Connecticut SIM
December 09, 2013

Approach

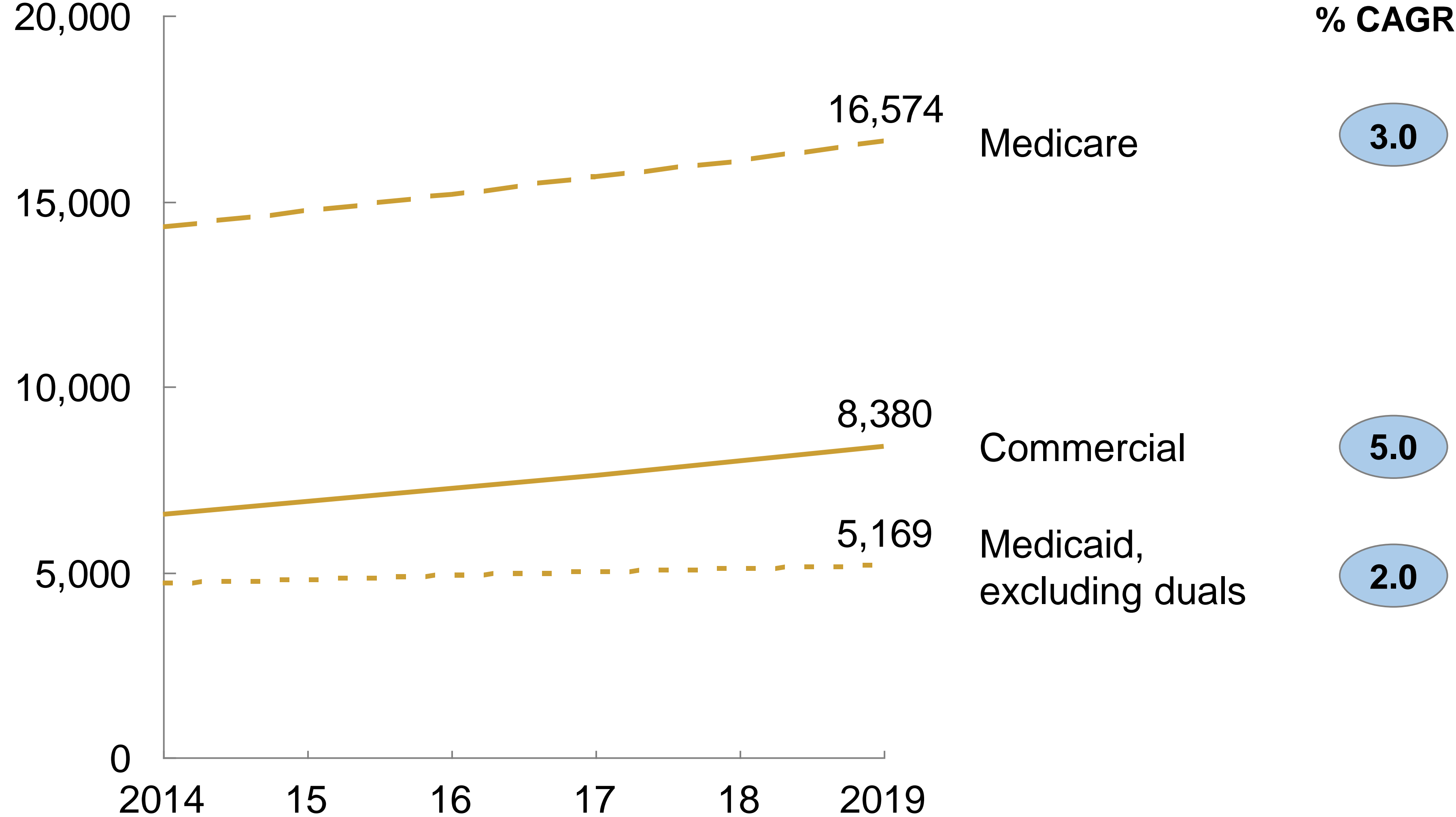
To support the state and key stakeholders' decision-making process on SIM model design and roll-out strategy, we have modeled the potential savings impact and investment requirements of Connecticut's Advanced Medical Home (AMH) model.

There are five major components of the CT SIM impact and investment model:

- **Baseline spending.** Expected growth in enrollment and cost per enrollee
- **Pace of adoption**. Expected penetration of the new payment models based on targeted provider adoption and payer adoption
- **Impact before investments**. Potential savings that can be generated from the proposed Shared Savings Program (SSP) and Pay for Performance (P4P) programs
- **Value-based payments to providers**. Care coordination fees, P4P payments and/or Shared Savings payments
- **Investments**. Required amount of investment in care coordination fees, practice transformation support, HIT, and program management

