MAPOC Care Management Committee

DSS Primary Care Program Design Update

November 8, 2023

Agenda

- Update on Primary Care Program Design Stakeholder Engagement

Reminder: Primary Care Stakeholder Engagement Plan

Primary care program design will be conducted in close partnership with stakeholders, leveraging newly established and existing stakeholder engagement forums.

	Description	Participation	Meeting Cadence
Primary Care Program Advisory Committee (PCPAC)	Newly established committee that will serve as the primary program design advisory body	A diverse array of representatives, including providers, advocates, and state agency partners	Monthly
Primary Care Program Advisory FQHC Subcommittee	Newly established subcommittee that will advise on FQHC-specific program design topics	Representatives from each FQHC	Monthly, following PCPAC meetings
MAPOC Care Management Committee	Ongoing updates to and engagement with MAPOC Care Management Committee	Existing forum	Established cadence, every other month
Non-FQHC Primary Care Provider Subcommittee	As needed forum for primary care provider engagement	Broad-based forum for Medicaid primary care providers	TBD, as needed
CHNCT Member Advisory Workgroup	As needed engagement with HUSKY members through existing member advisory workgroup	Existing forum	TBD, as needed

Update: Primary Care Stakeholder Meetings Held Since Last Update

Today, we'll provide an update on the primary care stakeholder meetings held since our September update to this committee.

Month	Primary Care Program Advisory Committee	FQHC Subcommittee	MAPOC Care Management Committee
September			***September 13th*** – Last Update to MAPOC Care Management Committee
October	***October 5th*** Process and Timeline ***October 26th*** Care Delivery Priorities	***October 17th*** FQHC Payment Model Examples	
November			***November 8th*** – Today's Update to MAPOC Care Management Committee
Update	***The Advisory Committee has wrapped up Phase 1 and is embarking on Phase 2 of program design***	***The FQHC Subcommittee met in October to review examples of FQHC payment models and discuss next steps***	***The MAPOC Care Management Committee has continued to receive regular updates on primary care stakeholder engagement***

Update: Timeline for Primary Care Program Design

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – Feb 2024+***	***Mar – Dec 2024+***
✓ Establish advisory committee and FQHC subcommittee ✓ Review prior work with committees ✓ Respond to requests for additional starting point data and information ✓ Host listening sessions to understand priorities	❑ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including: ❑ Care Delivery Requirements ❑ Performance Measurement ❑ Payment Model ❑ Equity Strategy	❑ Review key decision points in the development of program technical specifications and incorporate feedback ❑ Discuss key budget, authority, and program implementation model decisions

Update: Advisory Committee Accomplishments

Since our last update to the MAPOC Care Management Committee, the Primary Care Program Advisory Committee has:

- ✓ Concluded **Phase 1: Background and Context** and aligned on a set of opportunities that will help guide primary care program design
- ✓ Kicked off **Phase 2: Program Design** with a half-day in-person meeting to discuss care delivery priorities

All meeting materials (agendas, presentations, meeting minutes, and links to meeting recordings) can be found on the Primary Care Redesign website: https://portal.ct.gov/DSS/Health-And-Home-Care/Primary-Care-Redesign/Meetings

Opportunities Ahead

1. **Address disparities** in quality of care and member outcomes.

2. **Ensure members have easy and timely access to care** and address the range of barriers that make it challenging for members to access care.

3. Acknowledge the role that social determinants of health play in member health and well-being and **better identify and address health related social needs.**

