Primary Care Modernization and Health Enhancement Communities: Pathways to Better Care and Better Health

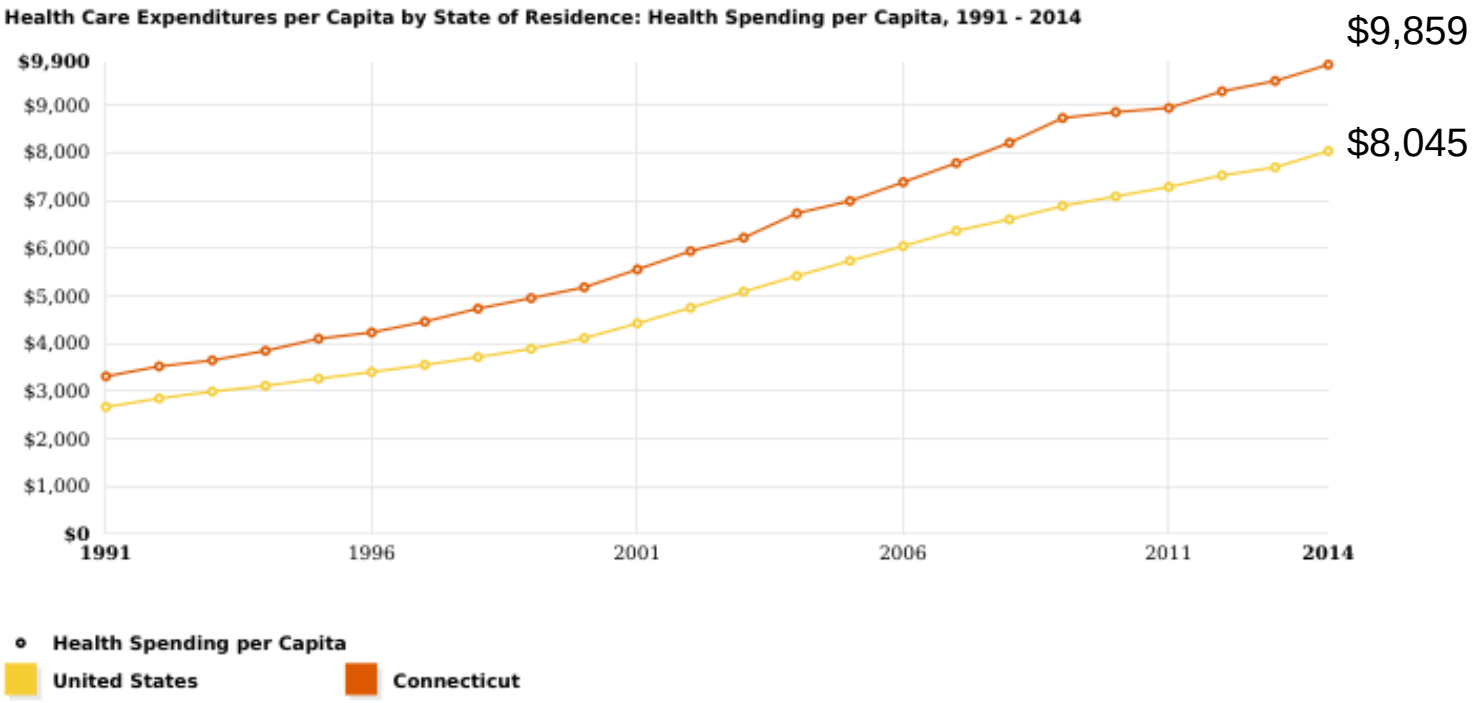
Presentation to the Delaware Primary Care Collaborative

October 10, 2018

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



SOURCE: Kaiser Family Foundation's State Health Facts.

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

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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

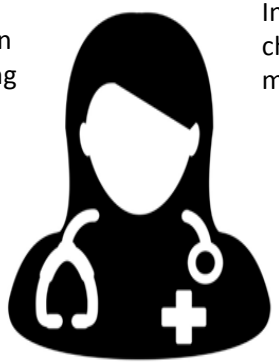
- Limitations…
  - Primary care remains largely untransformed
  - Little or no savings under MSSP
  - Limited investments in preventing avoidable illness and injury

The Primary Care System We Need

Primary care's challenges…

Insufficient coordination and coaching

Ineffective chronic care management



Too little revenue dedicated to primary care, inflexible FFS payment

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

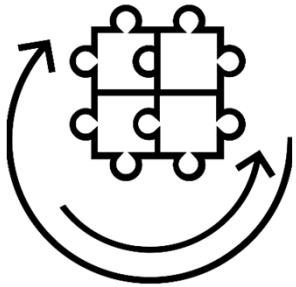
Care coordination, decision support and occasional help navigating the system