Baseline healthcare spending

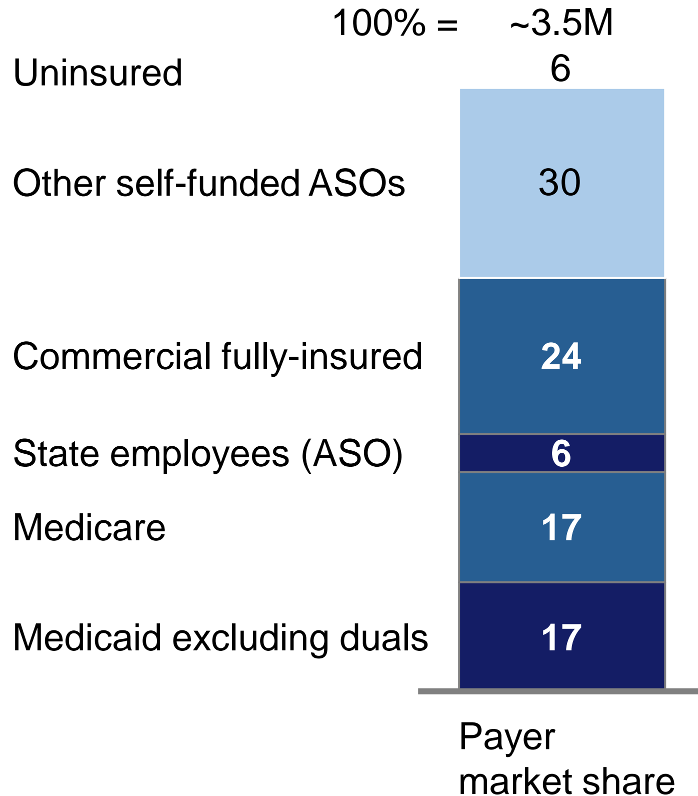
$ per member per year



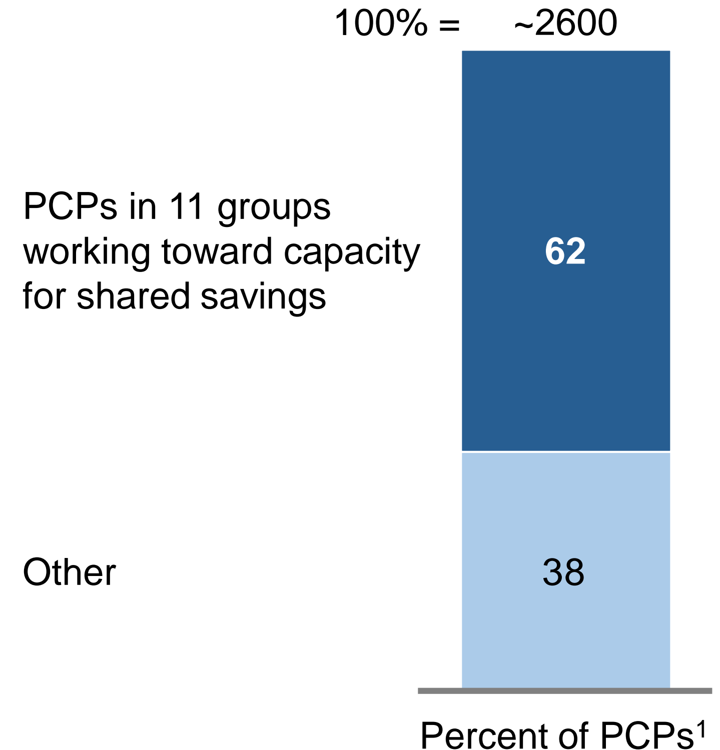
SOURCE: Interstudy, CT Office of the State Comptroller, RAND, Connecticut DSS, CMS, team analysis

Breakdown of population by payer type, and PCPs by affiliation

Insurance status of individual lives
% of individuals (2014 estimate)



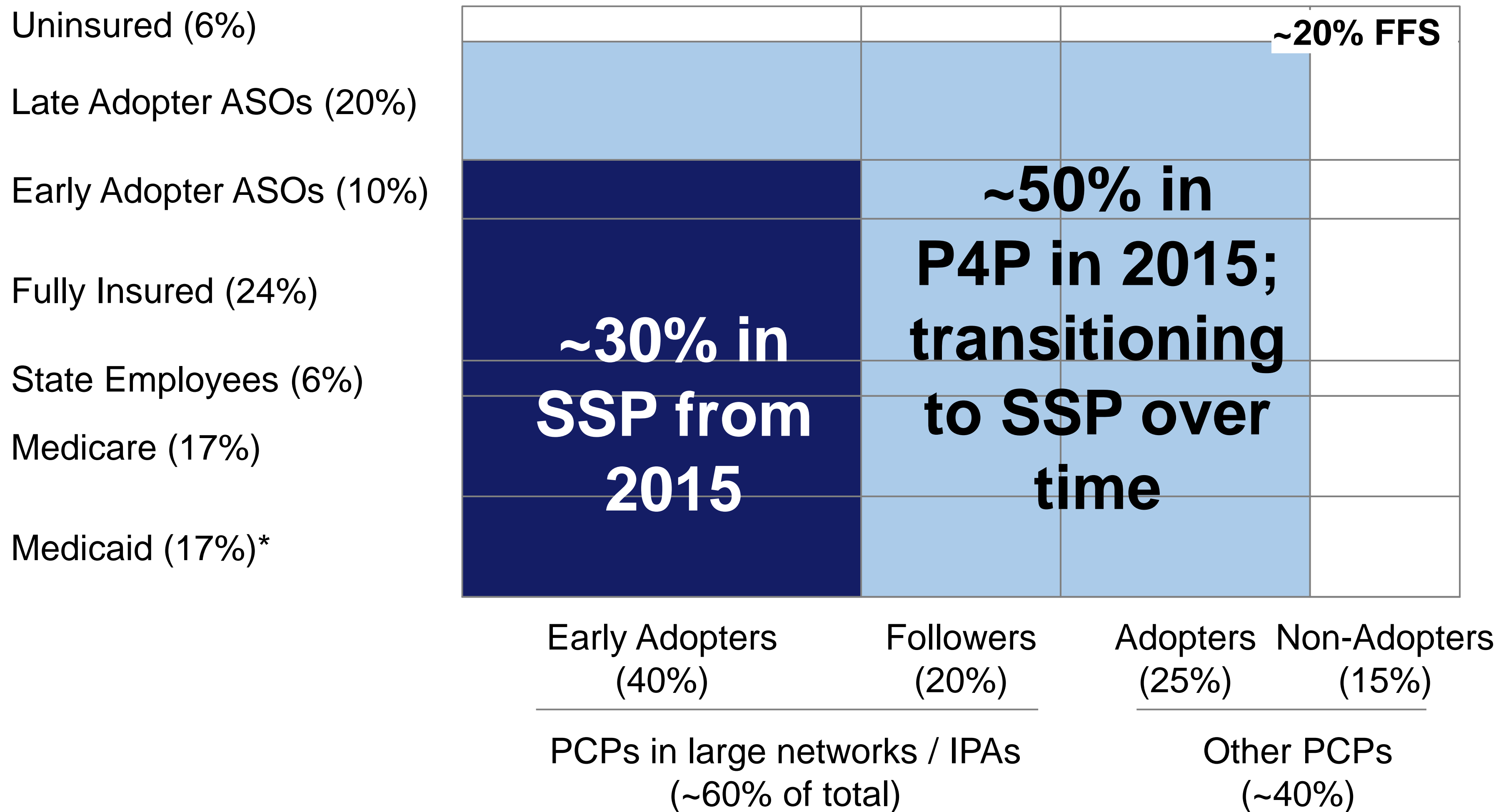
PCPs with groups making progress toward SSP
% of PCPs (Estimate as of Sept 2013)



1 PCP includes internal practice, general practice, family medicine, OB/GYN, and pediatrics, 2 Excludes dual eligibles

SOURCE: Interstudy, CT Office of the State Comptroller, CHNCT for average Medicaid enrollees AMA Physician Masterfile via CT SIM workforce taskforce report, literature review

Targeted percent of population attributed to PCPs in Shared Savings (SSP), Pay for Performance (P4P), or purely Fee-for-Service (FFS)

