CT DSS Primary Care Assessment

Update to MAPOC Care Management Committee

December 14, 2022

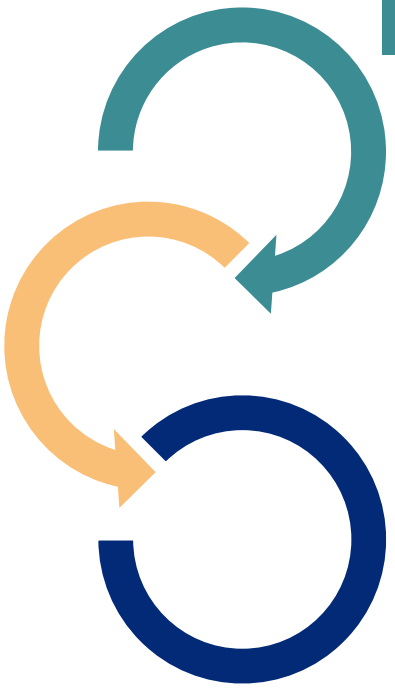
Faulkner CONSULTING GROUP

Update to MAPOC Care Management Committee

Agenda for Today

- **Starting Point:** National and State Level Context
- **CT DSS Primary Care Assessment:** Program Recommendations
- **Next Steps:** Program Design Stakeholder Engagement
- **Follow-up:** From Oct. 12th MAPOC Care Management Meeting

Primary Care: Foundation of a High-Functioning Health Care System



High-quality primary care is the foundation of a high-functioning health care system and is critical for achieving health care's quadruple aim - enhancing patient experience, improving population health, reducing costs, and improving the health care team experience.

- Absent access to high-quality primary care, minor health problems can spiral into life-altering chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, and preventive care lags.

Because of chronic underinvestment, primary care in the United States is slowly dying. The U.S. system is in crisis and being eroded by many forces.

- Primary care is under-resourced, accounting for 35 percent of health care visits while receiving only about 5 percent of health care expenditures.
- The foundation is crumbling: visits to primary care clinicians are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative health care fields.
- The COVID-19 pandemic amplified pervasive economic, mental health, and social health disparities that ubiquitous high-quality primary care might have reduced – and pushed many primary care practices to the brink of insolvency, with most practices uncertain about their financial viability.

Primary care remains the largest platform for continuous, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities.

Excerpted from: National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

Federal Priorities

Reminder from Feb 2022

CMS Strategic Priorities

Innovation Center Strategic Objective 1: Drive Accountable Care

Aim:
Increase the number of people in a care relationship with accountability for quality and total cost of care.

Measuring Progress:
- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Presidential COVID-19 Health Equity Task Force

Health Care Access and Quality

Everyone has equitable access to high-quality health care.

Improve health equity through measurement and incentives.

By:
- Developing a health equity framework, inclusive of formal metrics, equity impact statements and process to monitor […]
- Supporting the development of reimbursement models that encourage data- and community-driven approaches focused on improving equity-centered health care delivery for communities of color and other underserved populations where they live and work.
- Providing payment incentives to providers that improve metrics of health care quality and patient experience in communities of color and other underserved populations.

Source: (Left) CMS, *Innovation Center Strategy Refresh*, 2021
(Right) Presidential COVID-19 Health Equity Task Force, *Final Report and Recommendations,* October 2021

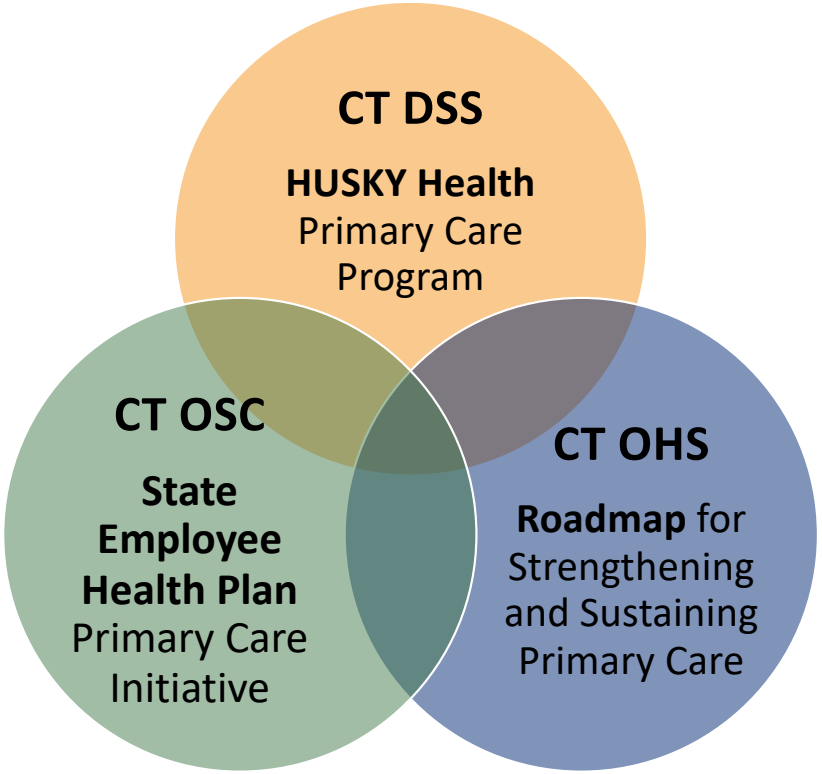
Connecticut's Coordinated Primary Care Reform Effort

Connecticut is pursuing a coordinated, multi-payer strategy to support the state's primary care infrastructure, improve quality of care, equity and population health, and improve affordability of health care.

