Enhanced Primary Care

The CDPHP® Medical Home

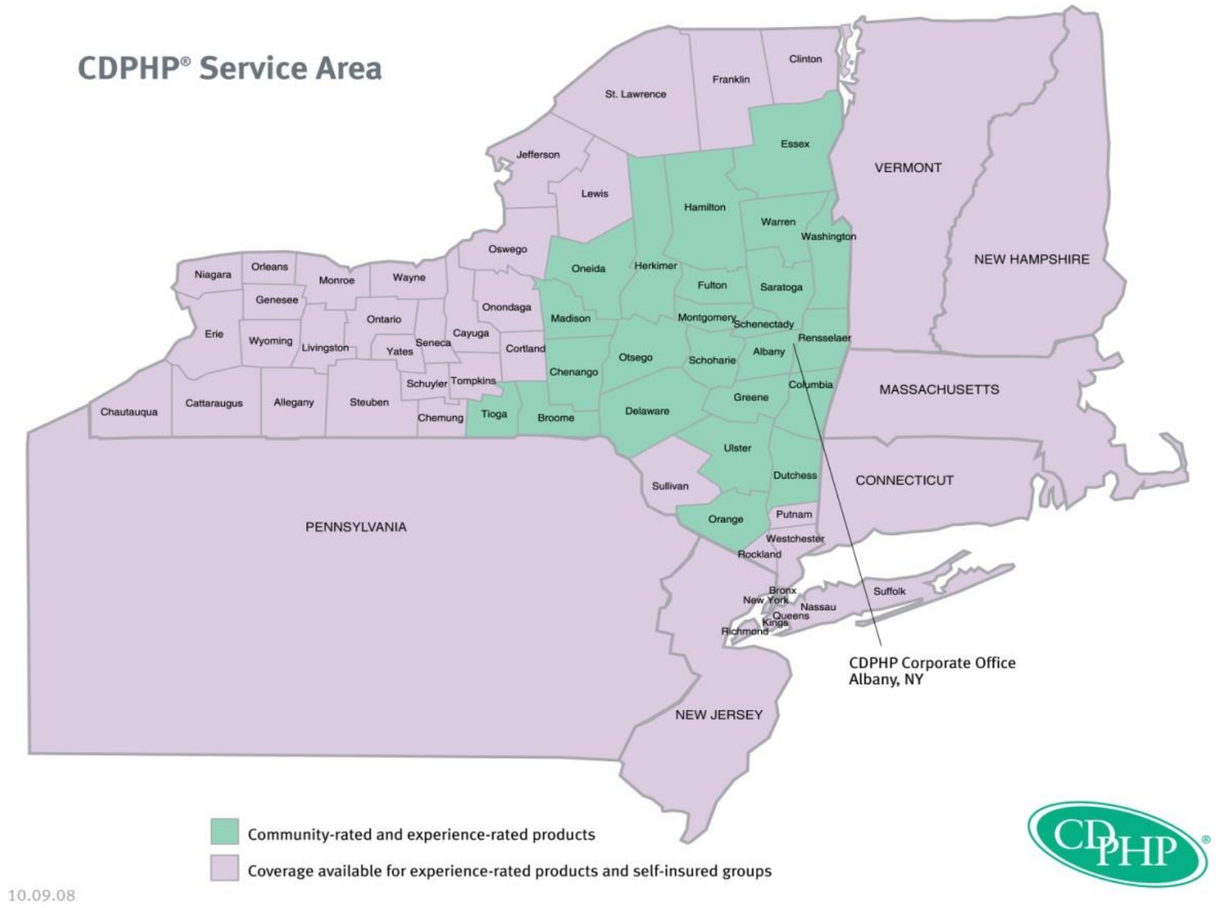
Eileen F. Wood, RPh, MBA

Vice President, Clinical Integration

Chief Pharmacy Officer

CDPHP® Background

- Physician-founded and governed
- Serves 24 counties in New York
- Nearly 460,000 members
- More than 1,000 employees



Vision and Mission

Create an innovative and ***sustainable model*** for the reimbursement of primary care physicians that leads to a ***resurgence in the interest in primary care*** medicine as a career for medical students. Accomplish this while demonstrating ***better health outcomes*** and market-leading ***satisfaction*** scores for patients, employers, and physicians.