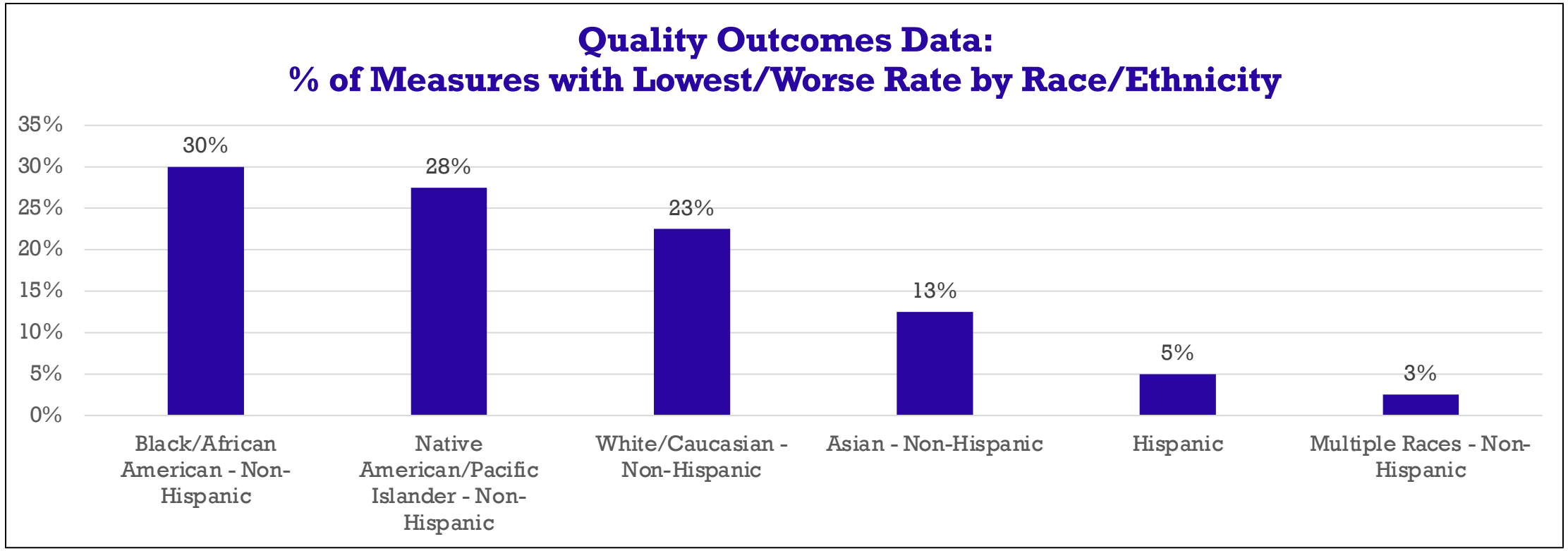
4. **Enhance care coordination and team-based care** with a focus on integrating community health workers.

5. **Improve chronic conditions management** with a focus on reducing unnecessary inpatient and ED utilization.

6. **Invest more in primary care as a percent of total spend** with the intent to increase preventive care spending and decrease acute care spending.

Opportunity 1: Address disparities in quality of care and member outcomes.

Out of 40 total measures, Black/African American HUSKY members and Native American/Pacific Islander HUSKY members have the highest share of quality measures with the lowest or worse rate.



Source: CHNCT, Inc. – MY 2021 Summary of Health Measures by Race/Ethnicity (excluding Unknown)

Opportunity 2: Ensure members have easy and timely access to care and address the range of barriers that make it challenging for members to access care.

Access data demonstrates the importance of both maintaining – and improving – easy and timely access to care.

- **93% of HUSKY members are within 15 miles of a** HUSKY Health PCP or Pediatrician with an **open panel** (vs. limited or closed).

- **~80% of members surveyed reported that they *usually or always get routine care quickly.***

DSS Primary Care Assessment Focus Group Findings

"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)

Major barriers *that impact the equitable delivery of care and member health outcomes:*

- access to transportation
- translation supports
- technology enabled care
- behavioral health access
- extended care hours
- disability access
- cultural competency
- workforce diversity

