OHS CONNECTICUT Office of Health Strategy

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

AGENDA

- Share information on Primary Care Modernization, including a set of provisional primary care capabilities and flexible payment model options
- Hear your thoughts on the proposed initiative and whether it aligns with the interests of Connecticut's family physicians
- Discuss next steps

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…

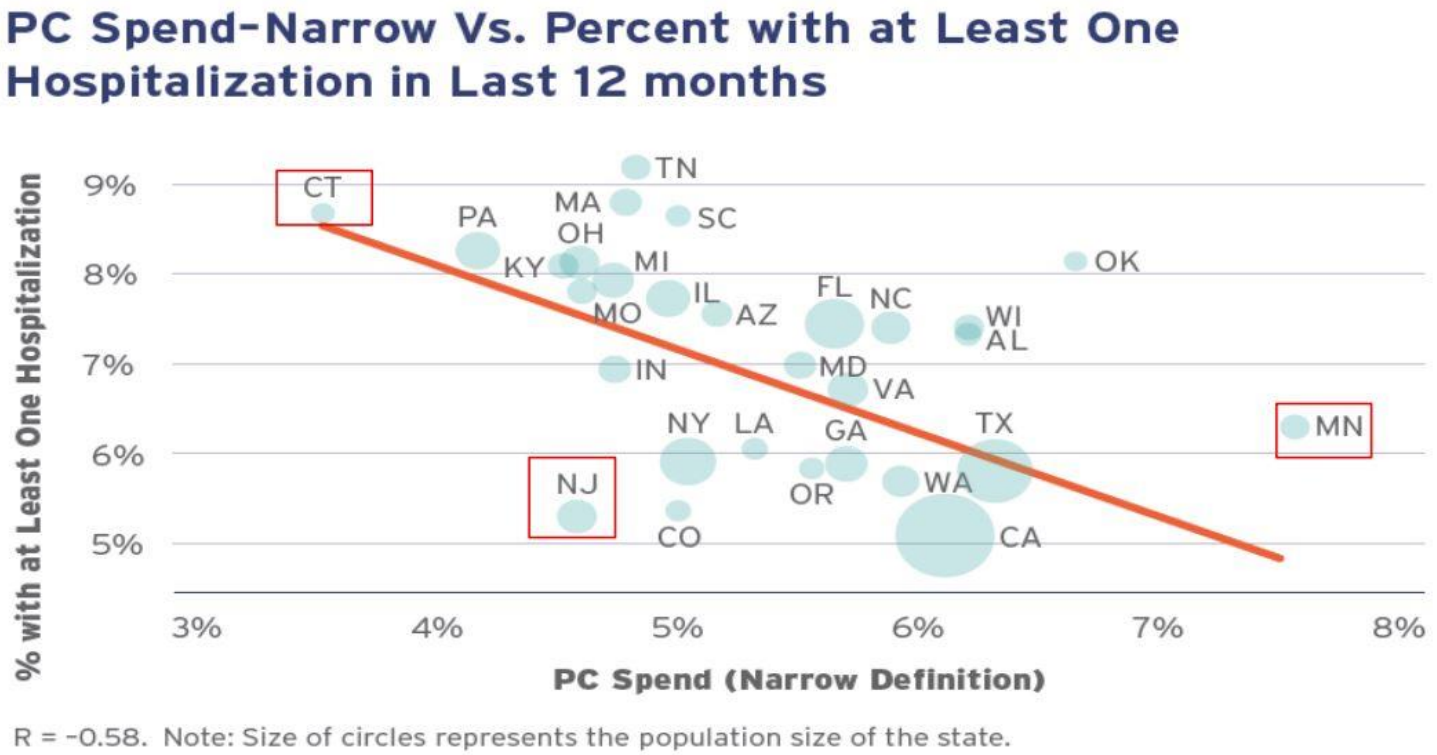
- Lowest percentage spend (3.5%) on primary care out of total healthcare expenditure of 29 state analysis[6]
- 32nd worst in the nation in avoidable hospital use and costs, largely driven by avoidable ED use[1]
- 6th highest private health insurance spending per capita and 5th highest for Medicare[2]
- 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]
- 47th worst state to practice medicine in[7]