Pilot Hypothesis:

The ***aggregate savings*** associated with better health outcomes and lower utilization is sufficient to fund the ***enhanced compensation*** to a primary care physician, as well as provide a ***surplus*** to the plan.

EPC Program Evolution

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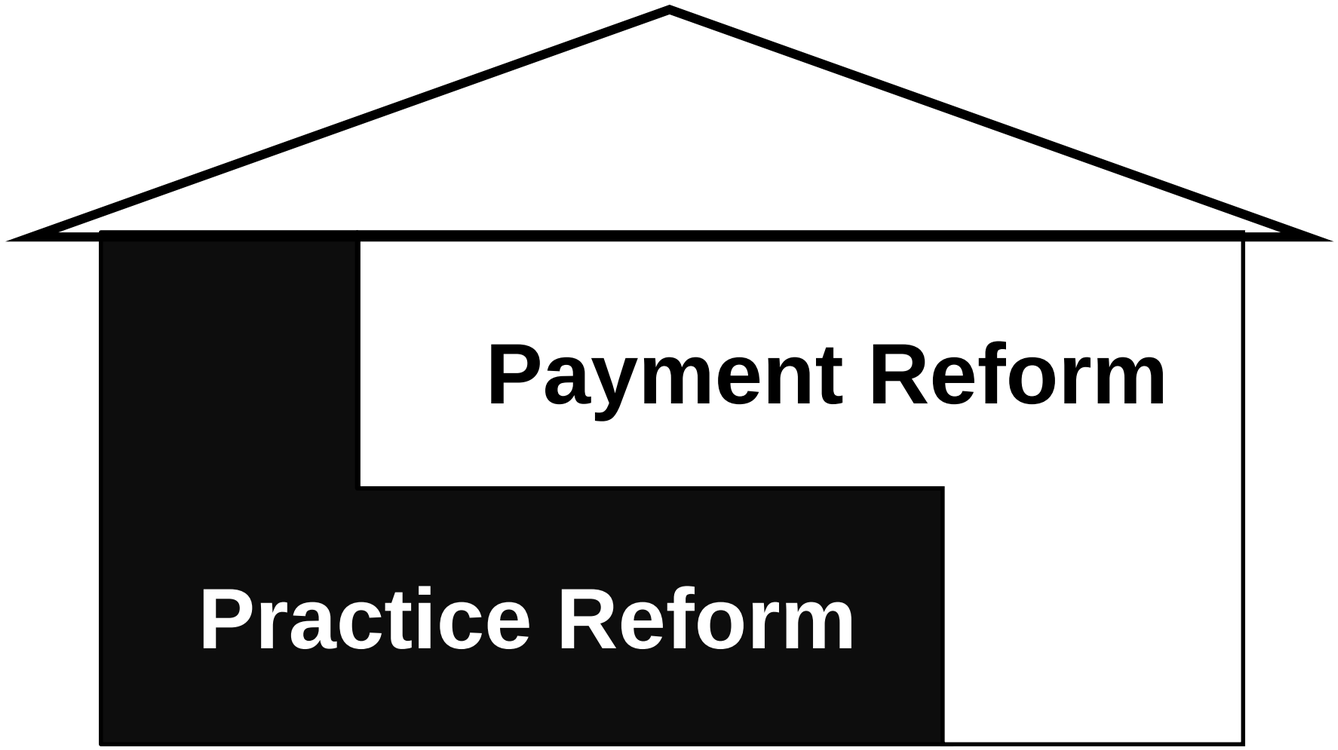