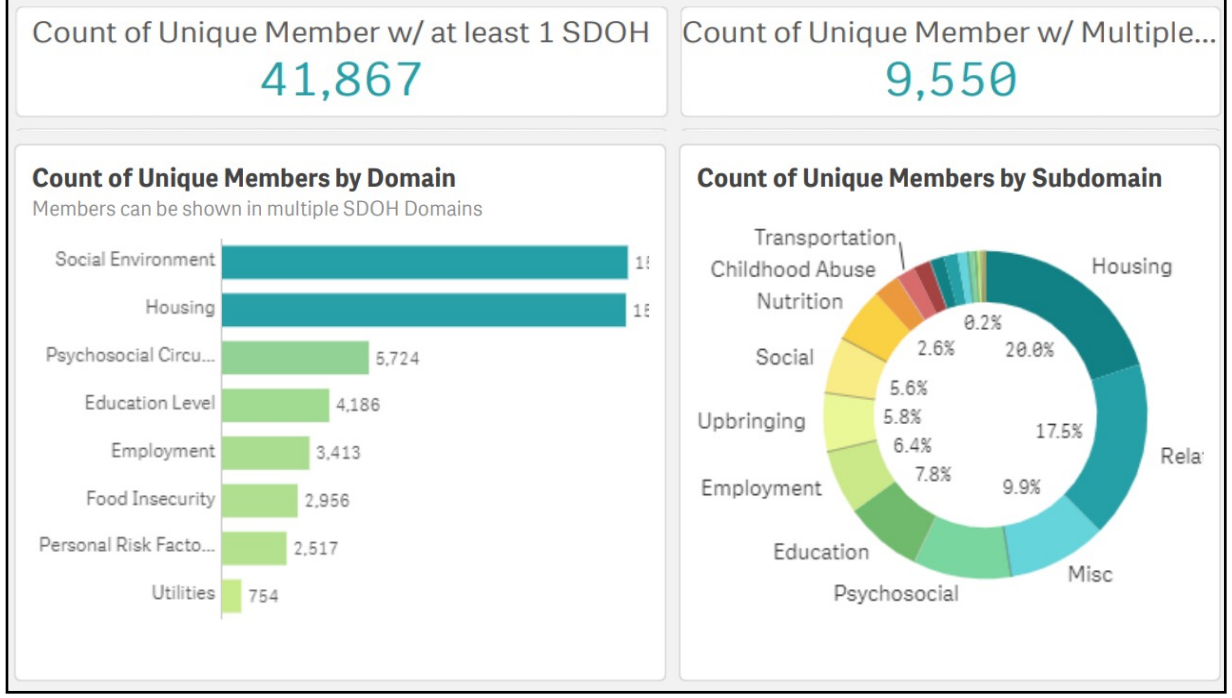
Source: CHNCT, Inc., Gap and Network Adequacy Analysis, July 2023
CAHPS, 2022 Summary Rates, Q6 (Getting routine care)

Source: DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 3: Acknowledge the role the social determinants of health play in member health and well-being and better identify and address health related social needs.

In a **non-random sample** of members in 2022 there were 41,867 unique members with at least one SDOH need. The top three domains were:

1. **Social Environment** – 38%
2. **Housing** – 37%
3. **Psychosocial Circumstances** – 14%



Source: CHNCT, Inc. SDOH Dashboard (Member Level); sources include claims and CHNCT, Inc. staff interactions with members

DSS Primary Care Assessment Focus Group Findings

"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)

Source: DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 4: Enhance care coordination and team-based care with a focus on integrating community health workers.

Feedback from this committee during the July listening session, and during last year's focus groups, emphasized the importance of integrating community health workers to provide effective care coordination.

Primary Care Advisory Committee July Listening Session - SDOH/HRSN Screening, Referral, and Outreach

- **Build capacity of CHWs and CBOs:** Given the large volume of HUSKY members with HRSN, there is a critical need and opportunity to expand use, access, and capacity of community health workers (CHWs) and community-based organizations (CBOs).
- **Increase community representation:** CHWs should have community-based connections and be representative of the HUSKY population served. Effective care coordination and case management requires developing trusting relationships.
- **Integrate CHWs into care teams:** CHWs are more likely to be trusted messengers than healthcare providers and staff. CHWs should partner with primary care providers to help HUSKY members navigate their care and benefits.

DSS Primary Care Assessment Focus Group Findings

"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)

Sources: Primary Care Program Advisory Committee Meeting 5 Materials, August 3, 2023
DSS Primary Care Assessment, 2022, Focus Group Key Learnings

Opportunity 5: Improve chronic conditions management with a focus on reducing inpatient and ED utilization.

Top Chronic Conditions

1. Behavioral Health
2. Hypertension
3. Asthma
4. Diabetes

HUSKY **members with chronic conditions utilize ED and Inpatient care substantially more often** than HUSKY members overall.

- ED utilization = 2x overall rate
- Inpatient utilization = 2.7x overall rate

Acute Care Utilization – Members with Chronic Conditions, 2022

Condition	Condition Member Count	ED Visit Count**	ED Visit Rate / 1000 Members	Inpatient Visit Count***	Inpatient Rate / 1000 Members
Asthma	105,703	148,387	1,404	18,580	176
Behavioral Health	325,577	334,798	1,028	51,007	157
Cancer - Breast - Female	2,764	2,166	784	574	208
Cancer - Colon	1,140	1,321	1,159	711	624
Cancer - Prostate	914	811	887	228	249
Cancer Other	8,965	9,453	1,054	4,588	512
Chronic Heart Failure (CHF)	9,636	15,665	1,626	8,644	897
COPD	14,695	25,927	1,764	8,695	592
Coronary Artery Disease (CAD)	14,511	23,981	1,653	8,994	620
Diabetes	52,714	60,285	1,144	15,120	287
HIV	3,582	4,894	1,366	1,140	318
Hypertension	106,342	125,477	1,180	28,957	272
Sickle Cell	1,914	2,591	1,354	801	418
Total	**648,457**	**755,756**	**1,165**	**148,039**	**228**
HUSKY Members Overall			**590**		**86**
Comparison - HUSKY Members Overall vs. Members with Chronic Conditions			**2.0**		**2.7**