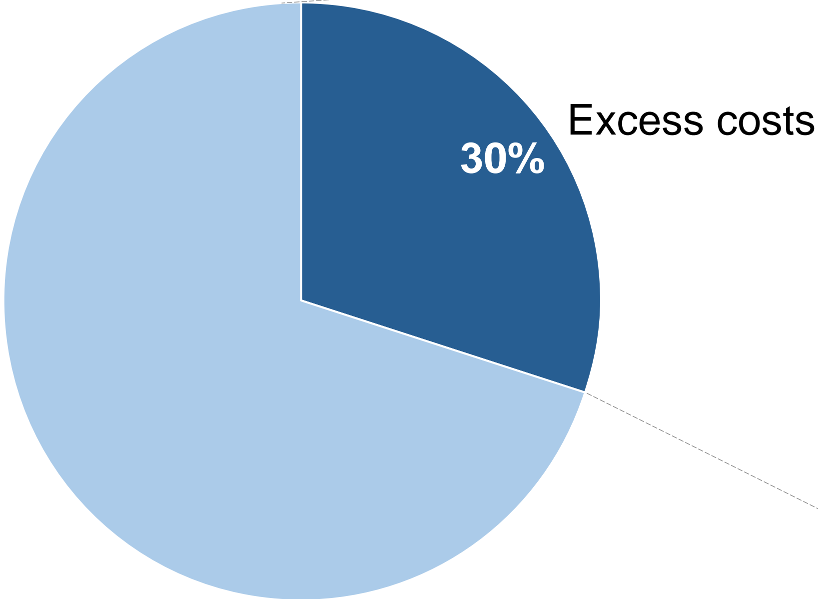


*Exact phasing of Medicaid SSP Phase In to be determined

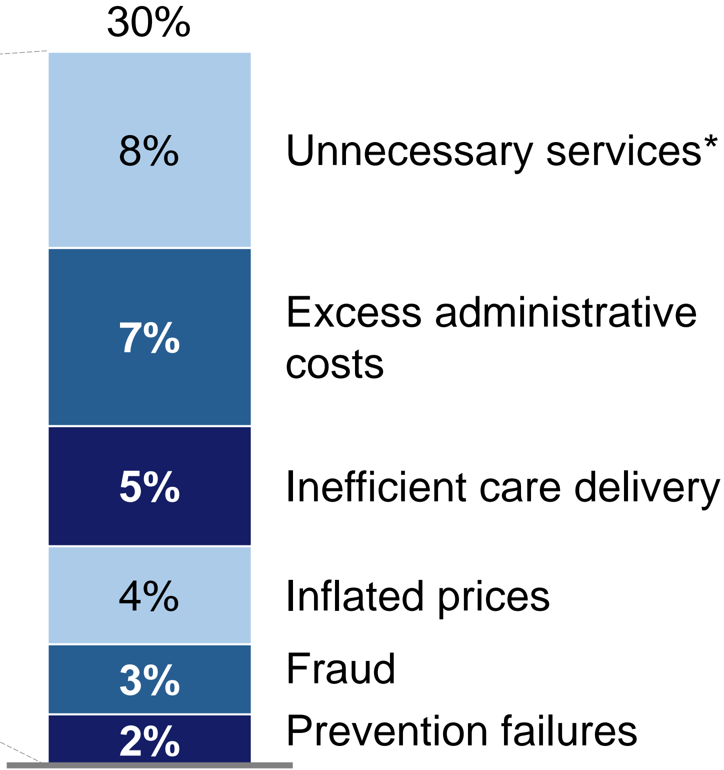
SOURCE: CT Office of the State Comptroller, CHNCT for average Medicaid enrollees AMA Physician Masterfile via CT SIM workforce taskforce report, literature review

Institute of Medicine Findings

Health care spending
% of health care dollars



Sources of excess costs
% of health care dollars



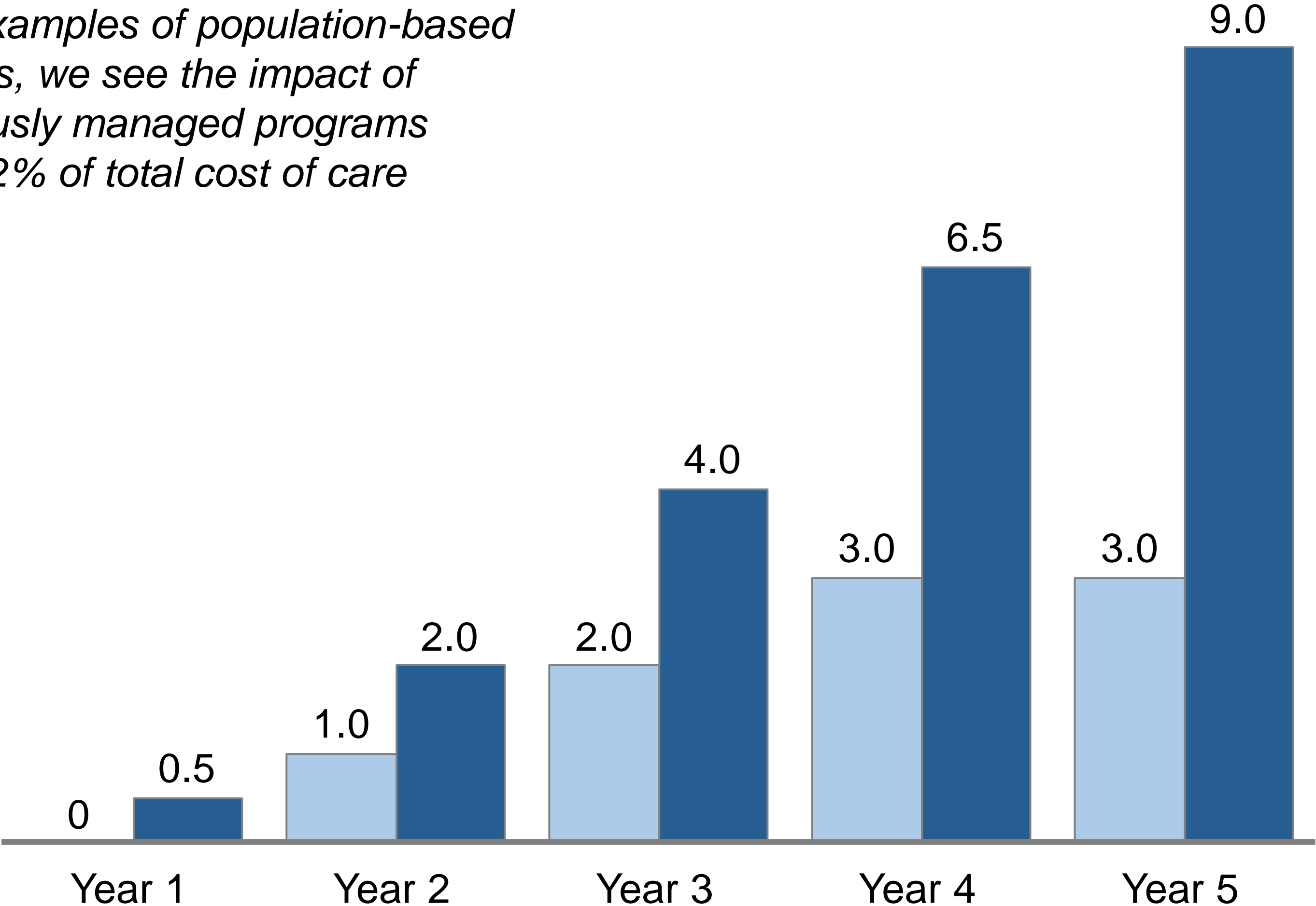
*Includes: overuse—beyond evidence-established standards; discretionary use beyond benchmarks; and unnecessary choice of higher-cost services
SOURCE: Institute of Medicine September 2012 report on 2009 health care spend