DSS is aiming to develop a primary care program that:

(1) **Recognizes the unique needs of the HUSKY Health population** and incorporates a strong focus on addressing SDOH needs and promoting equity, ***while***

(2) **Leveraging opportunities for multi-payer alignment** that reduce provider administrative burden, maximize program impact, and build on broader statewide efforts where possible



Primary Care Assessment Project: Status

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 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**

Reviewed during the October MAPOC Care Management Committee Meeting

Today's MAPOC Meeting Agenda:
- Discuss program recommendations
- Collect feedback

CT DSS HUSKY Health: Primary Care Goals and Opportunities

CT DSS has distinct goals and opportunities for primary care program development that are responsive to the unique needs of the HUSKY Health population.

Goal

Improve the biopsychosocial health and well-being of our members - *especially for our most historically disadvantaged members and in a way that reduces inequities and racial disparities.*

Targeted Outcomes

Members
Access to culturally appropriate, integrated, whole-person care

Providers
Flexibility to fully address member needs and take accountability for member outcomes

State
Improvements in member outcomes and quality of care, with aligned incentives and increased accountability for the provision of effective and affordable care

Opportunities

Care Delivery Redesign

- **Enable an expanded care team to coordinate care** for medical, behavioral, and social needs
- Give providers **more flexibility to tailor care delivery to member needs**, including through technology-enabled modalities
- Support **easy and timely access to primary care and** address the need for more timely **access to Medicaid specialists**

Performance Measurement

- Partner with providers to more effectively **identify and address SDOH needs, integrate behavioral health and promote equity**
- Enhance the **focus on measuring and addressing disparities in care**
- Increase the availability of **timely, actionable data** and ensure that measurement methods are **transparent and understandable**

Payment

- Ensure programs are **data, evidence, and member experience** informed and adopt a "test and learn" mindset
- Provide sufficient payment to **enable and integrate** care delivery redesign and performance measurement opportunities
- Ensure that payment adequately **supports and advances biopsychosocial health** and **drives accountability** for outcomes

Develop a **cross-cutting equity strategy** with the goal of reducing inequities and racial disparities

Pursue **multi-payer alignment** on select design features

DSS Primary Care Program: Recommendations for Program Design

Care Delivery Redesign	**Provide support for practices to achieve and demonstrate core practice functions foundational** to the delivery of high-quality primary care **–** with a focus on **expanded care teams, enhanced care coordination, and technology-enabled care modalities** that support easy and timely access to care, behavioral health integration, identifying and addressing health related social needs, and promoting equity.

	Program Elements
Care Coordination	**Expanded care teams that coordinate care** for members between visits and across the continuum of care, inclusive of clinical care management personnel and non-clinical care coordination personnel to address biopsychosocial member needs (i.e., community and peer-based health workers)
Care Transformation Infrastructure	**Infrastructure to enable and support care coordination** (e.g., screening and referral tools, business processes, data collection and analysis, billing/EMR systems changes)
SDOH Supports	**Tools, supports, and flexibility to enable providers to address members' social determinant of health needs**, either directly or through referral
Practice Recognition	**A practice recognition process** that ensures practices are able to meet core practice function expectations
Technical Assistance	**Technical assistance for practices** to support achievement of practice function expectations and fulfillment of practice recognition requirements

DSS Primary Care Program: Recommendations for Program Design

Performance Measurement	Establish a **performance measurement program that drives accountability and improvement**, with an enhanced **focus on measuring and addressing disparities in care**. Ensure performance data is available to support provider performance improvement, and ongoing program monitoring.

	Program Elements
Quality Measurement	**A quality measurement program** that drives improvements in quality of care and is incorporated in any payment model to ensure accountability, utilizing the OHS core measure set where feasible and appropriate Bring an **enhanced focus on measuring and addressing disparities in care** by incorporating equity-sensitive quality measures and enhancing data collection and measure stratification requirements
Data Sharing	**Bi-directional data sharing between DSS and providers** that supports payer/provider transparency, drives improvement, and minimizes administrative burden (e.g., use of HIE)

