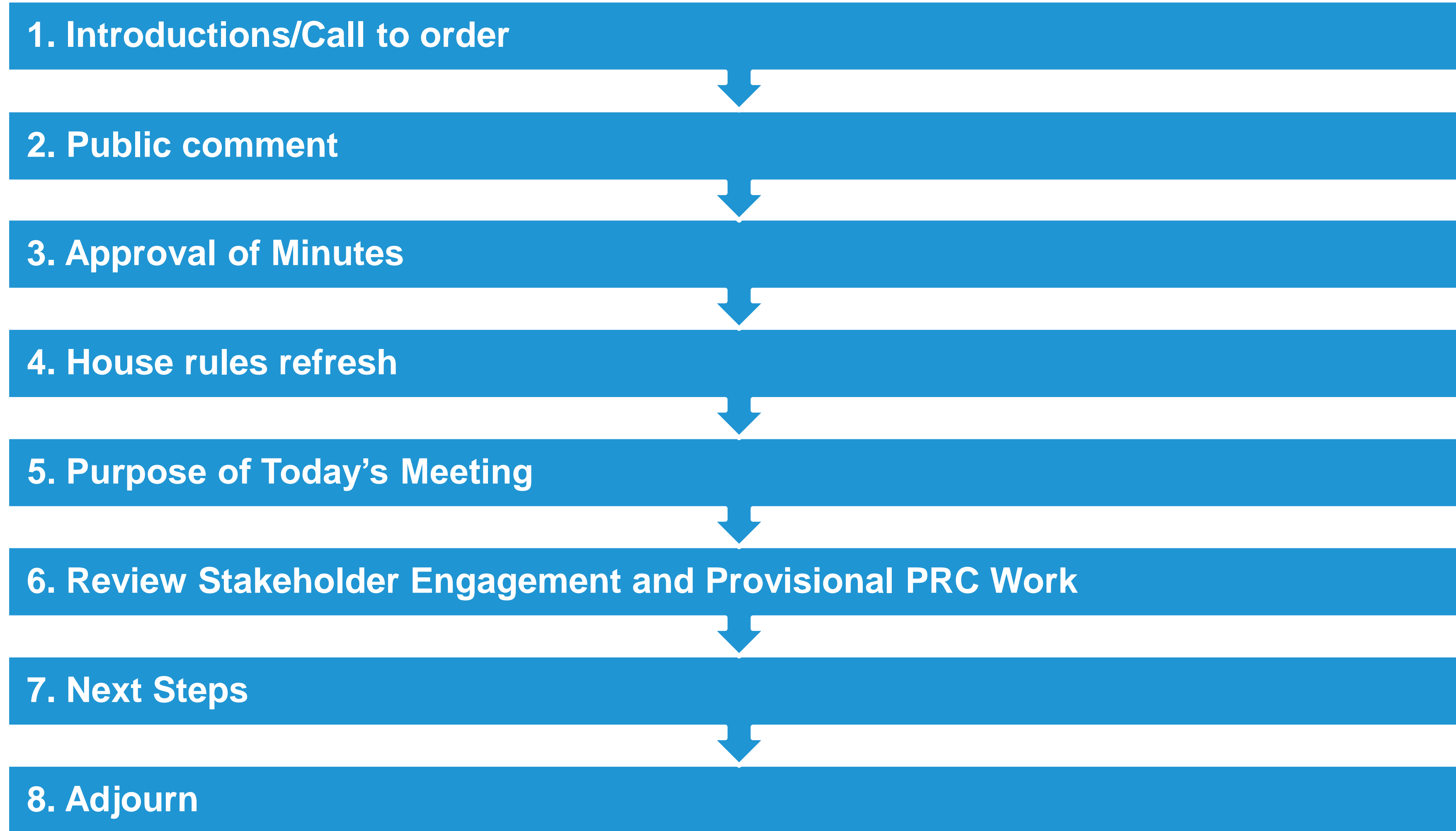
Practice Transformation Task Force

April 16, 2019

AGENDA



Introductions/Call to Order

Public Comment

Approval of the Minutes

House Rules

House Rules for PTTF Participation

1. Please identify yourself and speak through the chair during discussions
2. Be patient when listening to others speak and do not interrupt a speaker
3. 'Keep comments short (less than 2 minutes if possible) and to the point/agenda item (*the chair will interrupt if the speaker strays off topic or talks longer than 2 minutes*)
4. *Members should avoid speaking a second time on a specific issue until every PTTF member who wishes to speak has had the opportunity*
5. *Members should take care to minimize interference (please mute all phones, turn off cell phones, limit side conversations or loud comments)*
6. Please read all materials before the meeting and be prepared to discuss agenda/issues
7. Please participate in the discussion—ALL voices/opinions need to be heard
8. *Participation in the meetings is limited to Task Force members and invited guests; all others may comment only during the initial public comment period*
9. After the meeting, please raise any concerns with meeting process/content or other issues with members of the Executive Team (Elsa, Lesley, Dan)

Purpose of Today's Meeting

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- Receive PTTF feedback on presentation of capabilities and model for stakeholders
- Review provisional Payment Reform Council recommendations:
  - Does the current model support PTTF approved capabilities?

Review Stakeholder Engagement and Provisional PRC Work

Primary Care Modernization:
Unlocking the Potential of Primary Care to Improve Health and Affordability

OUR SHARED CHALLENGE

The highest performing health systems spend 10 to 12% of health care dollars on primary care. In Connecticut, primary care spending is 5% or less. The result is underuse of high value services, overuse of low value services, higher spending and worse outcomes.

Connecticut ranks…

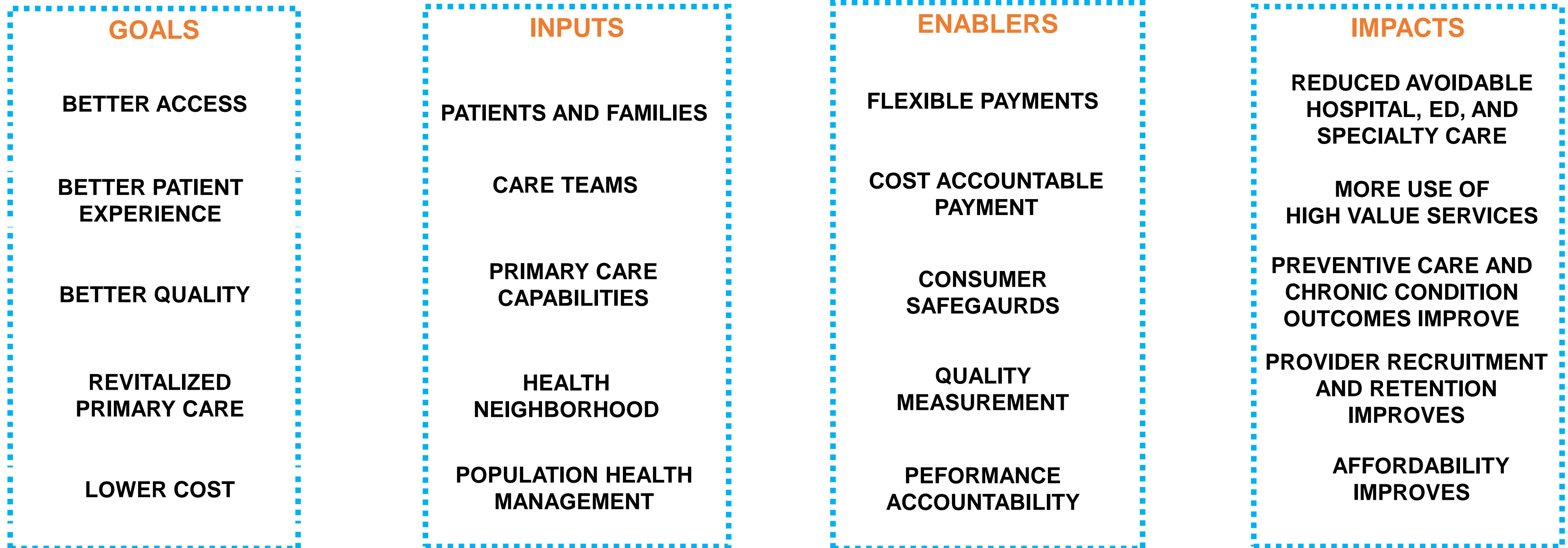
- 32nd worst in the nation in avoidable hospital use and costs, largely driven by avoidable ED use[1]
- 6th highest private health insurance spending per capita and 5th highest for Medicare[2]
- 43rd worst in the nation in health disparities[3]
- 44th worst in the nation in adults with diabetes without a hemoglobin A1c test[2]
- 33rd worst in the nation in adults with mental illness reporting unmet need[2]
- 39th worst in the nation in deaths from drug use[3]