**Limited Benefit Excluded and Data based on the CY2022 QM Evaluations Condition Report*

***ED Visits counts captured from Care Analyzer. ED visits include all visits regardless of primary diagnosis.*

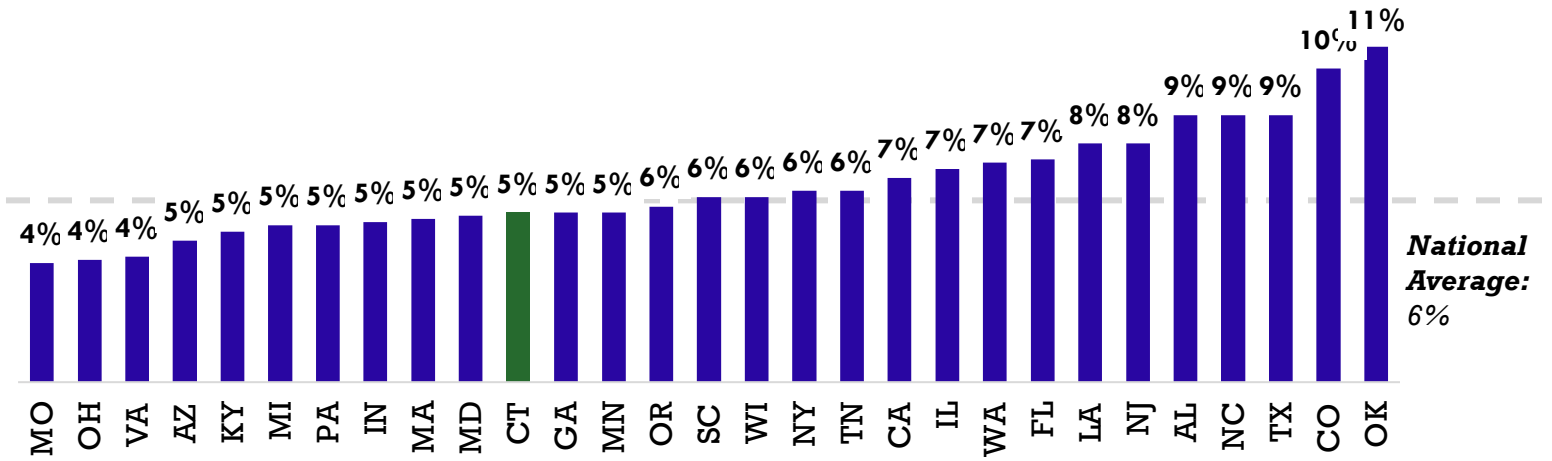
****Inpatient visit counts captured from CY 2022 Readmission Report with 5 months run out. Inpatient visits include all visits*

Source: CHNCT, Inc., PCPAC Additional Data – Chronic Conditions (CY2022 QM Evaluations Condition Report)

Opportunity 6: Invest more in primary care as a percent of total spend with the intent to increase preventive care spending and decrease acute care spending.

DSS has an opportunity – and a target - to increase the percent of total Medicaid spend on primary care.