Based on examination of ~20 examples of population-based payment models, we estimate the potential to eliminate 6-12% in costs over 5 years

Example	Savings	Drivers
BCBS Mass. AQC Model emphasizes payment reform: risk adjusted capitated payments and P4P incentives	3% decrease in health care spending growth rate in 2012 (1.9% in 2011)	▪ Reduced readmission rates ▪ Decreased non-emergent ER use ▪ Shifted lab procedures, imaging, and tests to lower cost facilities
CareFirst Providers paid an Outcome Incentive Award based on savings relative to global budget and quality	2.7% lower costs than total projected 2012 health care costs for (1.5% in 2011)	▪ Reduced unnecessary hospital admissions ▪ Reduced ER utilization
Sacramento ACO Model emphasizes care coordination, pooled upside/downside risk between payer and provider	2% reduction in PMPM in Year 1	▪ Reduced hospitalization ▪ Reduced preventable readmissions ▪ Reduced costly out-of-network care ▪ New drug purchasing strategies ▪ Lowered administrative costs with electronic record-keeping

SOURCE: Patient-Centered Primary Care Collaborative report on PCMH outcomes and savings, literature review, case examples, expert interviews

Gross savings as percent of total cost of care



SOURCE: Assumptions used for impact projections, based on review of case examples in literature

Types of investments required[1]

- Budgeted as a pure investment (light blue)
- Budgeted as an offset to savings with a reserve for years 1 and 2 (dark blue)

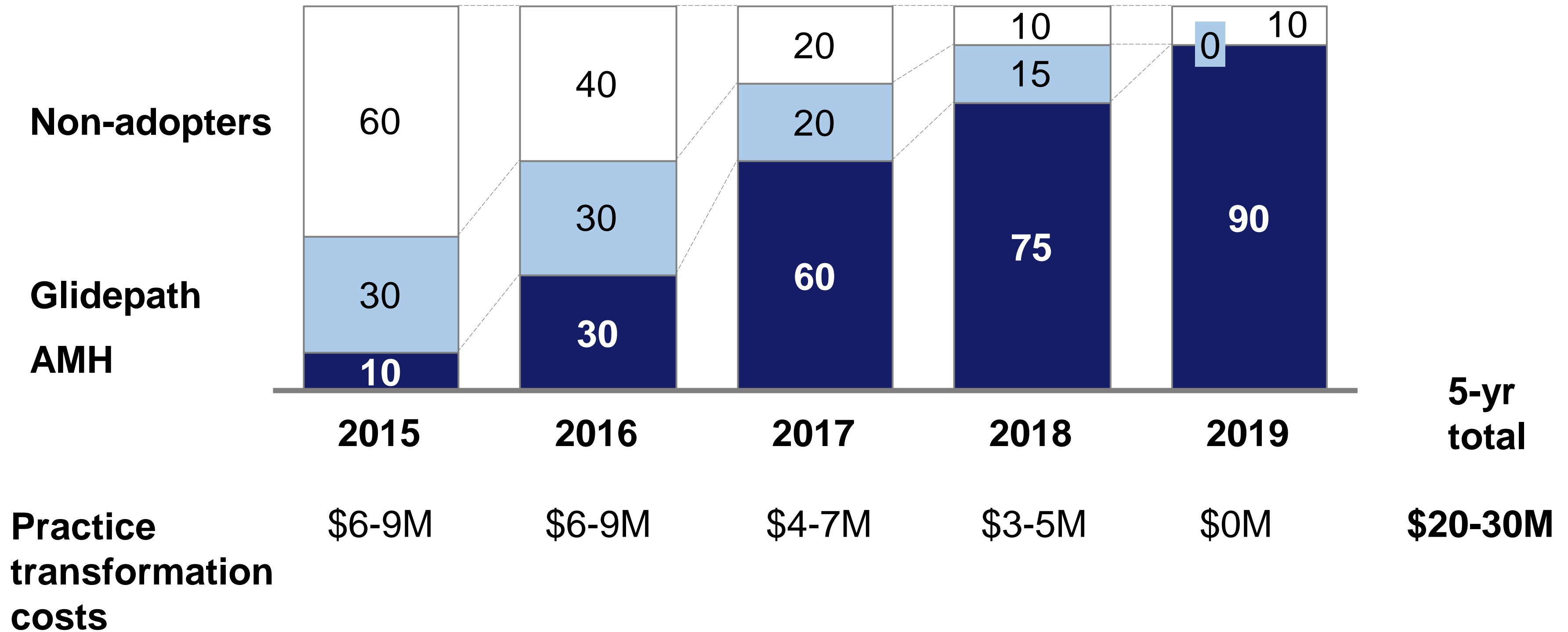
Investment type	Description	Range determinants
Practice transformation support (budgeted as a pure investment)	▪ Plan for practice transformation and support ▪ Practice transformation coaches ▪ Implementation of and certification of practices to AMH standards	▪ Curriculum format and level of customization ▪ Coach experience/ salary ▪ Support duration
Care coordination fees[3] (budgeted as an offset to savings with a reserve for years 1 and 2)	▪ PMPM fees for providers to facilitate and manage the care of an individual	▪ Payer funding level, expectations ▪ Provider eligibility for CC fees
HIT: data capture, performance analytics/reports[2] (budgeted as a pure investment)	▪ Payer analytics ▪ Provider portal ▪ Consumer portal ▪ Care management tools	▪ Existing infrastructure ▪ Portal functionality (e.g., bidirectionality, data visualization) ▪ Integration with HIE ▪ Cross-payer functionality/ standardization
Program management (budgeted as a pure investment)	▪ Program leadership and management ▪ Taskforce support ▪ Budget and financial management ▪ Vendor procurement, contracting, management ▪ Communications/stakeholder outreach ▪ Program implementation ▪ Self-evaluation ▪ Model and strategy design/refinements	▪ Scope of innovation: number of care delivery/ payment models to be rolled out ▪ Level of internal capacity and expertise ▪ Whether Medicaid is managed through MCO