The United States ranks last in primary care providers per 1,000 among developed countries[4]. Connecticut is projected to require a 15% increase in primary care physicians by 2030 to keep pace with current utilization[5].

[1] Commonwealth Fund Scorecard on State Health System Performance, 2018, https://interactives.commonwealthfund.org/2018/state-scorecard/files/Connecticut.pdf
[2] Kaiser Family Foundation State Health Facts, 2017, https://www.kff.org/other/state-indicator/per-capita-state-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[3] America's Health Rankings 2018 Annual Report, https://www.americashealthrankings.org/
[4] Organisation for Economic Cooperation and Development, https://stats.oecd.org/Index.aspx?QueryId=30173
[5] Connecticut: Projecting Primary Care Physician Workforce, https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Connecticut.pdf

TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.



IMPACT
HEALTH EQUITY

Through capabilities focused on identifying and addressing health disparities and payment model options that recognize social factors impact cost, PCM would improve health equity in Connecticut.

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Disparities are largely driven by systemic barriers.

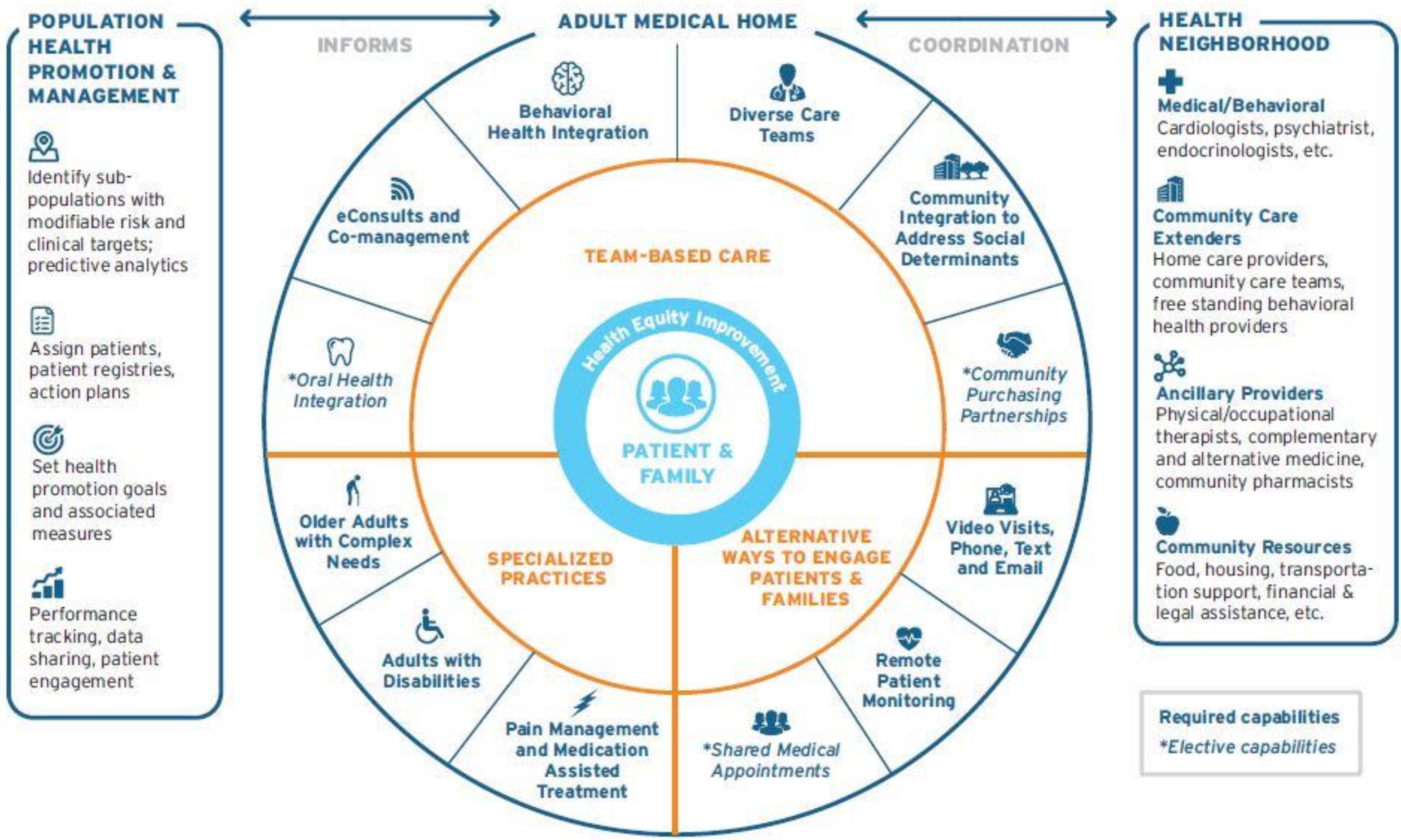
By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to address barriers such as:

- Language differences, including ASL
- Culture
- Lack of transportation, childcare, food security, housing stability
- Difficulty taking time off work
- Literacy
- Practice accessibility for people with disabilities
- Lack of communication devices for patients with speech impairments or who are non-verbal

DRAW SHARED FOCUS TO PROVEN CAPABILITIES

Practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, convenient and responsive to patients' needs while improving health equity.

