Overview

• Discuss CT healthcare reform history and current landscape

• Discuss one of two major design initiatives to promote better care and better health: *Primary Care Modernization*

• Share information on a Medicare Multi-payer Demonstration as the vehicle for advancing these reform initiatives
Health Care Spending in Connecticut

- Among Highest Per Capita in the US
- Steeper Increases than Nation

**Health Care Expenditures per Capita by State of Residence: Health Spending per Capita, 1991 - 2014**

- **Health Spending per Capita**
  - United States
  - Connecticut

**SOURCE:** Kaiser Family Foundation's State Health Facts.
Healthcare Reform in Connecticut

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- SIM achievements
  - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
  - 1,000,000+ beneficiaries (all payer) attributed under shared savings arrangements
  - Commercial payers 60% aligned on Core Quality Measure Set
  - 125 practices achieved PCMH recognition through SIM
  - 5 provider organizations representing 735 PCPs and 414,174 attributed lives receiving Community and Clinical Integration Program support
  - 14 provider organizations and CBOs negotiating service agreements under Prevention Service Initiative
  - Implementation of information exchange and data analytic solutions underway
Healthcare Reform in Connecticut

- Limitations…
  - Primary care remains largely untransformed
  - Little or no savings under MSSP
  - Limited investments in preventing avoidable illness and injury
The Primary Care System We Need

Primary care’s challenges...

- Insufficient coordination and coaching
- Ineffective chronic care management
- Limited consumer support between visits
- Inconvenient; limited access via phone, email, text = more time away from work, family
- Poor integration of mental health and substance use services

How we’ve tried to fix them....

- Shared “savings” with no downside financial risk
- ASO or carrier programs to manage chronic conditions, complex cases, care transitions and care gaps
- Care coordination, decision support and occasional help navigating the system
- Investments in analytics and predictive modeling, closing gaps in care, national telemedicine

What we really need.....

- Integrated, expanded care teams that engage patients in their health, identify risks and manage conditions
- Technology to keep providers connected with each other and their patients
- Convenient, accessible care with options for email, phone, text and virtual visits
- Increased investment in primary care; bundled payment; downside risk to drive reductions in total cost of care

OHS CONNECTICUT Office of Health Strategy
# Research: Investments in Primary Care Pay Off

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<th>Example</th>
<th>Cost Savings</th>
<th>Focus</th>
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<td>Iora Health</td>
<td>Reductions in total health care costs of 15% to 20% since 2010</td>
<td>Expanded care teams, integrated behavioral health, patient support</td>
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<td>Rhode Island Commercial Health Plan Mandatory Increased Investment in Primary Care</td>
<td>Total spending per capita grew slower in RI than in any other New England state. (0.6% in RI vs. 5.5% in CT)</td>
<td>Primary Care Medical Homes, Accountable Care Organizations, HIT</td>
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<td>Boeing Intensive Outpatient Care Program</td>
<td>20% decrease in spending per patient</td>
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<td>Proven Health Navigator by Geisinger Health System</td>
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<td>Group Medical Home</td>
<td>$10.30 per patient per month</td>
<td>Primary Care Medical Home</td>
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Primary Care Modernization

Design a new model for primary care to:
• Expand and diversify care teams
• Expand patient care and support outside of the traditional office visit
• **Double** investment in primary care over five years through more flexible *bundled* payments
• Reduce trend in total cost of care

**Foundational Assumptions for designing model:**
• Eligibility limited to practices in Advanced Networks/ACOs/FQHCs
• Multi-payer
• Existing MSSP or other shared savings arrangements remain in place, but model introduces downside risk *(may propose program adjustments)*
• Hybrid, partial or full bundle for primary care services
Support from CT Providers & Consumers

“The changes suggested and recommendations offered are essential to move our state and our nation out of the dismal performance on quality metrics globally that we currently occupy.” - **H. Andrew Selinger, MD, Family Medicine Physician.**

“We need more flexibility in how primary care is paid for so that we can take further strides towards innovative, patient-centered, and interprofessional care.” - **Yale Primary Care Progress.**

“This draft presents the possibility to rejuvenate and remake primary care in the state of CT. When you think about it, the primary care provider drives the cost of the system down if they have the time needed— we keep patients out of the hospital, same day visits keep patients out of urgent care, and we know our patients so prevent medication interactions or use of medications that a patient has had an adverse effect with.” - **Rebecca Andrews, MD, Governor, CT chapter, American College of Physicians.**

“The Fee-For-Services (FFS) model does not promote the overall health of primary care patients. The FFS model only rewards providers who schedule more patient visits, order more tests, and negotiate higher fees with payers.” - **Theanvy Kuoch, Executive Director of Khmer Health Advocates.**
Stakeholder Engagement