1 Does not include program-specific investments (e.g. Choosing Wisely), SNAP/ NuVal, workforce (e.g., CT Service Track, CHW training)
2 Excludes HIE costs
3 CC fees incorporated into current net savings calculation as 1% of TCC

SOURCE: Literature review, testing grant application review

Statewide investment in practice transformation

% of PCPs working toward Advanced Medical Home certification



	2015	2016	2017	2018	2019	5-yr total
Practice transformation costs	$6-9M	$6-9M	$4-7M	$3-5M	$0M	**$20-30M**

Assumptions

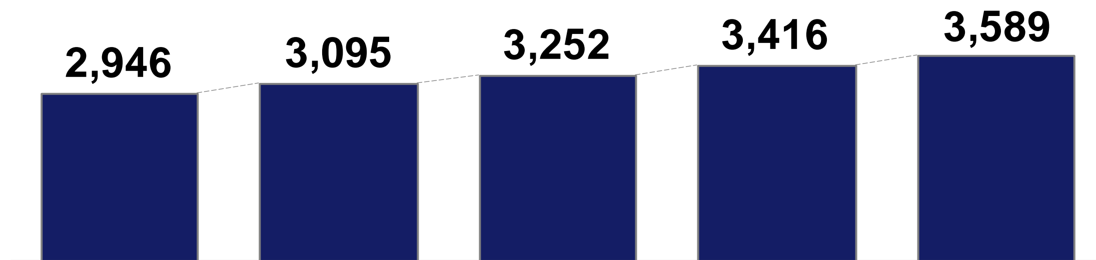
- 1600 – 2000 PCP practice sites
- 50% requiring practice transformation support
- 18-month transformation support program
- $24,000-30,000 per site in costs

1 Of the 62% of PCPs moving toward SSP today, assumes SSP arrangements are in place today only with 20% of their patient panel;

SOURCE: CT Office of the State Comptroller, CSMS interview, Department of Social Services, benchmarking with practice transformation vendors

Medicaid investment in care coordination fees (non-expansion, gross)

Medicaid claims costs excluding duals ($ millions)[1]



	2015	2016	2017	2018	2019	5-yr total
% of PCPs receiving care coordination fees[2]	25%	45%	70%	82%	90%	
Care coordination fees at 1% of in-scope spend	$7M	$14M	$23M	$28M	$32M	**$105M**
Comparison to current program expenses						
Intensive Care Management at current trajectory[3]	$14M	$14M	$15M	$16M	$17M	**$77M**
PCMH performance payments[4]	$3M	$3M	$3M	$3M	$3M	**$15M**

1 Excludes dual eligibles, institutional spend, transportation and other non-medical services
2 Assumes 50% of glidepath providers, and 100% of AMH providers receive care coordination fees
3 Based on costs in 2011-2013, projected forward at 6.5% CAGR
4 Based on costs in 2012 projected forward at 0% CAGR

SOURCE: 2012 Medicaid Claims data; Department of Social Services

Program investments[1]

	Benchmark range	Connecticut estimate	Total budget ($M)
Practice transformation	▪ $10,000-50,000 per PCP site	▪ 1600 – 2000 PCP sites ▪ 50% requiring practice transformation support ▪ 18-month transformation support program ▪ $24,000-30,000 per site	▪ 2015: 6-9 ▪ 2016: 6-9 ▪ 2017: 4-7 ▪ 2018: 3-5 ▪ 2019: 0
Health information technology[2]	▪ $20-30M over 3 years ▪ $3-5M per year thereafter	▪ $30M over 3 years based on relatively modest HIT capability in the state ▪ $4M per year based on high number of payers, moderate PCP fragmentation	▪ 2015: $10M ▪ 2016: $10M ▪ 2017: $10M ▪ 2018: $4M ▪ 2019: $4M
Program management	▪ $10-30M per year for initial 3-4 years ▪ $3-5M per year thereafter	▪ $10-15M per year for 3 years beginning 2014, focused on AMH, excluding support for special needs populations ▪ Tapering to $3M per year thereafter	▪ 2014: 10 ▪ 2015: 15 ▪ 2016: 13 ▪ 2017: 4 ▪ 2018: 3 ▪ 2019: 3

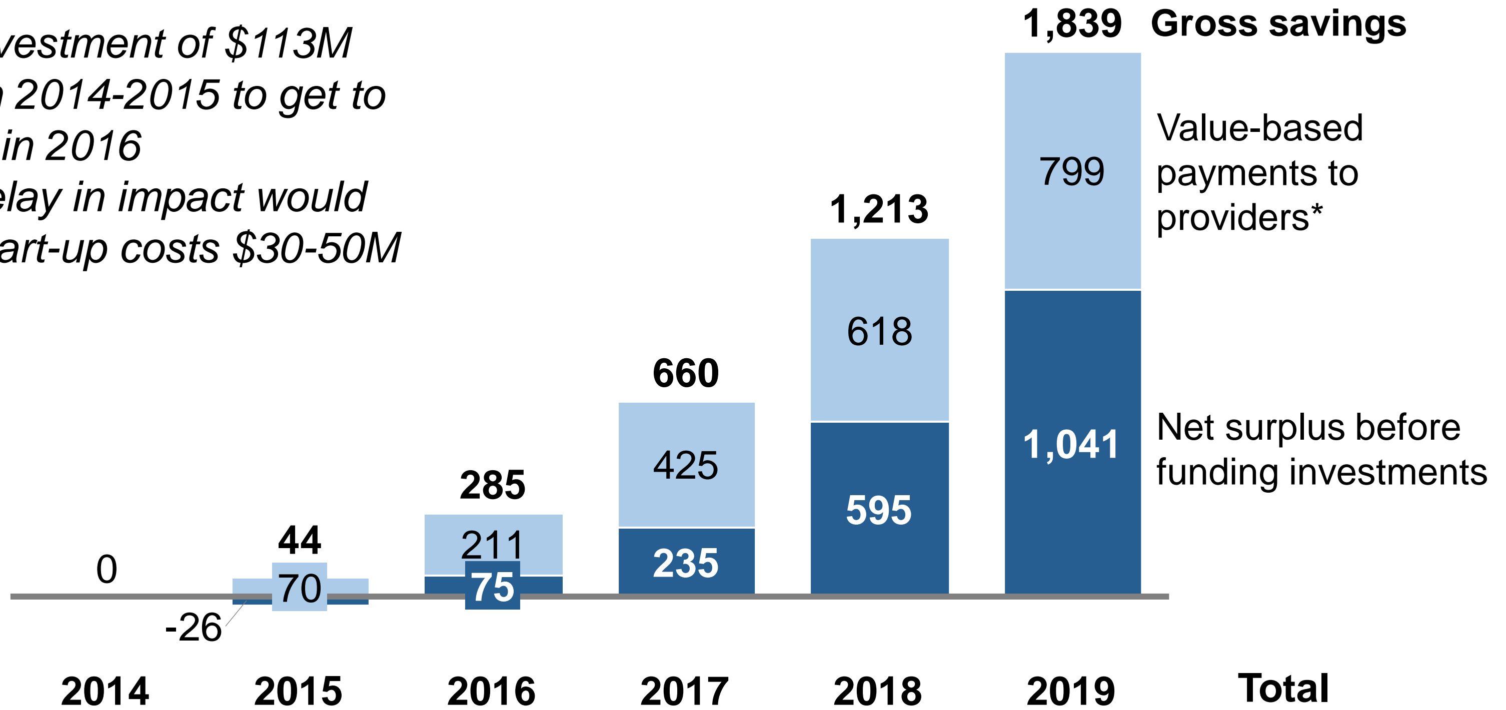
1 Does not include program-specific investments (e.g. Choosing Wisely), SNAP/ NuVal, workforce (e.g., CT Service Track, CHW training)
2 Excludes HIE costs
SOURCE: Literature review, testing grant application review