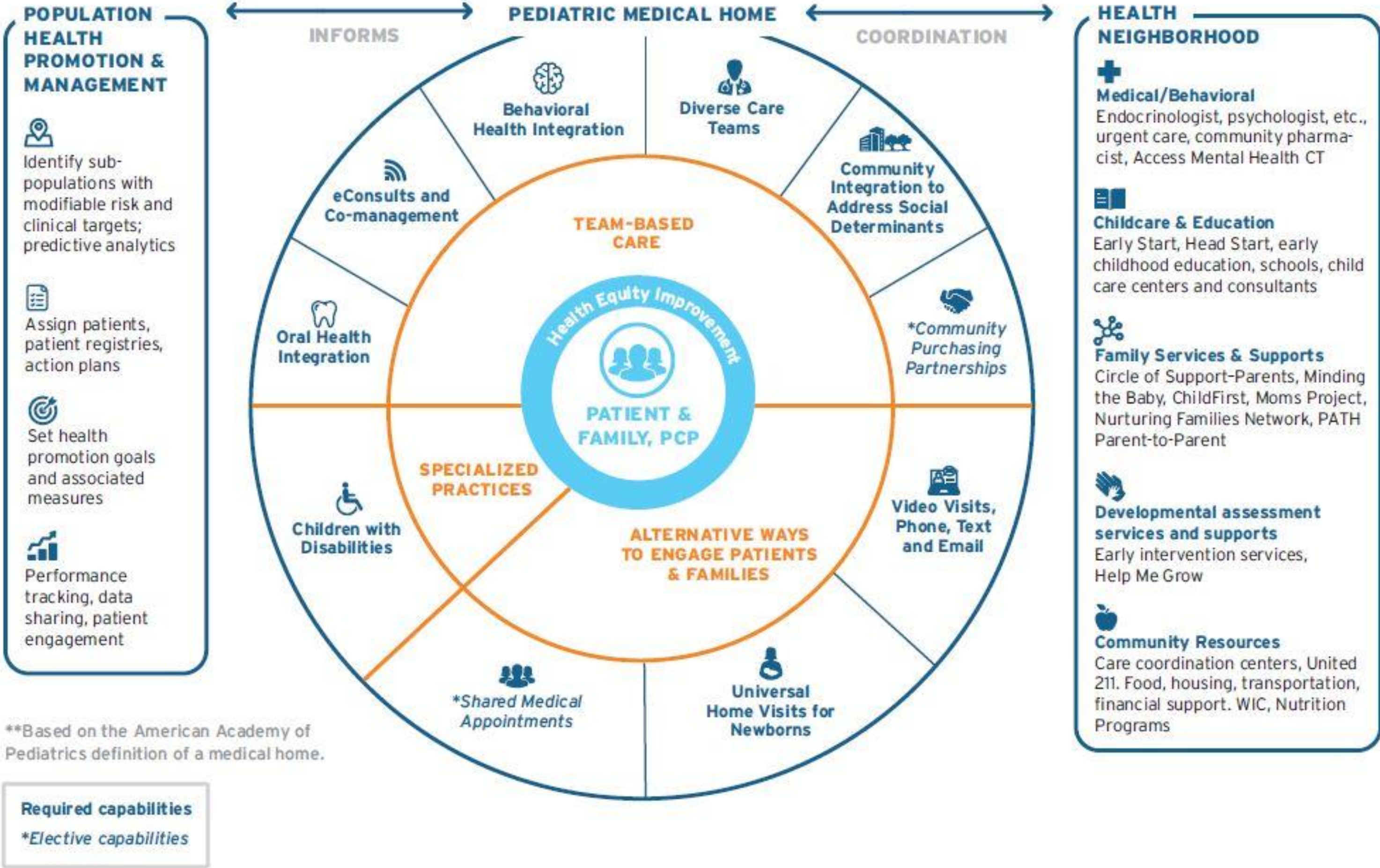
Adult Primary Care Capabilities



ADDRESS SPECIFIC NEEDS OF PEDIATRICS

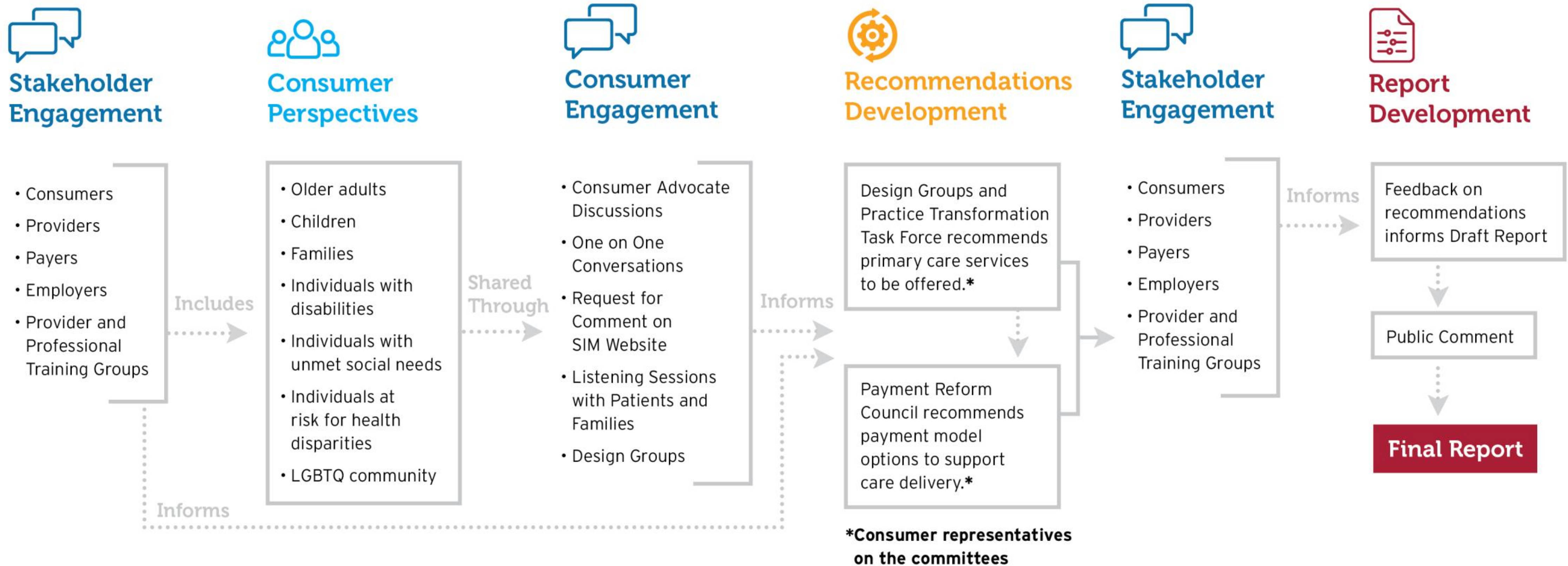
Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Pediatric Primary Care Capabilities



DESIGN SOLUTIONS WITH INPUT FROM ALL STAKEHOLDERS

More than 500 Connecticut stakeholders worked collaboratively to develop provisional recommendations that would drive immediate improvement and long-term transformation.



MEET DR. NEIL

Dr. Neil is a primary care physician trying to provide good care. She feels overwhelmed by billing, coding and other administrative hassles. She wishes she had more clinical support too.

MEET DR. NEIL'S PATIENTS

Chris and Mr. Jones need more support than Dr. Neil can provide alone. They are frustrated and worried. They want to feel well again.

CHRIS' STORY

Chris was diagnosed with Crohn's disease in her teens. Lately, her condition has been flaring up more often and its affecting her work and her mental health.

Chris' Needs

- Help managing her Crohn's flare-ups
- Support for her depression
- More coordinated care to reduce the number of specialists she is seeing
- Fewer days of missed work and fewer trips to the emergency room

Dr. Neil's Practice Solutions

- Part-time LCSW identifies behavioral health needs, makes referrals, and provides monthly support
- Coordinated care between the gastroenterologist, PCP, and LCSW
- eConsult addresses new skin problem
- Nutritionist counsels Chris on changes to her diet such as limiting fiber and dairy

MR. JONES' STORY

Mr. Jones has a complex medical history including heart failure, stroke, diabetes, and kidney disease. Recently, he began having serious complications.

