MAPOC Care Management Committee

FCG Primary Care Assessment Project

June 8, 2022

Faulkner CONSULTING GROUP

Primary Care Assessment Project: Overview

The Primary Care Assessment is a multi-phased project that aims to assess CT DSS primary care program opportunities and provide recommendations to inform the future direction of CT DSS primary care programs.

	Objective	2022
Phase 0 *Establish Process*	• Establish detailed workplan/ project framework	**Feb**
Phase 1 *Initial Assessment*	• Review existing program documentation • Interview state team for background/ context • Complete preliminary program assessment	**Mar** **Apr** **May**
Phase 2 *Primary Data Collection*	• Interview members, providers, and other key stakeholders to understand stakeholder priorities	**Jun** **Jul** **Aug**
Phase 3 *Recommendations*	• Develop options and recommendations for the future of CT DSS primary care programs	**Sep** **Oct**
Phase 4 *Support Implementation*	• Outline implementation considerations and key activities to support implementation of recommendations	**Nov** **Dec**

Progress to date:
Initial assessment - establishing starting point

Next step:
Focus group sessions

Initial Assessment: Approach

We are conducting an initial assessment to establish a starting point that will be further refined based on input from members, providers, and other key stakeholders in Phase 2.

(1) Internal Assessment: Program Performance Initial Observations

Synthesize existing program documentation and key informant input into a directional assessment of primary care program performance to date

		CMAP Overall	PCMH	PCMH+
Equity	Member Access and Provider Participation			
	Cost			
	Quality			
	Member and Provider Experience			

(2) External Assessment: Payment Model Evidence Base

Catalog and summarize VBP model results to date and lessons learned, across payers and payment model type

	Summary of Key Findings
	Summary Statement • Key Findings by Source [Source #]
Results to Date	*Payment Model Evidence Base*
Lessons Learned	*Payment Model Design*
	Program Implementation

(3) Establish DSS Primary Care System Goals

Identify the overarching goals and guardrails that will guide the identification of primary care program options for consideration

Input Session
Collect input from DSS team

Categorize & Synthesize
Categorize proposed goals and guardrails and synthesize related goals

Refine & Finalize
Solicit feedback on draft goals – add, refine, finalize

Next Steps:

- Conduct focus group interviews and layer in findings (Phase 2)
- Develop program options and recommendations

Program Performance Initial Observations

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Program Performance Initial Observations: Approach

Initial Observations are intended to synthesize existing program documentation and key informant input into a directional assessment across program elements that serves as a starting point for the identification of opportunities and options.

		Program Dimension	CMAP Overall	PCMH	PCMH+
Equity *(assessed for each dimension)*	**Program Performance**	**Member Access and Provider Participation**	**Key Sources:** • PCMH/ PCMH+ program performance data and requirements • CMAP primary care system performance data • Multi-state benchmarking • CT DSS input sessions		
		Cost			
		Quality			
		Member and Provider Experience	*Member and provider experience information to date is limited – will be more substantively explored during Phase 2 (Primary Data Collection)*		

The learnings collected here are preliminary and inconclusive. Initial Observations are the result of a rapid review of a range of sources, not a rigorous evaluation – and should be interpreted as such.

Access and Participation: Key Findings

CMAP performs comparatively well on measures of primary care access and preventive care, however there are disparities in performance by race/ethnicity. The majority of CMAP PCPs participate in PCMH, but participation in PCMH+ is more limited, and especially limited amongst non-FQHC providers.

	CMAP Overall	PCMH	PCMH+	Equity Lens
Member Access and Provider Participation	• There are **currently no major gaps in CMAP member PCP access**, as measured [6] • CMAP overall shows **strong comparative performance on measures of *Primary Care Access and Preventive Care*,** compared to other state Medicaid programs [14]	• Participation in PCMH **grew considerably in the initial years** of the program, driving gains in member access, and has since leveled off [17] • **55% of HUSKY members** are attributed to a PCMH; 80% of those attributed to a PCP (Dec 2020) -- **56% of CMAP participating PCPs** are participating in PCMH (MY 2020) [7]	• Provider participation in PCMH+ appears to be **notably shaped by the financial incentives available – the majority of PCMH+ participants are FQHCs**, very few non-FQHC practices have elected to participate [2] • **17% of HUSKY members** are attributed to a PCMH+; 25% of those attributed to a PCP (Dec 2020) -- **18% of CMAP participating PCPs** are participating in PCMH+ (MY 2020) [7]	• The **PCMH+** attributed population is **disproportionately Black and Hispanic**, as compared to the overall population, while **PCMH** attributed members are **more likely to be white than Black or Hispanic** [11] • **Disparities in performance by race/ethnicity identified** for the majority of CMAP measures of ***Prevention and Screening*** **and** ***Access/ Availability of Care*** [8]