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
[6] PCPCC Evidence Report Investing in Primary Care: A State-Level Analysis, 2019, https://www.pcpcc.org/sites/default/files/resources/PCPCC%202019%20Evidence%20Report%20Presentation.pdf
[6] Best and Worst States for Doctors: https://wallethub.com/edu/best-and-worst-states-for-doctors/11376/

PRIMARY CARE INVESTMENT

According to a narrow definition on primary care (family medicine, general practice, internal medicine, pediatrics, geriatrics), Connecticut primary care spending is the lowest of 29 states at 3.5% of total health care expenditures.



R = -0.58. Note: Size of circles represents the population size of the state.

Implications on Outcomes

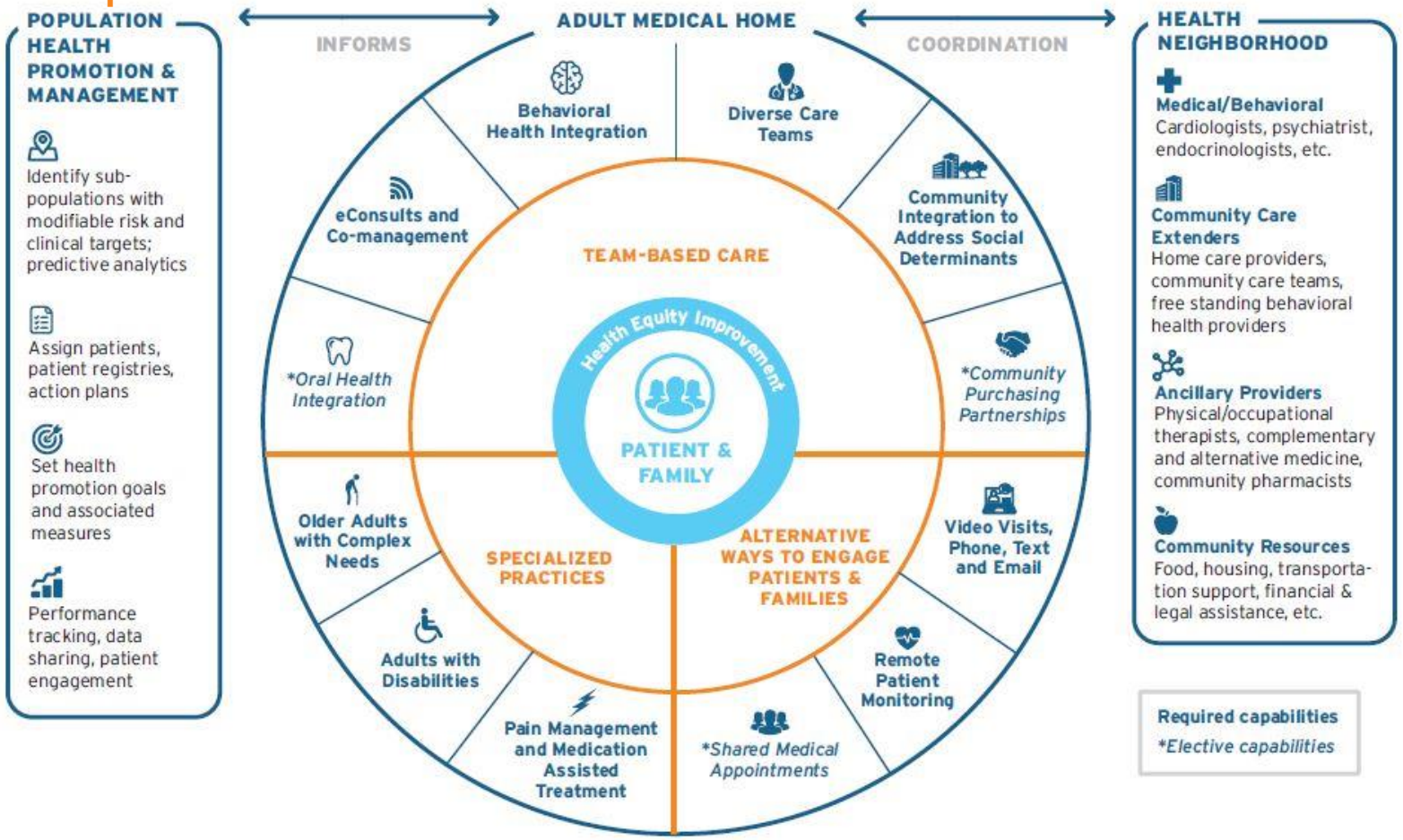
- A high population percentage with at least one hospitalization in the last 12 months
- A high population percentage with at least one ED visit in the last 12 months
- A high percentage of avoidable hospitalizations