Mr. Jones' Needs

- Help managing prescriptions for diabetes, congestive heart failure, kidney disease
- More frequent and closer monitoring of changes in condition
- Fewer avoidable trips to the doctor due to mobility challenges related to a stroke

Dr. Neil's Practice Solutions

- Home visit by part-time pharmacist
- eConsult with cardiologist
- Video check-ins with PCP and/or RN care manager
- Remote patient monitoring for congestive heart failure
- Frequent communication with care team through phone and email

DR. NEIL'S ADVANCED NETWORK

Dr. Neil's practice is part of ABC Health Partners. Its adult internal medicine physicians and nurse practitioners serve about 50,000 patients a year.

Five Year Primary Care Modernization Implementation Plan

YEAR 1

CARE TEAM EXPANDS. Pilot practices include RN care managers, pharmacists, CHWs. Care transitions are a focus.

PCPs and care team receive technical assistance to support workflow redesign.

Phone, text, email upgraded for better patient experience.

eConsult, remote patient monitoring offered.

YEAR 2

INTEGRATED BEHAVIORAL HEALTH PILOTED with hiring of LCSW.

Patients connected to community resources after analysis of social determinants data.

Care team expands to additional practices; new care team roles introduced. Technical assistance continues.

YEAR 3

FORMAL PARTNERSHIP LAUNCHED with local housing referral service.

Integrated behavioral health expanded to all practice sites.

Care team expansion and technical assistance continues.

YEAR 4

TWO SPECIALIZED PRACTICES DEVELOPED. One supports older adults with complex medical needs. Another focuses on chronic pain management.

Existing capabilities refined and expanded.

YEAR 5

ALL PRACTICES ACHIEVE ALL CORE CAPABILITIES.

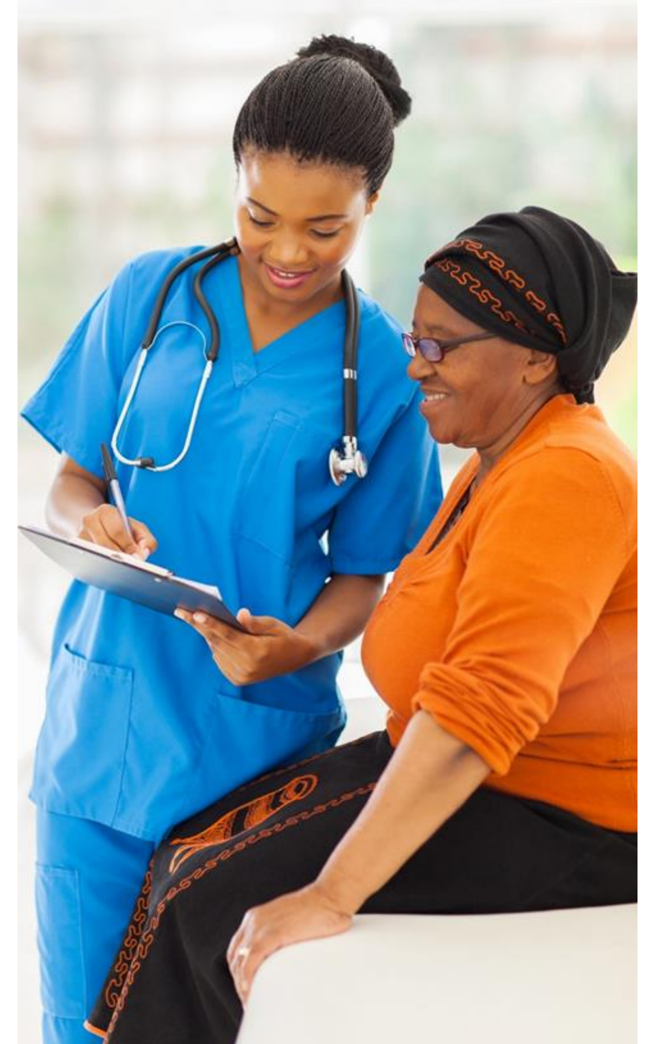
Technical assistance continues.

Two additional partnerships with community-placed resources launch.

When ABC Health Partners began MSSP, it hired five community health workers. They immediately saved money. Patients loved the program. Then, ABC Health Partners abruptly ended the CHW pilot.

Why did ABC end the CHW pilot?

- After training and overhead, the five employees cost about $300,000.
- It estimated savings of $450,000 due to avoided ED visits, hospital stays and at least one skilled nursing facility stay. .
- ABC had to split those savings with Medicare, 50/50. Its gain of $150,000 became a loss of -$75,000. For ABC, there is no reward for incremental improvements in efficiency.
- Hiring CHWs highlighted other gaps too. ABC had insufficient data to identify high-needs patients; weak connections to community resources; and lacked certain care team members to address specific needs such as pharmacists to troubleshoot medication problems.
- ABC realized it needed advance funding across its payers to redesign its systems and maximize the shared investment.



THE CASE FOR ADVANCE FUNDING

Today, many care delivery investments are not made due to structure of some shared savings programs. With upfront investment, providers have greater incentive to transform care delivery and lower costs.

THE MATH TODAY

CHW Cost Paid by Provider	$300,000
CHW Savings	$450,000
Provider Share of Savings	$225,000
Provider Loss after Costs	$225,000 - $300,000 **- $75,000**

No Win

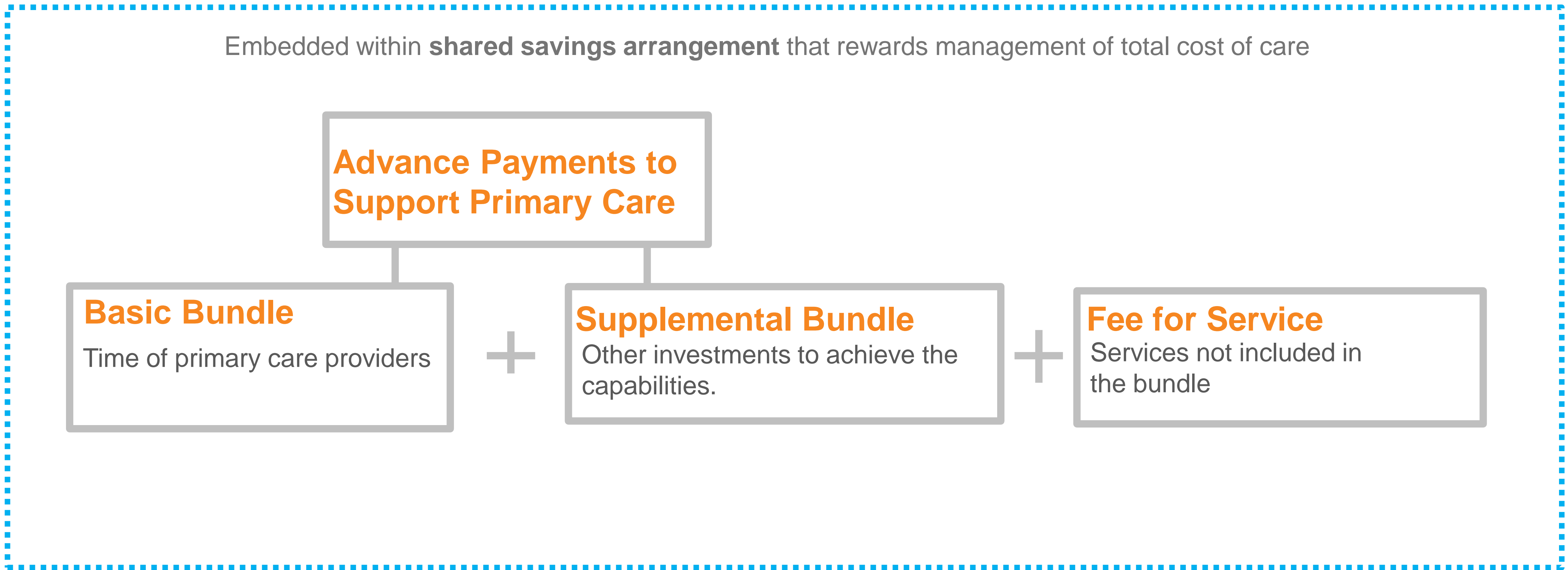
THE MATH WITH PCM

CHW Cost Paid with Advance Funding	$300,000
CHW Savings	$450,000
Savings Net of Investment	$150,000
Payer Share of Savings	**+$75,000**
Provider Share of Savings	**+$75,000**

