

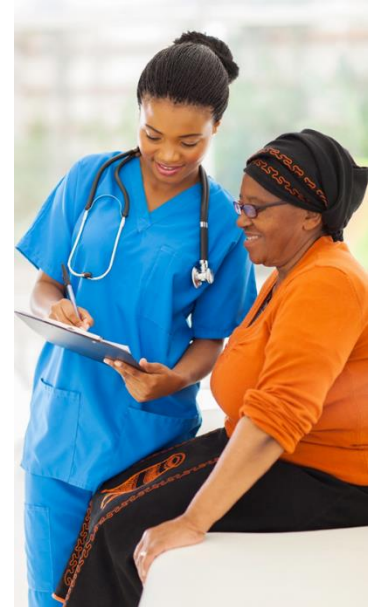
Primary Care Modernization (PCM) proposes to align Connecticut around proven capabilities, and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently. The design process currently underway will result in a proposal for consideration by the Lamont Administration, commercial payers and Medicare.

Too many Connecticut residents report they are in poor health, have difficulty managing chronic conditions, and are impacted by rampant health disparities. High rates of avoidable services highlight problems with access, coordination, and care planning. In tandem, Connecticut faces an unsustainable healthcare cost trend. Medicare per capita costs are the third highest in the country, driven largely by higher utilization of hospital, emergency department, and skilled nursing facility services. Healthcare spending among the commercially-insured is higher than national averages and is rising more quickly.

Across the country, states are spending more of every health care dollar on primary care. This investment has improved access, quality, and patient experience, while lowering cost. With shared, targeted investment in evidence-based approaches to primary care redesign, Connecticut will achieve rapid and meaningful reductions in avoidable utilization, address barriers to health that increase cost and widen disparities, and support patients in preventing disease, identifying health problems early, and better managing chronic illnesses.

Connecticut has the benefit of learning from others. Findings demonstrate the importance of:

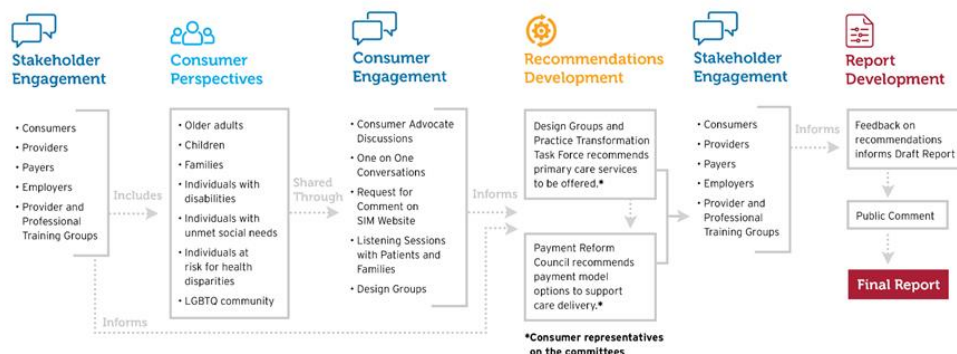
- Broad deployment of diverse care teams, including integrated behavioral health
- Payment mechanisms that free clinicians from the confines of fee-for-service billing
- Identifying and addressing individual patients' social needs
- Multi-payer commitment to align with care delivery goals as well as the capabilities and payment model options that enable them



Collaborative Design Process Builds Support for Cohesive, Evidence-Based Capabilities

More than 500 Connecticut stakeholders brainstormed the state's most pressing primary care needs, consulted the evidence, and worked collaboratively to develop a set of capabilities that will drive immediate improvements and long-term transformation. Tapping into the knowledge and experience of consumers, including those with complex health and social needs, practicing physicians, Advanced Network executives, and business leaders enriched the dialogue and resulted in recommendations that can be implemented and evaluated.

Primary Care Modernization Stakeholder Engagement Process



An initial set of adult capabilities provisionally approved by the Practice Transformation Taskforce, the multisector workgroup that initiated the focus on primary care, is shown below. PCM funding would be available to Advanced Networks (ANs) and Federally-Qualified Health Centers (FQHCs) that, through an application process, show how they would achieve the capabilities.

