Primary Care Program Advisory Committee

Meeting 3

June 1, 2023

CT Department of Social Services

Agenda

Topic	Timing
Opening Remarks	5 Minutes
Response to Requests from Last Meeting	5 Minutes
Follow-up on Primary Care Goals and Strategies	10 Minutes
Scope of Primary Care Program Design	15 Minutes
Program Design Timeline Update	10 Minutes
Review of Primary Care Assessment Findings	30 Minutes
Questions/Comments	15 Minutes

Response to Requests from Last Meeting

Today's meeting will focus on responding to the requests made during this committee's last meeting.

	Requests from Last Meeting	Meeting Follow-up
Goals & Strategies	*Provide committee members more opportunity to weigh in on the goals and strategies*	• Used last meeting for further discussion and distributed goals after the meeting with a request that additional feedback be submitted in writing • No additional feedback on the goals and strategies submitted after last meeting • **TODAY:** Review requested definitions of key terms
Scope	*Expand the scope of this work to encompass an overall Medicaid strategy, inclusive of community infrastructure to address health related social needs (HRSN)*	• **TODAY:** Frame the scope of primary care design work in the context of broader strategies to address HRSN • **We will use the next meeting of this committee (July 13th) for a more in-depth discussion on how to better meet Member needs – what information do committee members want before that meeting?**
Timeline	*Reconsider and extend the timeline for program design work; allow the committee more time to engage, don't rush*	• **TODAY:** Review updated program design timeline
Data & Evidence	*Spend more time orienting committee members to the prior work, including program data and evidence*	• Revisited last meeting and distributed a more detailed version of the primary care assessment after the meeting • **TODAY:** Discuss findings from the primary care assessment in more detail
Records	*Distribute meeting minutes and create a central repository for meeting materials*	• A webpage for meeting materials has been created: https://portal.ct.gov/DSS/Health-And-Home-Care/Primary-Care-Redesign • Meeting minutes for last meeting have been distributed and posted

DSS Primary Care Goals

DSS has established the following goals and strategies to guide primary care program assessment and design.

End Goals

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.

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.

Strategies

1. Incorporate **health equity** as a guiding principle for system change
2. Maintain **member choice and access**
3. Uphold a **model of mutual accountability**
   - 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
   - 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
4. **Maximize program impact**
   - Participate in statewide primary care reform efforts, pursue multi-payer alignment, and ensure primary care programs are broadly appealing to providers
   - Align other reform initiatives so that primary care is supported by specialty care, behavioral health care, and community-based services
5. 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.

Clarification: Definition of Terms

Below are definitions of key terms, as requested by committee members.

- **Biopsychosocial:** The biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.[1] The biopsychosocial model was proposed by George Engel in the 1977 paper *The Need for a New Medical Model: A Challenge for Biomedicine*, in which Engel argued for a more holistic way of understanding and responding to illness: "The dominant model of disease today is biomedical, and it leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. A biopsychosocial model is proposed that provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care."[2]

- **Health Equity:** The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[3]

- **Health Disparity:** A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[3]

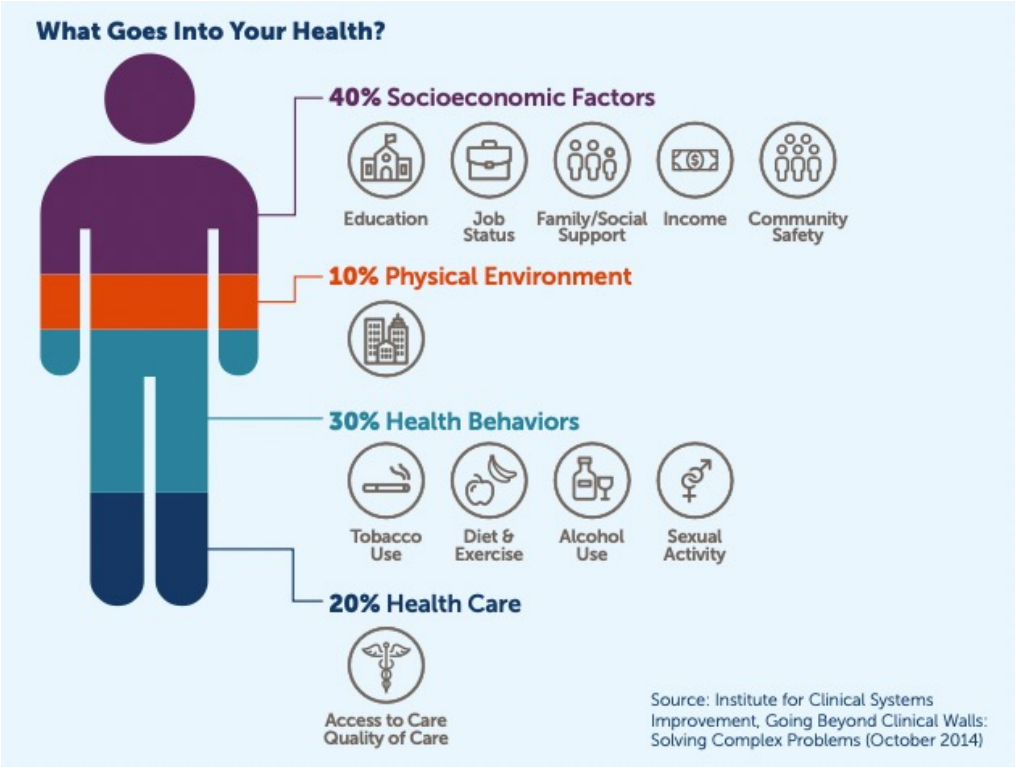
- **Social Determinants of Health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[3]