Win-Win

UPFRONT PAYMENTS OFFER FLEXIBILITY

Clinical need and patient preference drives decision-making without the financial and administrative constraints of fee-for-service payments.



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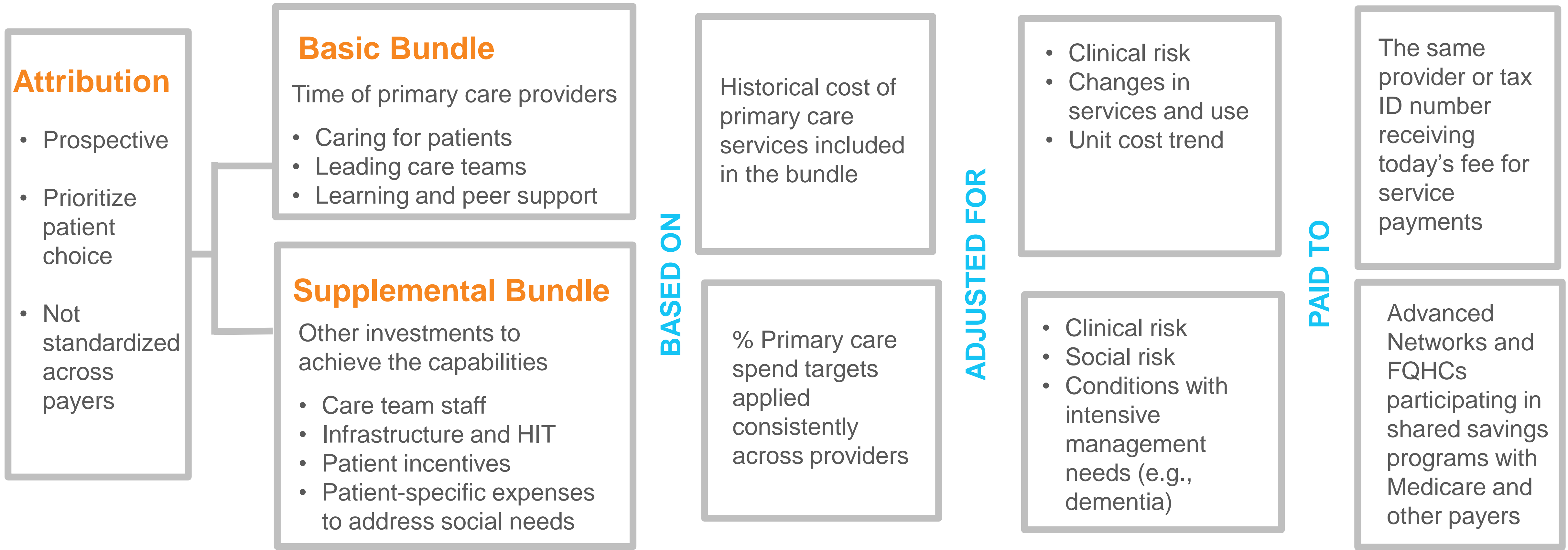


CAPTURING DATA ON PRIMARY CARE ACCESS

Using a standardized format, practices would document all patient touches by all practice-associated personnel.

Access Tracking Report ABC Healthcare								
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)**	**All Clinical Encounters & Contacts**
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

CAPTURING DATA ON PRIMARY CARE ACCESS

Types of encounters captured for all practice-associated personnel. This would provide greater insight into care delivery than available today.

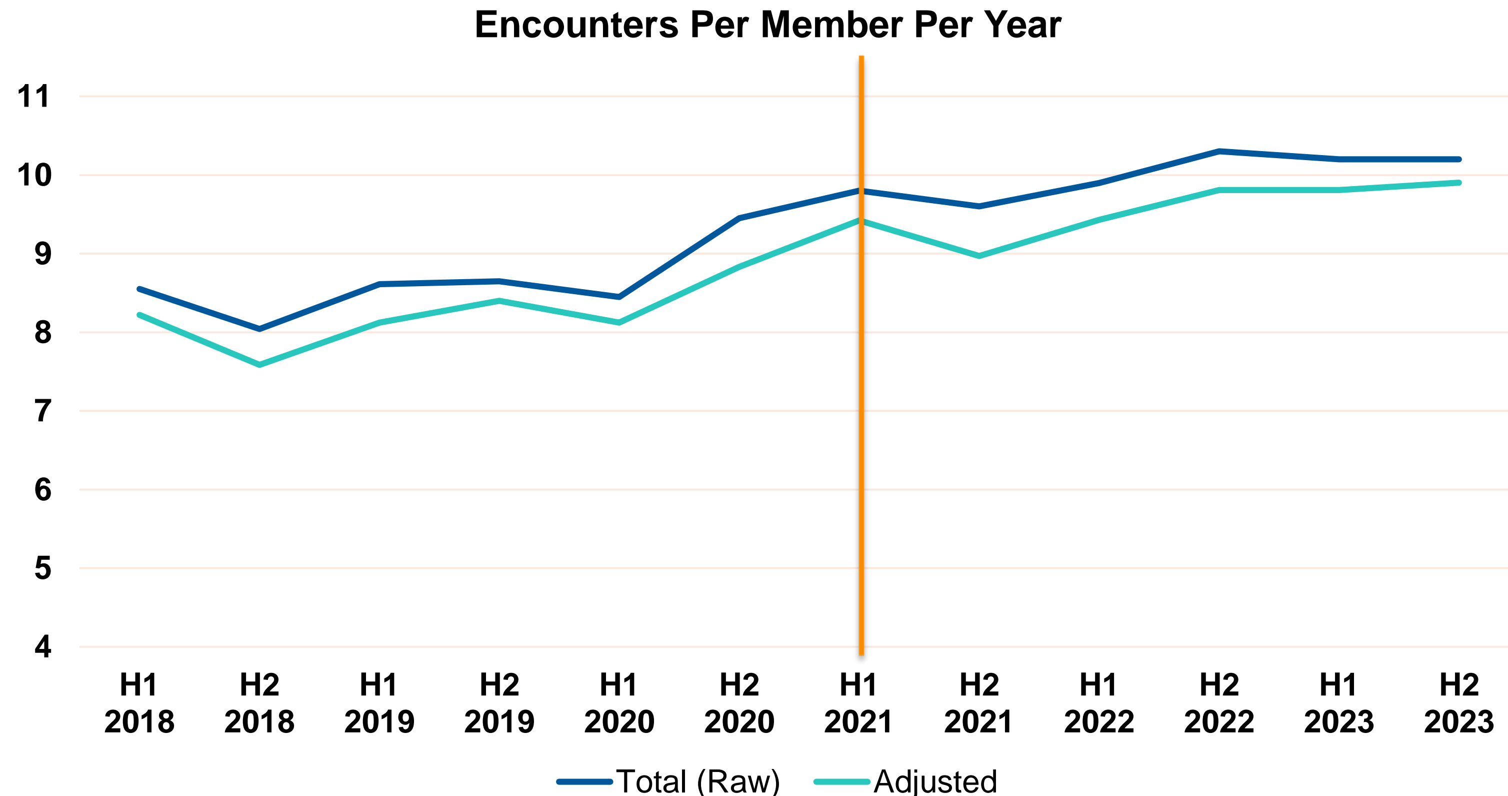
Access Tracking Report **ABC Healthcare** **April 1, 2018-March 31, 2019 (rolling 12 months)**						
Practices included: Acton, Bridgefield, Essex, Marston and Overbrook						
Clinical Encounter: Office visits with physicians, nurse practitioners and physician assistants; synchronous and asynchronous 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		**PCP**				
Total Number of Patients Attributed		**Office Visits**	**Telemedicine Visits**	**Home Visits**	**Phone/Text/E-mail contacts**	**Total Clinical Encounters**
RAW TOTALS	6,149	7,230	2,987	1,172	10,001	21,390
RAW AVERAGES (PER ENROLLEE PER YEAR)		1.18	0.49	0.19	1.63	3.48
RISK ADJUSTED AVERAGES		1.13	0.47	0.18	1.56	3.34

