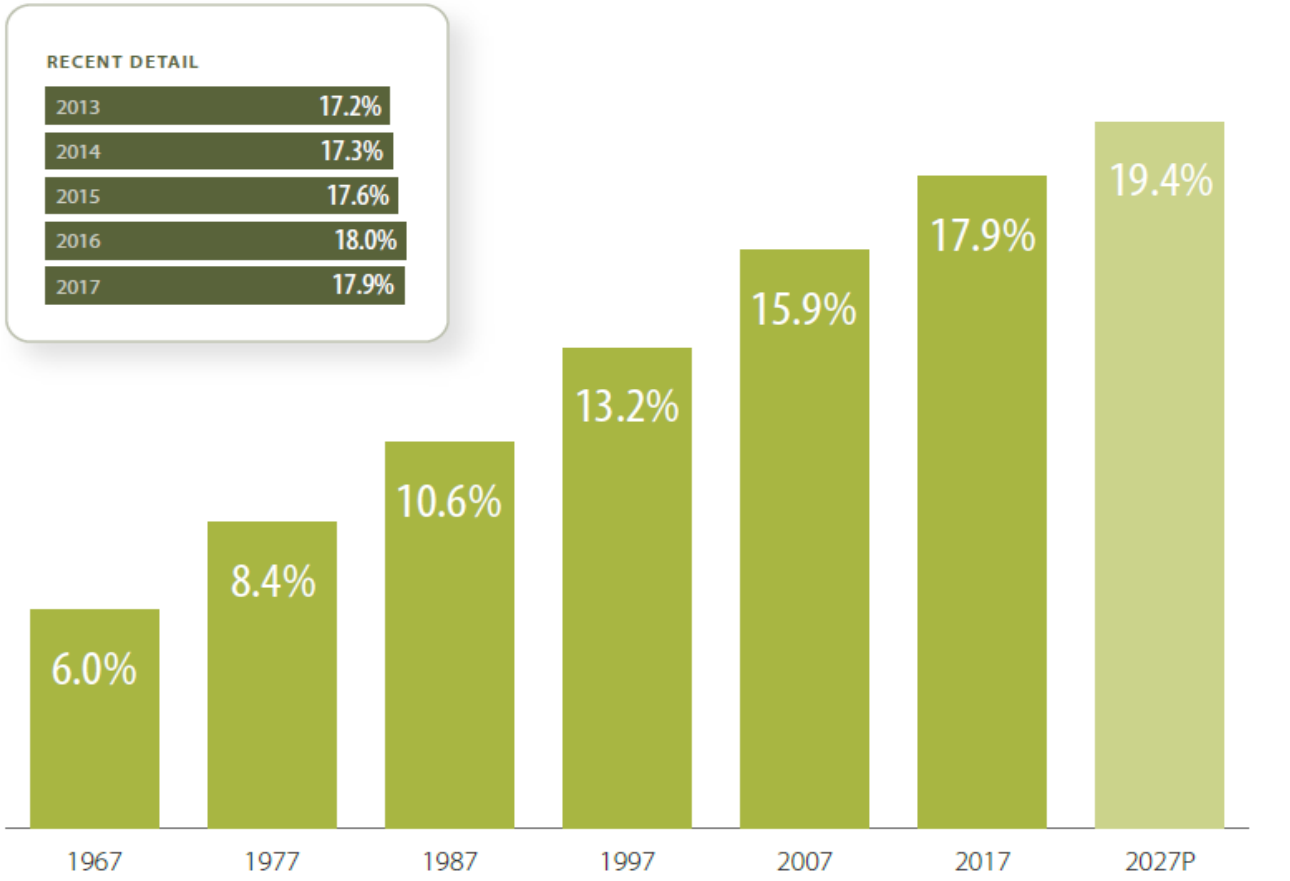
Federal Health care spending

Health Spending as a Share of GDP

United States, 1967 to 2017, Selected Years, and 10-Year Projection



Notes: *Health spending* refers to national health expenditures. Projections are shown as *P* and are based on current law as of December 2018. The 2017 figure reflects a 4.2% increase gross domestic product (GDP) and a 3.9% increase in national health spending over the prior year. See page 30 for a comparison of economic growth and health spending growth.

Sources: National Health Expenditure (NHE) historical data (1960–2017), Centers for Medicare & Medicaid Services (CMS), www.cms.gov; and NHE projections (2018–27), CMS, www.cms.gov.

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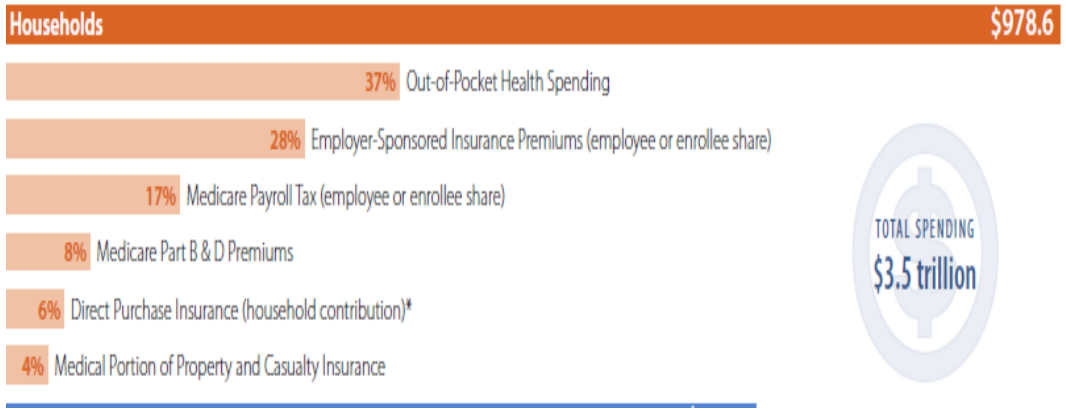
Who pays the bills?

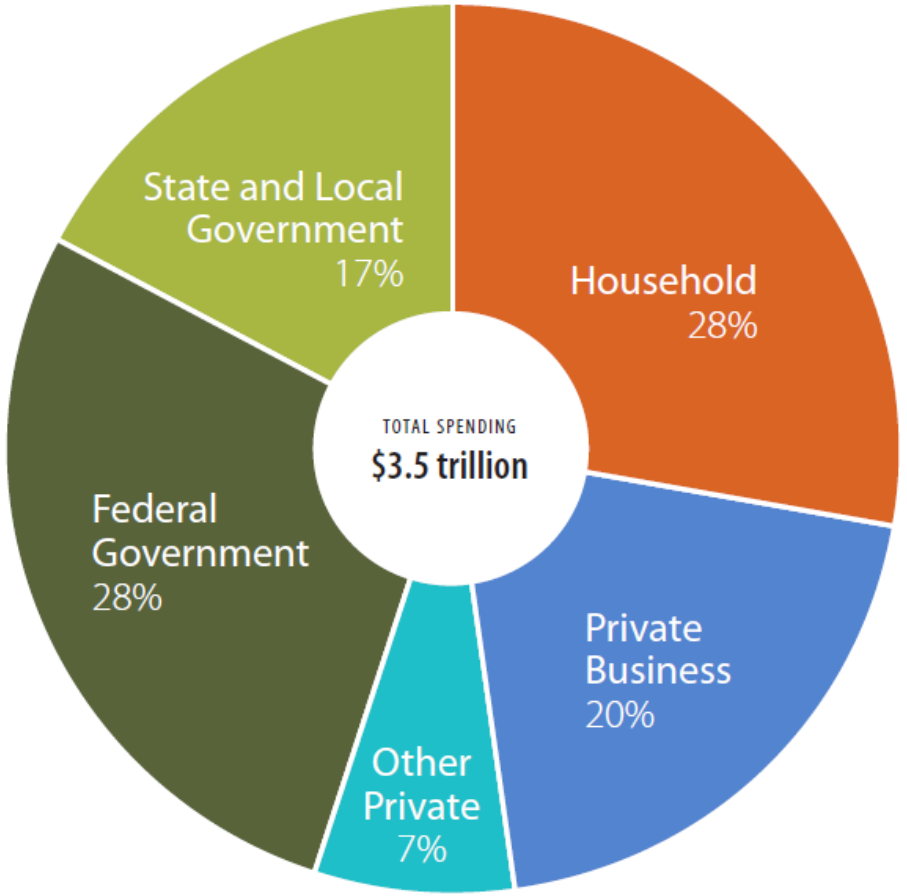
Private spending makes up 55% of our health spending;

Federal government makes up 28%



Health Spending Distribution, by Sponsor

United States, 2017



Notes: *Health spending* refers to national health expenditures. *Sponsors* are the entities that are ultimately responsible for financing the health care bill. See page 18 for trend data.
Source: National Health Expenditure historical data (1960–2017), Centers for Medicare & Medicaid, www.cms.gov.

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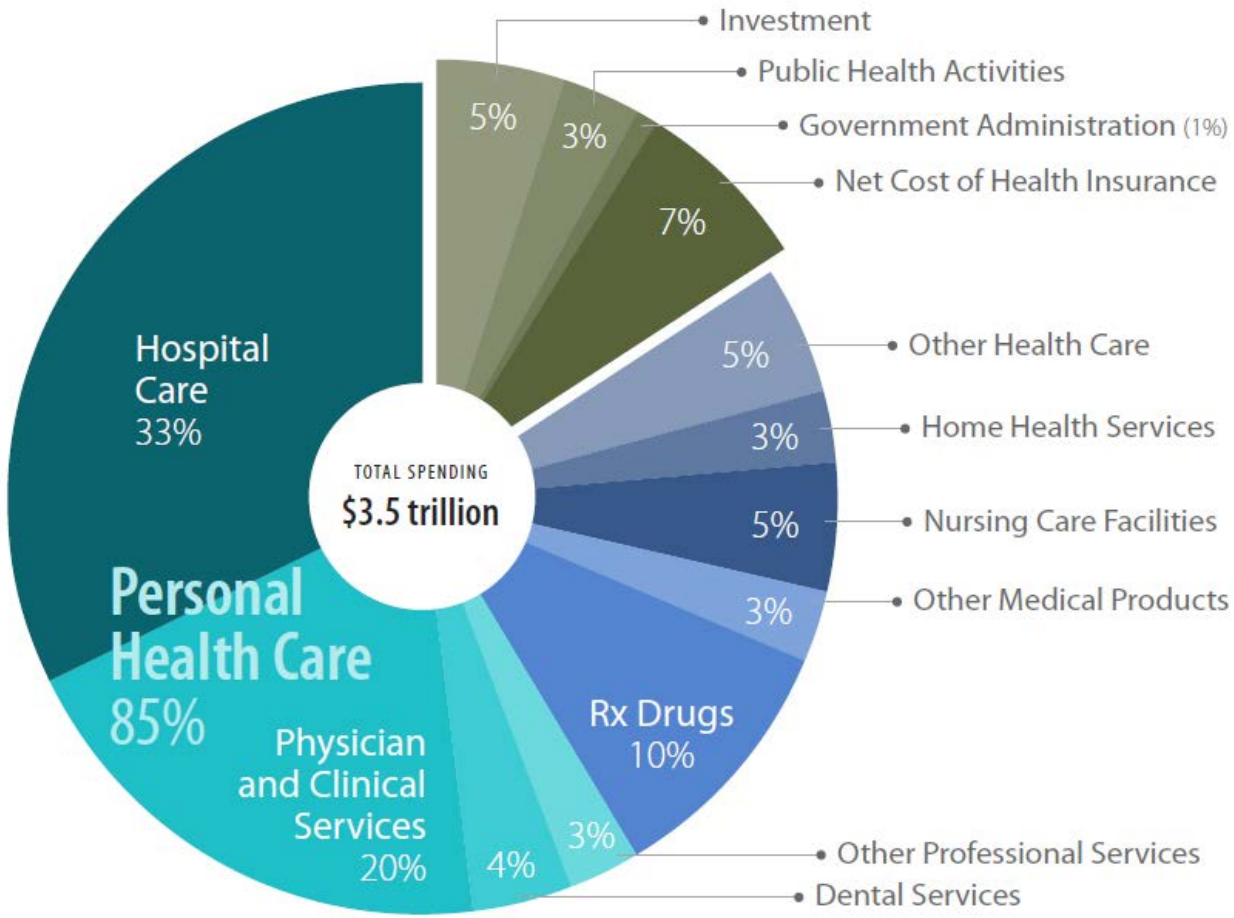
Hospital and physician services combined accounts for over half of health care spending.

Health Spending Distribution, by Category

United States, 2017



Notes: *Health spending* refers to national health expenditures. Segments may not total 100% due to rounding. For additional detail on spending categories, see page 15 and Appendix A.
Source: National Health Expenditure historical data (1960–2017), Centers for Medicare & Medicaid, www.cms.gov.