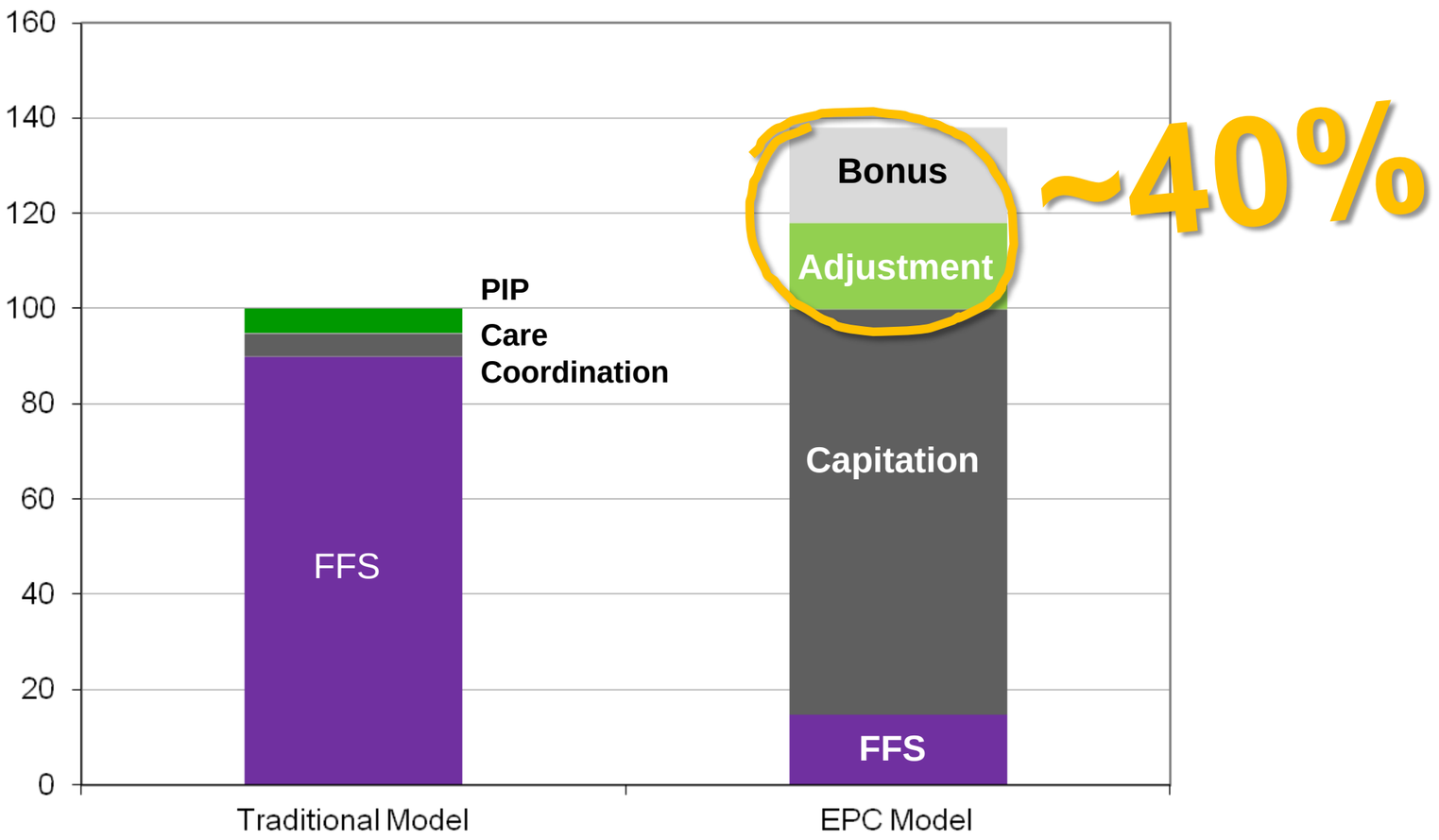
	Sites	Clinicians	Members
Phase I	3	33	14,322
Phase II	23	159	50,616
Phase III	48	243	54,695
Phase IV	62	238	68,008
Phase V	38	103	37,560
CPCi Only	19	60	19,451
On Payment Model	100	487	155,582
Totals	**193**	**836**	**244,652**