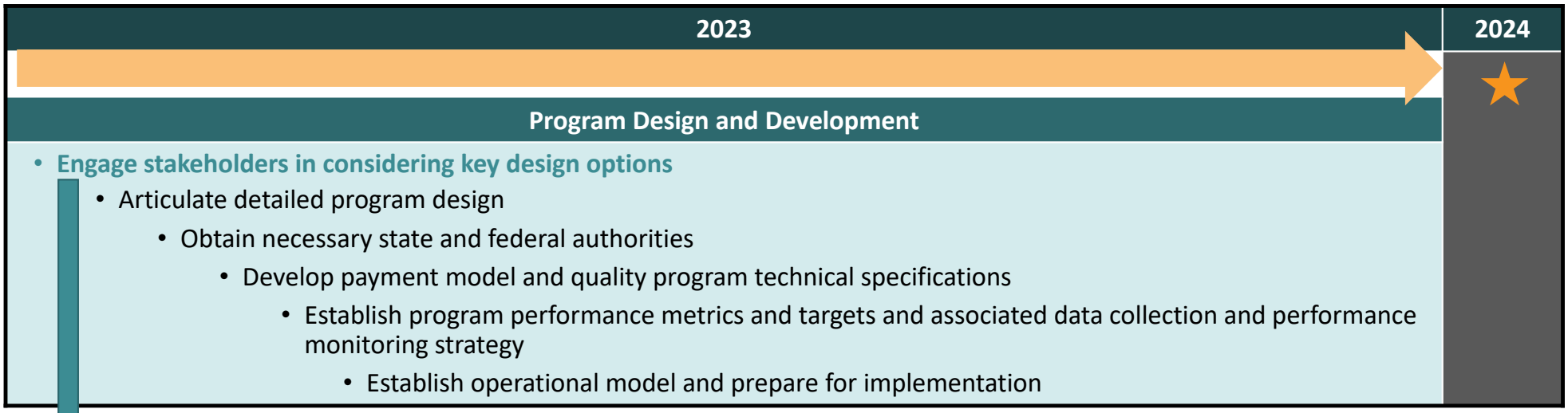
DSS Primary Care Program: Recommendations for Program Design

$ **Payment**	Provide sufficient payment to **enable and integrate** care delivery redesign and performance measurement opportunities and ensure that payment adequately **supports and advances biopsychosocial health** and **drives accountability** for outcomes.

	Program Elements
Funding for Care Delivery Redesign	**Funding that supports care coordination** personnel and infrastructure and enables providers to address members' **social determinant of health needs**, either directly or through referral.
Funding for Performance	**Funding to establish a performance measurement program that drives accountability and improvement**, with an enhanced focus on measuring and addressing disparities in care.
Aligned Incentives	Ensure that any **funding is designed to align incentives and encourage** targeted outcomes for members, providers, and the state

Next Step: Program Design

Program design and development work to articulate a detailed program design will occur throughout 2023, towards a new program launching in January 2024.



Primary care program design and implementation planning work will be conducted in close partnership with stakeholders throughout 2023.

Primary Care Program Design: Stakeholder Engagement Plan

Primary care program design and implementation planning work will be conducted in close partnership with stakeholders.

Goal: Leverage a combination of new and existing forums to collect input into primary care program design and implementation planning; provide ongoing program updates and education to HUSKY Health providers, members, and key stakeholders

	Cadence	Participants
New Forums		
Primary Care Program Advisory Committee	**Monthly**	**Representatives from the following key cohorts, participation by invitation:** • Medicaid members, community-based organizations, primary care providers, Federally Qualified Health Centers (FQHCs), hospitals, other state agencies, CT legislature, academic and/or research partners
Primary Care Provider Subcommittees **FQHCs** / **Non-FQHCs**	**As needed**	**HUSKY Health primary care providers**, FQHC and Non-FQHC
Existing Forums		
CHNCT Member Advisory Workgroup	**As needed**	**Existing forum**, standing membership of the HUSKY Health Member Advisory Workgroup
MAPOC Care Management Committee	**As needed**	**Existing forum**, standing membership of the MAPOC Care Management Committee

State agency partners (e.g., CT Office of Health Strategy and Office of the State Comptroller) will be engaged throughout

Follow-up: From Oct. 12th MAPOC Care Management Meeting

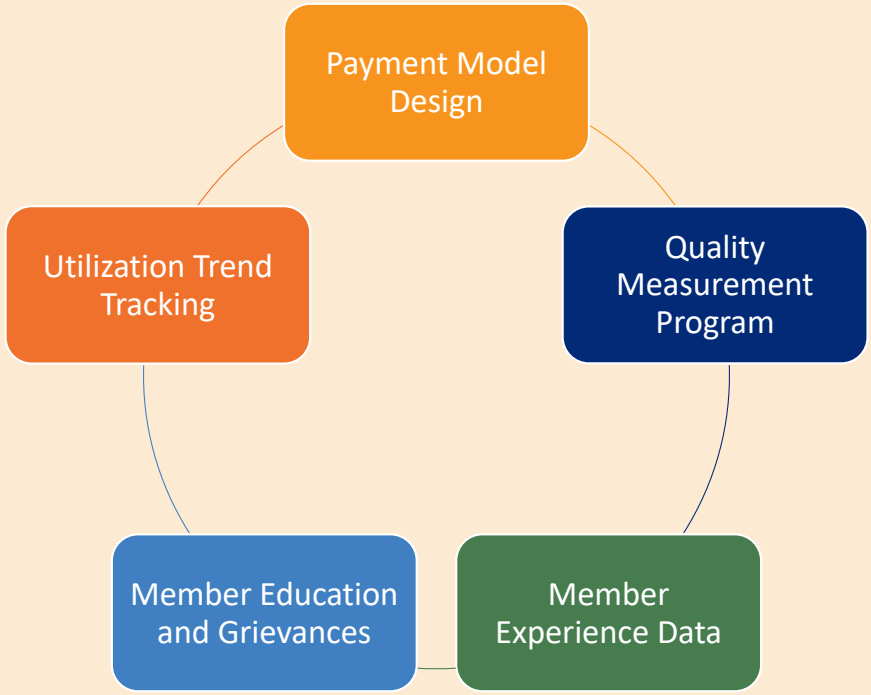
PCMH+ Underservice Evidence	*"No evidence of under-service utilization has been found in the early years of the program."*
Source	Mercer PCMH+ Under-Service Utilization Monitoring Strategy, July 2020