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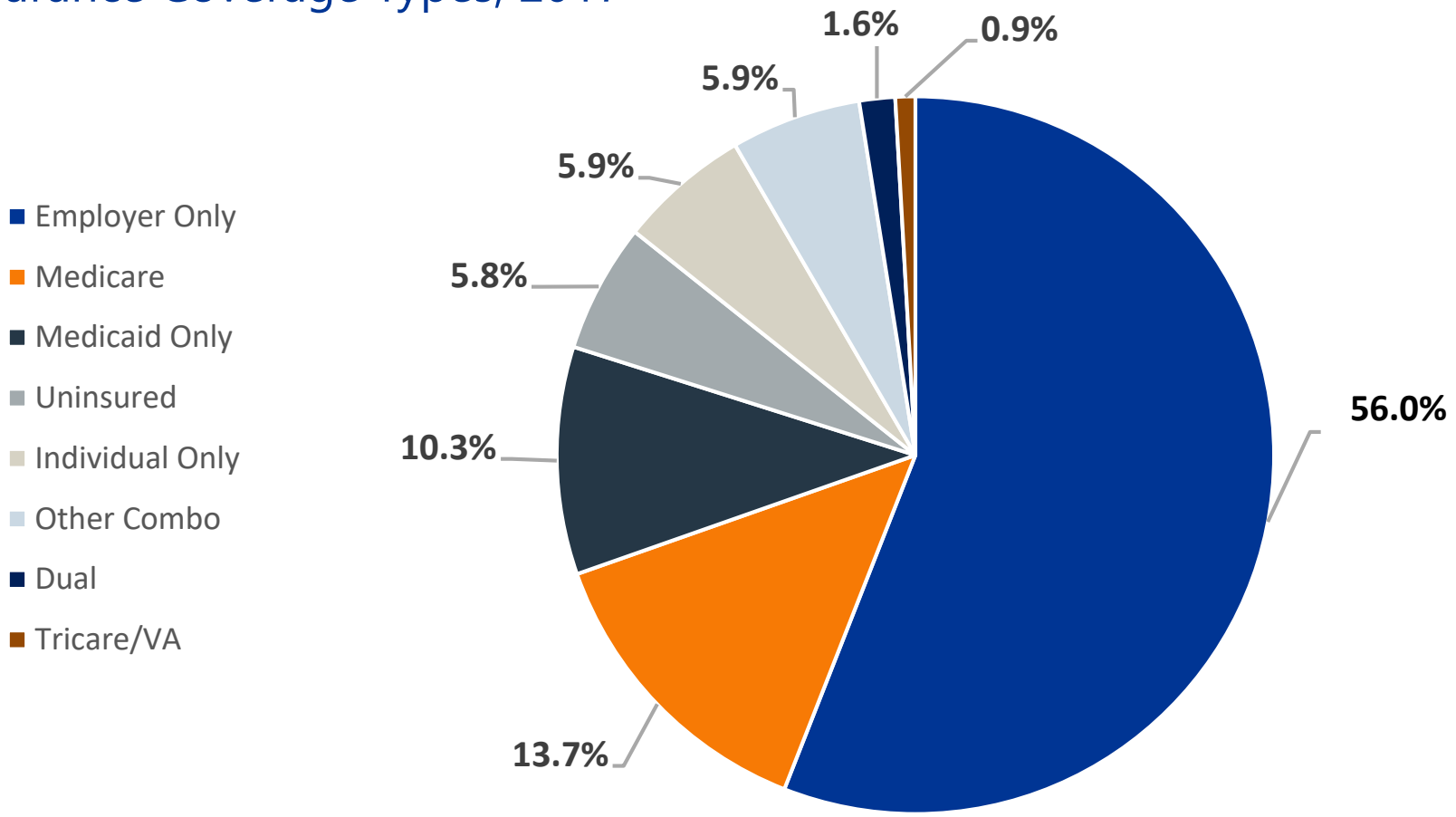
In NH, what's our source of coverage?

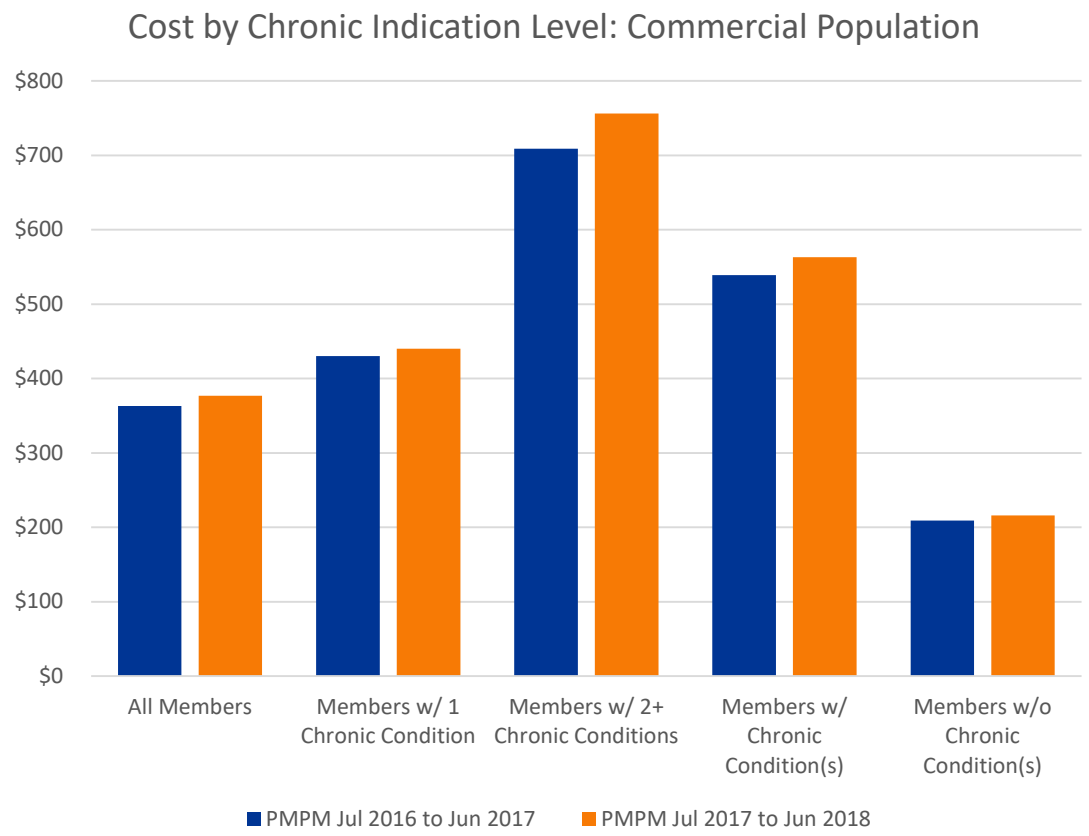
NH Insurance Coverage Types, 2017



Source: IHPP Analysis of American Community Survey Data from US Census; https://www.census.gov/acs/www/data/data-tables-and-tools/

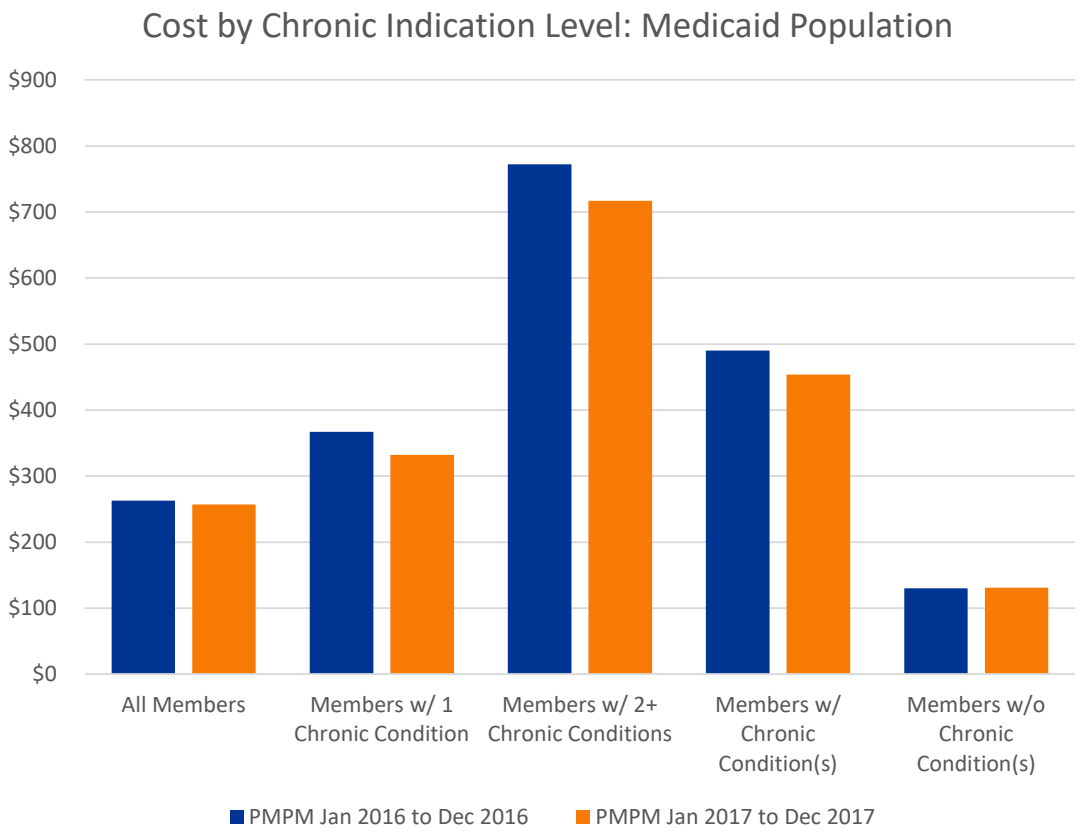
Cost by Chronic Condition Indication: Commercial Population

Chronic Indication Level	% of Member Months Jul 2016 to Jun 2017	PMPM Jul 2016 to Jun 2017	% of Member Months Jul 2017 to Jun 2018	PMPM Jul 2017 to Jun 2018
All Members	100.00%	$363	100.00%	$377
Members with 1 Chronic Condition	28.47%	$430	28.38%	$440
Members with 2+ Chronic Conditions	18.21%	$709	17.98%	$756
Members with Chronic Condition(s)	46.68%	$539	46.36%	$563
Members without Chronic Condition(s)	53.32%	$209	53.64%	$216



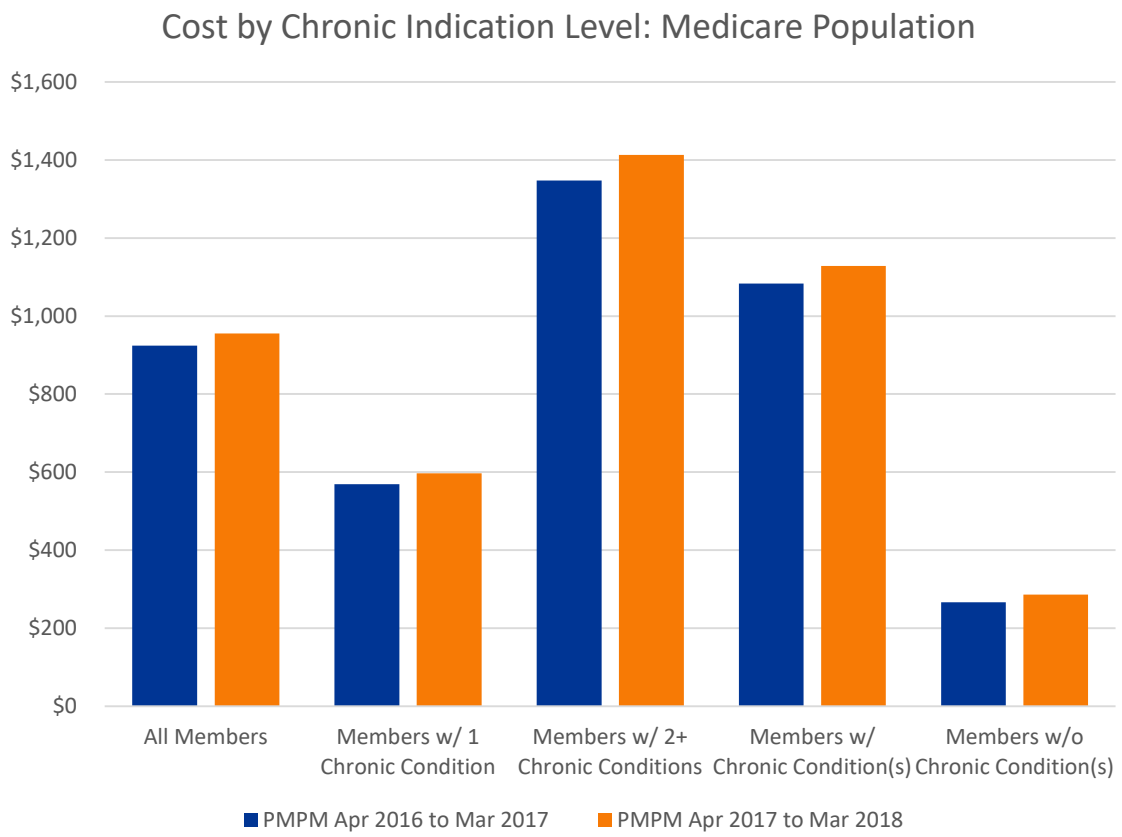
Cost by Chronic Condition Indication: Medicaid Population

