

State of Connecticut Preventative Care Initiatives: HEP and PCMH Pilot

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Overview

- **Health Enhancement Program (HEP)**
 - Historical context
 - Requirements articulated by SEBAC agreement
 - Procedural protections
 - Cost savings assumptions
 - Evaluation
- **PCMH Pilot**

Health Enhancement Program

Historical Context

Plan Structure:

- State of Connecticut was fully insured until 2010
- In 2010, became self-insured
- two carriers act as plan administrators: Anthem and United

Historical Context (cont.)

Key data points:

- identified clusters in which there is high incidence of encounters
- compared with a baseline “expected” group composed of national and regional data, state employees had higher incidence of emergency room visits

Historical Context (cont.)

Key data points:

Graphs depicting "established" (continuing) and new use of "preventive services" (annual physical) by state employees show that:

- established visits have since 2008 modestly trended upward for women but have remained fairly constant for men
- new visits have since 2008 been fairly constant for both
- there is **stark** gender disparity in the rate at which participants receive physicals

Historical Context (cont.)

Key data points:

- incidence of mammograms is improving over time, but in 2010, only 593 per 1,000 state employee women between the ages of 50 and 74 had mammograms
- in 2010, only 231 per 1,000 state employee women and 239 per 1,000 state employee men had colon screenings

Historical Context (cont.)

Acute/chronic care is much more costly than preventative care. Men are 24% less likely than women to have visited the doctor within the last year, 28% more likely to be hospitalized for congestive heart failure and 32% more likely to be hospitalized for complications of diabetes.

[Source: Health and Human Services Administration (HHS)]

SEBAC Agreement

Health Enhancement Program (HEP)

- enrollment:
 - current state employees and employees who retire after 10/1/11
 - pre- 10/1/11 retirees participate on voluntary basis
- enrollees were required to make attestation to participate

SEBAC Agreement

Health Enhancement Program (HEP)

- 51,500 (97%) enrolled
- 200 declined
- under 1,000 took no action

SEBAC Agreement (cont.)

Required screenings:

Well child visits

- Birth to 1: 6 exams at specified intervals
- Ages 1-5: one per year
- Ages 6-17: one per year

SEBAC Agreement (cont.)

Required screenings:

Adult Wellness Physical Examinations

- Ages 18-39: one every three years
- Ages 40-49: one every two years
- Age 50+ : one each year

SEBAC Agreement (cont.)

Required screenings:

Preventative Screenings

- Cholesterol screening:
 - Ages 20-29: one every five years
 - Ages 40-50: one every two years
 - Age 50+: one each year

SEBAC Agreement (cont.)

Required screenings:

Preventative Screenings

- Clinical breast exam/mammogram:
 - breast exam by provider every three years
 - mammogram as recommended by provider
 - one screening mammogram for women between age 35 and 39
- Cervical cancer screening:
 - Ages 21+: one every three years

SEBAC Agreement (cont.)

Required screenings:

Preventative Screenings

- Vision exam:
 - one every two years
- Dental cleanings:
 - two per year

SEBAC Agreement (cont.)

Required screenings:

Preventative Screenings

- inapplicable where against physician or other health care professional's recommendation

SEBAC Agreement (cont.)

Optional additional preventative benefits:

- weight management
- tobacco cessation

SEBAC Agreement (cont.)

Disease Counseling and Education Programs:

- Types 1 & 2 diabetes
- Asthma and COPD
- Heart failure/heart disease
- Hyperlipidemia
- Hypertension

SEBAC Agreement (cont.)

Incentives for participation:

- maintain current premium cost share
- co-pays for urgent care and walk-in clinics are the same as for office visits
- for those enrolled in Disease Education and Counseling:
 - \$100 cash payment per year for successful participation
 - medications used to treat chronic conditions cost less:
 - » \$0 co-pay for Tier 1 (generic)
 - » \$5 co-pay for Tier 2 (preferred)
 - » \$12.50 co-pay for Tier 3 (non-preferred)
 - » \$0 co-pay for medications used to treat diabetes (Type 1 and Type 2)

SEBAC Agreement (cont.)

Program modifications/cost sharing intended to promote desired outcomes:

- no financial incentives to carriers or providers
- \$35 co-pay for emergency room visits, unless admitted to hospital from ED or there was no reasonable alternative
- for those who elect not to participate:
 - \$100 per month premium cost share
 - \$350 per person annual deductible (maximum \$1,400 for families)

SEBAC Agreement (cont.)

