Connecticut's Evolving Health Care Landscape

Moving from a Sick Care System to a Health Care System

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THE SITUATION

86¢ of every health care dollar spent goes toward people with chronic and mental health conditions.[1]

Insufficient care coordination can increase the cost of a person's chronic disease management by **more than** $4,500 over three **years.**[2]

Lack of focus on **social drivers** creates a hamster wheel affect – we fail to address the underlying causes of poor health status

Payment models matter. Fee for service does not support a health care system

"Without major transformation, Americans will continue paying more and receiving less from their healthcare."[4]

1. https://www.cdc.gov/chronicdisease/overview/index.htm CDC: Chronic Disease Overview
2. HealthITAnalytics, https://healthitanalytics.com/news/poor-care-coordination-raises-chronic-disease-costs-by-4500, May 18, 2015, Jennifer Bresnick. The American Journal of Managed Care > May 2015 – Published on: May 14, 2015 and Care Fragmentation, Quality, and Costs Among Chronically Ill Patients. Brigham R. Frandsen, PhD; Karen E. Joynt, MD, MPH; James B. Rebitzer, PhD; and Ashish K. Jha, MD, MPH

As a result, we have a sick care system and not a health care system

What if we transitioned to a model that…

- Builds greater affordability and a sustainable business case for providers
- Aligns financial incentives across the delivery system and all stakeholders
- **Treats every patient as an *N* of one, tailoring treatment and encouraging active participation in their health**
- Provides relief from administrative burden for providers and employers
- **Focuses on social drivers and enhances the patient/provider relationship**
- **Supports primary care** as the **foundation** of an efficient, effective and equitable health care system

Collaborating to move to a health care system

HISTORICALLY

01

- Focus on primary care. Programs only includes ACO & practices with a ***foundation of primary care***
- Provide ACOs with meaningful and actionable insights
- Quality based on (many) **process measures**
- **One-size fits all** program design (payment and clinical delivery model)

AT THE PRESENT

02

- Value-based payment stratified to accommodate different practice types
- ***Mandatory PCP selection***
- ***Continued strong focus on primary care*** but add specialty payment models
- ***Outcomes-based quality metrics –*** short list of meaningful measures
- ***Begin to address social drivers***
- ***Patient centered approach:*** *Different models for different populations*

FUTURE VISION

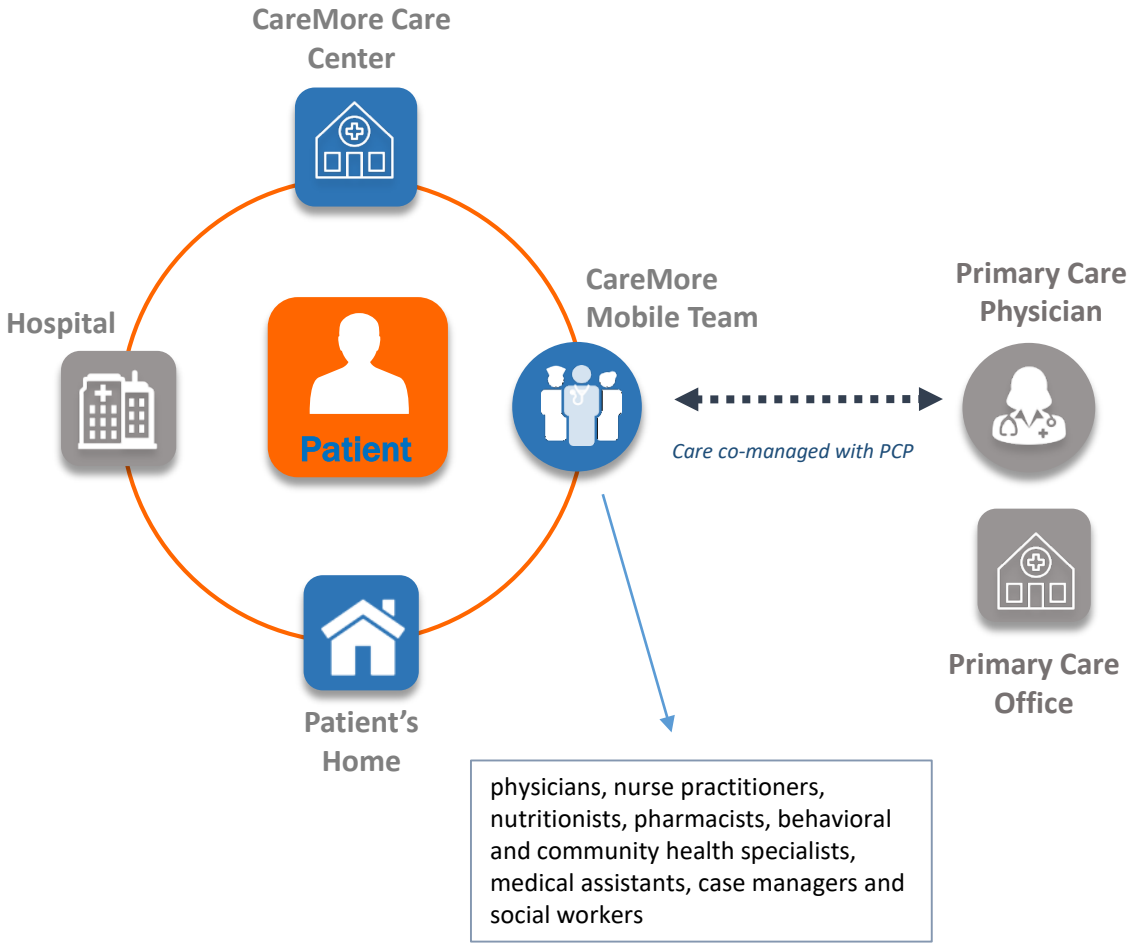
03

- Incorporate value-based insurance design
- Heighten solutions that address **social drivers of health**
- Introduce **new care delivery models** (e.g., Hospital at Home)
- **Realign provider fee schedule** to address distortions
- **Leverage AI** to support highly personalized care experiences and proactive engagement

CareMore in-home program

Available exclusively through Anthem in Connecticut

High-risk care, integrated behavioral health, and urgent response to acute care needs deployed to the patient's home



A proactive model of care to support the needs of complex patients and respond urgently to acute needs.

Scope of services:

- Chronic disease management
- Behavioral health
- Urgent care
- 24/7 clinical coverage
- Longitudinal case management including transitions of care, medication adherence, coordination of specialists and ancillary services
- Coordination of care across care continuum including inpatient and SNF in-person visits and coordination with inpatient/post-acute care team
- Long term planning and advance directives
- Entitlements and benefits assistance
- Counseling and health coaching