As of June 30, 2015

Enhance PCP Potential Payments



EPC Payment Model Performance - 2013

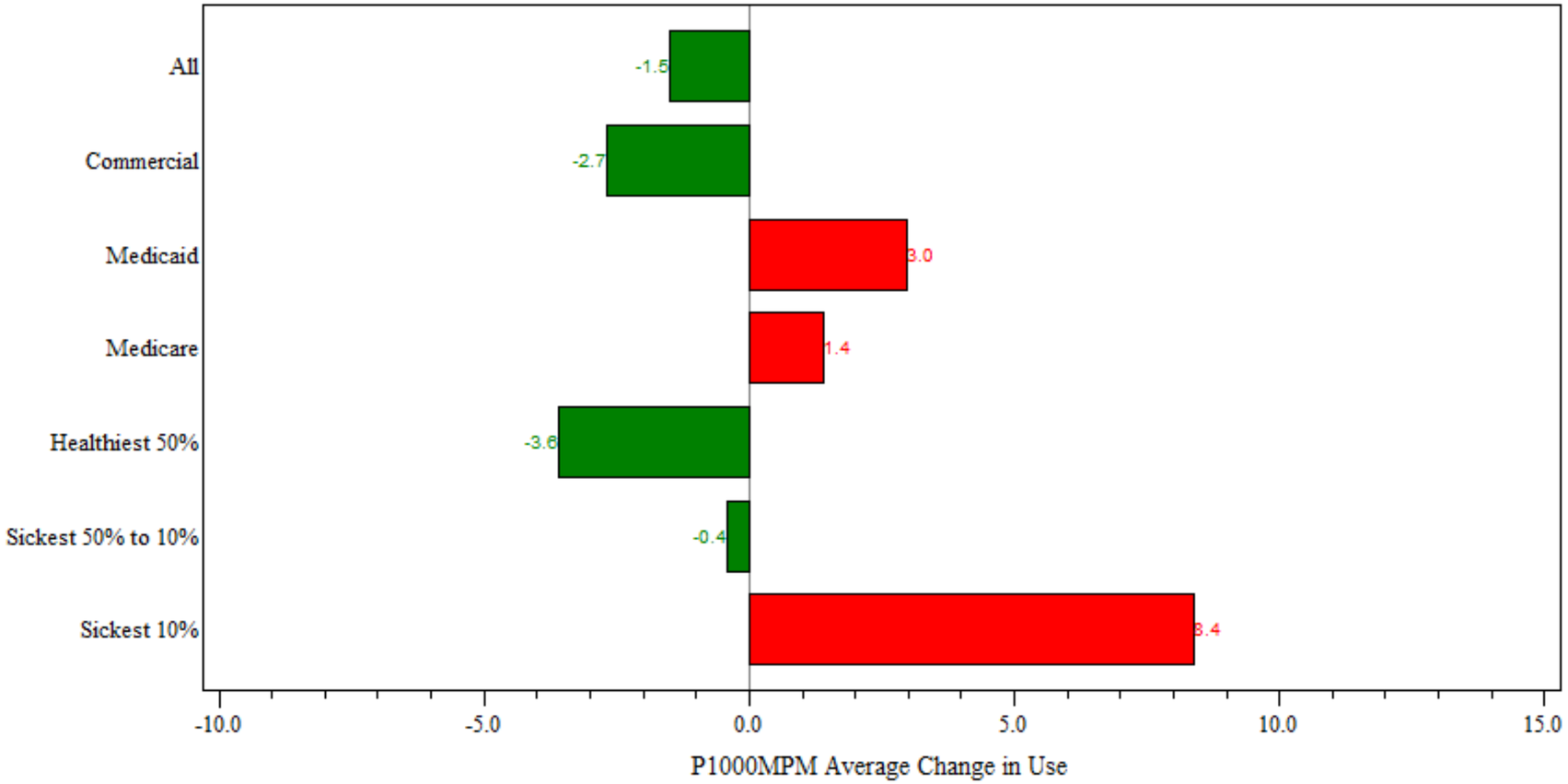
- EPC capitation paid 40% more than FFS (what we were billed for codes covered under the capitation).
  - 17% is attributable to higher payment rates than FFS
  - 23% is attributable to decreased utilization
- EPC practices are earning an additional amount as well, capturing on average one-third of their potential bonus.

Spring 2015 Analysis

- By the third year of the EPC model (2014), EPC showed a meaningful ***overall reduction in total cost of care of $17.11 PMPM, or $20.7M.***
  - Almost 60% of the total cost reduction occurred within the ***commercial*** market.
- ***Primary care services*** cost an additional $10.7M ($8.91 PMPM) in 2014.
  - Increases were offset by reductions of $11.4M ($9.46 PMPM) for ***outpatient services*** and $4.1M ($3.35 PMPM) for ***prescription drugs***, among other categories.
- Vulnerable, high-risk members (***sickest 10%***, ***Medicaid***, and ***Medicare***) experienced higher than expected primary care visits, while ***overall*** members in EPC have fewer primary care visits than expected.
  - EPC providers are likely spending more time with members with greater needs, as well as providing care to healthier members in a more efficient manner.