- **Health-Related Social Needs (HRSN):** Factors that drive health care utilization and impact health outcomes. These factors include housing instability and quality, food insecurity, utility needs, Interpersonal violence, and transportation needs beyond medical transportation.[4]

1. University of Rochester Medical Center. The biopsychosocial approach. https://www.urmc.rochester.edu/medialibraries/urmcmedia/education/md/documents/biopsychosocial-model-approach.pdf
2. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977 Apr 8;196(4286):129-36 https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/medical-humanities/documents/Engle-Challenge-to-Biomedicine-Biopsychosicial-Model.pdf
3. "Presidential COVID-19 Health Equity Task Force Final Report and Recommendations." U.S. Department of Health and Human Services, October 2021. https://www.minorityhealth.hhs.gov/assets/pdf/HETF_Report_508_102821_9am_508Team%20WIP11-compressed.pdf
4. "Accountable Health Communities (AHC) Model Fact Sheet." CMS, January 5, 2016. https://www.cms.gov/newsroom/fact-sheets/accountable-health-communities-ahc-model-fact-sheet

Why Aim to Improve Biopsychosocial Health and Well-being?

The focus on improving biopsychosocial health and well-being emerges from the recognition that health outcomes are substantially driven by factors outside of health care – often called the "social determinants of health" (SDOH).

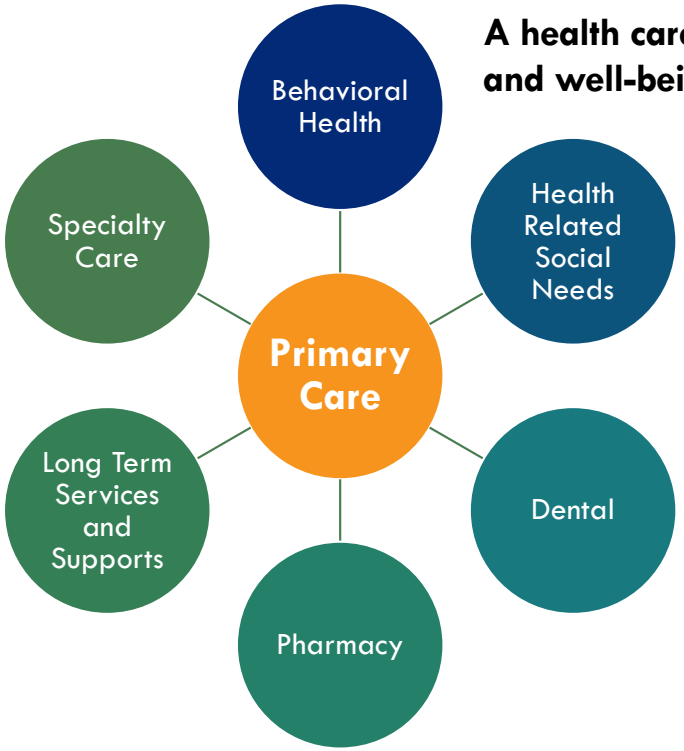


Graphic Source: Robert Wood Johnson Foundation, *Medicaid's Role in Addressing the Social Determinants of Health*, Issue 5, February 2019

Primary care is a foundational component of the healthcare system that can help identify and address health related social needs – it is not the whole solution.