Flexible Payment Model Options Remove Barriers to Convenient, Effective, Efficient Care

To enable providers to implement these capabilities, more flexible payments will be needed. The Payment Reform Council, which was formed to develop payment model options to support PCM, is considering two, upfront bundled payments. Such payments would be made to advanced networks and federally-qualified health centers that are participating in shared savings arrangements. In fact, the PCM payments are intended to complement the Medicare Shared Savings Program *Pathways to Success* model and other total cost of

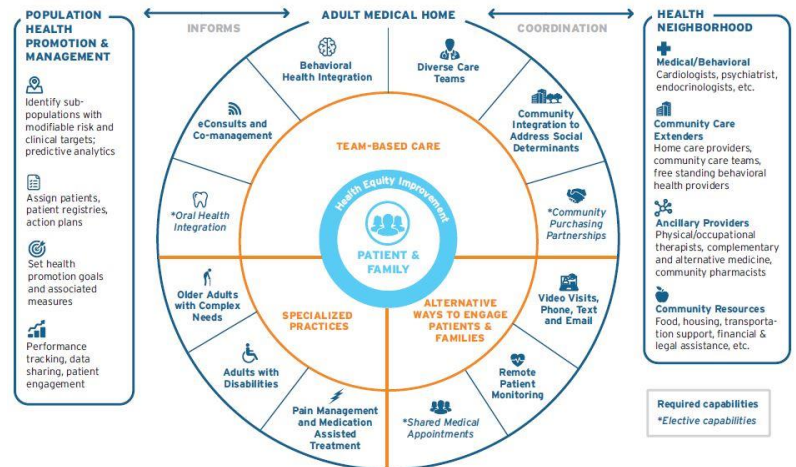
care accountability programs offered by commercial payers and the state's Medicaid program. Payers would determine the terms of those programs, including whether and how they incorporate downside risk for total cost of care. Services included in the bundle or provided to unattributed patients will be paid fee for service.

The **Basic Bundle** is currently envisioned as an advance payment to purchase the time of primary care clinicians, including physicians, advanced practice nurse practitioners and physician assistants. With this approach, primary care teams can treat patients based on clinical need and patient preference without the financial and administrative constraints of a fee-for-service environment.

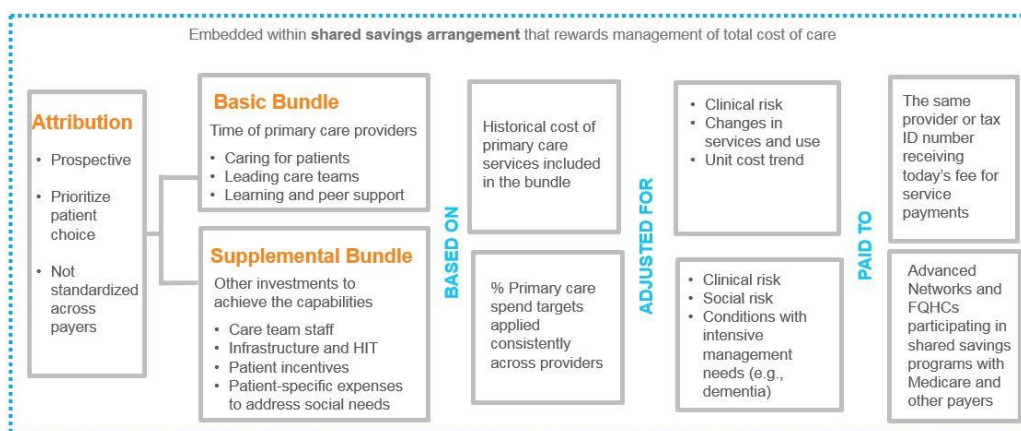
Recently, the Centers for Medicare and Medicaid Services have added new codes and fees to support providers in offering more virtual care, monitoring patients' conditions remotely and connecting with specialty expertise without a face to face visit. These changes, combined with concerns regarding the need to safeguard against underservice, have prompted the Payment Reform Council to seek additional input from stakeholders on whether it would be preferable to move forward with the **Basic Bundle** or request that other payers align with the new CMS codes and fees.

The **Supplemental Bundle** would be an upfront, incremental payment to support activities and investments necessary to achieve the capabilities, such as care teams, new investments in technology and infrastructure, beneficiary incentives, and patient-specific expenses to address social determinant of health needs such as food security/food as medicine, housing instability, and transportation.

Adult Primary Care Capabilities



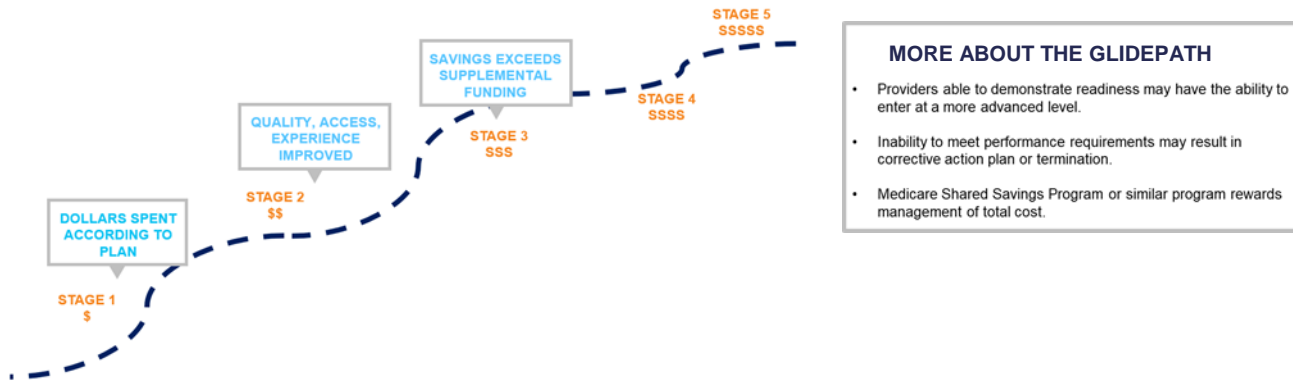
Flexible Bundled Payments to Support Primary Care