PCP Visit Rate was 1.5 Visits/1,000 Members/Month Lower

The most vulnerable populations were higher.



Commercial members and the ***healthiest 50%*** showed lower than expected primary care usage while more vulnerable populations showed higher than expected primary care usage, suggesting that EPC providers are shifting their focus to members with greater needs and potentially reducing churn. While not shown, the rate of primary care usage has declined since 2012.

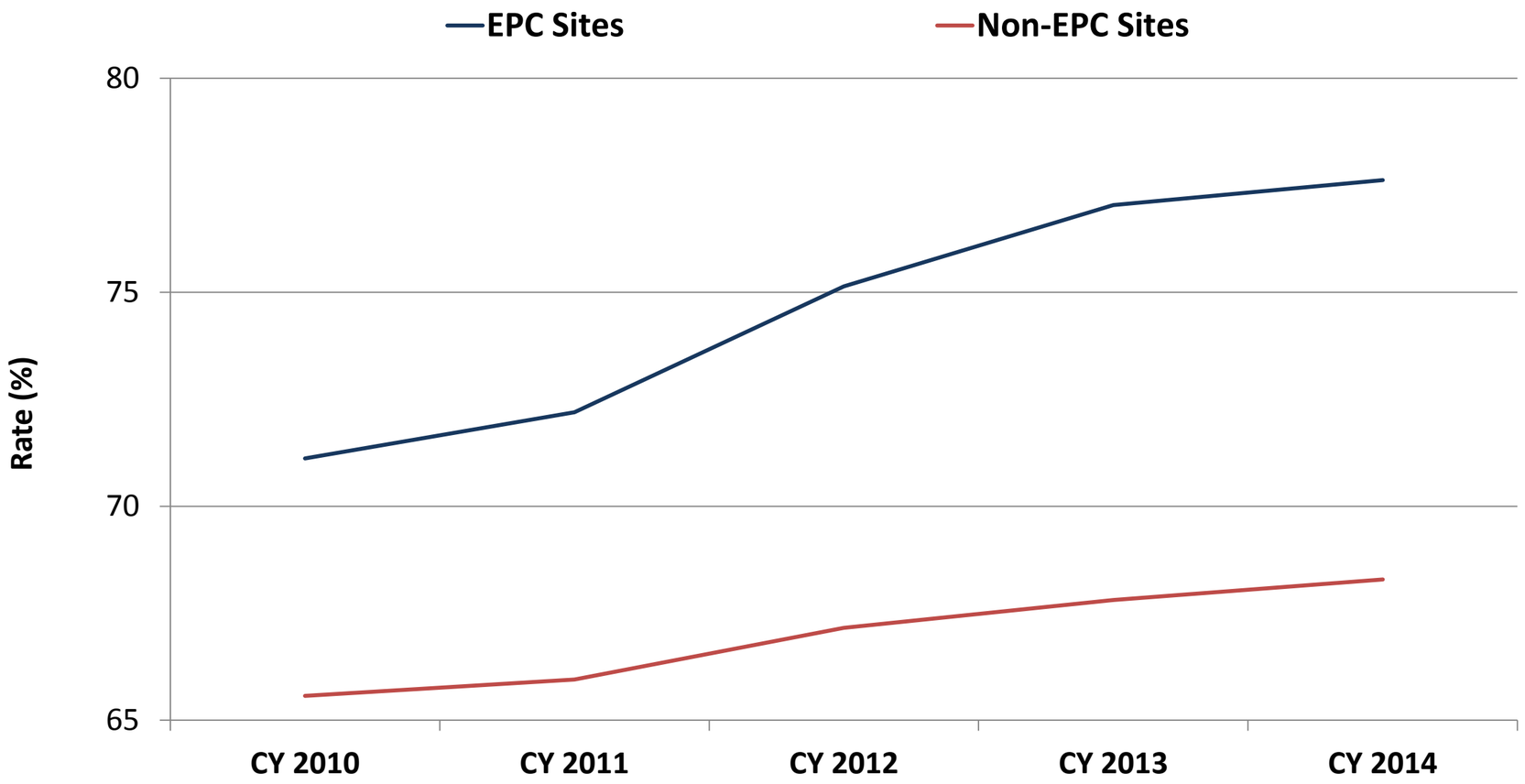
Impact of EPC on Total Cost of Care (TCOC)