Quality of Care: Key Findings

CMAP generally performs well on quality measures, and the PCMH and PCMH+ programs have shown targeted, measurable improvements on incentivized quality measures. However, disparities in quality performance by race/ethnicity were identified across programs.

	CMAP Overall	PCMH	PCMH+	Equity Lens

Quality of Care	• CMAP **generally performs well on quality measures**: CMAP scored above the national average on 80% of Medicaid/CHIP Scorecard measure components, and was in the top quartile for more than half (52%) of measures [14]	• There have been **targeted, measurable improvements on the specific PCMH/PCMH+ measures that have financial incentives attached** [1]
		• Broader **quality performance strengths appear well aligned with the goals and structure of PCMH/PCMH+** [1]
		  • The emphasis on prevention and screening can be seen in substantial improvements on these measures across PCMHs and FQHCs
		  • FQHCs perform better on Overuse/ Appropriateness and Behavioral Health measures vs. PCMH and non-PCMH practices (potentially encouraged by the structure of the PCMH+ program, among other factors)
				Disparities in quality measure performance by race/ethnicity identified [8]
				• Overall, there were observable disparities in quality performance by race/ethnicity for 83% of CMAP measures
				• Disparities in quality performance were most prevalent in the Black CMAP population - quality performance rates were worse than the overall rate for 70% of measures

Cost of Care: Key Findings

PCMH+ has demonstrated success in controlling cost trend, while PCMH practices have had a less substantial impact on cost trend in recent years. Reducing hospital utilization remains an opportunity to impact total cost of care.

	CMAP Overall	PCMH	PCMH+	Equity Lens
Cost of Care	• CMAP appears to be **relatively low cost overall**, although there may be an **opportunity to shift spending and invest more significantly in primary care,** as a share of total Medicaid spend. [15, 16]	• PCMH practices have had a **less substantial impact on cost trend** in recent years, as compared to FQHCs. [1] • PCMH practices perform roughly comparably to non-PCMH practices on measures of hospital utilization and have improved less on these measures in recent years (vs. non-PCMHs), suggesting there may be **some opportunity for improvement on hospital avoidance.** [8]	• PCMH+ has **demonstrated success in generating statistically significant decreases in spending and acute care utilization** and controlling cost trend in aggregate. However, shared savings performance has varied by provider. [3, 2] • **No evidence of under-service utilization has been found** in the early years of the program. [5] • FQHCs have improved on measures of hospital utilization but **may still have some opportunity for improvement** relative to PCMH and non-PCMH practices (though higher rates of utilization may also be attributed to a higher risk population, among other factors). [8]	**Disparities in hospital utilization by race/ ethnicity identified** • The Black CMAP population had a higher-than-average rate of hospital/ED utilization on 4 out of 4 measures; the Hispanic CMAP population had a higher-than-average rate on 3 out of 4 measures. [8]

Program Performance Initial Observations: Sources

For discussion: Any important starting point context missing from this review to date?