	Evaluation/ Monitoring Method	**Key Finding**
Preventative and Access to Care Measures	21 measures that tracked preventative care rates and monitored appropriate clinical care for specific health conditions	*No evidence of PCMH+ underutilization has been found in the review of Quality Metrics in the early years of the program.*
Member Surveys and Reviews	PCMH CAHPS survey, onsite review process, in-person interviews with PCMH+ members	*No evidence of underservice was detected during the onsite reviews. No evidence of underservice was detected during the member interviews.*
Utilization Trend Tracking	Overall service cost reports, movement of members, claim count per 1,000 members for major categories of service	*No evidence of underservice was detected during utilization trend tracking.*
	Additional Strategies	
Member Education and Grievances	Member welcome letter, information sessions, website, and grievance process and monitoring	
Shared Savings Design Elements	The PCMH+ model design has several elements that may act as deterrents to providers underserving members as a means of increasing potential shared savings – e.g.: Savings Cap, Upside-only Model, High Cost Claims Truncation, Concurrent Risk Adjustment Methodology, Requirements to Receive Savings Payments, PE Reporting	

DSS Approach

Consistent with best practices, DSS will implement a multi-pronged strategy to monitor for and protect against unintended consequences as part of any primary care program design.

Detailed design of the monitoring strategy will be conducted with stakeholder input as part of program design and development.



Literature Review: National Evidence

	Evidence to Date
Underservice	**Concerns about ACOs encouraging stinting on care have not been borne out so far. No evidence indicates that the incentives for cost reduction in ACOs resulted in negative impacts on processes or outcomes of care.** • The evidence for the impact of ACOs on health service use, processes, and outcomes of care is mixed; however, no evidence indicates that the incentives for cost reduction in ACOs resulted in negative impacts on processes or outcomes of care. [1] • Although findings on ACO impacts are mixed, the reviewed studies suggest that ACOs reduce costs without reducing quality. [2] • Concerns about ACOs encouraging stinting on care have not been borne out so far. ACO savings appear to have been generated without decrements to quality, access, or limits on freedom of beneficiaries to choose providers. Though quality measures are imperfect, performance on care processes have not systematically fallen, and early evidence suggests patient experiences have improved, particularly among high-risk patients. [3]

Overservice	**Overtreatment is a cause of preventable harm and waste in the health care system.**
	• **Overtreatment is directly associated with patient harm** as evidenced by studies of antibiotic overuse leading to resistance and Clostridium difficile infection, overuse of diagnostic testing, such as pap smear and colonoscopy, and the inherent postoperative complications from unnecessary surgical procedures. [4]
	• In this review based on 6 previously identified domains of health care waste, **the estimated cost of waste in the US health care system ranged from $760 billion to $935 billion, accounting for approximately 25% of total health care spending**. [5]
	  • Computations yielded the following estimated ranges of total annual cost of waste:
	  • Failure of care delivery, $102.4 billion to $165.7 billion;
	  • Failure of care coordination, $27.2 billion to $78.2 billion;
	  • Overtreatment or low-value care, $75.7 billion to $101.2 billion;
	  • Pricing failure, $230.7 billion to $240.5 billion;
	  • Fraud and abuse, $58.5 billion to $83.9 billion; and
	  • Administrative complexity, $265.6 billion.
	• **Clinical waste is caused by failures of care delivery, failures of care coordination, and overtreatment, accounting for 5.4–15.7 percent of all health spending in the US.** [6]

Sources

[1] 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.

[2] 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.

[3] Chernew, Michael, et al., “The Case For ACOs: Why Payment Reform Remains Necessary,” Health Affairs, January 2022.

[4] Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, Daniel M, et al. (2017) Overtreatment in the United States. PLoS ONE 12(9): e0181970. https://doi.org/10.1371/journal.pone.0181970

[5] Shrank, William, et al. (2019) Waste in the US Health Care System Estimated Costs and Potential for Savings. JAMA. 2019;322(15):1501-1509. doi:10.1001/jama.2019.13978

[6] “The Role Of Clinical Waste In Excess US Health Spending," Health Affairs Research Brief, June 9, 2022.DOI: 10.1377/hpb20220506.432025

Appendix

Primary Care Program Assessment

Materials previously shared with the MAPOC Care Management Committee

- Preliminary Program Assessment
- Primary Care Focus Group Learnings

Reminder: **Preliminary Program Assessment**

The Preliminary Program Assessment documents learnings from the Initial Evaluation phase of the Primary Care Assessment.