GENERATING THE REPORT

- AN/FQHC configures EHR to capture all care team contacts, by patient and by type of contact
- PCP and care team personnel record their patient contacts in the *normal course of business* similar to other visit types
- AN/FQHC runs a quarterly summary report (de-identified) and uploads or transmits the report in a standard format to OHS and participating payers.
- Summary report includes contacts/patient by type of coverage (Medicare, Medicaid and commercial)

SHARING DATA ON PRIMARY CARE ACCESS

As part of program monitoring, the state could report both practice and system performance over time. As an example, the total encounters for one group might appear as shown below, with the vertical line representing the start of bundled payments.



TRADE OFFS OF THE BASIC BUNDLE

The basic bundle would allow primary care teams to treat patients based on clinical need and patient preference without the constraints of fee-for-service. However, as CMS adds codes and fees for additional services, some wonder if this would be a preferable approach for all payers.

Benefits of Basic Bundle

- Maximum flexibility
- Lightened coding burden
- Option to reduce consumer cost share*

Benefits of Additional Codes and Fees

- Ease of administration for payers
- Certainty regarding services provided
- Familiarity and reliability for providers

Requirements of Both Approaches

- Documentation to ensure patient access and capabilities achieved
- Adaptation of billing systems
- Changes in culture and workflow to maximize effectiveness

** For commercial only*

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

PMPM savings reflects the estimated per member, per month savings across the entire Medicare population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Medicare Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%, inpatient costs decrease 10%. *(PWC 2016)*	$32.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$4.03
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.70
Specialized Practices: Pain Management/MAT	Total medical expense decreases 45%. *(Duke 2017)*	$2.10
Specialized Practices: Older Adults with Complex Needs	Skilled nursing facility utilization decreases 16%. *(Gross 2017)*	$15.03
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$2.34
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

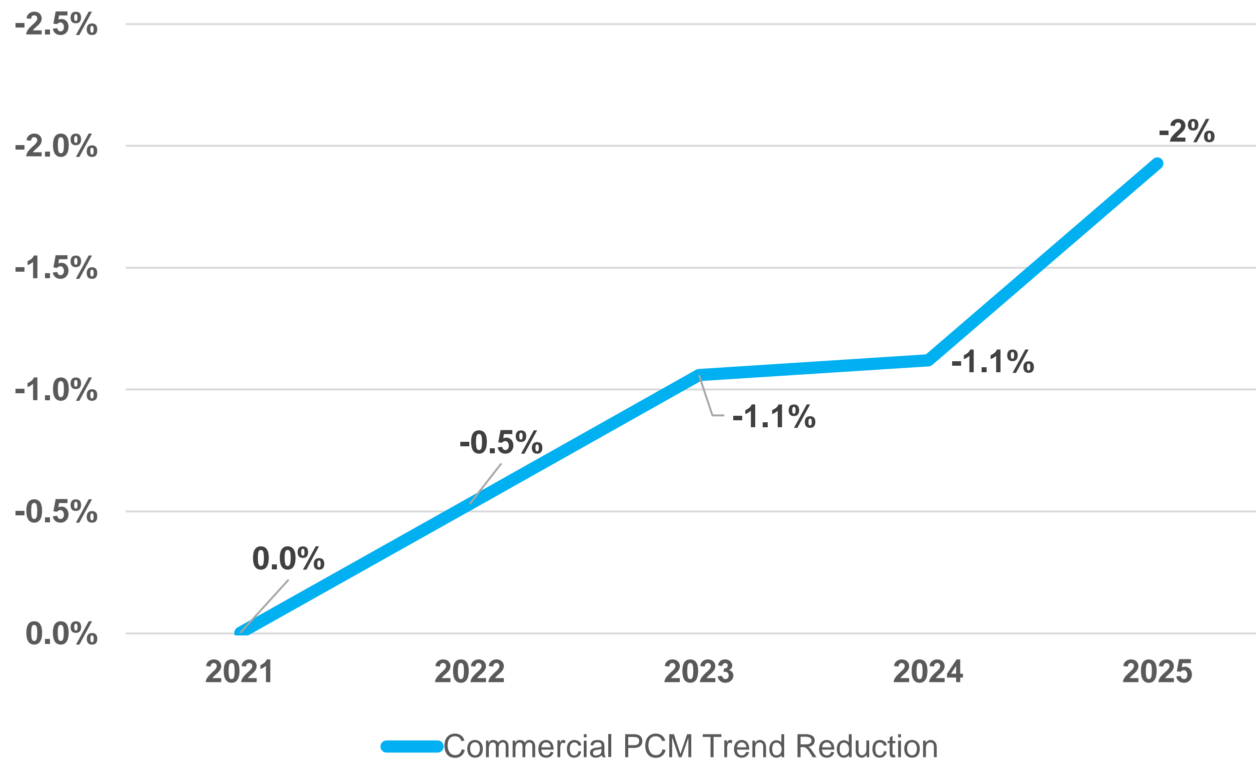
EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

PMPM savings reflects the estimated per member, per month savings across the entire Commercial population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Commercial Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%; inpatient costs decrease 10%. *(PWC 2016)* Other outpatient facility costs decrease 12% *(NEJM, 2014)*	$19.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$1.27
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 3.6-6%. *(Strumpf, 2016;* The Commonwealth Fund March 2012)	$2.00
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$1.91

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year two.



PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for commercial payers
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Four percent of spend redeployed to primary care, similar to successful BCBS MA program (NEJM, 2016)
- Aligned with value-based insurance design
- Ability to reduce consumer cost share for commercial members, if desired

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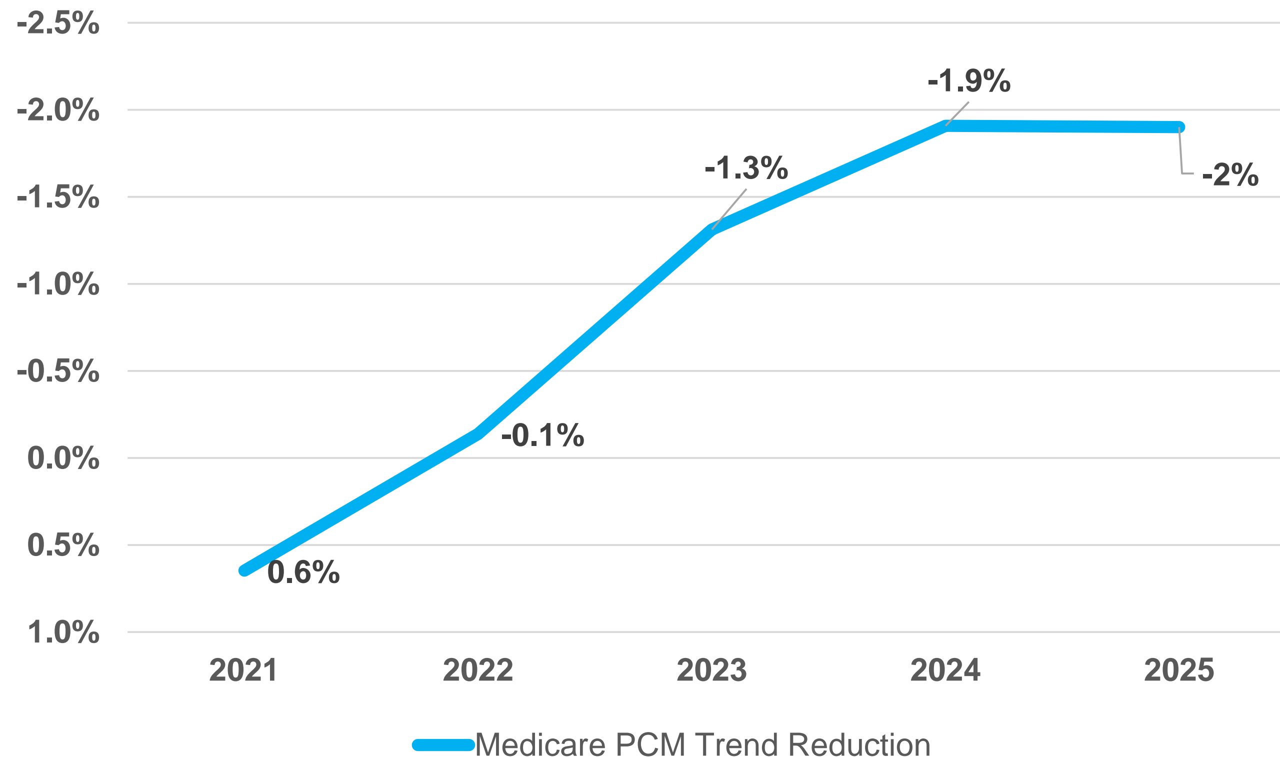
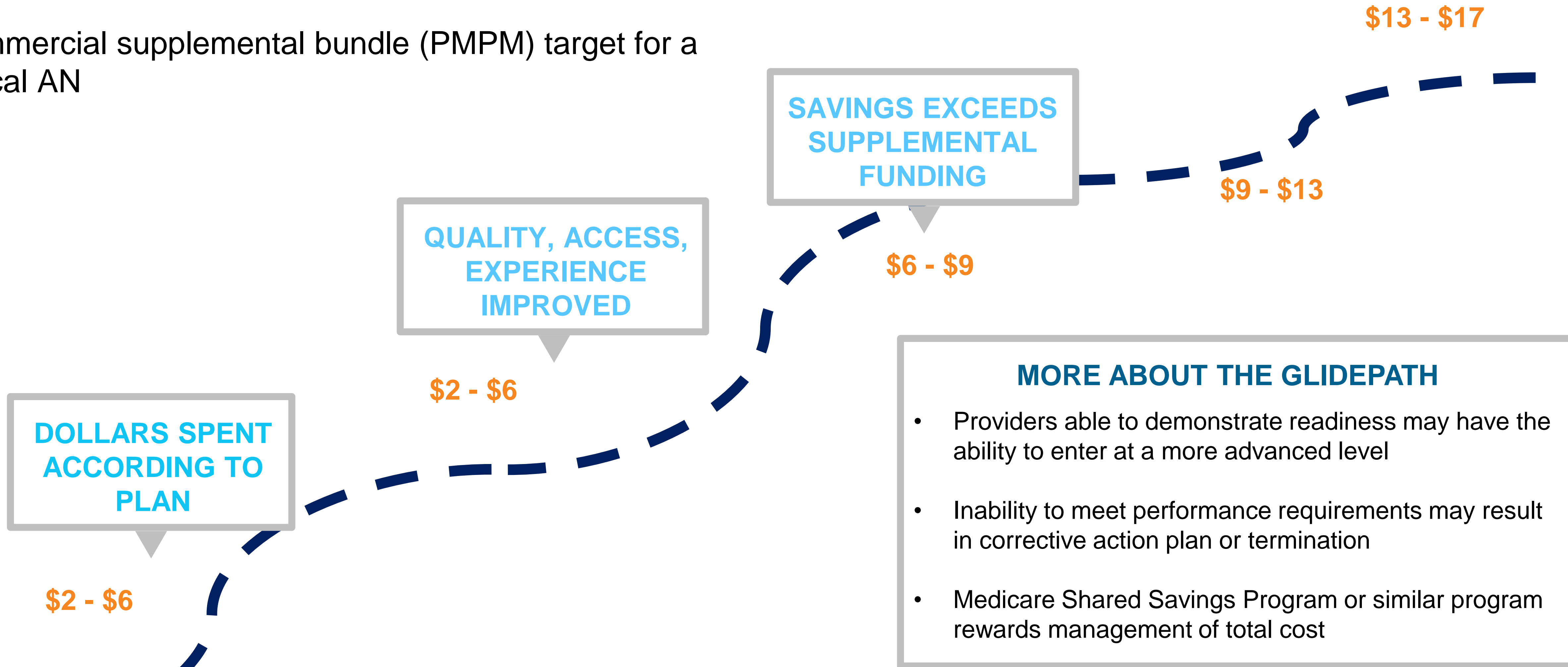


PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for Medicare
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Approximately 4.7% spend redeployed to primary care

GLIDEPATH ENCOURAGES SMART INVESTMENT

Supplemental payments will increase gradually and "proof of performance" will be required to advance.