	Sources
PCMH/ PCMH+ Program Performance Data	1. CHN PCMH Longitudinal Review 2. Mercer PCMH+ Annual Shared Savings Reports 3. PCMH+ Formal Evaluation: RTI, *Evaluation of the State Innovation Models (SIM) Initiative Round 2: Model Test Final Report*, June 28, 2021
PCMH/ PCMH+ Program Requirements	4. PCMH and PCMH+ Program Guidance and RFPs 5. Mercer PCMH+ Under-Service Utilization Monitoring Strategy, July 2020
CMAP Overall Primary Care Data	6. CHN Gap and Network Adequacy Analysis 7. CHN MY 2020 Annual Provider Profiling Report 8. CHN 2021 HUSKY Health Program Health Equities Report (MY 2019 Performance) 9. CT OHS Cost Growth Benchmark Program 10. CMAP CAHPS Survey Data - SPH Analytics, *2020 Medicaid Adult and Child At - A - Glance Reports* 11. CHN Member Attribution data request; attribution as of 1/1/2022 12. Supplementary enrollment, utilization, and expenditures data as requested
Multi-State Benchmarking	13. Kaiser Family Foundation Primary Care Access Indicators 14. Medicaid/ CHIP Scorecard Quality Measures – *FY 2020 Child and Adult Core Set Performance* *15. Primary Care Expenditures: Investing in Primary Care, A State-Level Analysis*; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center 16. Medicaid.gov Medicaid Per Capita Expenditure Estimates for States and Data Quality Assessment (2019)
CT DSS Input Sessions	17. Input Sessions with CT DSS, CHN, and Mercer teams *18. Report from Advisory Board for Transparency on Medicaid Cost and Quality*, July 2021

Payment Model Evidence Base

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Payment Model Evidence Base: Approach

The literature review aims to catalog and summarize VBP model results to date and lessons learned, across payers and payment model type, using the Urban Institute's *Typology of Payment Methods* as the organizing framework.

(1) Review and identify pertinent sources in the following categories

	Evidence Breadth
VBP Model Systematic Reviews	Med-High
Base Payment Assessments	Med
CMS Innovation Center Models	High
State Medicaid Program Models	Med
Primary Care Start-up Models	Low
Driving Equity through Payment	Low

(2) Catalog key findings from each source

Source	Focus Area	Key Findings

(3) Categorize and synthesize key findings across sources

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Payment Model Evidence Base: Sources

For discussion: Any other areas of evidence, or specific studies, you would recommend including in this review?

	Evidence Breadth	Focus Area	Reviewed Sources
VBP Model Systematic Reviews	Med-High	ACO	1. Wilson, Michael, et. al. "The impacts of accountable care organizations on patient experience, health outcomes and costs: a rapid review." Journal of Health Services Research & Policy, 25;2, 2020. 2. Kaufman, Brystana, et. al. "Impact of Accountable Care Organizations on Utilization, Care, and Outcomes: A Systematic Review." Medical Care Research and Review, 76;3, November 2017.
		P4P	3. Kim, Kyung, et. al., "Do penalty-based pay-for-performance programs improve surgical care more effectively than other payment strategies? A systematic review," Annals of Medicine and Surgery, 60, November 2020. 4. Chee, Tingyin, et. al. "Current State of Value-Based Purchasing Programs." Circulation, 133;22, May 31 2016. 5. RAND Corporation, "Measuring Success in Health Care Value-Based Purchasing Programs," 2014.
		Commercial	6. Milad, Marina, et. al. "Value-Based Payment Models In The Commercial Insurance Sector: A Systematic Review." Health Affairs, 41;4, April 2022.
Base Payment Assessments	Med	Primary Care Capitation Analysis	7. Tummalapalli, Sri Lekha, et al., "Capitated versus fee-for-service reimbursement and quality of care for chronic disease: a US cross-sectional analysis," BMC Health Services Research, 22:19, 2022. 8. Basu, Sanjay, et al. "High Level of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care," Health Affairs, 36:9, September 2017. 9. Pearson, William, et al. "Capitated Payments to Primary Care Providers and the Delivery of Patient Education," Journal of the American Board of Family Medicine, 26, 2013. 10. Landon, Bruce, et al. "Physician Compensation Strategies and Quality of Care for Medicare Beneficiaries," American Journal of Managed Care, 20;10, 2014. 11. Landon, Bruce, et al. "The Relationship between Physician Compensation Strategies and the Intensity of Care Delivered to Medicare Beneficiaries," Health Services Research, 46;6, December 2011.
CMS Innovation Center Models	High	CMMI Lessons Learned	12. CMS Innovation Center Strategy Refresh, October 2021. 13. Smith, Brad. "CMS Innovation Center at 10 Years – Progress and Lessons Learned." New England Journal of Medicine, 384;8, February 2021. 14. Chernew, Michael, et al., "The Case For ACOs: Why Payment Reform Remains Necessary," Health Affairs, January 2022.
		Multi-Model Reviews	15. Systematic Review of CMMI Primary Care Initiatives: Final Report, Prepared for CMS by Kennell and Associates, Inc., February 2018. 16. Perla, Rocco, et. al., "Government as Innovation Catalyst: Lessons from the Early Center for Medicare and Medicaid Innovation Models." Health Affairs, 37;2, February 2018.
State Medicaid Program Models	Med	Multi-Model Reviews	17. Rutledge, Regina. "Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts." The Milbank Quarterly, 97;2, 2019. 18. McConnell, John, et. al. "Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado." JAMA Internal Medicine, 177;4, April 2017.
Primary Care Start-up Models	Low	Industry News	19. Bates, Matthew. "Operationalizing Value-Based Primary Care: Lessons from the Field." KaufmanHall, February 2022. 20. Sinsky, Christine and Thomas. "Lessons From CareMore: A Stepping Stone to Stronger Primary Care of Frail Elderly Patients." The American Journal of Accountable Care, 3;2, June 2015.
Driving Equity through Payment	Low	VBP and Equity	21. Michigan Department of Health & Human Services, *Medicaid Health Equity Project Year 8 Report (HEDIS 2018)*, January 2021 22. Anderson, Andrew, et al. "Promoting Health Equity and Eliminating Disparities Through Performance Measurement and Payment," Health Affairs, 37;3, 2018. 23. Anderson, Ryan, et al., "Quality of Care and Racial Disparities in Medicare Among Potential ACOs," Journal of General Internal Medicine, 29;9, May 2014.