[1] PCPCC Evidence Report Investing in Primary Care: A State-Level Analysis, 2019, https://www.pcpcc.org/sites/default/files/resources/PCPCC%202019%20Evidence%20Report%20Presentation.pdf

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

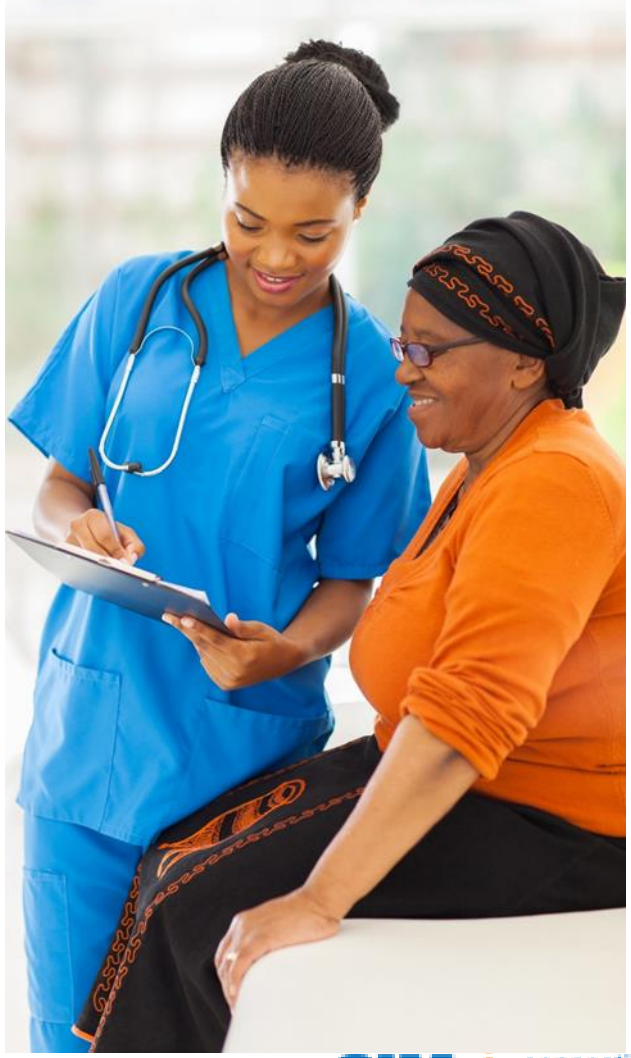


WHY DR. NEIL AND ABC HEALTHCARE NEED PCM

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 share of the savings ($225,000) results in a net loss of -$75,000 for the organization. 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