Investments in analytics and predictive modeling, closing gaps in care, national telemedicine

ASO or carrier programs to manage chronic conditions, complex cases, care transitions and care gaps

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

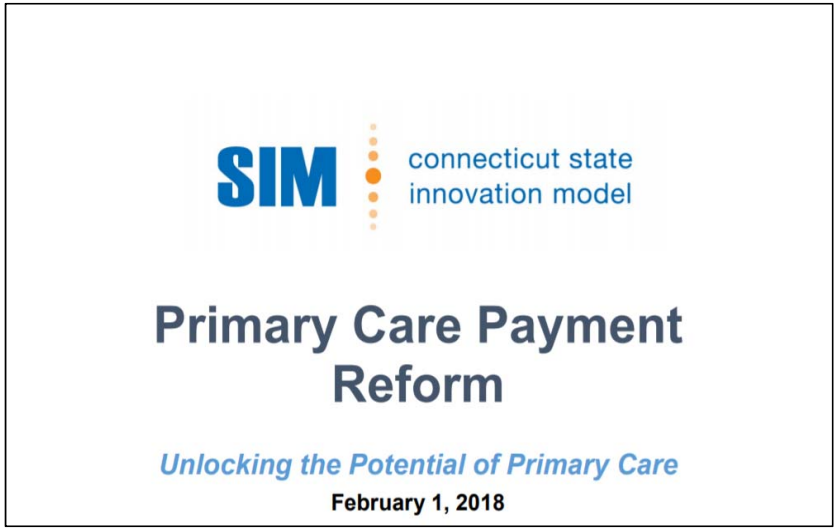
Research: Investments in Primary Care Pay Off

Example	Cost Savings	Focus
Iora Health	Reductions in total health care costs of 15% to 20% since 2010	Expanded care teams, integrated behavioral health, patient support
Rhode Island Commercial Health Plan Mandatory Increased Investment in Primary Care	Total spending per capita grew slower in RI than in any other New England state. (0.6% in RI vs. 5.5% in CT)	Primary Care Medical Homes, Accountable Care Organizations, HIT
Boeing Intensive Outpatient Care Program	20% decrease in spending per patient	High-Intensity Primary Care
Proven Health Navigator by Geisinger Health System	1.7 ROI	Primary Care Medical Home
Group Medical Home	$10.30 per patient per month	Primary Care Medical Home

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

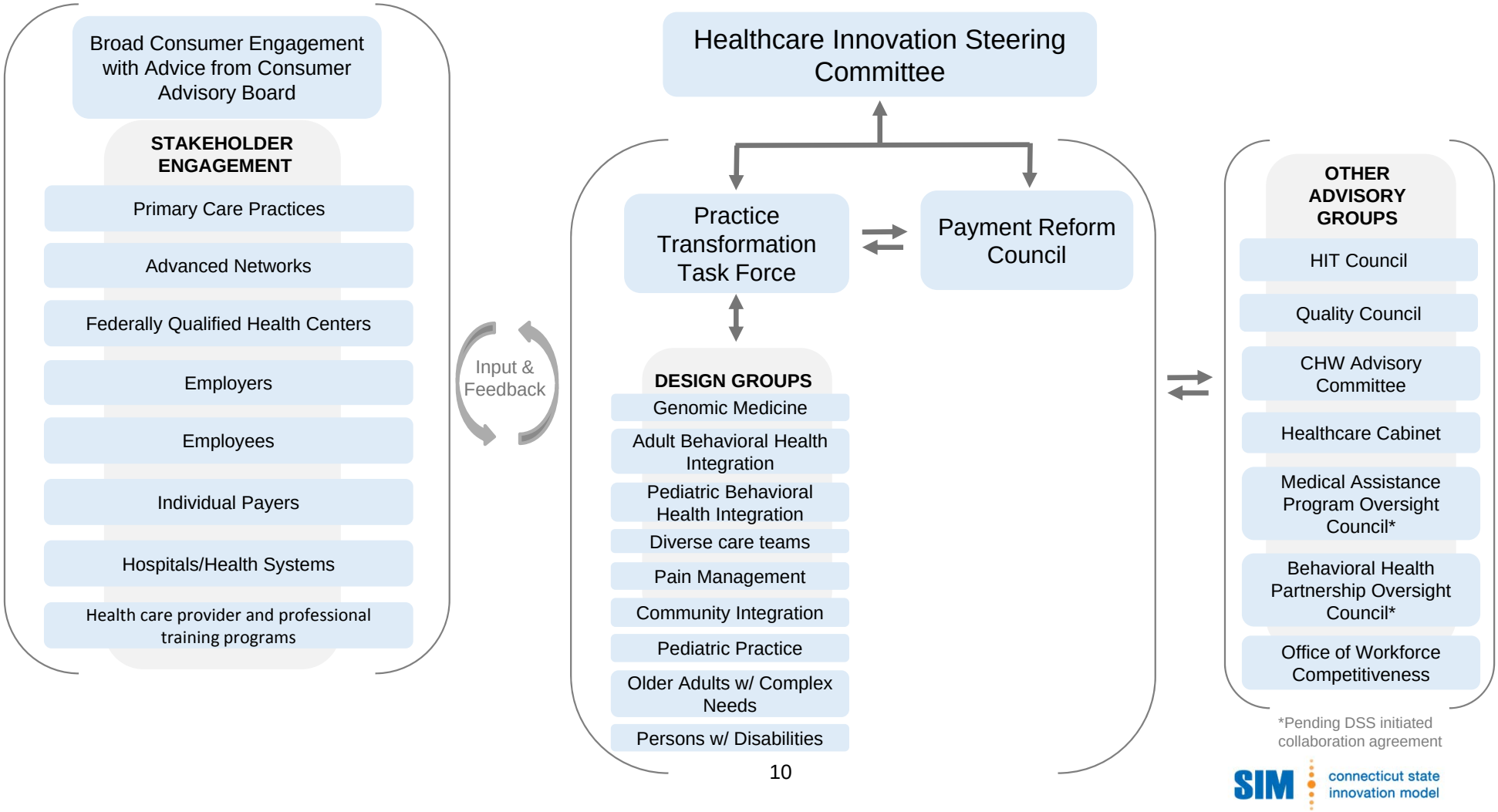
“The changes suggested and recommendations offered are essential to move our state and our nation out of the dismal performance on quality metrics globally that we currently occupy**.”** - **H. Andrew Selinger, MD, Family Medicine Physician.**