% change from expected in 2014

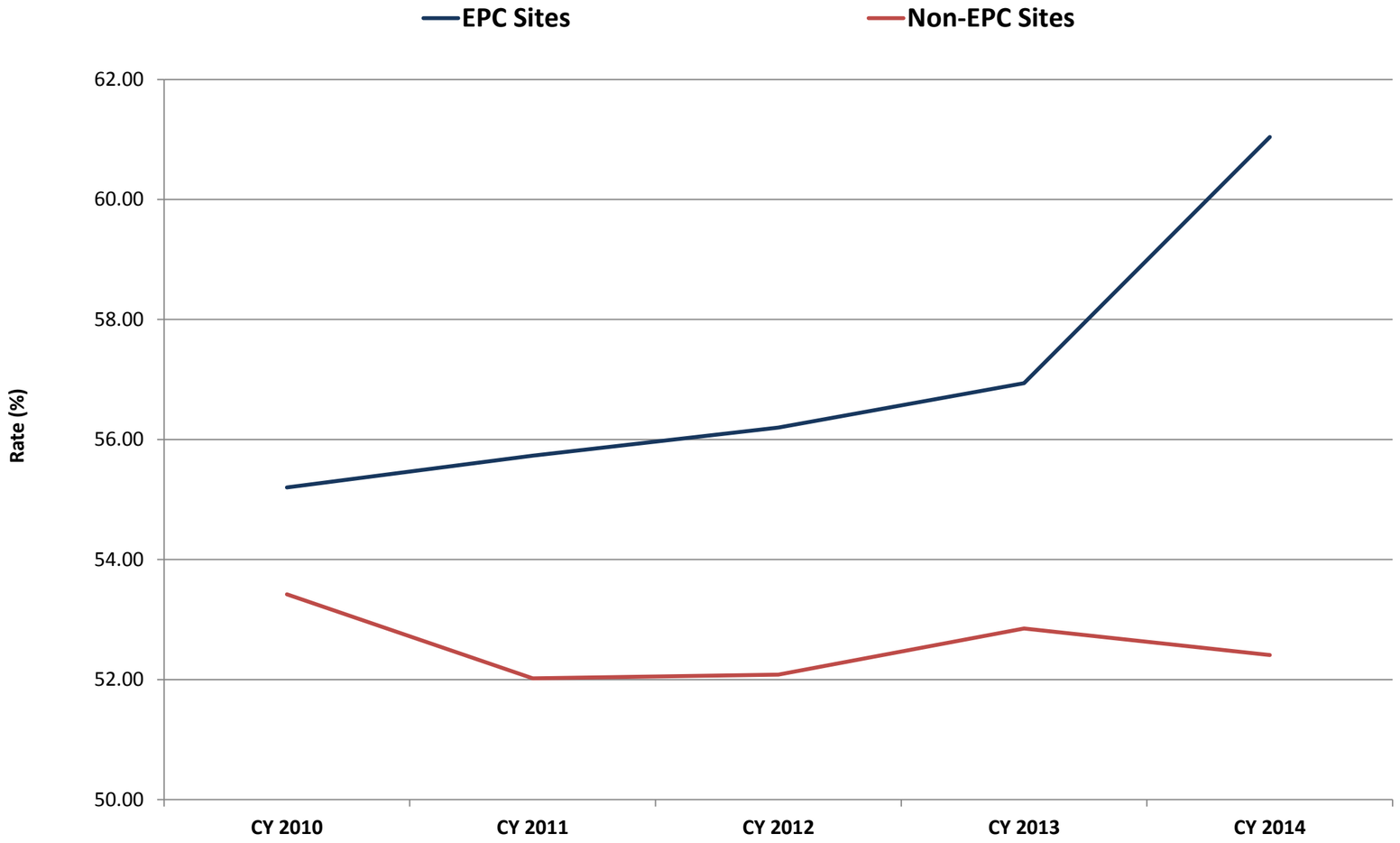
Percent Change	All	Healthiest 50%	Sickest 50%-10%	Sickest 10%
All	-2.9%	-1.6%	-4.0%	-2.4%
Commercial	-3.3%	-1.0%	-6.2%	-0.9%
Medicaid	-3.9%	-2.0%	-2.4%	-5.6%
Medicare	-2.6%	-2.4%	-2.6%	-4.8%