Incremental Investments Recognize the Trajectory of Care Delivery Transformation

In our conversations with providers, we find their reluctance to invest in care delivery transformation is often rooted in concerns about their ability to generate sufficient savings to cover upfront costs. Through a staged glidepath, the Supplemental Bundle overcomes this barrier while maintaining shared accountability for total cost of care. PCM gradually increases supplemental payments by requiring “proof of performance” to advance to the next stage. Providers phase-in the capabilities as payments increase.

Supplemental Bundle Glidepath



The Supplemental Bundle glidepath addresses several common barriers to success:

- Advancements in primary care, such as the introduction of new methods of patient support (e.g., telemedicine) or the integration of new care team members (e.g., community health workers) take time to design and implement.
- Managing change is a complex endeavor that requires investments in clinical workflow re-engineering and training, as well as connections to technical assistance and peer learning opportunities. It also requires staff development and training to support a shift in practice culture.
- An available workforce will not be fully available on day one. It will take time for the market to adjust.

Accountability to Consumers, Employers, and Payers Built into the Model Design

PCM envisions an accountability matrix where data coming in from providers, health plans, and consumers would be utilized by the state to support program monitoring, ensure access, patient experience and quality, and evaluate financial success.

Program Monitoring: Participating ANs/FQHCs would provide quarterly or semi-annual reports demonstrating progress toward achieving the capabilities and outlining plans for next steps.

Access: Participating ANs/FQHCs would be required to submit information on the volume of patient encounters by type of encounter and care team member role. A view from a draft report is shown to the right.

Access Tracking Report

Patient Experience: Standardized reporting from Consumer Assessment of Healthcare Providers and Systems surveys would be analyzed in aggregate and by race, ethnicity, and income to identify disparities. This data would be augmented with information gained through consumer feedback and complaints submitted to the state.

Quality: PCM would also leverage the quality reporting included in the total cost of care management programs within which PCM would be embedded. PCM would ask

Access Tracking Report ABC Health Partners								
Practices included: Acton, Bridgefield, Essex, Marston and Overbrook								
Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous clinical communications with physicians, nurse practitioners and physician assistants. Other Clinical Contact: office visits or community visits with non-practitioner staff (e.g., medical assistants, pharmacists, educators, community health workers); synchronous and asynchronous communication with non-practitioner staff on clinical matters (test results, medication advice, etc.).								
Attributed Patients	Categories						Total	
	Total Number of Patients Attributed	PCP	Care Manager (RN, MSW)	Pharmacist	BH Clinician	CHW		Other (Navigator, Coach, Nutritionist)
RAW TOTALS	6,149	21,390	19,262	18,137	9,827	8,201	7,230	84,047
RAW AVERAGES (PER ENROLLEE PER YEAR)		3.48	3.13	2.95	1.60	1.33	1.18	13.67
RISK ADJUSTED AVERAGES		3.34	3.01	2.84	1.54	1.28	1.13	13.14

that payers harmonize quality measures in these programs over time, and as needed, consider additional measures to reflect PCM goals.

Cost: As outlined in the glidepath, participating ANs/FQHCs would be required to demonstrate savings by year three of participation. Those unable to do so may face a corrective action plan or termination from the program.

Modeling Shows PCM Would Improve Health Outcomes and Affordability

Based on an extensive review of the evidence, modeling shows PCM would improve chronic condition management, drive immediate reductions in avoidable utilization, and cost savings would quickly exceed investment.

Examples of Expected Impact:

- Reductions in avoidable ED use, hospital stays, and low value services
- Improvements in blood sugar and blood pressure control
- Increased primary care provider satisfaction and retention
- Improvements in patient experience and reduced disparities across patients
- Time off work decreased; health, functioning at work improved
- Reduced cost trend
- Smaller portion of wages absorbed by health benefits

The PCM design process is ongoing. We look forward to hearing your thoughts on the work to date and how it could be better meet your needs and the needs of those you serve. For more information, to share ideas, or to become involved, please email OHS@ct.gov.

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