Chronic Indication Level	% of Member Months Jan 2016 to Dec 2016	PMPM Jan 2016 to Dec 2016	% of Member Months Jan 2017 to Dec 2017	PMPM Jan 2017 to Dec 2017
All Members	100.00%	$263	100.00%	$257
Members with 1 Chronic Condition	25.93%	$367	26.74%	$332
Members with 2+ Chronic Conditions	11.26%	$772	12.34%	$717
Members with Chronic Condition(s)	37.19%	$490	39.08%	$454
Members without Chronic Condition(s)	62.81%	$130	60.92%	$131



Cost by Chronic Condition Indication: Medicare Population

Chronic Indication Level	% of Member Months Apr 2016 to May 2017	PMPM Apr 2016 to May 2017	% of Member Months Apr 2017 to May 2018	PMPM Apr 2017 to May 2018
All Members	100.00%	$924	100.00%	$955
Members with 1 Chronic Condition	27.27%	$569	27.71%	$597
Members with 2+ Chronic Conditions	53.18%	$1,347	51.70%	$1,413
Members with Chronic Condition(s)	80.45%	$1,083	79.41%	$1,128
Members without Chronic Condition(s)	19.55%	$267	20.59%	$286



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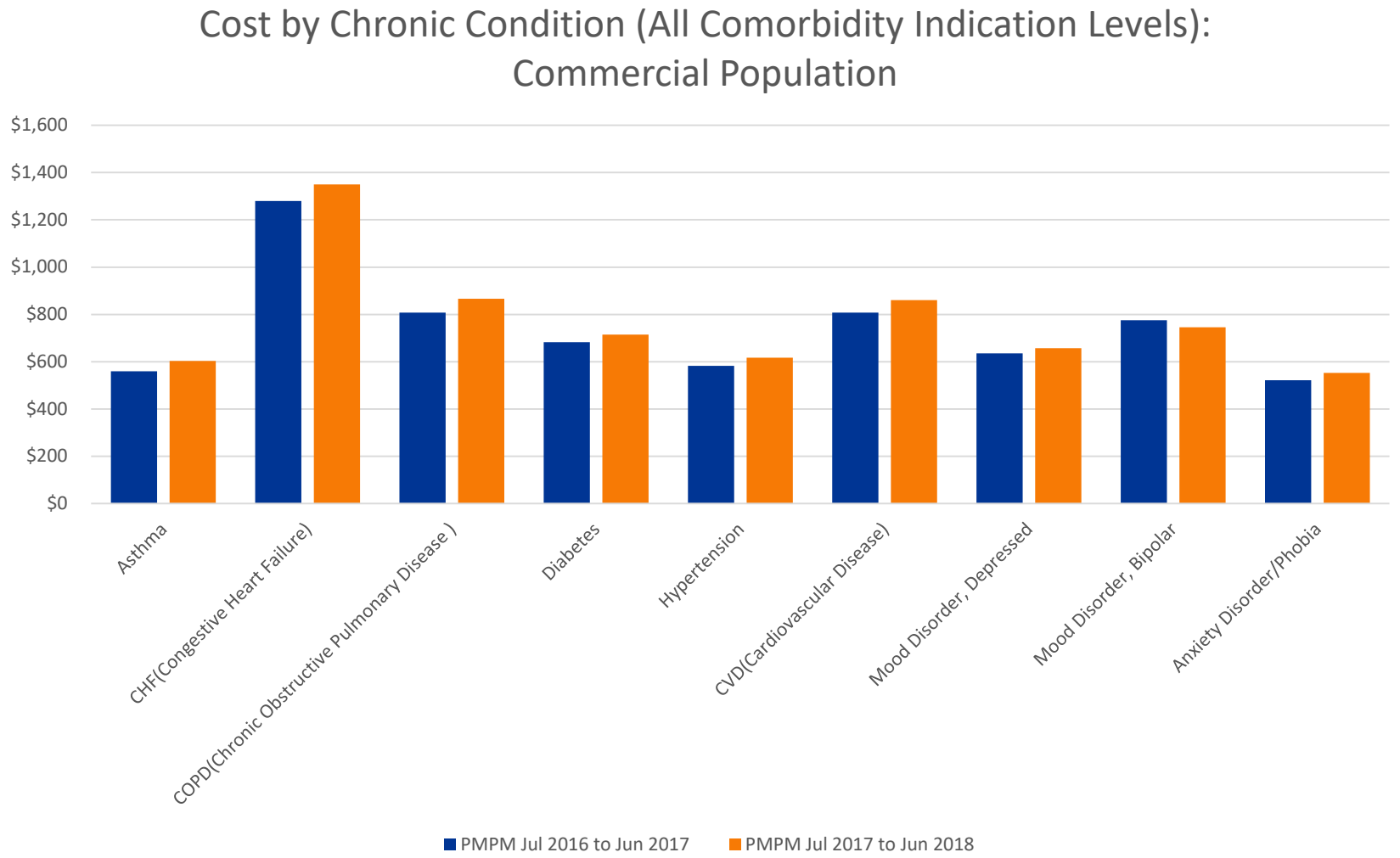
Cost by Chronic Condition and Comorbidity Level:

Commercial Population



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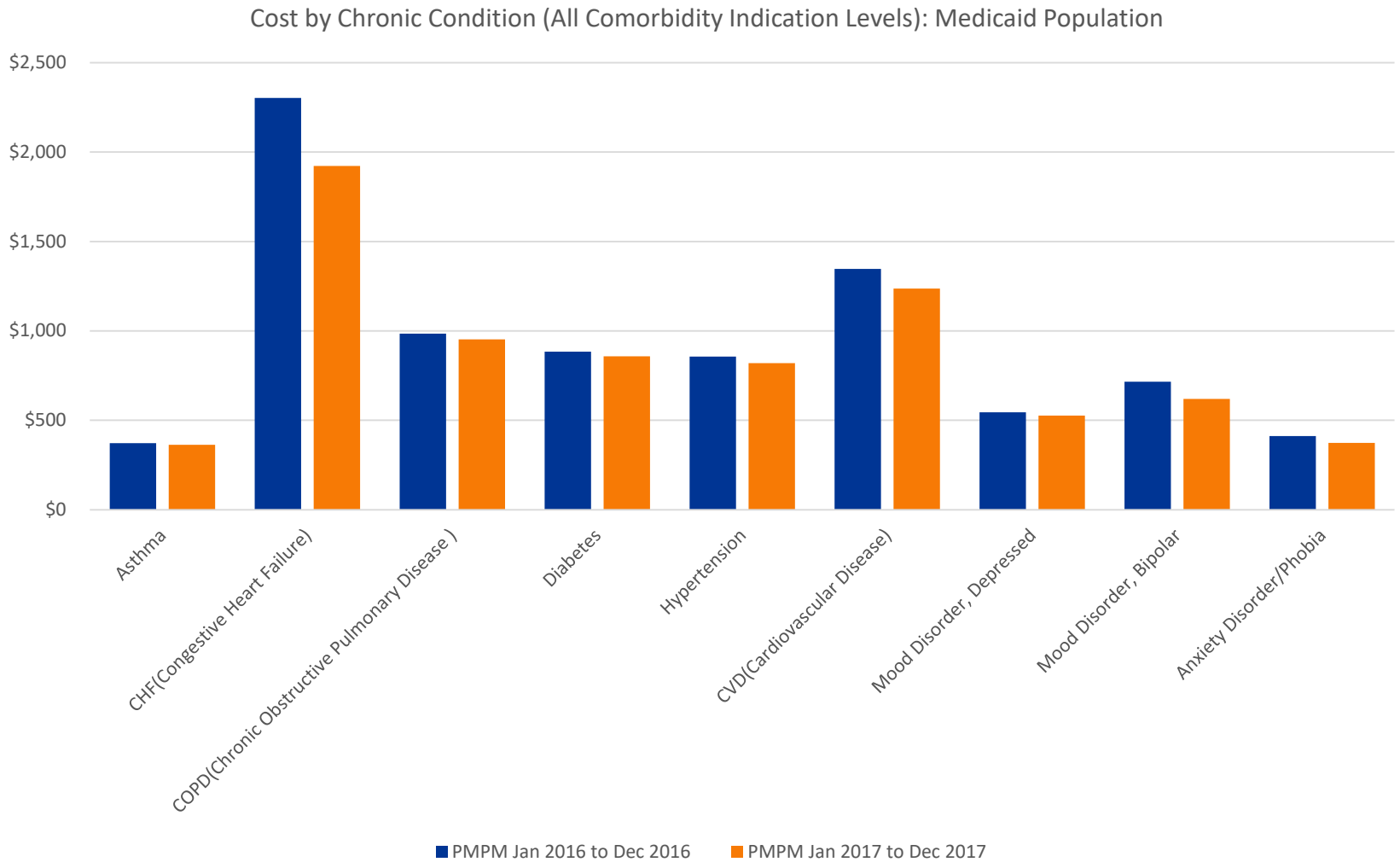
Cost by Chronic Condition and Comorbidity Level:

Medicaid Population



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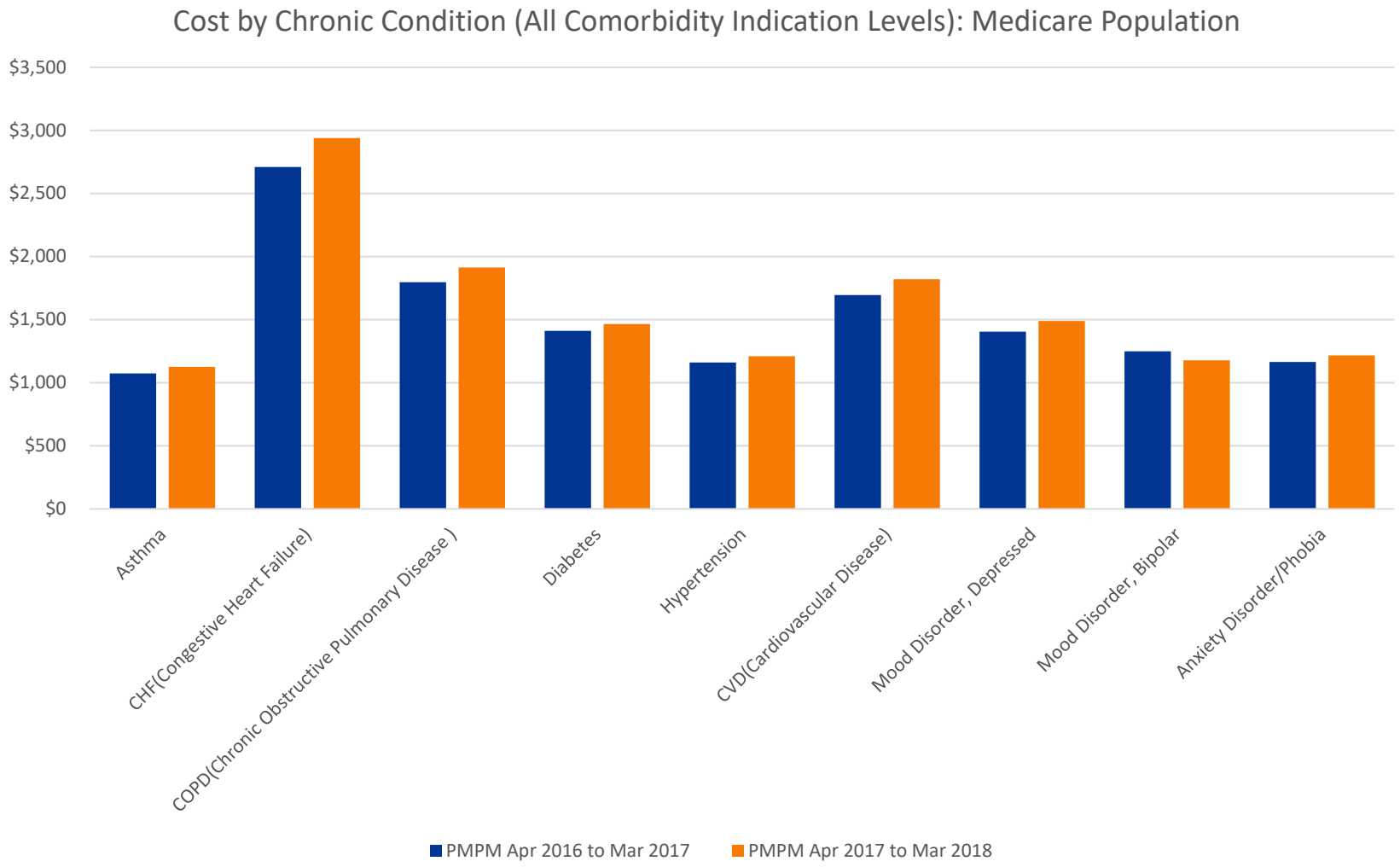
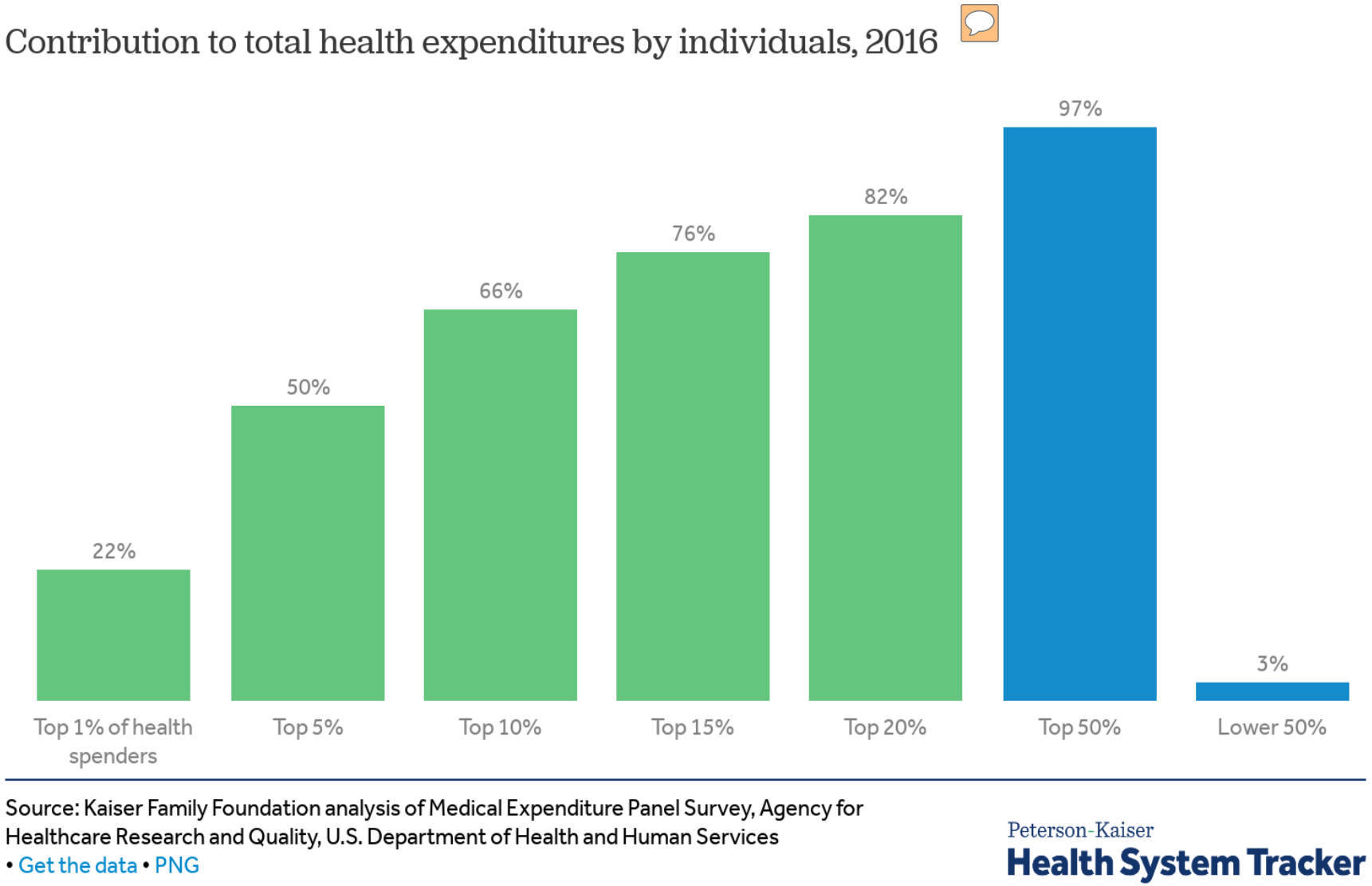
Cost by Chronic Condition and Comorbidity Level:

Medicare Population



Who Do We Spend it on?



America's Health Rankings, 2018: New Hampshire – overall 6th best

Category	Ranking
Total ESI Spending Per Enrollee- $5,487	6th highest
Infant Mortality	1st best
Immunizations	4th best
Adult Obesity (28%)	13th best
Excessive Drinking	10th worst
Death rate from Drugs, Alcohol, Suicide	2nd worst

https://www.americashealthrankings.org/explore/annual/measure/Overall/state/NH
Commonwealth Fund Scorecard on State Health System Performance, 2018

merger/affiliation activity

New Hampshire Hospitals

A View from the Economists:

- Overall prices are 12 percent higher for monopoly hospitals than for hospitals with four or more competitors. *The Price Aint Right? Hospital Prices and Health Spending on the Privately Insured., NBER, May 2018. https://www.nber.org/papers/w21815*
- When hospitals and health systems merge they often cite lower costs and operational efficiencies as the main reasons, and a report this year from the National Bureau of Economic Research indicates that only very modest savings take place. https://www.healthcarefinancenews.com/news/hospital-merger-and-acquisition-activity-slows-down-third-quarter-large-scale-transactions

"…**what we do know is that after a merger, even if there are cost advantages, those most certainly do not translate into lower prices**. For instance, one study found that, when hospitals in the same market merge, prices tend to increase by 7% to 10%. Another estimated that the average price of a hospital stay in the markets with the highest rates of consolidation increased by 11% to 54% in the years following M&A**. I am aware of no study that suggests that M&A leads to lower prices for consumers."**

1/9/19 David Willis, Advisory Board;https://www.advisory.com/research/health-care-advisory-board/blogs/at-the-helm/2019/01/hype-mergers;

https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html

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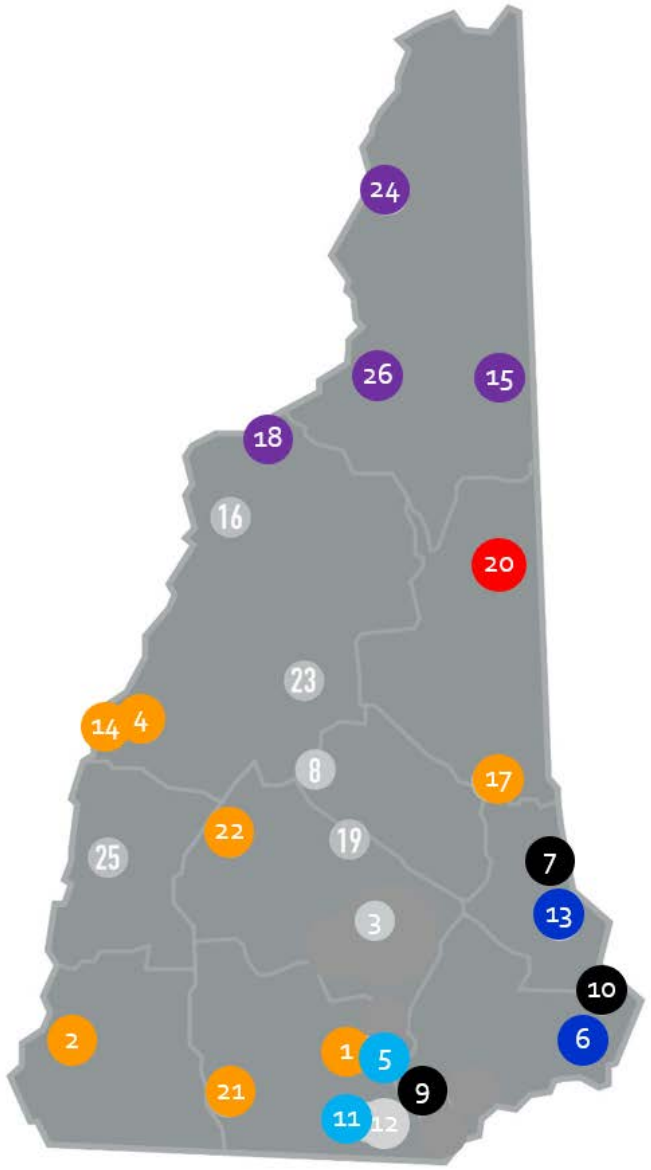
MAP OF PENDING AND COMPLETED HOSPITAL MERGERS AND AFFILIATIONS



Prospective Payment Systems Hospitals

3 Concord Hospital
8 LRGHealthcare, Lakes Region General Hospital
12 St. Joseph Hospital, *a member of Covenant Health*

Critical Access Hospitals

16 Cottage Hospital
19 Franklin Regional Hospital, LRGH Healthcare
23 Speare Memorial Hospital
25 Valley Regional Healthcare

North Country Healthcare: 2016

15 Androscoggin Valley Hospital
18 Littleton Regional Healthcare (pending withdrawal)
24 Upper Connecticut Valley Hospital
26 Weeks Medical Center

MaineHealth, ME

20 Memorial Hospital

HCA Healthcare, Inc, TN

7 Frisbie Memorial (**pending**)
9 Parkland Medical Center
10 Portsmouth Regional Hospital

Mass General Hospital (Partners), MA: 2016

13 Wentworth Douglass Hospital
6 Exeter Hospital (**pending**)

Clinical Affiliations with MGH

1 Catholic Medical Center
11 Southern NH Medical Center

SOLUTIONHEALTH: 2017

5 Elliot Hospital
11 Southern NH Medical Center

GraniteOne Health

1 Catholic Medical Ctr.
17 Huggins Hospital
21 Monadnock Comm Hosp. 2016

pending

Dartmouth Hitchcock

2 Cheshire Medical Ctr.
4 Dartmouth Hitchcock Medical Center
14 Alice Peck Day
22 New London Hosp.
Mt. Ascutney Hosp. (VT)

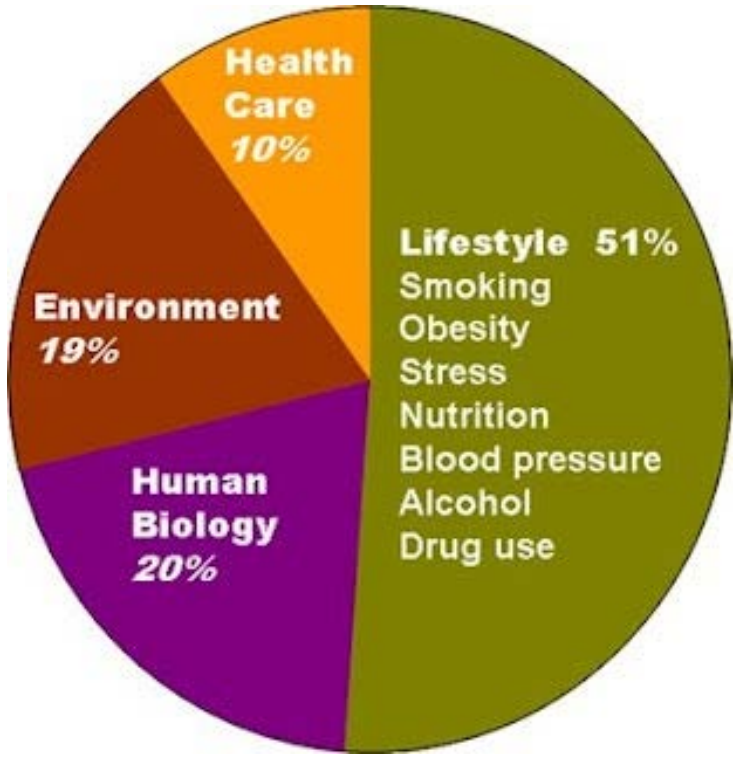
What Makes Mergers Work?