Potential financial impact – All Connecticut

$ millions

Aggregate investment of $113M

- *$40-50M in 2014-2015 to get to breakeven in 2016*
- *1-2 year delay in impact would increase start-up costs $30-50M*



	2014	2015	2016	2017	2018	2019	Total
Investments**	(12)	(32)	(31)	(20)	(11)	(7)	**(113)**
Net savings	(12)	(58)	44	215	584	1,034	**1,808**
Net savings as % of baseline	-0.04%	-0.2%	0.2%	0.7%	1.9%	3.1%	

*Includes care coordination fees, shared savings, and bonus payments tied to quality, experience, and efficiency

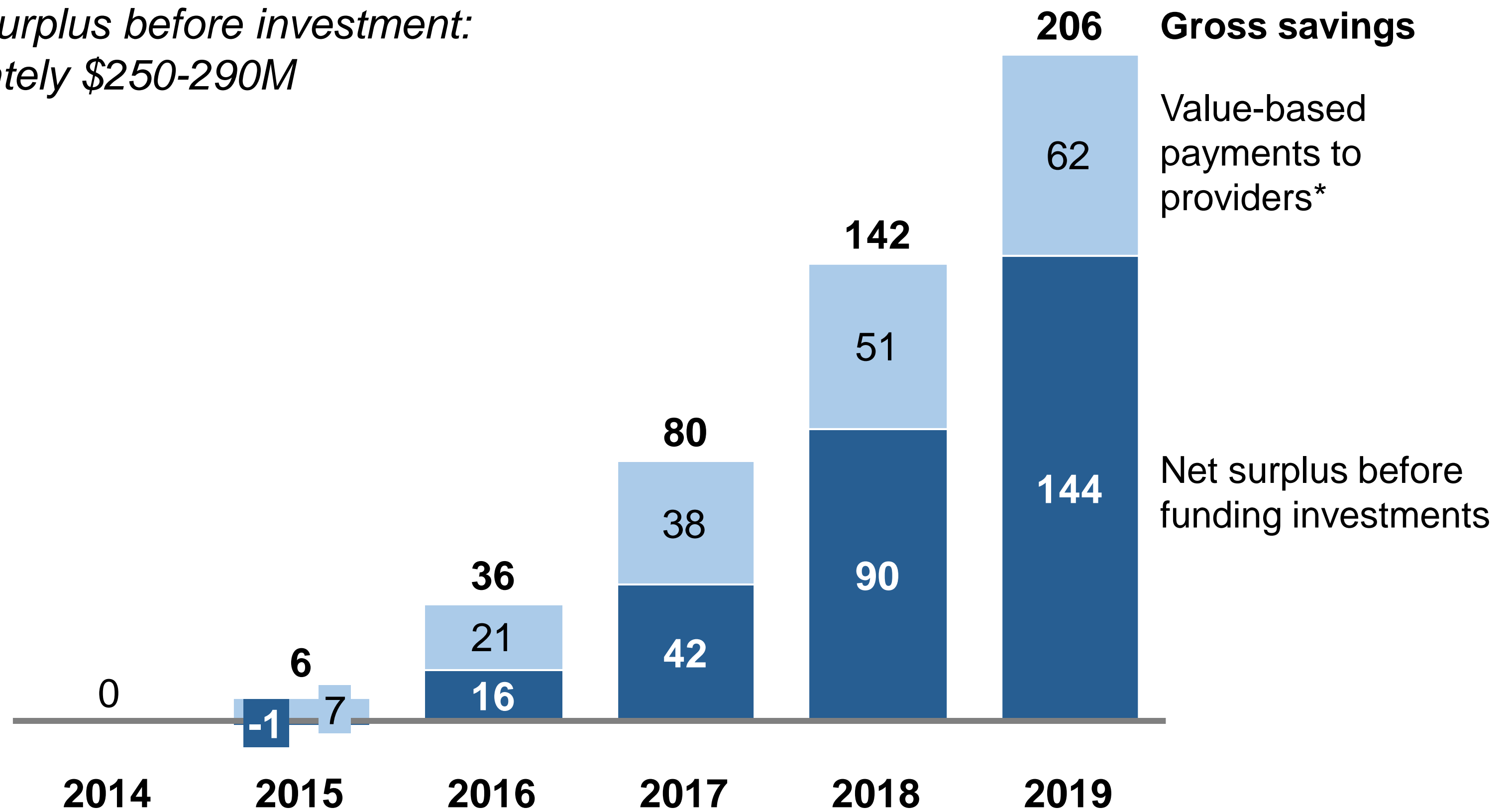
**Reflects practice transformation support, HIT, and Program Management

Potential financial impact – Medicaid non-expansion population

$ millions (gross, 50% match rate)

2014-2019 surplus before investment:

- *Approximately $250-290M*



	2014	2015	2016	2017	2018	2019
Baseline spend**	2,804	2,889	2,976	3,066	3,159	3,254
Net surplus as % of baseline		(0.1%)	0.5%	1.3%	2.6%	4.0%