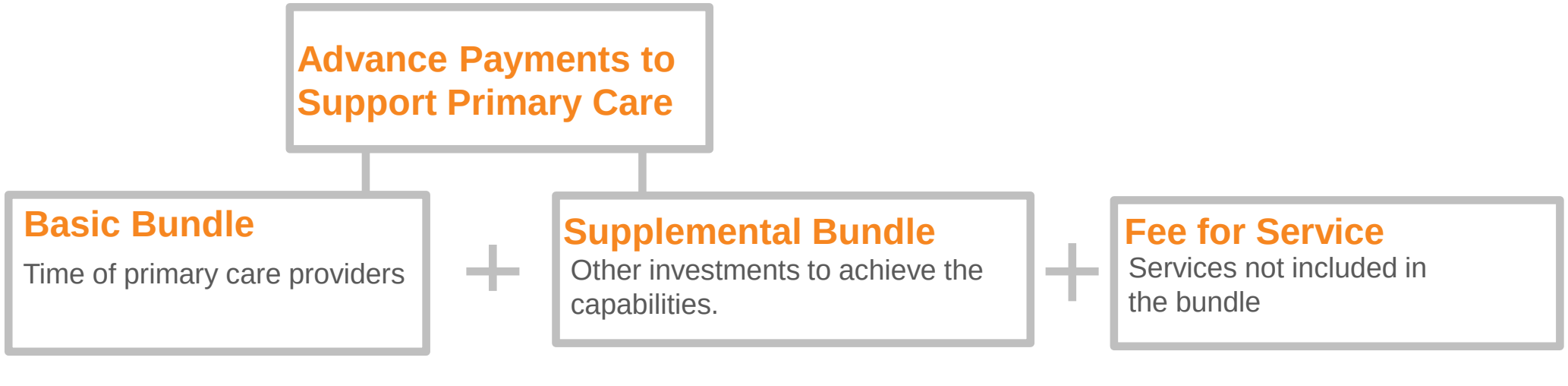
CHW Cost Paid with Advance Funding	$300,000
CHW Savings	$450,000
Savings Net of Investment	$150,000
Payer Share of Savings	**+$75,000**
Provider Share of Savings	**+$75,000**

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.

Embedded within **shared savings arrangement** that rewards management of total cost of care



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Attribution

- Prospective
- Prioritize patient choice
- Not standardized across payers

Basic Bundle

Time of primary care providers

- Caring for patients
- Leading care teams
- Learning and peer support

Supplemental Bundle

Other investments to achieve the capabilities

- Care team staff
- Infrastructure and HIT
- Patient incentives
- Patient-specific expenses to address social needs

BASED ON

Historical cost of primary care services included in the bundle

% Primary care spend targets applied consistently across providers

ADJUSTED FOR

- Clinical risk
- Changes in services and use
- Unit cost trend

- Clinical risk
- Social risk
- Conditions with intensive management needs (e.g., dementia)

PAID TO

The same provider or tax ID number receiving today's fee for service payments

Advanced Networks and FQHCs participating in shared savings programs with Medicare and other payers

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)*	$1.47
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