STAKEHOLDER ENGAGEMENT
- Primary Care Practices
- Advanced Networks
- Federally Qualified Health Centers
- Employers
- Employees
- Individual Payers
- Hospitals/Health Systems
- Health care provider and professional training programs

Input & Feedback

Healthcare Innovation Steering Committee

Practice Transformation Task Force

Payment Reform Council

DESIGN GROUPS
- Genomic Medicine
- Adult Behavioral Health Integration
- Pediatric Behavioral Health Integration
- Diverse care teams
- Pain Management
- Community Integration
- Pediatric Practice
- Older Adults w/ Complex Needs
- Persons w/ Disabilities

Payment Reform Council

STAKEHOLDER ENGAGEMENT
- HIT Council
- Quality Council
- CHW Advisory Committee
- Healthcare Cabinet
- Medical Assistance Program Oversight Council*
- Behavioral Health Partnership Oversight Council*
- Office of Workforce Competitiveness

*Pending DSS initiated collaboration agreement
Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients’ Needs

Diverse Care Teams
- Pharmacists, Nurses
- Care Coordinators, Community Health Workers
- Health Coaches, Nutritionists

Alternative Modes of Support & Engagement
- Phone/Text/e-mail
- Home Visits
- Telemedicine

Technology
- Patient generated data & Remote patient monitoring
- Precision & Genomic Medicine
- E-Consults

Integration and Specialization
- Behavioral Health Integration
- Practice Specialization (e.g., geriatrics, chronic pain)
- Community Integration
Preventive Care to Avoid Acute to Chronic Pain Progression
- Basic assessments, diagnosis, and care planning
- Self-care, e.g., nutrition, exercise, meditation, and self-management resources
- Referrals of complex cases to advanced treatment

Routine Care for Acute and Chronic Pain
- Team-based, biopsychosocial approach to care
- Treatment for acute and chronic pain
- Appropriate prescribing and management for pain meds

Advanced Primary Care Chronic Pain Management
- Chronic pain management and reassessment
- Specialized expertise in alternative therapies, e.g., behavioral health, acupuncture, self-management, etc.

Centers of Excellence in Pain Management
- Pain re-assessment service
- Multidisciplinary team-based care
- Advanced pain medicine diagnostics and interventions

Medication Assisted Treatment (MAT)
- Treatment for opioid addiction

Subset of Primary Care Providers with specialized expertise in pain management or MAT

All Primary Care Providers

Primary care referrals to subspecialty care for pain, and Centers of Excellence for pain for most complex cases

Specialized PCPs manage complex patients and provide reassessment services and consultative support to all network PCPs

COEs provide
- Subset of PCPs: Project Echo guided practice, eConsults, and reassessment service to support advanced pain management
- All PCPs: Training and technical assistance in pain assessment and management

Increasing pain acuity and treatment complexity

Patient education and engagement at all levels of care

Routine Care for Acute and Chronic Pain

Preventive Care to Avoid Acute to Chronic Pain Progression

Advanced Network / FQHC
Payment Model Options: Key Questions

Basic Bundle
• Which services to include?
• Still pay additional, reduced fee for office visits?
• Base off previous experience?

Supplemental Bundle
• Paid separately?
• Risk adjusted?

Fee for Service Payments
• What services will still be paid fee for service?

MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

• How will patients be attributed to providers?
• How will payments flow to advanced networks and FQHCs?
• How might internal compensation models and patient cost-sharing need to adjust?
• How could these primary care payment options fit into broader shared savings/downside risk programs aimed total cost of care?
Aligned and Complementary Reforms
Connecticut’s augmented strategy to incentivize quality and prevention

Payer/provider focused delivery system and finance reforms intended to support better health care outcomes for attributed patients

PCM
ACOs
PSI

Develop better community linkages

Community Members

HEC
Multi-sector investments that reward community partners that contribute to prevention outcomes for community members

Improve access to high-quality primary care
Reform Goals Require Engagement Across Payers and Providers

Medicare Multi-Payer Demonstration

• A multi-payer demonstration project to improve health, drive efficiency and reduce total cost of care
• Pay for primary care differently by leveraging payment ‘bundles’ to support advanced care delivery
• Create an innovative community-driven model that can encourage investments in community health by monetizing prevention efforts
• In Maryland, Vermont, and Pennsylvania, negotiated agreements with CMS have enabled Medicare investment and participation in model reforms.
• These demonstrations typically:
  • Define how Medicare will invest in the model
  • Constrain Medicare growth compared to a defined baseline
  • Achieve statewide cost growth reductions compared to a defined baseline
• OHS has begun preliminary discussions with CMS about engaging Medicare in our reform effort
Discussion