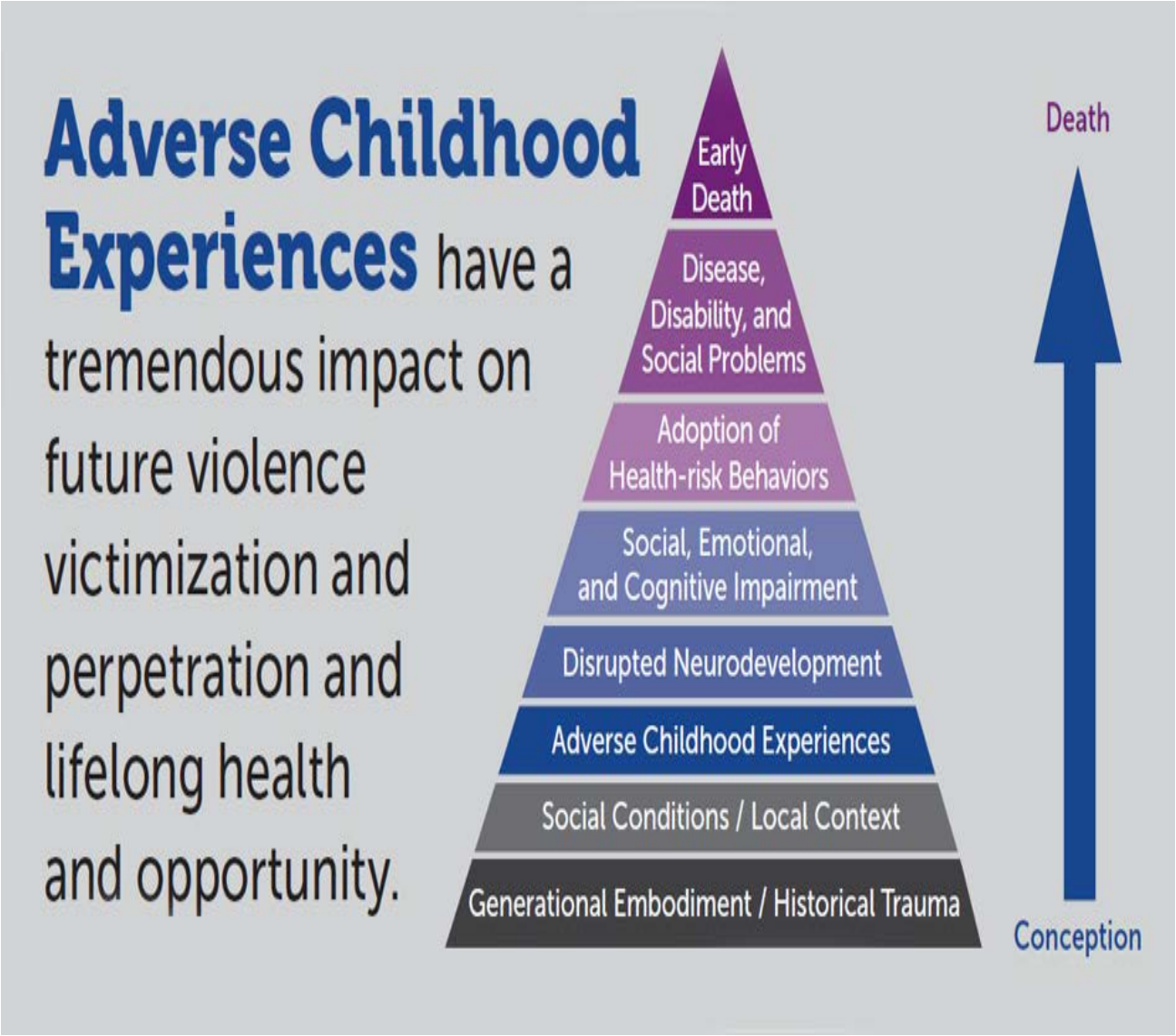
Deloitte surveyed hospital executives to identify integration practices that were more often associated with successful mergers and acquisitions. Specifically, they found that a merger was more likely to be viewed as successful when leaders:

- Developed a strong strategic vision for pursuing the transaction;
- Had explicit financial and non-financial goals;
- Held leadership accountable, often at the vice-president level, for integration efforts;
- Identified cultural differences between the organizations;
- Made clear and upfront decisions on executive and mid-management leadership;
- Aligned clinical and functional leadership early in the process;
- Followed best practices for integrating the acquired or merged organization into the parent organization; and
- Implemented project management best practices, with tracked targets and milestones, from day one of transaction close until two years after.

https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/hospital-mergers-and-acquisitions.html

Determinants of Health





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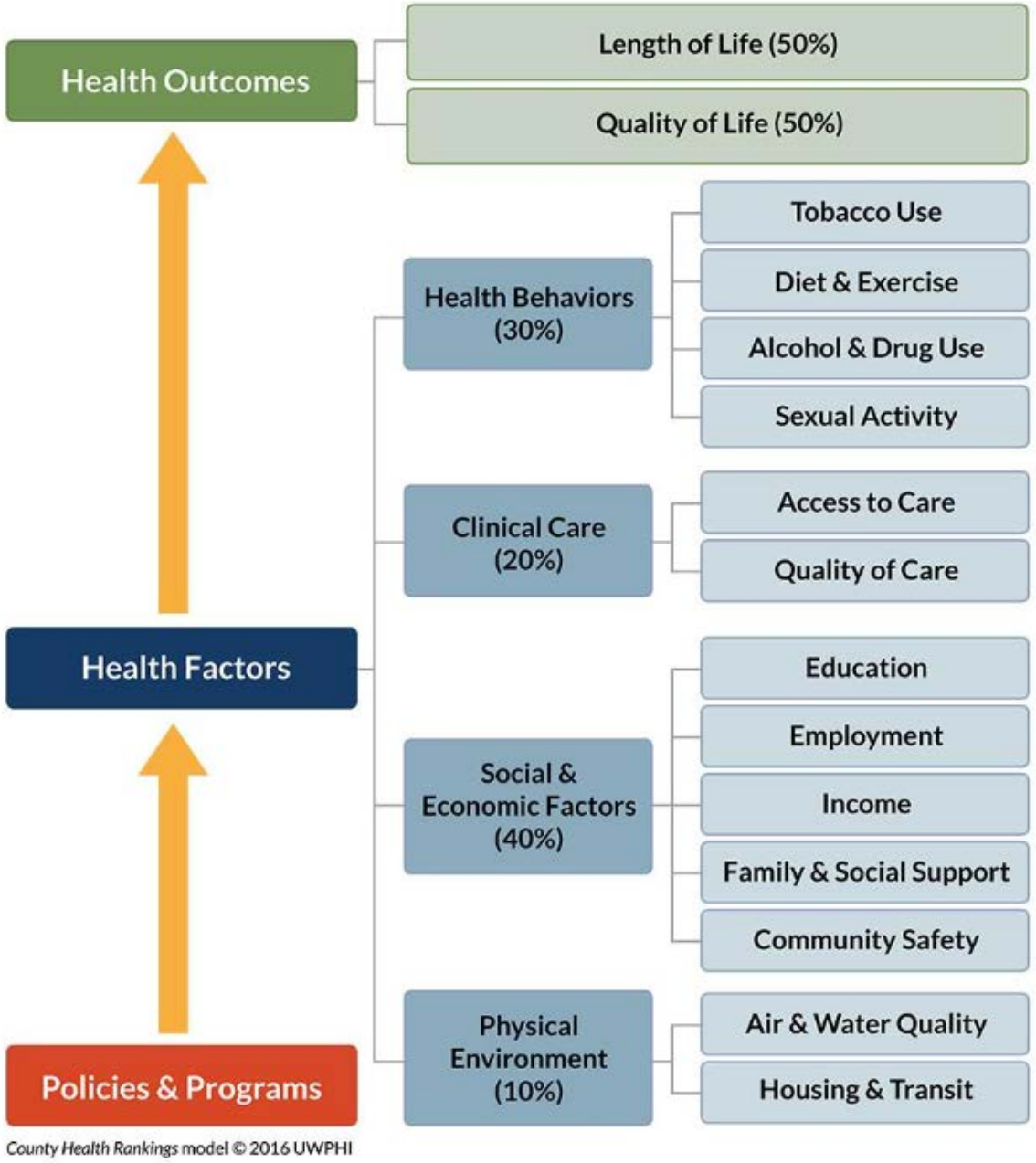
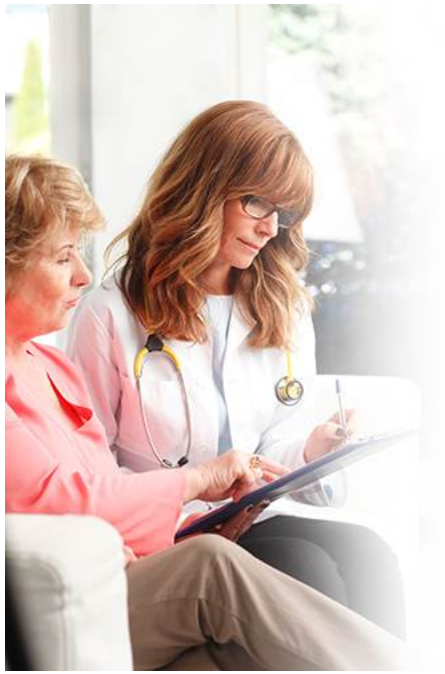
Public Health: The Other 80%



What is Population Health? What Does it Have to Do with Payment?

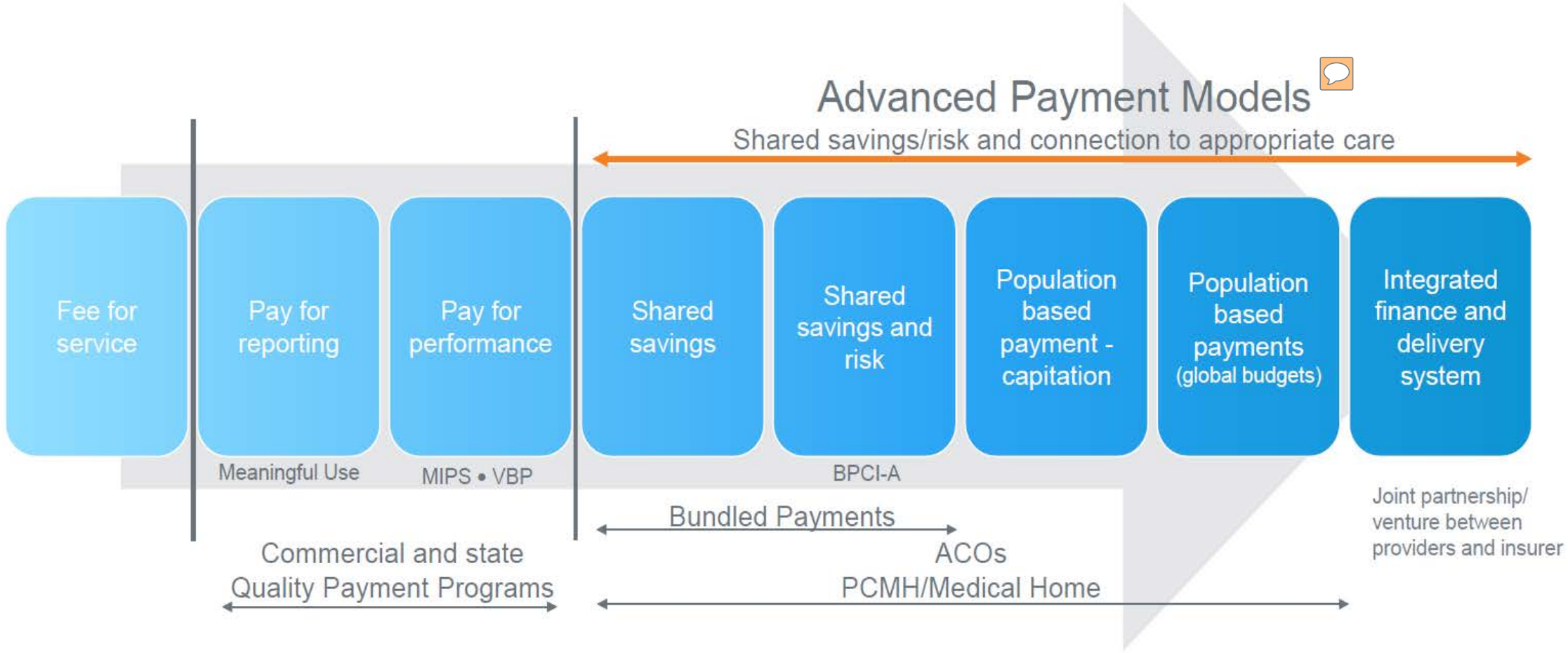
- Health care professionals partner with populations to improve the health of populations by promoting health, preventing disease, and addressing health inequities. Outcomes include:



- Advocacy to decrease health disparities
- Policy making to address health disparities
- Improving health outcomes of populations in need
- Implementing cost effective strategies to address health disparities
- Leadership strategies to impact safety, cost, and clinical outcomes
- Executing educational approaches to improve clinical decision making and evidence-based practice
- Developing practice guidelines

Alternative or Value Based Payment: Process by which the payments for services to address health needs are made in exchange for valuable care measured by the best achievable quality of the outcome and the patient experience for the price offered.

https://nhhealthcost.nh.gov/



Source: HCPLAN APM Framework

https://cernercorporation.gcs-web.com/static-files/4578dfdd-df4b-48b9-b97e-130cfc39ff62

Changes and Trends in APM Framework

Care management support strategies

Engagement with clinical and administrative providers

Using social workers and multidisciplinary teams to address SDOH and link community providers