“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



*Pending DSS initiated collaboration agreement

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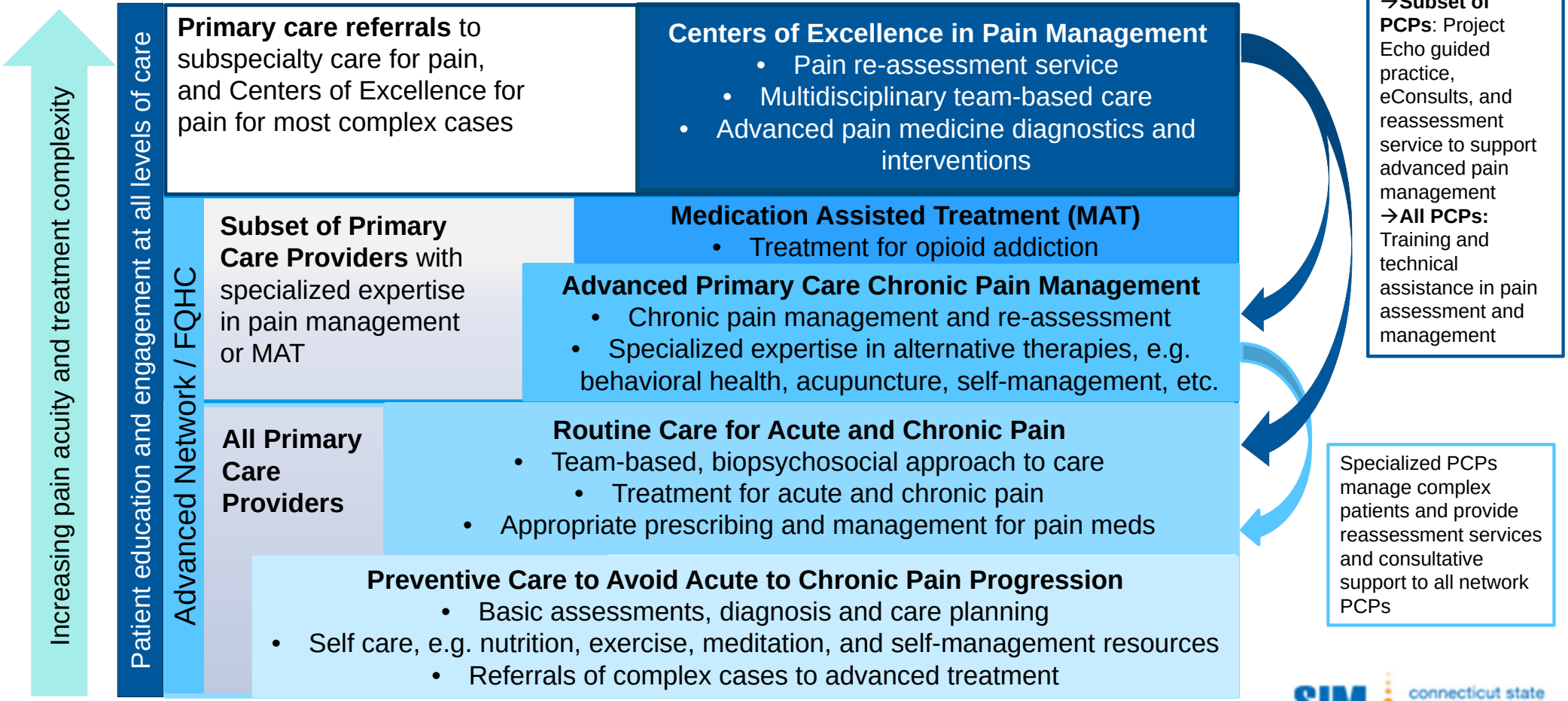
Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients' Needs