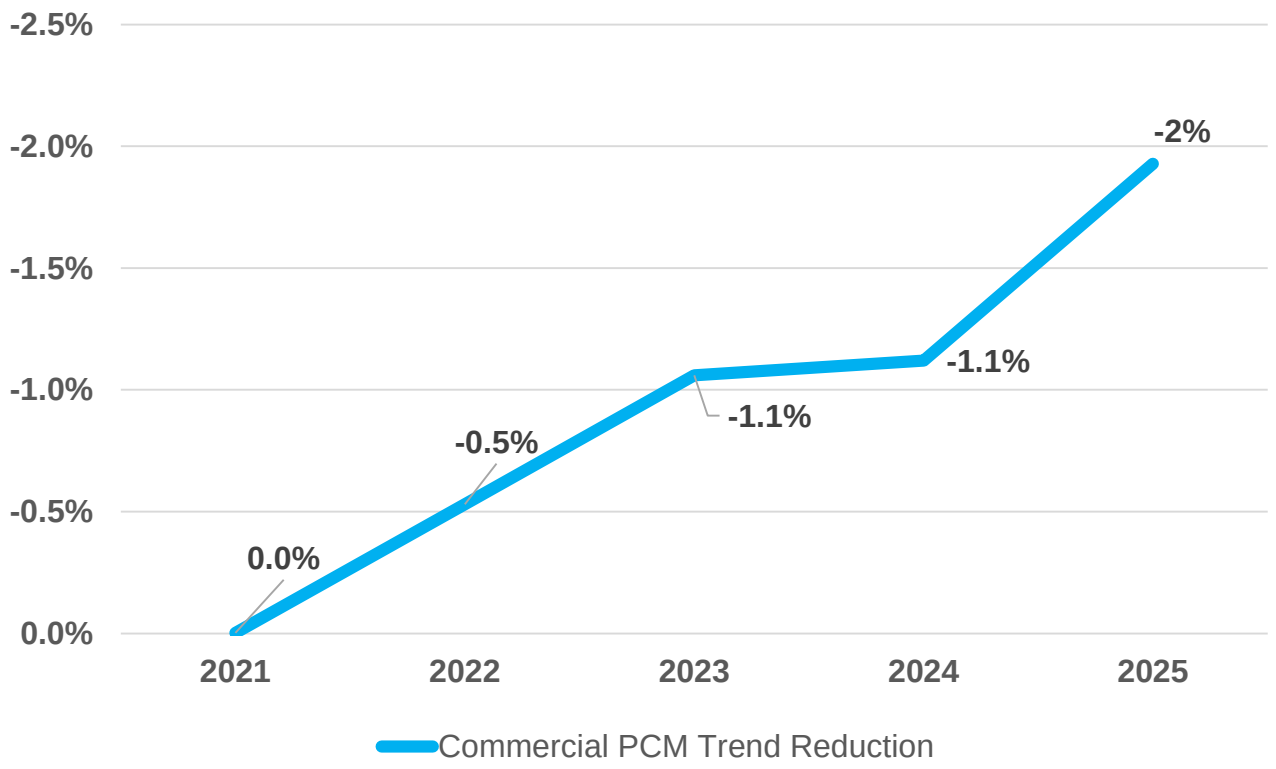
PMPM savings reflects the estimated per member, per month savings across the entire Commercial population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

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)*	$1.20

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 Impact on Commercial Total Cost of Care



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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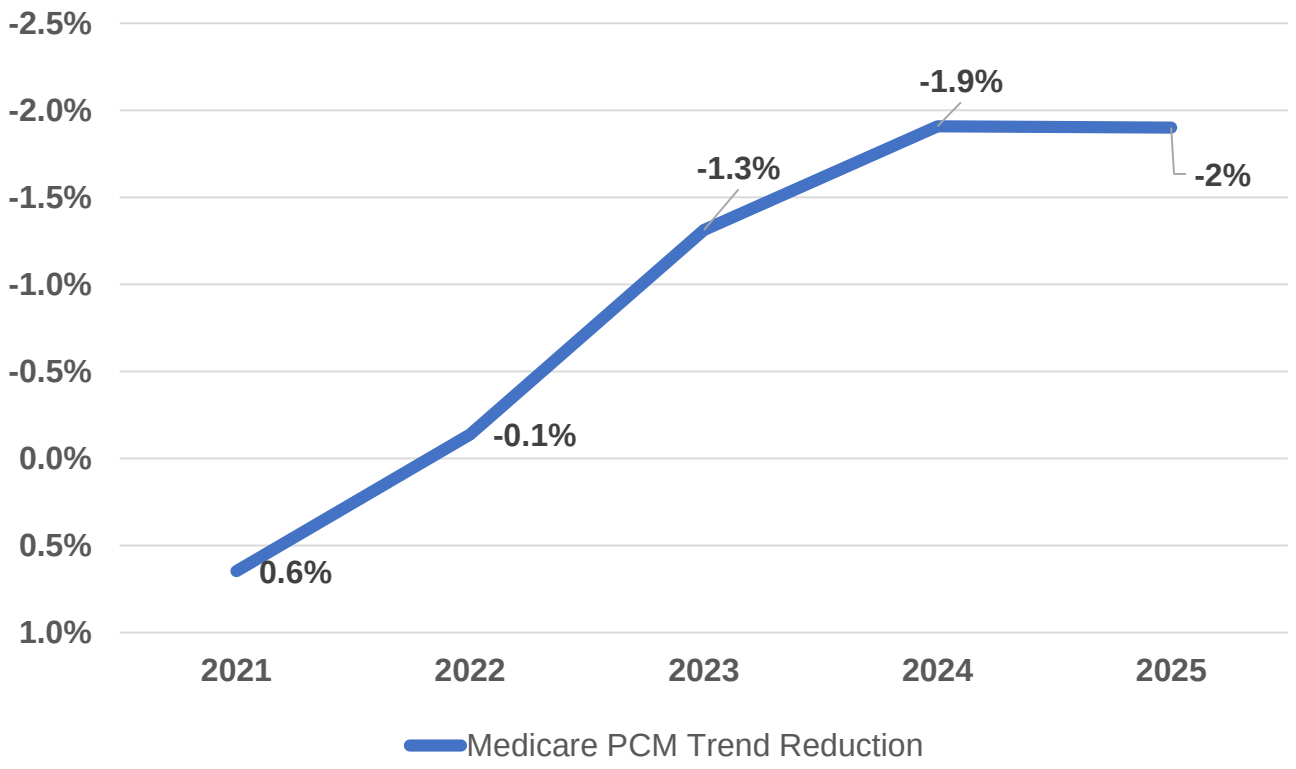
PCM Impact on Medicare Total Cost of Care