Percent Medicaid Primary Care Spend (Narrow Definition) - Across States, 2019



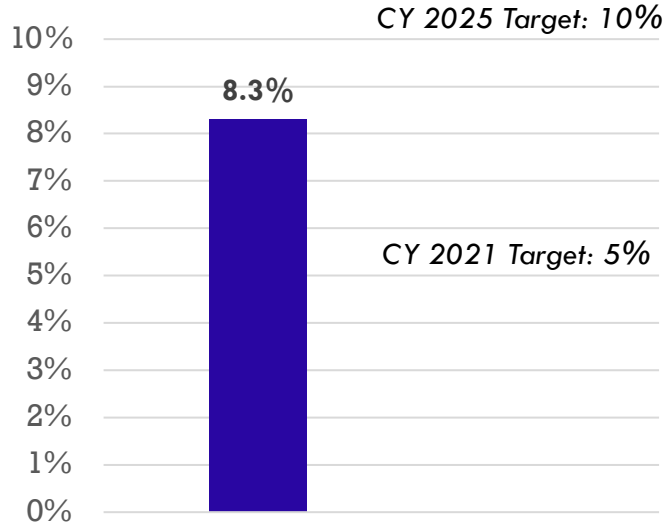
Note: The narrow definition of primary care restricts primary care services to physicians identified in MEPS as practitioners of family medicine, general practice, geriatrics, general internal medicine, and general pediatrics.
Source Listed: Medical Expenditure Panel Survey (2011-2016); Includes 29 states.

% Medicaid Primary Care Spend (2019)	Patient-Centered Primary Care Collaborative Study (for Multi-State Benchmarking)	CT Score	National Average	State Rank/ Total Reporting States
	Percent Medicaid Primary Care Spend (Narrow Definition)	5%	6%	19 / 29 (bottom half)
	Percent Medicaid Primary Care Spend (Broad Definition)	10%	11%	17 / 29 (bottom half)

Red shading indicates score is worse than the national average; *green shading* indicates score is better than the national average

Source: Investing in Primary Care, A State-Level Analysis; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center

Percent Medicaid Primary Care Spend (OHS Definition), 2021



Executive Order No. 5 established a statewide target to increase primary care spending to 10% by calendar year 2025.

Source: OHS, Healthcare Cost Growth Benchmark Steering Committee Meeting, March 27, 2023

Committee Input: Opportunities Ahead

During the October 26th meeting of the Advisory Committee, members provided feedback on these opportunities.

Suggestions included:

- Add "prevention" to chronic condition management
- Raise mental health/behavioral health to be more prominent
- Make it easier for providers to work with Medicaid
- Better define "access" and address access issues beyond Medicaid population
- Prioritize standardized, reliable data by race, ethnicity, and language

The Essential Questions of Program Design

Care Delivery	<u>What</u> are the key things that primary care should be doing differently or better to improve member health and well being?
Performance Measurement	What is the definition of success? How should this be <u>measured</u>?
Payment Model	How is primary care <u>paid</u> and incentivized for doing things that improve member health and well being?

Focus of Oct 26th meeting

Cross Cutting Equity Strategy: How do we reduce inequities and racial disparities?