(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

Reminder: **Program Performance Initial Observations**

(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	Summary of Key Findings
Member Access and Provider Participation	+	+	-	–	• CMAP **performs comparatively well on measures of primary care access and preventive care**, however there are disparities in performance by race/ethnicity. [14, 8] • The majority of CMAP PCPs participate in PCMH (56%), but participation in PCMH+ is more limited (18%), and especially limited amongst non-FQHC providers. PCHM+ participation appears to be **shaped by financial incentives – the majority of PCMH+ participants are FQHCs**, few non-FQHC practices participate. [2, 7]
Quality	+	+	+	–	• 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.** Broader **quality performance strengths appear well aligned with the goals and structure of PCMH/PCMH+** (e.g., prevention, screening). [1] • There were observable disparities by race/ethnicity for 83% of CMAP measures. Disparities were most prevalent in the Black CMAP population - where performance rates were worse than overall rate for 70% of measures. [8]
Cost	+	-	+	–	• 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 spend. [15, 16] • PCMH practices have had a **less substantial impact on cost trend** in recent years, vs. FQHCs. PCMH practices perform comparably to non-PCMH practices on measures of hospital utilization and have improved less on these measures in recent years (vs. non-PCMHs), suggesting **opportunity for improvement on hospital avoidance.** [1, 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. **No evidence of under-service utilization has been found** in the early years of the program. [3, 2, 5] • **Disparities in hospital utilization -** The Black CMAP population had a higher-than-average rate of hospital/ED utilization on 4 of 4 measures; the Hispanic CMAP population had a higher-than-average rate on 3 of 4 measures. [8]

Reminder: **DSS Primary Care System Goals**

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 inequities and racial disparities. **2. Be fiscally responsible and sustainable** relative to the no-reform baseline. Any 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, and wherever possible, adopt a "test and learn" mindset.

Primary Care Focus Groups: Approach

Over the summer, we conducted 11 focus groups with members, providers, and other key stakeholders.

	Identify Focus Groups	Outreach to Participants	Focus Group Facilitation
Member Focus Groups	(1) English - Adult (2) English - Pediatric (3) Spanish - Adult (4) Spanish - Pediatric	**Email Invitation with Follow-up Phone Calls to Member Sample** • CHN member engagement sent email invitations to 15,604 members • Member selection criteria used ADI to target underserved geographic areas (ADI: 5-10) • Member engagement team followed up with phone calls to increase response rate (especially for Spanish speaking groups) • Members received a $25 gift card for participating	1-hour sessions Spanish language sessions conducted with an interpreter
Provider Focus Groups	(5) PCMH Practices (Non-FQHC) (6) PCMH+ Practices (Non-FQHC) (7) PCMH+ Practices (FQHC) (8) Non-Participating Practices (FQHC + Non-FQHC)	**Email Invitation to Nearly All HUSKY Health Practices** • CHN provider contacts sent email invitations to their assigned PCMH/+ participating and non-participating practices	1.5-hour sessions
Non-Member/ Provider Stakeholders	(9) MAPOC Care Management Committee Members (10) Provider Advocates (11) Community Advocates	**Email Invitation to Stakeholder List** • All MAPOC Care Management Committee members invited • Provider advocacy organizations identified and invited via DSS/CHN contacts • Community advocacy organizations identified through DSS and CHN, list enhanced with suggestions from MAPOC CM Committee	1-hour sessions

Primary Care Focus Groups: Approach

Participants were asked to share their perspectives on Medicaid primary care broadly, and the PCMH and PCMH+ programs specifically.

Major Topics	Sample Prompts *(prompts were tailored to each group)*	*Substantially addressed by:*		
		Member	Provider	Advocate
Primary Care Experience and Goals	• What do you see as the biggest issues/challenges for the primary care system today? If you had to choose one thing for DSS to do to improve the primary care system – what would it be? • What do you like about your primary care clinician/primary care practice? Are there any things that you don't like about the way your primary care clinician/primary care practice provides your care?	✓	✓	✓
Health Equity	• What barriers are you aware of that would make it difficult for underserved populations to be able to access the care they should be receiving? // Have you experienced any barriers to being able to access the care you should be receiving? • Are there strategies you would recommend to better identify and address disparities in member access, experience, and quality of care?	✓	✓	✓
Member Preferences	• What are the top 1-3 things members want out of their primary care experience? Where are the biggest opportunities to improve member experience? • What suggestions do you have for ways that your primary clinician/ primary care practice could improve the way that they provide care for you and/or your family?	✓	✓	✓
PCMH and PCMH+ Program Experience	• What do you like most about the PCMH (+) program? In what ways has the program succeeded? • What do you not like about the PCMH (+) program? Where do you see room for improvement? What would you change?		✓	✓
Payment Model Preferences	• What has your experience with different provider payment models been (e.g., pay for performance incentives, shared savings or risk arrangements)? • What kinds of provider payment models are you participating in with other payers? What are the success factors or lessons learned from participation in these models?		✓	✓