Integrate benefit design guiding patients to lower cost higher quality providers

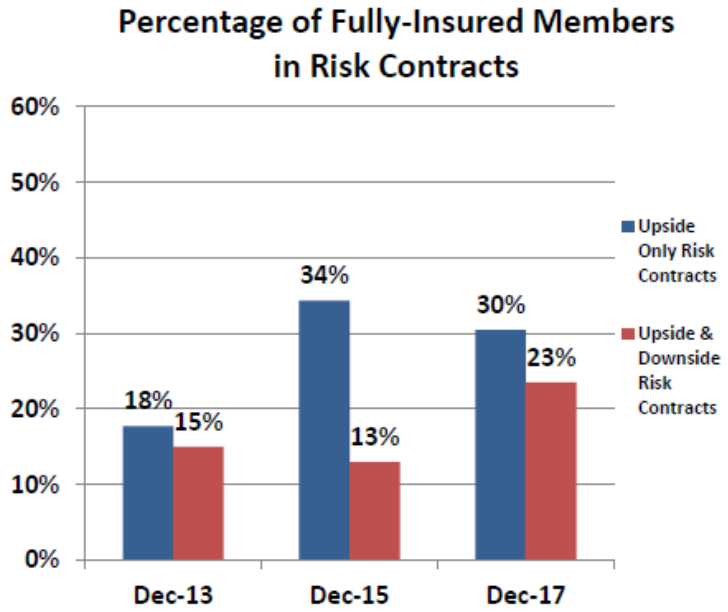
Tailoring analytic support to provider capabilities

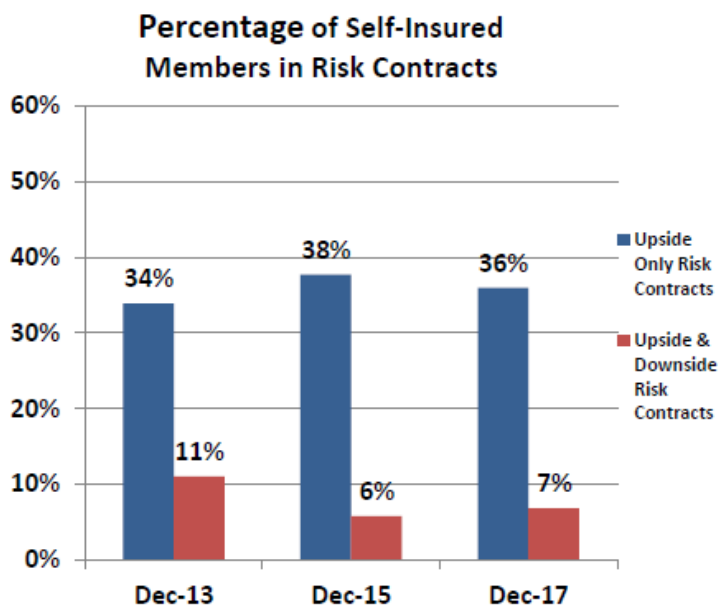
What's a Good Alternative Payment Model?

1. Does the APM pay for the high-value services needed to improve patient care?
2. Does the APM align the payment amount with the cost of delivering high-quality care?
3. Does the APM assure each patient they will receive appropriate, high-quality care?
4. Does the APM make the cost of diagnosing or treating a health condition more predictable and comparable?
5. Will a provider only be paid under the APM if a patient receives services?
6. Are payments under the APM higher for patients who need more services?
7. Is a provider's payment under the APM based on things the provider can control?
8. Will a provider know how much they will be paid under the APM before delivering services?

APPENDIX

Percentage of Fully-Insured and Self-Insured Members in Risk Contracts





Source: NHID Annual Hearing data 2014-2018. Includes all markets.

Current NH Commercial Carrier Efforts

Anthem	Cigna	Harvard	Tufts
• Enhanced Personal Health Care (EPHC) program	• Cigna Collaborative Care • Cigna Accountable Care (CAC)	• Provider partnerships • Elevate Health tiered network products • Benevera Health population health products	• Provider partnerships • Freedom Plan tiered network products

CMS- Medicare and Innovation

What's New from CMS

- CMS Primary Care Initiative:
  - Direct Contracting Path
  - Primary Care First Path
- Changes to Bundled Payments
- Adjustments to ACO/MSSP: Pathways to Success
- Meaningful Measures Initiative
- Medicare Advantage changes

What's Happening in NH

- FQHC Advanced Primary Care Practice Transformation Model (medical home)
- BPCI Advanced in cardio and ortho (physicians and systems)
- Million Hearts
- Health Care Innovation Awards
- NNE Practice Transformation
- New reformed ACOs

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MACRA, MIPS Transition

MACRA engenders widespread payment reform for physicians, regardless of their specialty

MACRA basics impacting Medicare beneficiaries

- Replaces the Sustainable Growth Rate (SGR)
- Extends the Children's Health Insurance Program (CHIP)
- Transitions from fee-for-service to pay-for-value

Physicians **must** choose one of two paths:

1 Advanced Alternative Payment Models (APMs)

5% Lump Sum Payment

- Comprehensive End-Stage Renal Disease Care Model
- Large Dialysis Organization (LDO) arrangement
- Non-LDO two-sided risk arrangement
- Comprehensive Primary Care (CPC+) Model
- Medicare Shared Savings Program (MSSP) Track 2
- Medicare Shared Savings Program (MSSP) Track 3
- Next Generation Accountable Care Organization Model
- Oncology Care Model, two-sided risk arrangement only

2 Merit-based Incentive Payment System (MIPS)

Performance-based payment adjustment

Clinicians are evaluated based on their Composite Performance Score (CPS)

Quality	60%
Resource Use	0%
Advancing Care Information	15%
Clinical Practice Improvement Activities	25%

*CPS domain weights (%) are for the 2017 performance year

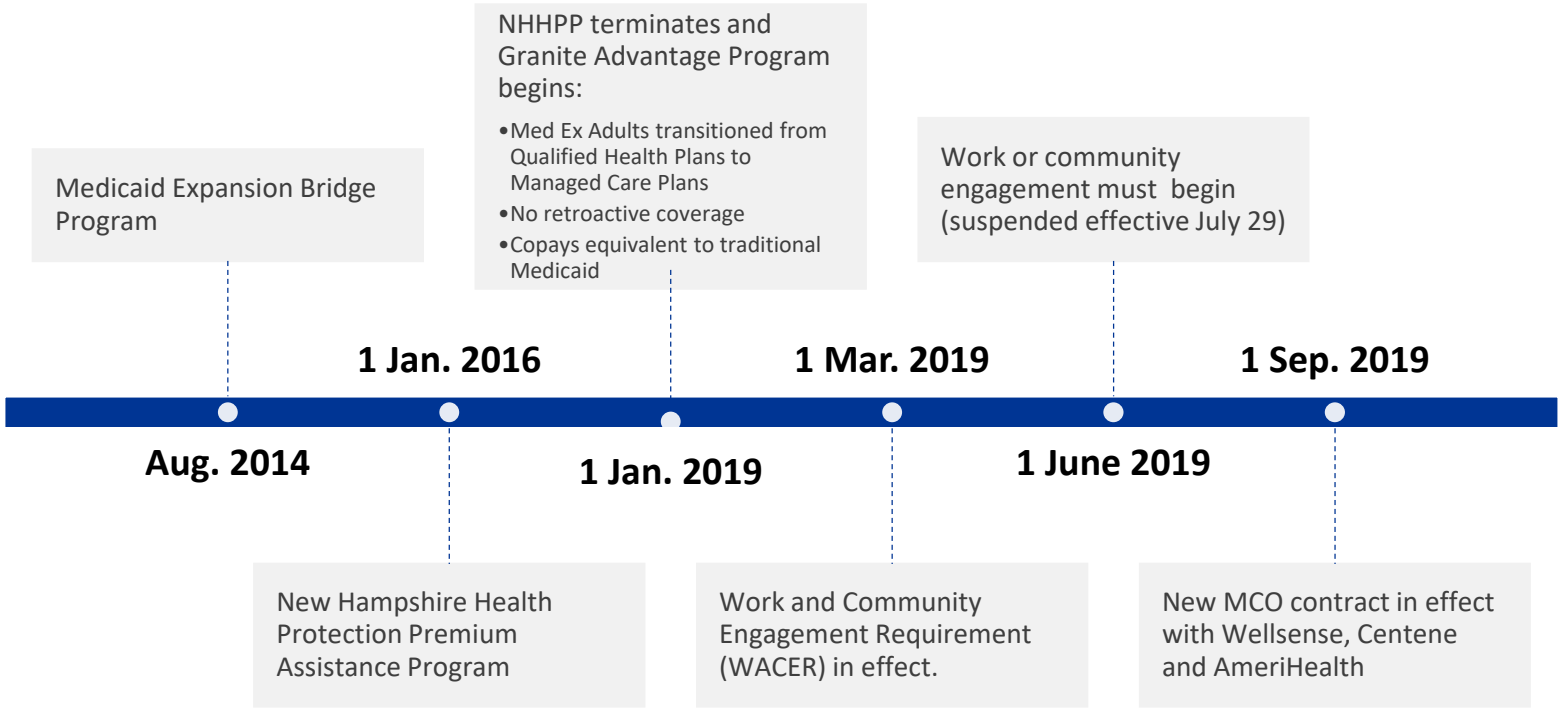
New Hampshire Medicaid expansion

Recent Developments

Medicaid Facts

- ~ 178,250 individuals in the Medicaid program
  - ~ 90,000 of them are children
  - ~50,000 Granite Advantage (Med Expansion) members
  - ~ 9,000 elderly
  - ~ 17,000 adults with disabilities

Changes For Medicaid Expansion



The Granite Advantage Program: 1115 Waiver Application

- 5 years of coverage for adults age 19-64
- **Work and Community Engagement Requirement**
- **Retroactive Coverage:** New Hampshire will not provide coverage to expansion adults prior to the date of application.
- **Presumptive Eligibility Authority for Corrections**: Allow State and county correctional facilities to conduct presumptive eligibility determinations for inmates.
- *Citizenship and Residency Documentation: The State requested (and has not received) authority to make eligibility for Granite Advantage contingent upon applicants verifying United States citizenship with two forms of paper identification, and New Hampshire residency with either a New Hampshire driver's license or a non-driver's picture identification card.*
- *Asset Test: The State requested but did not receive authority, to consider applicant or beneficiary assets in determining eligibility for the Granite Advantage program such that individuals with countable assets in excess of $25,000 would not be eligible for the program.*
- **Other Eligibility Policy Changes**: The State will require beneficiaries to provide all necessary information regarding eligibility, in compliance with DHHS rules; inform the department of any changes within 10 days of such change; and at the time of enrollment, acknowledge that the program is subject to cancellation upon notice.

Changes to the Current Medicaid Care Management Program

Key Areas

- Care Coordination and Care Management
- Behavioral Health (Mental Health and Substance Use Disorder)
- Emergency Room Waiting Measures
- Support the Community Mental Health Centers and Substance Use Disorder Providers
- Pharmacy Counselling and Management
- Beneficiary Choice and Competition
- Withhold and Incentive Program and Sanctions
- Alternative Payment Models
- Cost Transparency
- Accountability for Results
- Public Reporting
- New Provider Supports
- Quality Management and Access
- Children with Special Health Care Needs
- Community Engagement -- Granite Advantage Members
- Heighten Program Compliance and Integrity Provisions
- Medical Loss Ratio

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Work and Community Engagement Requirement

- Federal judge found NH's WACER and elimination of retroactive coverage illegal.
- CMS did not have authority to grant NH's 1115 waiver
- Case is on appeal

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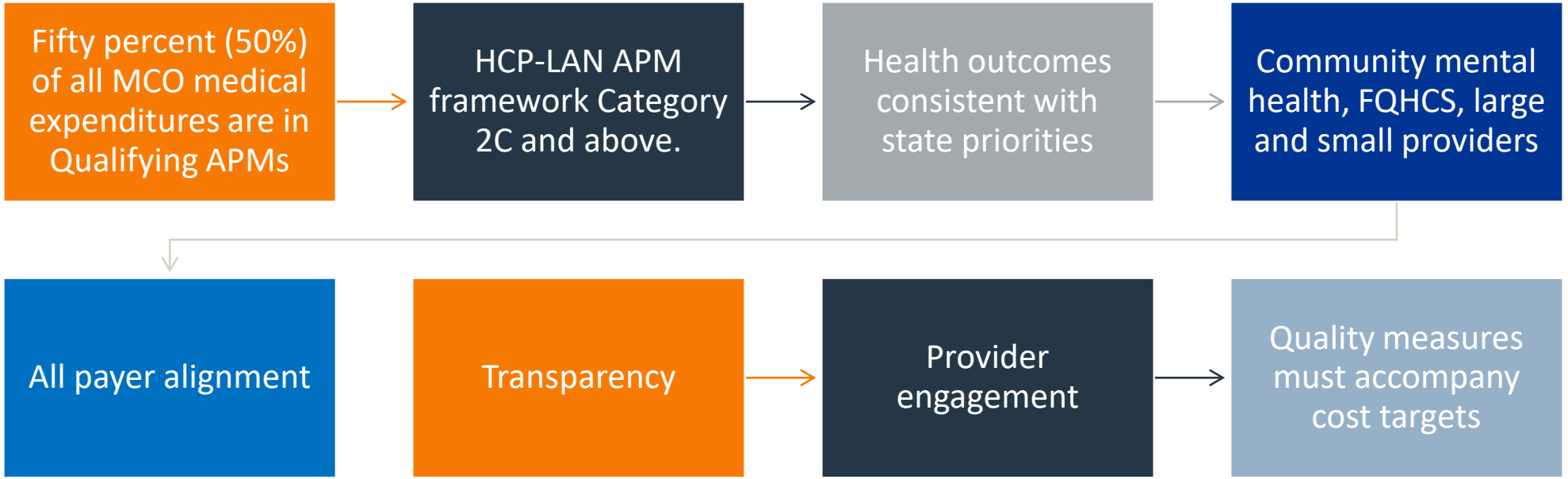
Medicaid APM Strategy: Managed Care Contracts – Sept. 2019