Primary Care in Context

Primary care is a foundational piece of a health care system that is oriented towards improving biopsychosocial health and well-being.



A health care system that is oriented towards improving biopsychosocial health and well-being has many interrelated components.

Primary care payment reform aims to strengthen the foundation for this system by:

- **Providing the tools, supports, and flexibilities** that enable primary care providers to play a foundational role in addressing biopsychosocial well-being through referral and coordination with a wider array of health and social service providers
- **Enhancing the focus on measuring and addressing disparities in care** and integrating performance measurement goals that drive accountability and improvement
- **Investing in primary care,** providing funding to support historically uncompensated activities and care delivery redesign activities and infrastructure (dependent on state budget approval)

Strategy for Addressing Health Related Social Needs (HRSN)

DSS is pursuing other strategies outside of this work to address health related social needs.

Starting Point
DSS Initiatives Underway

DSS has a range of targeted initiatives aimed at addressing HRSN currently underway, including:

- CHESS
- Integrated Care for Kids (InCK)
- Violence Prevention Professional Coverage
- SUPPORT Grants
- Community Options
- ASO CHW Assessment and Referral
- SUD 1115 Waiver
- Family Bridge Pilot Program

This Committee's Work
Primary Care Payment Reform

Primary care payment reform will build on this by giving primary care providers the flexibility and incentives to:

- Identify members' health related social needs
- Refer members to providers who can help address these needs
- Assist members in arranging for and obtaining HRSN services

Broader Strategies
Under Consideration

DSS is exploring* a Section 1115 waiver to provide HRSN services to Medicaid members, including:

- Housing and nutrition supports for specified populations

*Additional Executive and Legislative branch approval is required to pursue the waiver and has not yet been received

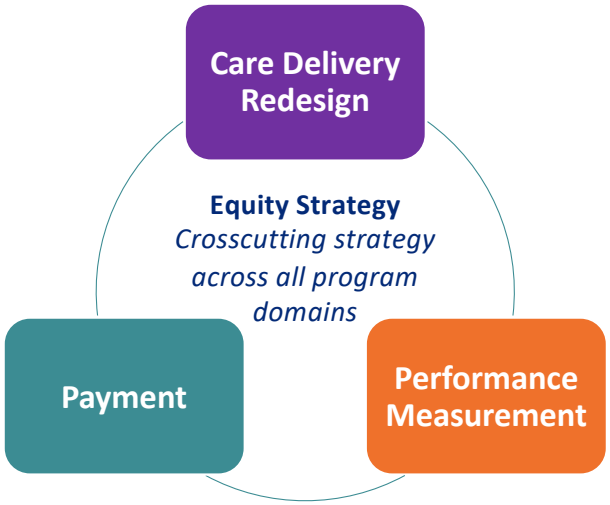
Broader strategies for addressing HRSN are outside of the scope of this process – however, DSS appreciates this committee's interest in this topic and intends to use ***the next meeting of this committee*** *to collect feedback to inform this effort*

Committee Members: *What other information would you like to have in advance of the July meeting?*

Updated Program Design Timeline

In response to this committee's request for a longer timeline, DSS has adjusted the targeted new program launch date from **July 2024 to January 2025**, and adjusted meeting topics to allow for more time before program design discussions begin.

PCMH+ Extension Update: DSS is planning to extend PCMH+ for CY 2024



Month	Agenda Topic	
April	Background & Introductions	
May	Background: Primary Care Goals and Strategies	
June	Background: Scope of Primary Care Design and Prior Work	
July	***Listening Session: Strategies for Addressing Community Needs***	
August	Care Delivery Redesign Priorities	***In person meeting planning in process – scheduling poll to come***
September	Primary Care Base Payment	
October	Primary Care Performance Based Payment	
November	Quality Measurement and Data Sharing	
December	*Technical Design*: Primary Care Base Payment	
January	*Technical Design*: Primary Care Performance Based Payment	
February	Practice Recognition and Provider Technical Assistance	
March	Equity Strategy Review – Assessing the Crosscutting Equity Strategy	
April	*Technical Design*: Quality Measurement	

EQUITY STRATEGY

Work to Date: Primary Care Program Assessment

Throughout 2022, DSS and FCG conducted a Primary Care Program Assessment that aimed 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 Evaluation*	• 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**

This work culminated in a set of recommendations for primary care program design and a plan for conducting primary care program design with substantial stakeholder engagement in 2023.