Focus Group Key Learnings: Summary

See appendix for additional details

Key Theme	Summary of Feedback	*Substantially addressed by:*			Excerpts
		Member	Provider	Advocate	
Identifying & Addressing SDOH Needs, Promoting Equity	Providers and advocates were almost unanimously **supportive of initiatives focused on identifying and addressing SDOH needs and promoting equity,** and generally recognized the **significant impact SDOH needs have on health outcomes.** Members, providers and advocates identified a **range of barriers that impact the equitable delivery of care and member health outcomes**, including: access to transportation, housing and food security, translation supports, technology enabled care, behavioral health access, extended care hours, disability access, cultural competency, and workforce diversity.	✓	✓	✓	*If you need insulin to manage your diabetes, and you don't have a refrigerator to keep your insulin cold, that's a huge barrier - but it's hard for me to fix that.* (Provider) *We do an SDOH screening and have a resource list to hand to patients, but we need more resources - the social work connection is really challenging.* (Provider)
Care Coordination	Providers and advocates generally cited care coordination as the area of greatest need for improvement and saw enhanced **care coordination as critical to addressing a member's full range of needs and improving health outcomes**. Providers and advocates stressed the substantial time and energy required to **help members navigate the system and connect to other services**, especially in the Medicaid population; and were broadly supportive of **expanded care teams, inclusive of community and peer-based health workers.** Members frequently mentioned office staff in describing what they liked and didn't like about their primary care experience – many **members value helpful, responsive, friendly staff who take the time to answer questions**.	✓	✓	✓	*Care coordination is a huge need, especially in this population. Members have trouble navigating the system, and that falls on office staff.* (Provider) *We need to connect community health workers to primary care doctors – they can support patients with questions, figure out what insurance covers, and help find specialists.* (Advocate)
Easy and Timely Access to Care	Members and providers most often reported **easy and timely access to appointments and more time with providers** as the things members most want out of primary care. Many providers and advocates saw **promise in technology enabled care options**; and while some members preferred office visits, many appreciated the **convenience and more timely access associated with telehealth**.	✓	✓	✓	*I really like telehealth, it's a great addition. Sometimes I don't need to go to the office, I can just do a quick, last minute telehealth call.* (Member)
Availability of Specialists	The **lack of specialists serving Medicaid members** was raised as a **critical issue** in nearly every focus group conducted – difficulty finding specialists impacts member experience and requires substantial care coordination time from providers.	✓	✓	✓	*We spend tons of time trying to locate specialists for Medicaid members – it's one of the biggest staff time consumers.* (Provider)

Focus Group Key Learnings: Summary

See appendix for additional details

Key Theme	Summary of Feedback	*Substantially addressed by:*			Excerpts
		Member	Provider	Advocate	
Timely Data & Measurement Transparency	Increased access to **timely data and greater transparency** in quality measurement and shared savings calculations was a significant priority amongst providers, especially those participating in the PCMH+ program.		✓		*We get all of the data 9 months after the year ends. With other insurers, you know how you're doing and where you stand all year long – it's much more incentivizing and you can correct more easily if you see where you're at.* (Provider, PCMH+)
Administrative Burden	Providers had some **concerns about the additional administrative burden** imposed by the PCMH and PCMH+ programs, especially the **NCQA PCMH recognition** process, and ongoing reporting requirements. Non-participating practices noted that administrative burden is **a significant deterrent to the participation of small, independent practices** in the existing value-based models.		✓		*Recognition is a giant, daunting process. We needed technical consulting help because it's an extremely arduous process. We have to submit a huge number of files every year.* (Provider, PCMH) *There is so much that PCMH wants to know. The reporting is really painful and is leading to provider burnout.* (Provider, PCMH)
Payment Model Preferences	Providers and advocates had **mixed feelings about value-based payment models**. Some saw the transition away from FFS-based models as positive or inevitable, while others had significant concerns. Some advocates were especially concerned that any model with a **savings incentive would impact quality of care or access**, especially for people with complex needs. Providers pointed out the **limitations of shared savings models** and were concerned that models that do not adequately adjust for patient complexity inappropriately penalize providers with complex, high-need patients.		✓	✓	*When there is an incentive for providers who save money, how do you ensure quality of care and access for people with disabilities or who have complex medical needs?* (Community Advocate) *Shared savings is tough because when you have a really good outcome already you can't improve and then there's no benefit.* (Provider) *This is where capitation avoids this issue entirely - the upfront, increased investment in primary care is foundational.* (Provider)

Opportunities

Reviewing the initial assessment findings and focus group learnings against DSS' primary care goals, we have identified nine key opportunities that will guide the development of recommendations.

DSS Primary Care System Goals - Strategies	Gap Identified		Opportunities
	Initial Assessment	Focus Groups	
Incorporate health equity as a guiding principle for system change	✓	✓	1. Support a whole-person care approach that promotes the biopsychosocial health of members and **enables an expanded care team to coordinate care** for medical, behavioral, and social needs 2. Enhance the **focus on measuring and addressing disparities in care**, with the goal of reducing inequities and racial disparities
Maintain **member choice and access**		✓	3. Support **easy and timely access to primary care** 4. Address the need for more timely **access to Medicaid specialists**
Uphold a **model of mutual accountability…** equip providers with tools, funding and flexibility		✓	5. Give providers **more flexibility to tailor care delivery to member needs**, including through different modalities (e.g., phone, email, patient portal, remote monitoring) 6. Partner with providers to more effectively **identify and address SDOH needs, integrate behavioral health and promote equity** 7. Increase the **availability of timely, actionable data** and ensure that measurement methods are **transparent and understandable**
Maximize program impact	✓	✓	**8. Expand program reach** by pursuing multi-payer alignment and increasing provider participation
Be **data, evidence, and member experience informed**	✓	✓	9. Ensure programs are **data, evidence, and member experience** informed