Primary Care Modernization – DRAFT Concept Map for Pain Management



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

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

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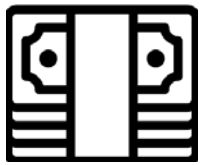
Payment Model Options: Key Questions

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

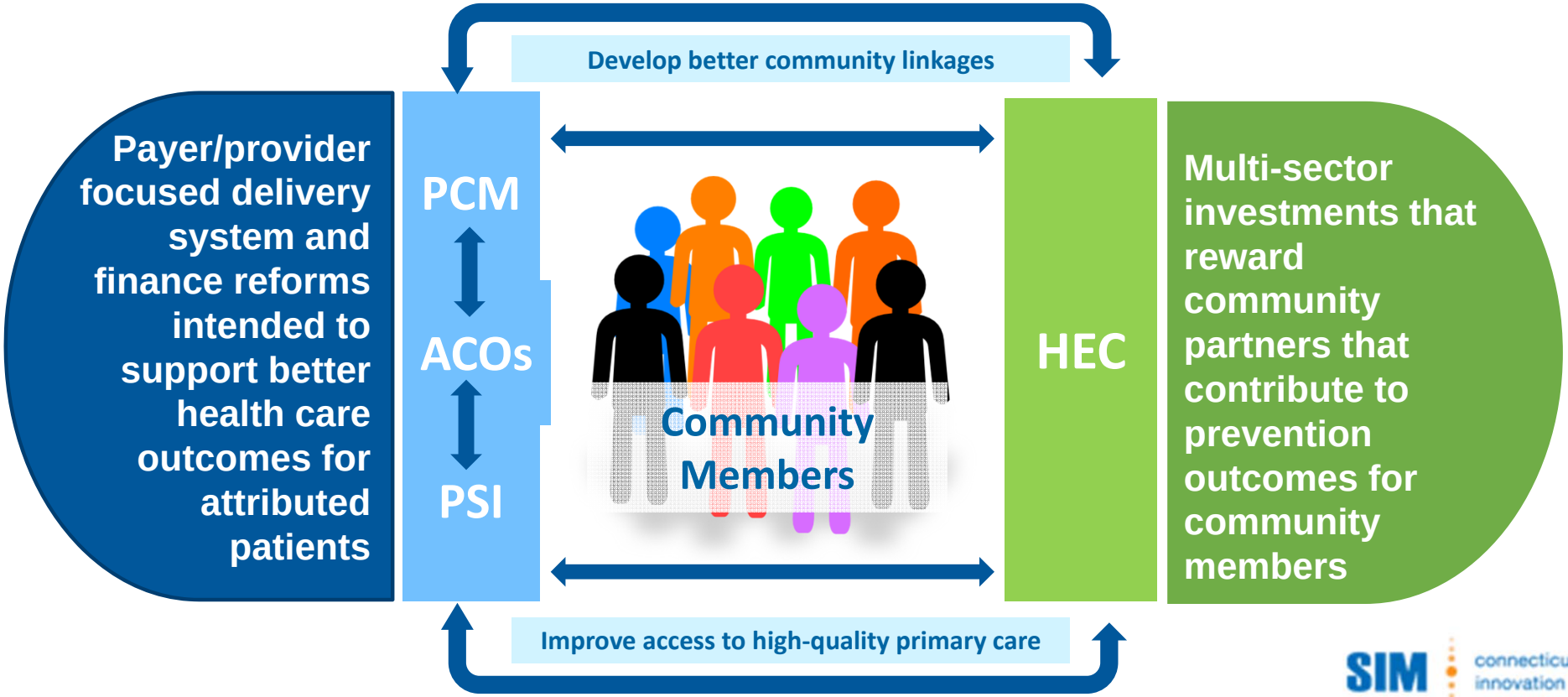
- ***What services will still be paid fee for service?***

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



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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