Program modifications/cost sharing intended to promote desired outcomes (cont.):

- participants may receive first fill of maintenance medications at any participating pharmacy, then must either:
 - receive them via mail order through Caremark; or
 - fill at pharmacy that participates in state's Maintenance Drug Network

Procedural Protections

Determining Compliance:

- in approximately February, the carriers will assess where participants are in achieving compliance
- to determine compliance, carriers will look back for the period of time in which the employee must have had the physical or test (e.g. if the person is required to have a physical each 3 years, the carrier will look back over that period to determine whether the requirement has been met)

Procedural Protections (cont.)

- those who elect HEP but do not fulfill requirements will be given notice and opportunity to improve
- if do not comply:
 - notice to, review by and approval/ rejection by Health Care Cost Containment Committee (HCCCC)
 - HCCCC will establish grounds for appeal (e.g. made good faith effort to comply, conscientious objection)

Procedural Protections (cont.)

- removal will solely be based on:
 - failure to get required screenings
 - if applicable, refusal to participate in disease counseling and education program
- if removed from participation, subject to increased cost sharing
- terms of re-election to be determined

SEBAC Cost Savings Assumptions

Feature	FY'12	FY'13
\$35 ED co-pay	\$ 1,200,000	\$ 3,700,000
HEP participation	\$102,500,000	\$102,500,000
HEP opt-outs	\$ 18,000,000	\$ 18,000,000
Drugs off patent	\$ 1,500,000	\$ 12,000,000
Tobacco Cessation/ Obesity programs	\$ 1,000,000	\$ 2,000,000
Other HCCCC initiatives	\$ 40,000,000	\$ 35,000,000
Rx mail order	\$ 19,876,000	\$ 20,500,000

Evaluation

- HEP will be tracked to:
 - evaluate influence on such factors as:
 - incidence of preventative health screenings and dental cleanings
 - maintenance of identified chronic conditions
 - incidence of hospitalization and re-hospitalization
 - evaluate capacity for cost savings:
 - in minimizing acute and chronic care costs
 - in reducing Rx costs

PCMH Pilot

PCMH Pilot

- initiative began in July, 2010
- PCMH measurements began March, 2011
- goals:
 - through coordination of care, emphasis on preventative care interventions, and use of common metrics, to improve health outcomes
 - through payment reform modalities, to reduce costs and reward providers for improvement in health outcomes

PCMH Pilot

- currently, no attribution involved – model relies on reaching individuals already served by the practices
- payment reform model is a hybrid that gives the carriers and providers flexibility in determining what best fits their needs

PCMH Pilot

- initiated with ProHealth Physicians:
 - prior to launch, already serving a significant locus of state employees and retirees
 - composed of 70 practices
 - achieved NCQI Level 3 certification in August, 2011
- expanded in June, 2011 to include Hartford Medical Group

PCMH Pilot

- involved negotiations with groups and carriers to gain agreements concerning:
 - use of **common metrics**
 - an example of a health outcome metric is whether a patient aged 18-75 with diabetes has received 2 HbA1c tests at least 3 months apart during the measurement year
 - OSC metrics include **process measures** (e.g. whether electronic health records are used on a regular basis), **quality measures** (e.g. whether vital signs or other indicators have been maintained within identified guidelines), and **clinical outcomes** (e.g. reduction in potentially avoidable emergency department visits, reduced hospitalizations and re-admissions)

PCMH Pilot

- involved negotiations with groups and carriers to gain agreements concerning (cont.):
 - **payment reform mechanisms** including:
 - up-front additional payment to enable the practice to invest in EHR, additional staffing, extended hours, etc. to transition to the PCMH model
 - fee-for-service compensation
 - enhanced fees/bonuses for achieving process, quality, and desired outcomes

PCMH Pilot

- preliminary comparative analysis of the performance of the two PCMH groups in July, 2011:
 - identified as "Group 1" and "Group 2", the PCMH were compared with both a "Base" group (composed of active state employees) and an "Expected" group on four key indicators: ER visits, "consults" (referrals to specialists), physicals and office visits
 - both groups showed a lower incidence of ER visits than the base, but incidence of ER visits in both was higher than the expected group
 - both groups showed a higher incidence of physicals and office visits (positive) and consults (needs analysis of whether the groups can handle more matters in office as opposed to making referrals to specialist) than both the base and expected groups

Conclusion

Ongoing, emphasis will be placed on:

- preventative care interventions
- use of financial incentives to inspire participation in disease management initiatives
- expansion of PCMH pilot to include additional practices and further more widespread use of common metrics and payment reform modalities