Focus Group Key Learnings: Program Specific Learnings

	PCMH Program Experience	PCMH+ Program Experience
Strengths	• PCMH practices value the **program's enhanced reimbursement rates**, which they've come to rely on. Practices would like to receive long-term assurances to continue to receive the enhanced rate for their work to improve quality of care and patient experience. • Non-traditional primary care providers found that **PCMH recognition gave its clinics more legitimacy** when they initiated primary care services.	• PCMH+ participants regard **investments in care coordination** as a major program success. Practices and FQHCs have used the funding to formalize and standardize care coordination processes. • The program established a **standardized set of quality measures** to base improvement upon. • Participants in favor of **shared savings** expressed that the bonus payments were significant and helpful. One FQHC appreciated the opportunity to test out shared savings in an upside only model.
Opportunities	• **PCMH's NCQA recognition process and reporting requirements** are difficult and time-consuming. Practices rely on the support of HUSKY Health CPTS representatives to assist in the recognition process. Many practices would readily forgo the NCQA recognition if not for the enhanced reimbursement rates. • There is a **large need for investment in care coordination**. Care coordination is very resource-intensive cost for practices, and practices and community advocates would like to receive more support and funding for this work. • Practices desire **greater program flexibility** to account for the evolving landscape of primary care, which impacts care delivery and quality metrics. • Nearly all stakeholders (members, providers, advocates) support increased **integration of SDOH assessment and resources.**	• PCMH+ health centers and practices requested improvements in the **timeliness and accessibility of data and reporting**, such as more interim reporting and data, to support proactive engagement with the program • Program participants would also like to see **greater transparency and integrity** in shared savings calculation and methodologies for quality measures and risk adjustment. There is also a desire for more communication and support from DSS. • Most **quality measures are not applicable to pediatric practices** and/or provide little room for improvement if they already perform well on the measure. • Community advocates worry that **PCMH+ primarily rewards cost savings**, which may unintentionally increase disparities and decrease quality of care. Advocates recommend that DSS realign the program with more explicit goals for quality of care and health equity. • Nearly all stakeholders (members, providers, advocates) support increased **integration of SDOH assessment and resources.**