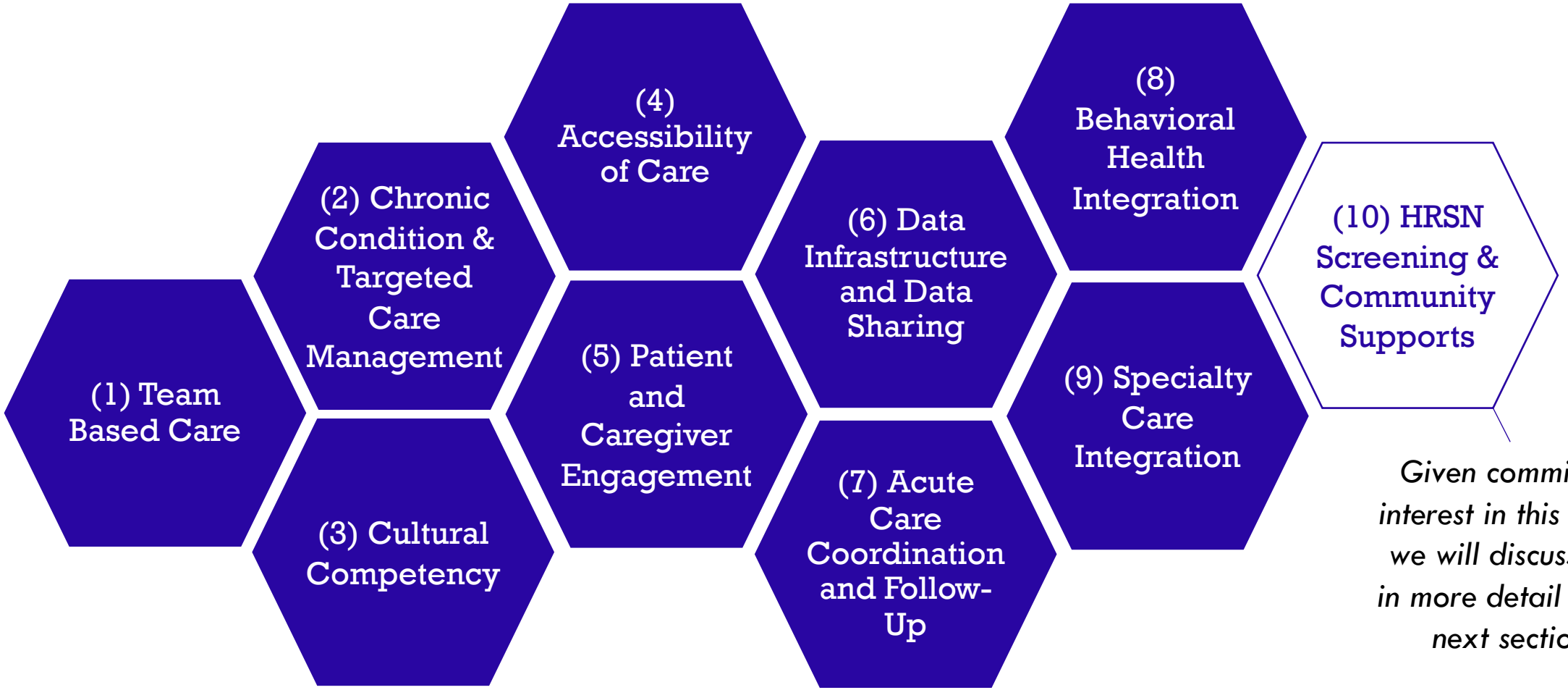
Committee Input: Care Delivery

During the October 26th meeting of the Advisory Committee, members provided feedback on three key care delivery topics.

1. What are the key things that primary care should be doing differently or better to improve member health and well being?
2. What role should primary care practices play in addressing health related social needs?
3. Should the approach to defining what primary care practices need to do be prescriptive or flexible?

Topic 1: Background

Primary care programs articulate care delivery expectations across a range of domains.

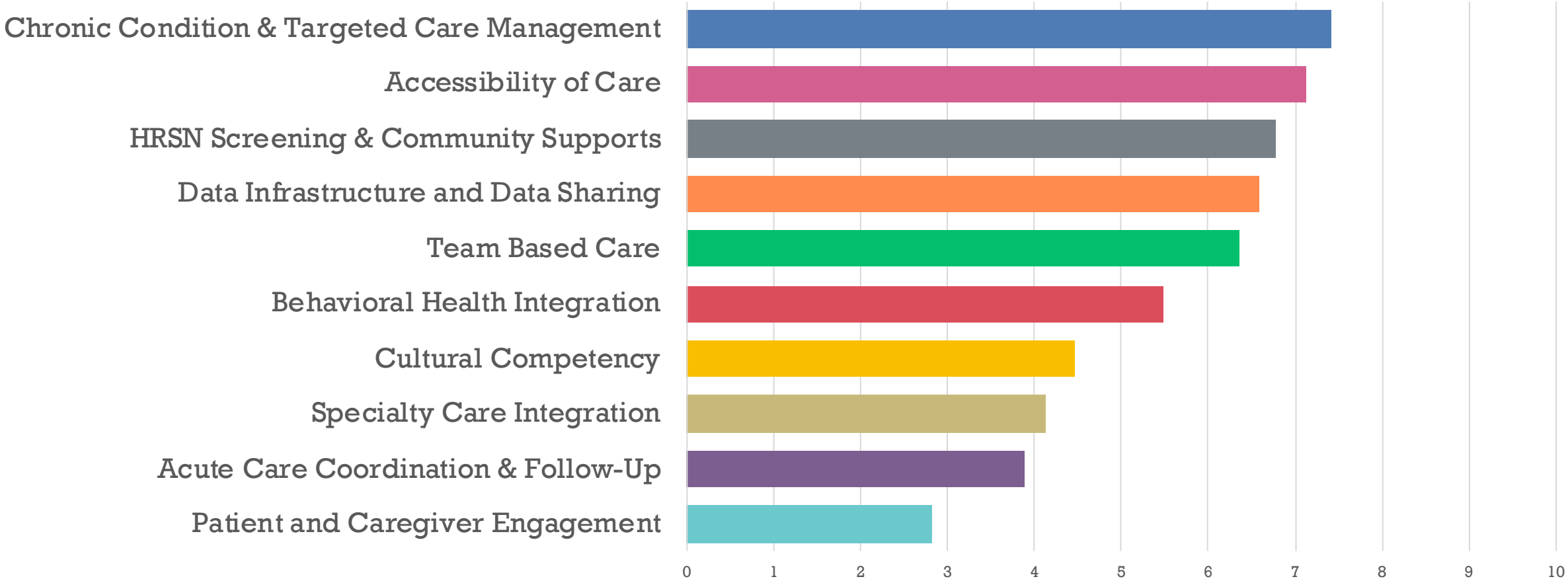


Given committee interest in this topic, we will discuss this in more detail in the next section