Note: Meaningful estimates are highlighted

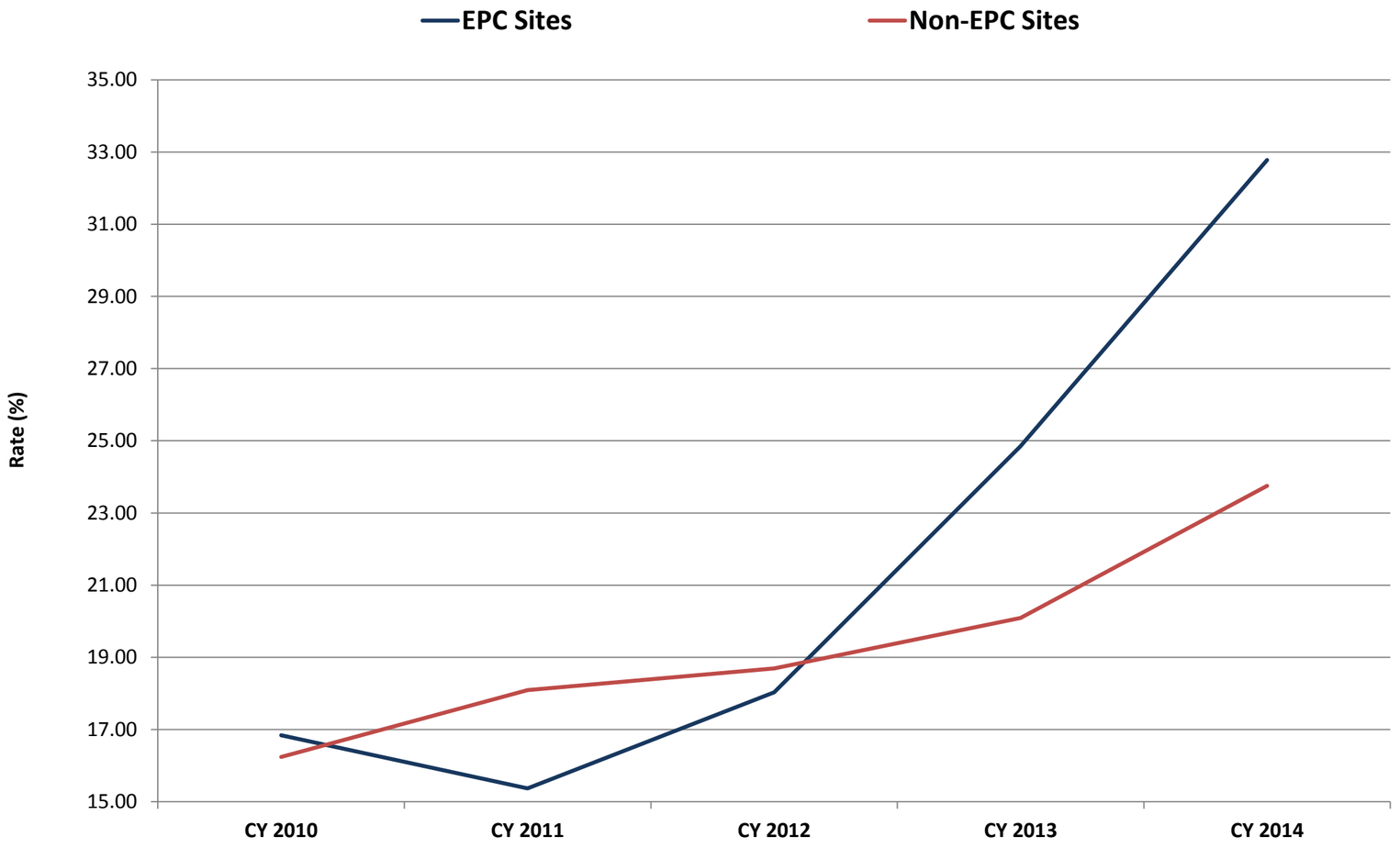
HEDIS Composite Rate Trends by EPC Site Status - 2010-2014