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Identifying and Addressing SDOH Needs and Promoting Equity	**Providers and advocates were almost unanimously supportive of initiatives focused on identifying and addressing SDOH needs and promoting equity. Members, providers, and advocates identified a range of barriers and strategies to promote equity.** • Providers noted challenges (and some successes) collecting information about SDOH needs and connecting members with SDOH supports – many identified the need for enhanced financial support for this work • Some community advocates stressed the importance of aligning payment models with explicit goals for reducing disparities and improving quality of care • Members, providers and advocates identified the following barriers/focus areas as key to promoting equity: access to transportation, housing and food security, translation supports, technology enabled care, behavioral health access, extended care hours, disability access, cultural competency (especially LGBTQ+, people with disabilities, non-English speakers), and workforce diversity.	*I haven't been referred to any of those* [social service] *organizations, but I feel it would be good because I wasn't aware that there were these kinds of services – other people have helped me and showed me where these places exist.* (Member) *I wouldn't care if they know about culture or anything like that; they don't need to know more about me, its just a medical appointment.* (Member) *If you need insulin to manage your diabetes, and you don't have a refrigerator to keep your insulin cold, that's a huge barrier - but it's hard for me to fix that.* (Provider) *I hope the next step is to address more SDOH concerns and have Medicaid payments for services provided in the community.* (Provider) *We do an SDOH screening and have a resource list to hand to patients, but we need more resources - the social work connection is really challenging.* (Provider) *Disparities are there – unless we address them and the things that cause them. We need to make sure any payment model addresses disparities instead of perpetuating them.* (Community Advocate)
Member Preferences	**Members and providers most often reported easy and timely access to appointments and more time with providers as the things members most want out of primary care.** • Convenient access to primary care, including extended hours and same-day care, was a major member priority, along with sufficient time with a physician, kindness and respect, and less time waiting • While some members preferred office visits, many appreciated the convenience and more timely access associated with telehealth • Many providers and advocates saw promise in technology enabled care options (e.g., phone, email, patient portal, remote monitoring), and suggested investments here could improve member experience	*The problem with appointments is when you get seen it's 5-8 minutes, but the time in the waiting room is way longer.* (Member) *My pediatrician is amazing – they are open late and on holidays and Sundays, especially for emergency visits.* (Member) *I really like telehealth, it's a great addition. Sometimes I don't need to go to the office, I can just do a quick, last minute telehealth call.* (Member) *We need to give providers more tools to make care faster and better for patients. More investment in technology and telehealth would be great for patients.* (Provider)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Care Coordination	**Providers and advocates generally cited care coordination as the area of greatest need for improvement and saw enhanced care coordination as critical to addressing a member's full range of needs and improving health outcomes. FQHCs participating in PCMH+ noted the investments in care coordination as a major success of the program. Community advocates were broadly supportive of investments in care coordination.** • Providers highlighted that there is huge unmet need for assistance in navigating the health care system within the HUSKY population and stated that additional funding is needed to support the work to find and arrange specialist referrals, navigate coverage limitations, track referrals, and provide member support • Community advocates were broadly supportive of funding for care coordination and saw the integration of community and peer-based health workers as a major priority • Members frequently mentioned office staff in describing what they liked and didn't like about their primary care experience – many members value helpful, responsive, friendly staff who take the time to answer questions.	*Care coordination is a huge need, especially in this population. Members have trouble navigating the system, and that falls on office staff.* (Provider, Non-FQHC) *It is a huge cost burden to have enough CHWs to support all of this work, and we get no payment for it.* (Provider, Non-FQHC) *Dedicated resources for care coordination has been a huge benefit.* (Provider, FQHC PCMH+) *We need more emphasis on care coordination in PCMH.* (Community Advocate) *We need to connect community health workers to primary care doctors – they can support patients with questions, figure out what insurance covers, and help find specialists.* (Community Advocate)
Availability of Specialists	**The lack of specialists serving Medicaid members was raised as a critical issue in nearly every focus group conducted.** • Members described long wait times and significant travel time to see specialists, especially dental • Providers spoke to the administrative burden and substantial care coordination effort required to find specialists who will accept their Medicaid members • Members of the advocate community pointed to low Medicaid reimbursement rates as a major driver of the specialist shortage, and some MAPOC members argued this should be the focus of any system improvement effort DSS takes on given the comparatively strong performance of the primary care system	*I've heard a lot of doctors say they don't want to take HUSKY insurance because they don't pay them. I wish it were possible to fix that and make doctors more available, so you don't have to drive long distances to be seen.* (Member) *We spend tons of time trying to locate specialists for Medicaid members – it's one of the biggest staff time consumers.* (Provider) *Access to behavioral health, dental, and specialists are the three things HUSKY needs to address.* (Community Advocate)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Timely Data and Measurement Transparency	**Increased access to timely data and greater transparency in quality measurement and shared savings calculations was a significant priority amongst providers, especially those participating in the PCMH+ program.** • PCMH+ providers cited the need for more real-time information and interim reporting to support accountability and proactive engagement with the program; year-end reports and out-of-date attribution rosters were a significant source of frustration. • PCMH+ providers also requested greater transparency and insight into measurement methodologies – proprietary risk adjustment and quality measurement methods make it difficult for providers to have confidence that performance calculations are meaningful and limit active participation in the program.	*We get all of the data 9 months after the year ends. With other insurers, you know how you're doing and where you stand all year long – it's much more incentivizing and you can correct more easily if you see where you're at.* (Provider, PCMH+) *Shared savings are calculated based on proprietary risk score calculations – we can't actively take part or be proactive about improving.* (Provider, PCMH+)
Administrative Burden	**Providers had some concerns about the additional administrative burden imposed by the PCMH and PCMH+ programs, especially the NCQA PCMH recognition process. Non-participating practices noted that administrative burden is a significant deterrent to the participation of small, independent practices in the existing value-based models.** • PCMH practices stressed that the NCQA PCMH recognition process is a very arduous annual burden; the support of the CPTS team was appreciated and considered an important support in obtaining PCMH recognition. • PCMH practices also highlighted the burden of ongoing reporting requirements and the staff time required to set up reports and track all of the measures – some measures were seen as unnecessarily burdensome and a waste of time.	*Recognition is a giant, daunting process. We needed technical consulting help because it's an extremely arduous process. We have to submit a huge number of files every year.* (Provider, PCMH) *Some of the measures help monitor, and some are a complete waste of time. We did it because we would get more money, but it's a full-time job for multiple people.* (Provider, PCMH) *There is so much that PCMH wants to know. The reporting is really painful and is leading to provider burnout.* (Provider, PCMH) *Independent practices have lots of challenges with HUSKY. Reimbursement rates are much lower and program administration is incredibly onerous, which pushes small practices to stop seeing HUSKY patients.* (Provider)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Payment Model Preferences	**Providers and advocates had mixed feelings about value-based payment models. Some saw the transition away from FFS-based models as positive or inevitable, while others had significant concerns.** • Some providers and advocates voiced significant concerns that population-based payment models do not adequately adjust for patient complexity and inappropriately penalize providers with complex, high-need patients. • Advocates were especially concerned that any model with a savings incentive would impact quality of care or access, especially for people with complex needs. • Some providers also voiced concerns that the opportunity for shared savings diminishes over time and is more limited for those that already have high marks on quality and cost • On the other hand, some providers saw the move away from FFS as positive or inevitable – and appreciated the opportunity to partake in savings resulting from improving patient care • At least one provider saw the flexibility of capitation as foundational to addressing SDOH needs and enabling providers to take full accountability for members.	*When there is an incentive for providers who save money, how do you ensure quality of care and access for people with disabilities or who have complex medical needs?* (Community Advocate) *The negative about shared savings is: if you have medically fragile patients, you can get penalized for taking care of them. It could be a two-year-old with a brain tumor – these are not people misusing the ER – but you can get dinged for that.* (Provider) *Shared savings is tough because when you have a really good outcome already you can't improve and then there's no benefit.* (Provider) *The FFS model is going to go away, and shared savings is a good way to do it. It benefits the patient – we focus on them, try to help them, and then get to partake in savings which is good for all of us.* (Provider) *This is where capitation avoids this issue entirely - the upfront, increased investment in primary care is foundational. To the point on social risks being taken on in the clinical setting – it's all intermingled. Better to fund the investment in a place where the work can be structured and coordinated.* (Provider)

Program Performance Initial Observations: Sources

	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