State Health Priorities

- 10 Year Mental Health Plan:
  - Recommendations for SFY20 & SFY21
    - Medicaid Rates for Mental Health Services
    - Action Steps to Address Emergency Department Waits
    - Renewed and Intensified Efforts to Address Suicide Prevention
    - Enhanced Regional Delivery of Mental Health Services
    - Community Services and Housing Supports
    - Step-up/Step-down Options
    - Integration of Peers and Natural Supports

DSRIP Transformation Waiver

- Integrated behavioral health
- Shared care plans
- Health risk assessments and care management

Doorways

- 2-1-1
- Access to evaluation and referral to treatment

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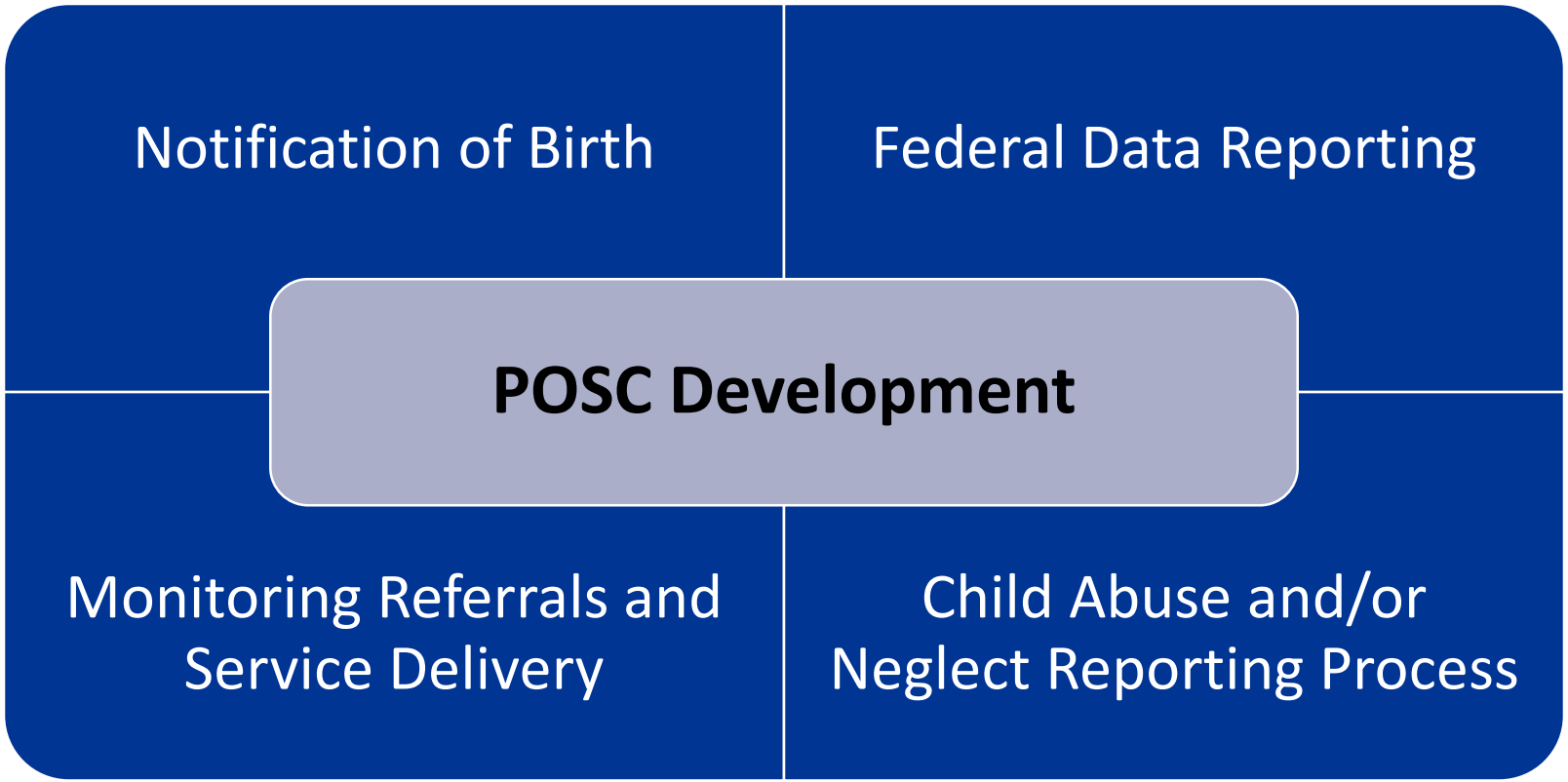
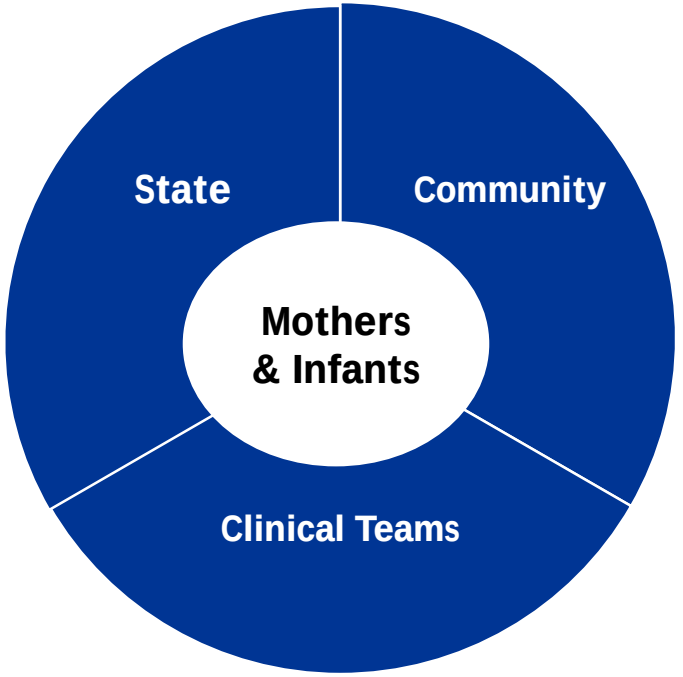
Plans of (Safe) Supportive care NH
State and Federal CAPTA/CARA Requirements



Framework to Support Mothers & Infants

- How can you engage mothers in a collaborative process to plan for healthy outcomes?
- How will you work with existing supports and coordinate new services to help infants and families stay safe and connected?
- How can Plans of Safe Care support mothers and infants during pregnancy, delivery, safe transition home and in parenting.



NH's Plan of Safe Care Process

SB 549: RSA 132:10-e and f

Infant Born…	Health Provider Shall..
"When an infant is born identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder…"	"… the health provider shall develop a Plan of Safe Care in cooperation with the infant's parents or guardians and NH DHHS, Division of Public Health Services, as appropriate."

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NH's Hope for Provider Engagement

Notify	Notify public health of the birth of an exposed infant as requested
Develop	Develop plan of safe care with all mothers or caregivers – required when infant is born identified as being affected
Provide	Provide the POSC to the mother upon discharge
Facilitate	Facilitate the mother's referrals and access to appropriate supports and services.
Submit	Submit the POSC to the Department if requestedPOSC to DCYF if a report of child abuse or neglect is made. .
Include	Include the POSC in information provided to mother's supports and services as authorized

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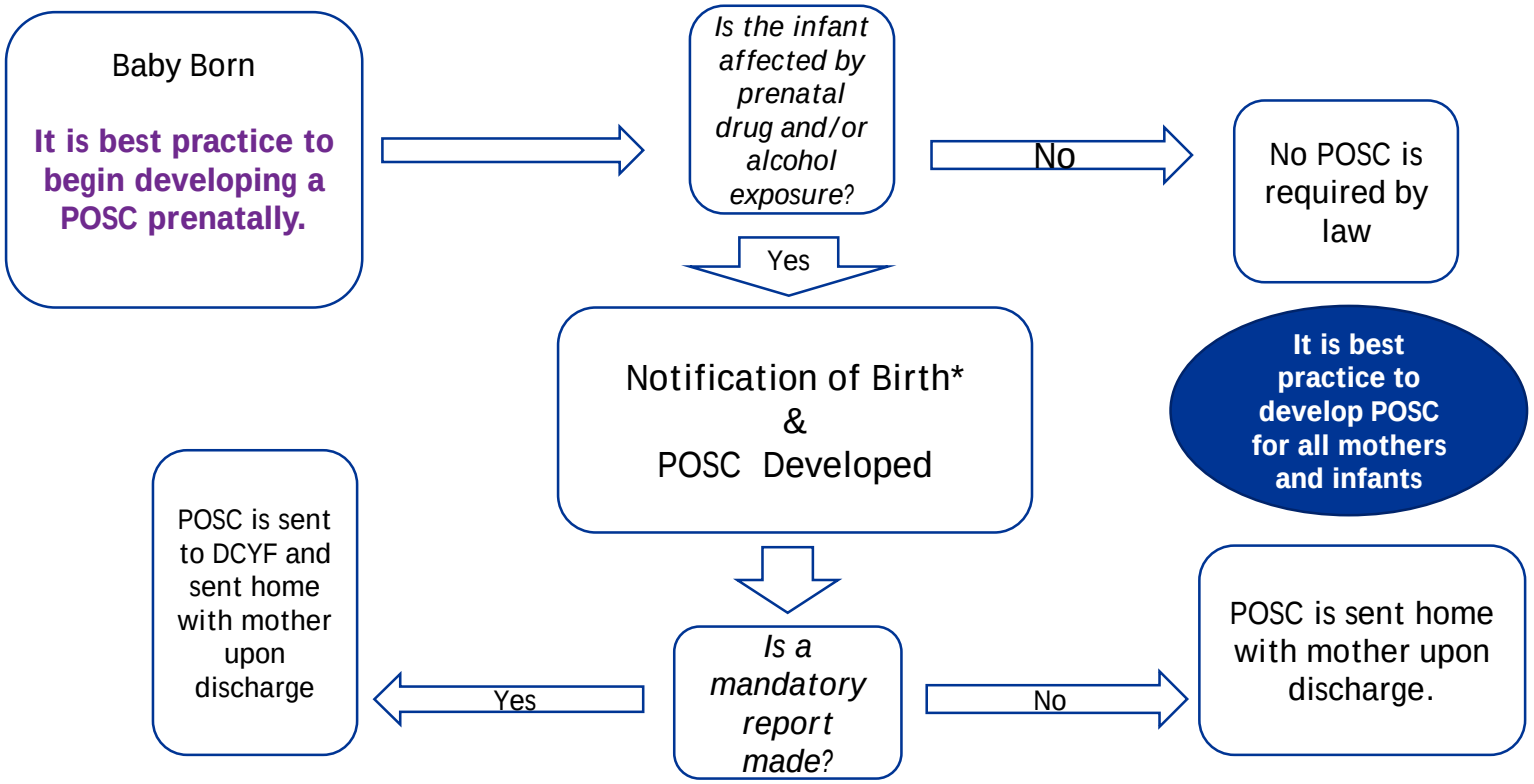
How is NH determining its POSC process?



*Notification is captured through two situational surveillance questions on the birth certificate.

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Where does the Plan of Safe Care go?

Reporting	Guidance
• A provider may determine circumstances that warrant a mandatory report to DCYF. • A report must be made when a provider 'has a reason to suspect' an infant has been abused or neglected pursuant to RSA 169-C:3. • If a report is made to DCYF, a copy of the POSC must accompany the report.	Mandatory reporting is required under NH RSA 169-C:29 whenever anyone has a reason to suspect child abuse and/or neglect. **The fact an infant is born with prenatal exposure to drugs and/or alcohol does not itself require a mandatory report.**

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Guidance Q&As

- What is a Plan of Safe Care? What is its purpose?
- Who needs a POSC?
- Who develops the POSC? When is it developed?
- What is “Notification”? How is it different than a mandatory report?
- Are hospitals required to make a mandatory report for all infants exposed prenatally to drugs and/or alcohol?
- What happens to the POSC when a report of child abuse and/or neglect is made?
- What types of information about infants exposed prenatally to drugs and/or alcohol is shared and with whom?
- POSC-Where does it go?
- Does the POSC contain information protected by 42 CFR Part 2 (Part 2)?
- What types of services are included in the POSC?
- What if a mother declines to participate in developing a POSC?