Committee Input: Topic 1

Question: What are the key things that primary care should be doing differently or better to improve member health and well-being?

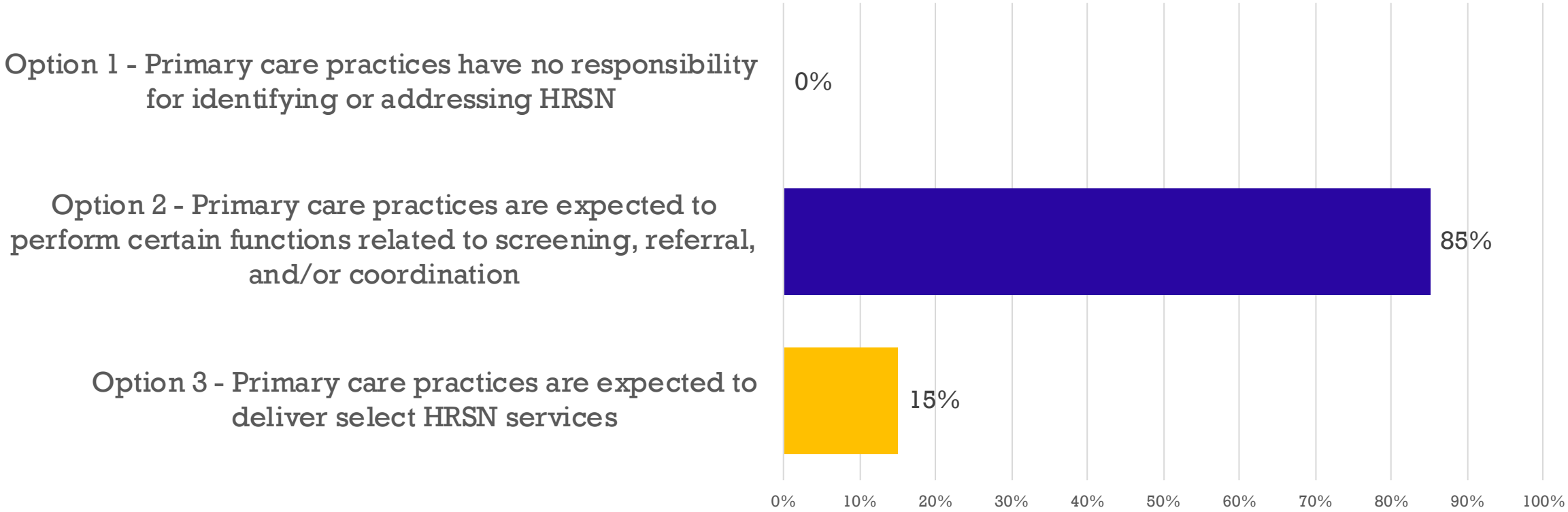
Please rank the below domains in order of importance (#1 being the most important)



Committee Input: Topic 2

Question: What role should primary care practices play in addressing health related social needs (HRSN)?

At this point, which of these options do you think is best?



Committee Input: Topic 3

Question: Should the approach to defining what primary care practices need to do be prescriptive or flexible?

- Ideally, we would **be prescriptive about outcomes**, and **flexible about how** practices achieve those outcomes
- **When reliable outcome measures are available, we can be more flexible**; when they are not, we may need to rely on priority process measures or requirements
- The level of prescription vs. flexibility we want will likely **vary by domain**

- There is a lot of variation amongst practices in terms of starting point – consider how the program structure will **give providers the flexibility and the time** to build out targeted capabilities

- The capabilities practices are developing should be **applicable across payers**
- We should avoid creating Medicaid specific processes and **use existing processes and requirements** where possible
- We need to be **careful not to create barriers to access** by putting more restrictions on providers

- We also need to consider what **implementation supports** practices will need

Next Steps

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