DSS Primary Care System Goals

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DSS Primary Care System Goals

Preliminary and subject to change

For discussion: Any comments on these goals? Anything you would change or add?

End Goals	1. **Improve the biopsychosocial health and well-being of our members** – especially for our most historically disadvantaged members and in a way that reduces racial disparities. 2. **Be budget neutral** – do not increase total cost of care relative to the no-reform baseline. Increases in primary care spending should be offset by savings from improved member outcomes and not by restricting access to services.
Proposed Strategies	A. Incorporate **health equity** as a guiding principle for system change B. Maintain **member choice and access** C. Uphold a **model of mutual accountability** 1. Equip providers with tools, funding, and flexibility… and commit to a streamlined program that is simple and easy to understand, with straightforward incentives tied to impactable outcome-oriented goals that will ultimately improve primary care providers' experience 2. Providers are expected to fully address member needs and take accountability for member outcomes by providing culturally competent and inclusive treatment, enhancing access, strengthening care coordination, integrating behavioral health care, and better identifying and addressing members' social determinant of health needs **D. Maximize program impact** 1. Participate in statewide primary care reform efforts, pursue multi-payer alignment, and ensure primary care programs are broadly appealing to providers 2. Align other reform initiatives so that primary care is supported by specialty care, behavioral health care, and community-based services E. Be **data, evidence, and member experience informed**. Build on the successes and failures of similar efforts elsewhere, and wherever possible, adopt a "test and learn" mindset.

Next Step: Primary Data Collection

Over the summer (June-July), we will be engaging members, providers, and other key stakeholders to share their perspectives on Medicaid primary care, and the PCMH and PCMH+ programs.

	2022
Phase 0 *Establish Process*	**Feb**
Phase 1 *Initial Evaluation*	**Mar**
	Apr
	May
Phase 2 *Primary Data Collection*	**Jun**
	Jul
	Aug
Phase 3 *Recommendations*	**Sep**
	Oct
Phase 4 *Support Implementation*	**Nov**
	Dec

This initial assessment of stakeholders aims to frame the current system and identify opportunities for improvement.

Member Focus Groups	(1) English - Adult (2) English - Pediatric (3) Spanish - Adult (4) Spanish - Pediatric
Provider Focus Groups	(1) PCMH Practices (Non-FQHC) (2) PCMH+ Practices (Non-FQHC) (3) Non-participating practices (Non-FQHC) (4) PCMH+ Practices (FQHC) (5) Non-participating practices (FQHC)
Non-Member/ Provider Stakeholders	**(1) MAPOC Committee Members** (2) Provider Advocates (3) Community Advocates

MAPOC Committee Member focus group:
June 9th 12-1pm