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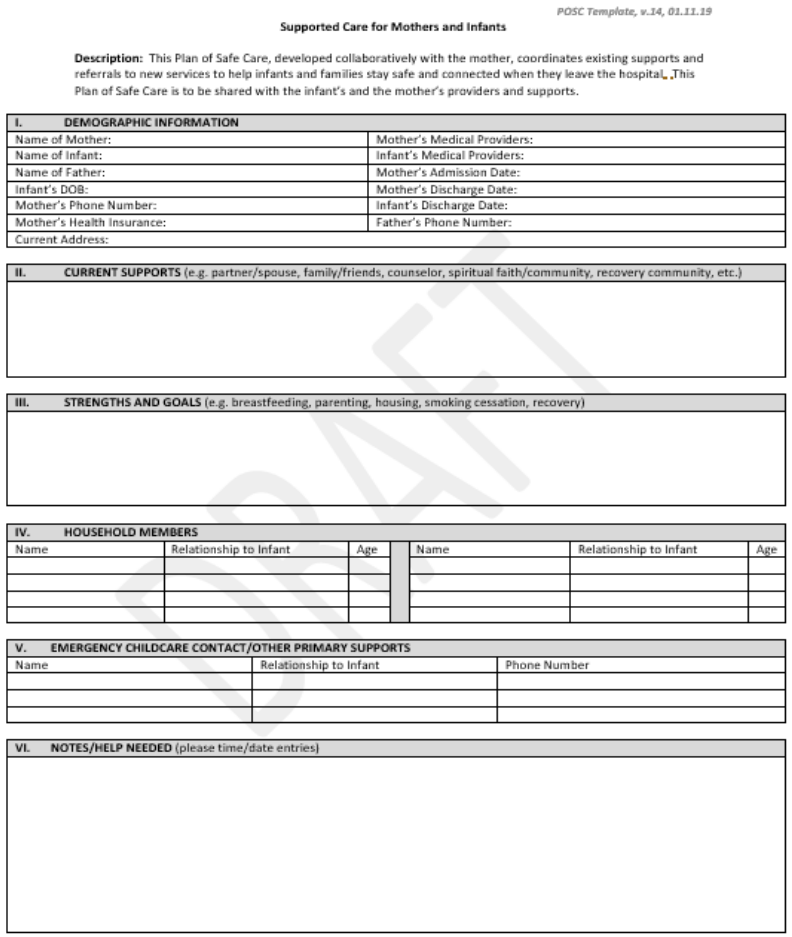
What is NH's Plan of Safe Care?



POSC Template, v.14, 01.11.19

Supported Care for Mothers and Infants

Description: This Plan of Safe Care, developed collaboratively with the mother, coordinates existing supports and referrals to new services to help infants and families stay safe and connected when they leave the hospital. This Plan of Safe Care is to be shared with the infant's and the mother's providers and supports.

I. DEMOGRAPHIC INFORMATION	
Name of Mother:	Mother's Medical Providers:
Name of Infant:	Infant's Medical Providers:
Name of Father:	Mother's Admission Date:
Infant's DOB:	Mother's Discharge Date:
Mother's Phone Number:	Infant's Discharge Date:
Mother's Health Insurance:	Father's Phone Number:
Current Address:	

II. CURRENT SUPPORTS (e.g. partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.)

III. STRENGTHS AND GOALS (e.g. breastfeeding, parenting, housing, smoking cessation, recovery)

IV. HOUSEHOLD MEMBERS

Name	Relationship to Infant	Age		Name	Relationship to Infant	Age

V. EMERGENCY CHILDCARE CONTACT/OTHER PRIMARY SUPPORTS

Name	Relationship to Infant	Phone Number

VI. NOTES/HELP NEEDED (please time/date entries)

POSC Template, v.14, 01.11.19

VII. SERVICES, SUPPORTS and NEW REFERRALS

	Discussed	Active	Referred	Contact Name	Organization/Phone Number
Visiting Nurse Association (VNA)					
Women, Infants, and Children Program (WIC)					
health insurance enrollment					
Family Resource Center (FRC)					
parenting classes					
safe sleep education/plan					
childcare					
other home visiting					
Early Supports and Services					
voluntary child welfare services					
family planning					
mental health					
smoking cessation/no smoke exposure					
housing assistance					
Temporary Assistance for Needy Families (TANF)					
financial assistance					
transportation					
legal assistance					
personal security/DV					
substance use					
Medication Assisted Treatment					
recovery support services (e.g. recovery coaching, meetings)					
Drug Court participation					
Other (_)					
Other (_)					

VIII. PRENATAL EXPOSURE

	Y/N	Notes
Does the infant have prenatal substance exposure?		
Is the prenatal substance exposure a result of prescribed medication?		
Is there prenatal substance exposure in addition to prescribed medication?		

IX. IS THE INFANT DISCHARGED IN THE CARE OF SOMEONE OTHER THAN THE MOTHER?

Name:	Relationship to Infant:	Court Involvement (Y/N):
Phone Number/Address:		

X. PARENT/CAREGIVER SIGNATURE

I acknowledge I have participated in the development of this Plan of Safe Care, I have a copy of the Plan of Safe Care, I will share the Plan of Safe Care with my baby's pediatrician and primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Signature: _____ **Date:** _____

XI. STAFF SIGNATURE

I, _____ provided _____ with the Plan of Safe Care upon discharge.

Signature: _____ **Date:** _____

This form complies with NH RSA 132:10-e and NH RSA 132:10-f.

Services, Supports and New Referrals

- VNA
- WIC program
- Health insurance information
- Family Resource Center
- Parenting classes
- Safe sleep education
- Childcare
- Other home visiting
- Early supports and services
- Voluntary child welfare services
- Family planning
- Mental health
- Smoking cessation/no smoke exposure
- Housing assistance
- Temporary Assistance for Needy Families
- Financial assistance
- Transportation
- Legal assistance
- Personal security/DV
- Substance use
- Medication Assisted Treatment
- Recovery support services (e.g., recovery coaching meetings)
- Drug Court participation
- Other

NH Doorways

- 9 Doorways
  - AVH
  - Littleton Hospital
  - LRGH
  - Wentworth Douglass
  - Concord/Riverbend
  - Cheshire Medical Center
  - DHMC, Lebanon
  - Granite Pathways, Manchester
  - Granite Pathways, Nashua
- Soft opening on January 1
- Funded by SORS grant – OUD patients

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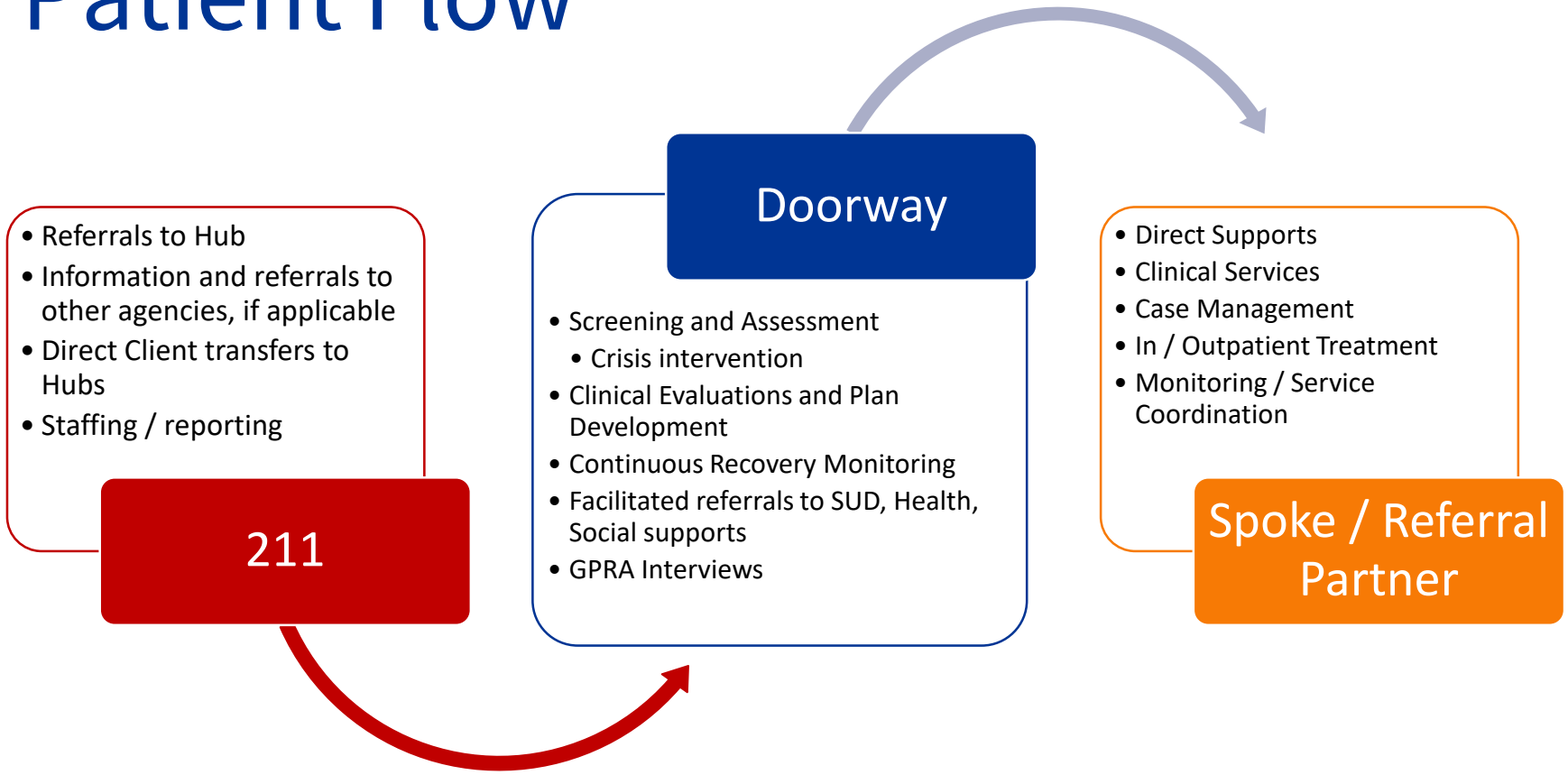
Patient Flow



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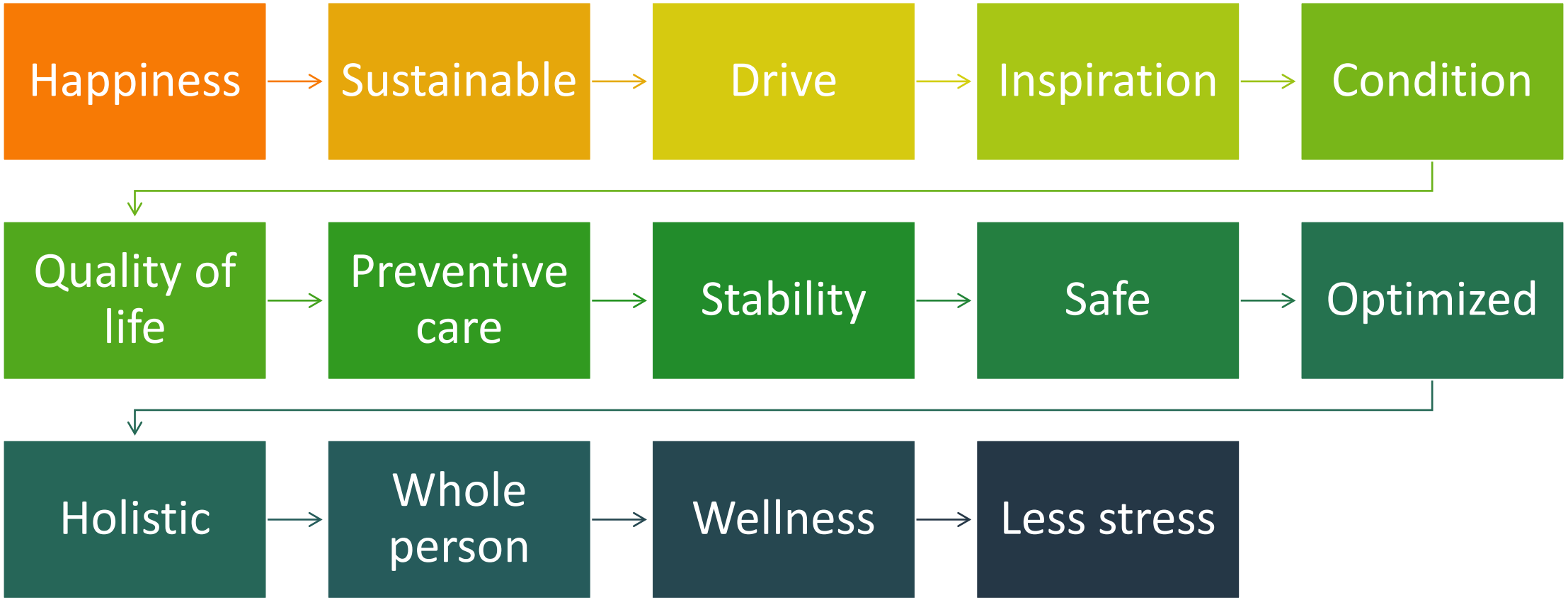

Thanks