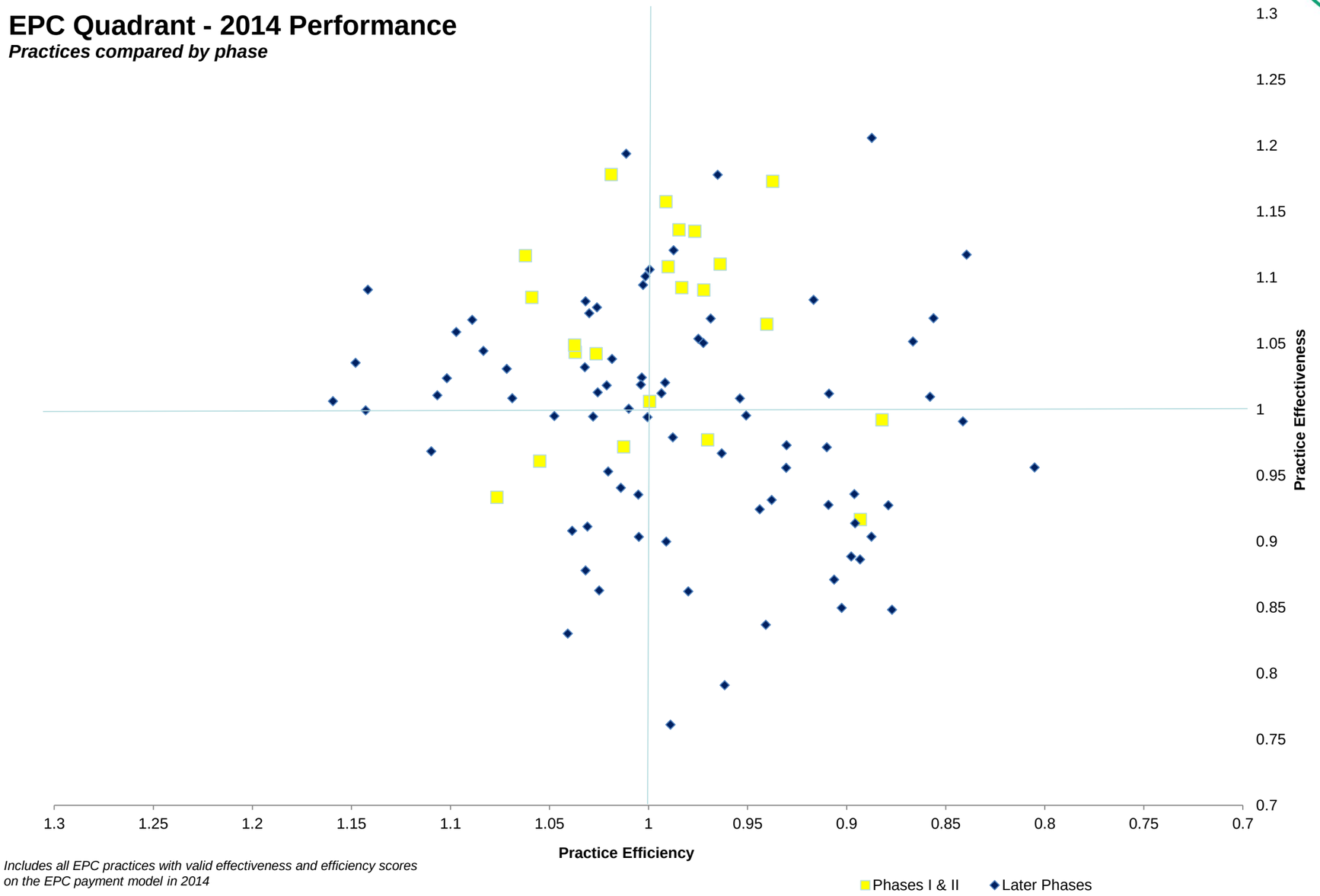
Diabetes Eye Exam, Trends by EPC Site Status, Calendar Year 2010-2014



Appropriate Antibiotic Use for Acute Bronchitis Management, Trends by EPC Site Status, Calendar Year 2010-2014



It Takes Time to “Transform”



Includes all EPC practices with valid effectiveness and efficiency scores on the EPC payment model in 2014