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

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

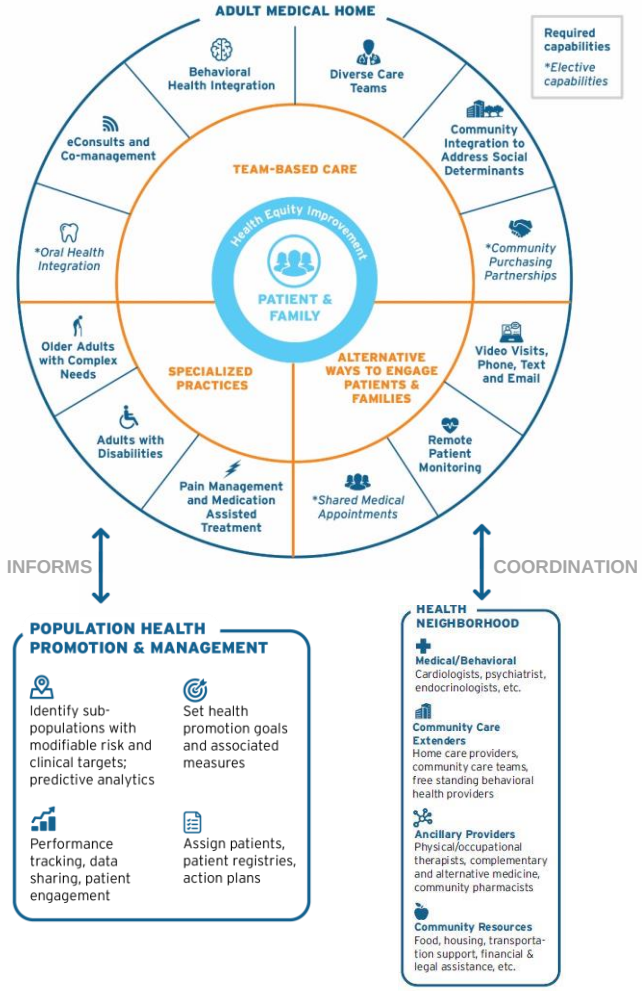
BETTER PATIENT EXPERIENCE
- Courteous and welcoming
- Listens and shares decision-making
- Advises and informs
- Coordinates and navigates

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

FLEXIBLE PAYMENTS

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

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
- Improve diabetes and blood pressure in control rates
- Improve rates of preventive screening (colonoscopy)
- Reduce health inequities (e.g. race, ethnicity, income)
- Reduce percent of residents with risk factors (e.g. weight, tobacco use)
- Improve CAHPS scores
- Increase in physician satisfaction, recruitment and retention (PCPs per 100,000)
- Reduce ED costs by 20%; hospital costs by 10%; Medicare skilled nursing facility use by 16%;
- Reduce commercial outpatient hospital costs by 6%
- Reduce specialty care spend by 3.6% in commercial and 6% in Medicare

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

QUESTIONS?

Contact: Mary Jo Condon
mcondon@freedmanhealthcare.com