MORE ABOUT THE GLIDEPATH

- Providers able to demonstrate readiness may have the ability to enter at a more advanced level
- Inability to meet performance requirements may result in corrective action plan or termination
- Medicare Shared Savings Program or similar program rewards management of total cost

PROVISIONAL PMPM ESTIMATES

GLIDEPATH ENCOURAGES SMART INVESTMENT

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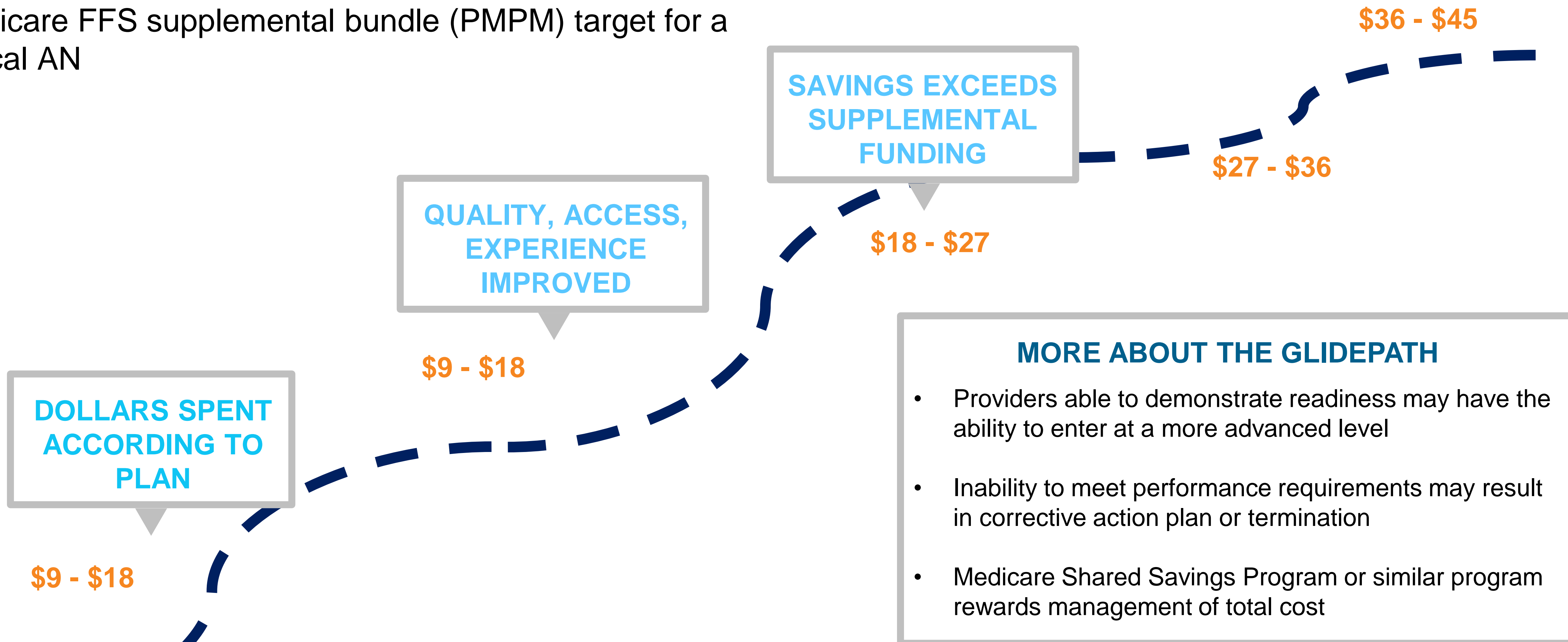


PROVISIONAL PMPM ESTIMATES

TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

BETTER ACCESS
- Convenience
- Timeliness
- Flexibility

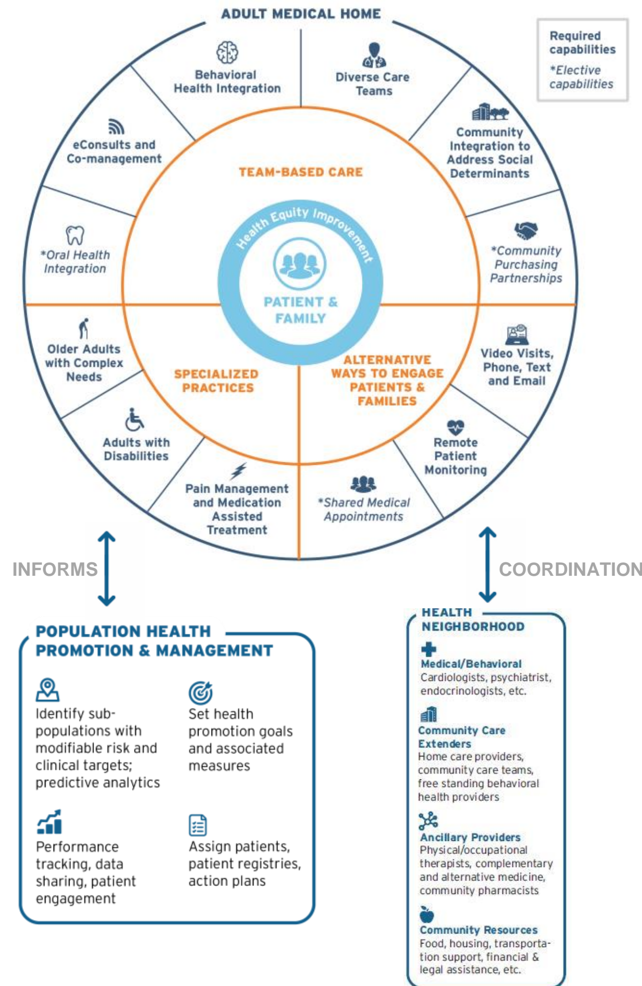
BETTER PATIENT EXPERIENCE
- Courteous and welcoming
- Listens and shares decision-making
- Advises and informs
- Coordinates and navigates

BETTER QUALITY
- Preventive care outcomes
- Chronic care outcomes
- Health equity

REVITALIZE PRIMARY CARE
- PCP and care team satisfaction
- Make primary care a more rewarding profession
- Incent incremental improvements in value

LOWER COST GROWTH
- Reduce cost growth
- Improve affordability for consumers

INPUTS



ENABLERS

BASIC BUNDLE
Advance payment for primary care provider time

SUPPLEMENTAL BUNDLE
Advance payment for primary care team staff and infrastructure

Shared savings program rewards total cost of care management

FLEXIBLE PAYMENTS

CONSUMER SAFEGAURDS
- Payments adjust for clinical and social risk
- Reporting demonstrates higher level of patient service and support

QUALITY MEASUREMENT
Quality and experience scorecard ties performance to shared savings rewards

ACCOUNTABILITY
"Proof of performance" required to qualify for supplemental payment increases

IMPACT

HEALTH OUTCOMES IMPROVE
- Diabetes & blood pressure control
- Improve rates of preventive screenings (e.g. colonoscopy)
- Reduce health inequities (e.g. race, ethnicity, income)
- Reduce percent of residents with risk factors (e.g. weight, tobacco)
- CAHPS scores improved
- Physician retention, satisfaction, recruitment increased (PCPs per 100,000)
- ED costs reduced 20%; Hospital costs reduced 10%;
- Medicare skilled nursing facility use reduced 16%;
- Commercial outpatient costs reduced 6%
- Spending on specialty care reduced 6% in Medicare and 3.6% in commercial

AFFORDABILITY IMPROVES
- 2% net reduction in total cost;
- 4.7% of Medicare, 4% commercial spend redeployed to primary care

Discussion

- Are you comfortable with the design of the proposed payment model to support PTTF approved capabilities?
- Are you comfortable with the proposed implementation approach that supports ANs and FQHCs in developing a path to achieving the capabilities over a five-year period?
- Do you have any questions about the savings estimates or the research used to develop them?
- Do you have any questions about the Access Tracking reports or how they would be generated?
- Other thoughts, questions or concerns?

SIM connecticut state innovation model

Next Steps

- Review stakeholder feedback on model in May
- Review draft report in June

DRAFT FOR DISCUSSION ONLY
SIM connecticut state innovation model

QUESTIONS?

Contact: Vinayak Sinha
vsinha@freedmanhealthcare.com

Adjourn