*Includes care coordination fees, shared savings, and bonus payments tied to quality, experience, and efficiency

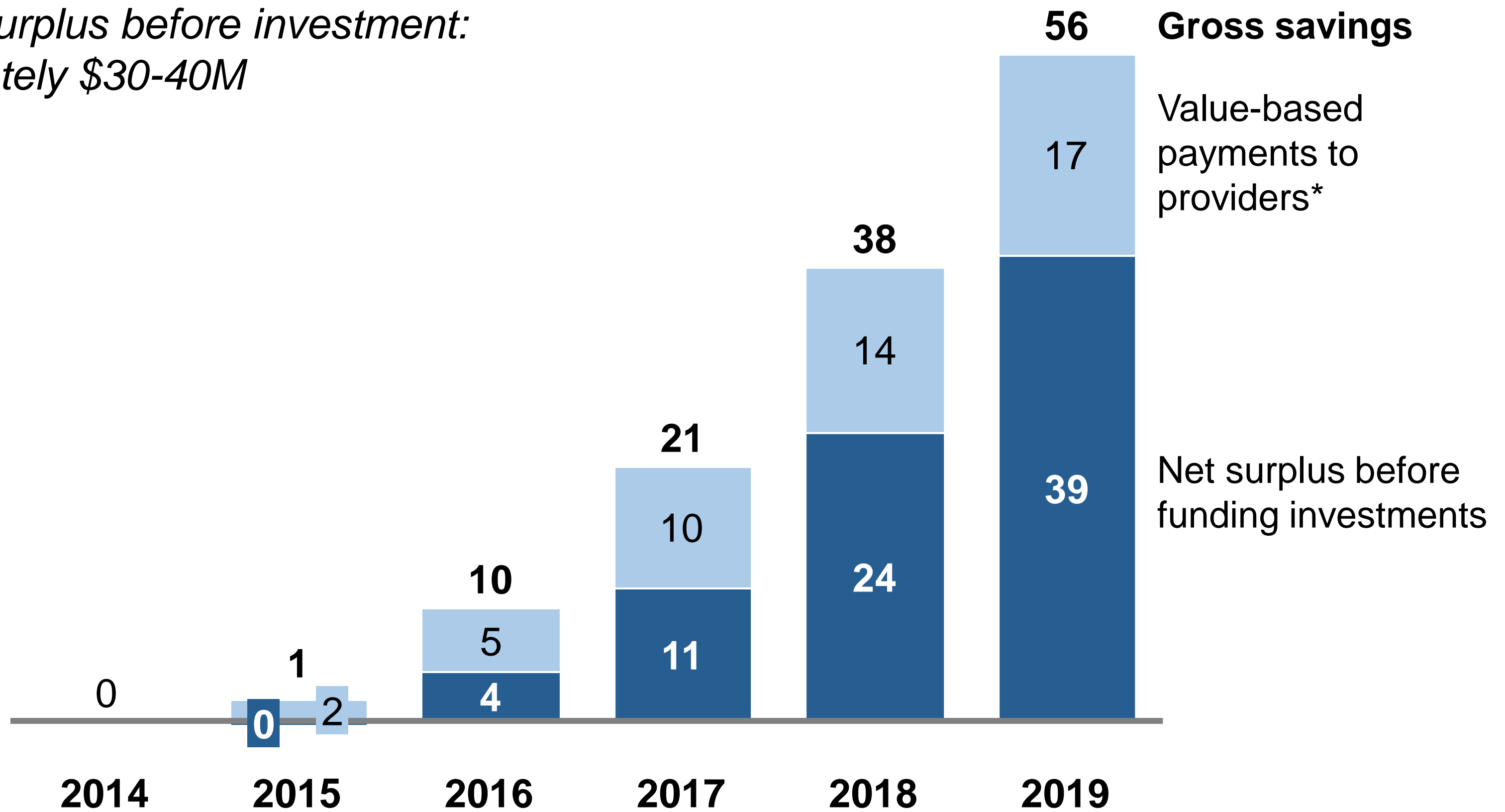
**Excludes dual eligibles, institutional spend, transportation and other non-medical services

Potential financial impact – Medicaid expansion population

$ millions (gross, 100% match rate)

2014-2019 surplus before investment:

- *Approximately $30-40M*



	2014	2015	2016	2017	2018	2019
Baseline spend**	375	386	398	410	422	435
Net surplus as % of baseline		(0.1%)	0.5%	1.3%	2.6%	4.0%

*Includes care coordination fees, shared savings, and bonus payments tied to quality, experience, and efficiency

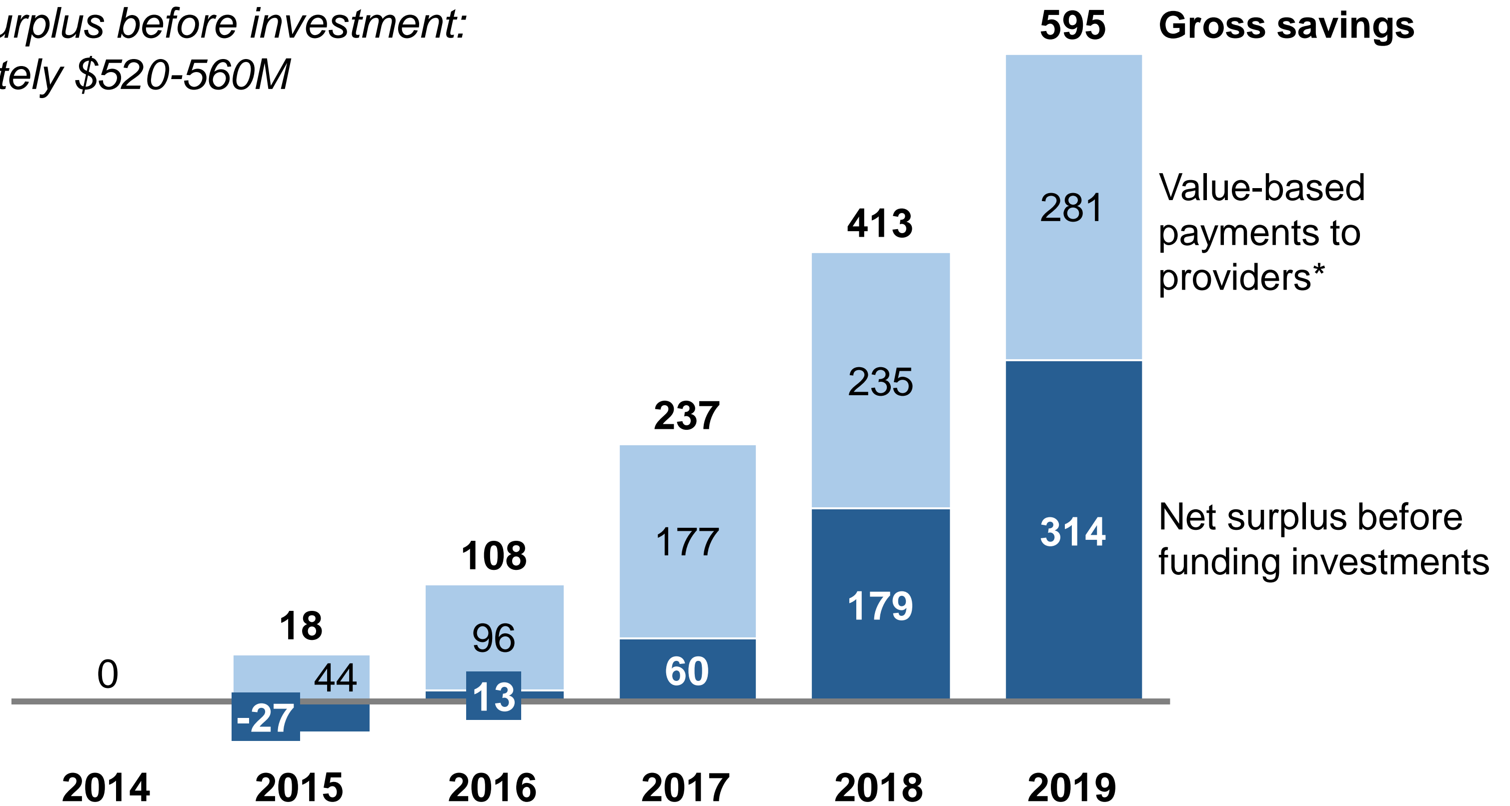
**Excludes dual eligibles, institutional spend, transportation and other non-medical services

Potential financial impact – Medicare

$ millions

2014-2019 surplus before investment:

- *Approximately $520-560M*

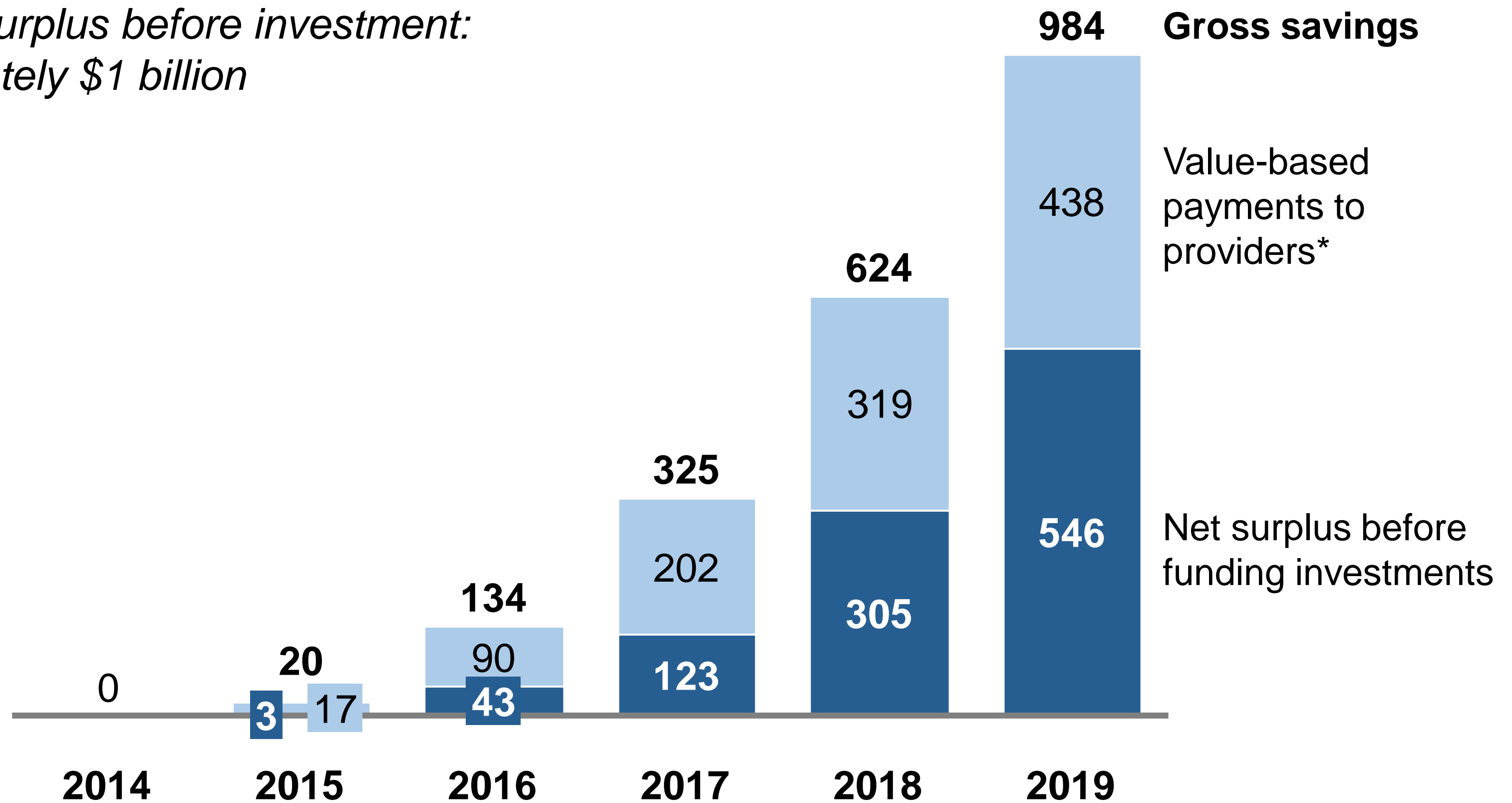


	2014	2015	2016	2017	2018	2019
Baseline spend	8,537	8,873	9,221	9,583	9,959	10,350
Net surplus as % of baseline		(0.3%)	0.1%	0.6%	1.8%	3.0%

*Includes care coordination fees, shared savings, and bonus payments tied to quality, experience, and efficiency

Potential financial impact – Commercial

$ millions



	2014	2015	2016	2017	2018	2019
Baseline spend**	13,798	14,553	15,349	16,189	17,076	18,010
Net surplus as % of baseline		0.0%	0.3%	0.8%	1.8%	3.0%

*Includes care coordination payments and shared savings tied to quality, experience, and efficiency