Primary Care Program Assessment: Contents

The Primary Care Program Assessment includes quantitative and qualitative data on DSS' existing value-based primary care programs – and a literature review summarizing results and lessons learned from VBP models implemented elsewhere.

(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: VBP 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) Primary Data Collection: Focus Group Learnings

Collect qualitative feedback from members, providers, and other key stakeholders

Outreach to Participants
Broad-based outreach

Conduct Focus Groups
Facilitate discussion around a set of prompts

Categorize & Synthesize
Complete thematic analysis and summarize key learnings

Data & Evidence: Topics for Review Today

Based on the results of the pre-meeting poll, we have rank ordered topic areas in order from highest interest to lowest interest so that we can prioritize topics that committee members have most interest in for further discussion as a group.

Topic Area	Total Points
Program Performance: Access and Participation	6
Evidence Base: Results to Date	5
Evidence Base: Lessons Learned	4
Program Performance: Quality	4
Focus Groups: Process and Approach	3
Program Performance: Cost	3
Program Performance: Member Experience	2
Focus Groups: Key Learnings	0
TOTAL	**27**

Pre-Meeting Poll Responses Received: 9

Scoring of Pre-Meeting Poll Results

- First choice topic area = 2pts
- Second choice topic area = 1pt

Primary Care Program Advisory Committee

Supplemental Report:

Learnings from the Primary Care Program Assessment

Faulkner CONSULTING GROUP

Appendix 1: 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	Member Access and Provider Participation			
	Cost			
	Quality			
	Member and Provider Experience			

See Appendix 1 for details

(2) External Assessment: VBP 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) Primary Data Collection: Focus Group Learnings

Collect qualitative feedback from members, providers, and other key stakeholders

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Background and Context: CT DSS Primary Care Programs

DSS currently has two primary care programs with distinct requirements and payment models: the Person-Centered Medical Home (PCMH) program, and the Person-Centered Medical Home Plus (PCMH+) program.

	Person-Centered Medical Home (PCMH)	Person-Centered Medical Home Plus (PCMH+)
Overview	• Based on widely-adopted **national PCMH model** • Enhanced reimbursement rates are **credited with improving member access** • The program is **generally popular** – with community advocates, and participating providers (who see parts of the program as administratively burdensome, but value the enhanced reimbursement)	• Established in 2017; **builds on PCMH with a more advanced payment model** and more intensive care coordination requirements • Has shown **success in decreasing spending** and acute care utilization and controlling cost trend in aggregate • **Program perceptions are mixed** amongst community advocates and providers
Key Program Features	• **NCQA or TJC PCMH Recognition** is required • **FQHCs do not receive enhanced** reimbursement rates • Glide path program for practices seeking to become PCMHs, and practice technical assistance available	• **NCQA or TJC PCMH Recognition** is required • **FQHCs receive additional** care coordination payments • 2,500 members minimum to participate
Provider Participation	• **56% of HUSKY participating PCPs** (with 55% of members)	• **18% of HUSKY participating PCPs** (with 17% of members) • **FQHC dominated program:** 10 of 12 participating providers in Wave 3 (Year 1) are FQHCs
Payment Model	**(1) FFS Medicaid, with Enhanced Reimbursement Rate:** +24% on primary care services supplemental to the current Medicaid fee schedule **(2) Per Member Per Month (PMPM) Performance-Based Payments:** PMPM payments earned based on performance and improvement on quality measures	**(1) FFS Medicaid** **(2) Care Coordination Add-on Payments** (FQHCs only): Prospective monthly payments for FQHCs **(3) Total Cost of Care Model Shared Savings Payments:** practices that generate savings and meet quality standards can share in up to 50% of the savings achieved; unearned savings can be earned based on quality performance

Preliminary Program Assessment

The Preliminary Program Assessment synthesized 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.

	CMAP Overall	PCMH	PCMH+	Equity	Key Finding
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. The majority of CMAP PCPs participate in PCMH, but participation in PCMH+ is more limited, and especially limited amongst non-FQHC providers.
Quality	+	+	+	–	• 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.
Cost	+	-	+	–	• 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.

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]	• **PCMH+ attributed members are more likely to be Black or Hispanic** and less likely to be White/Caucasian, as compared to PCMH attributed members [11] • **Disparities in performance by race/ethnicity identified** for 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

	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

Initial Observations: Details by Dimension

A. Member Access and Provider Participation

B. Cost

C. Quality

D. Member and Provider Experience

(A) Member Access and Provider Participation

	Key Questions	Learnings to Date	Equity Lens

(1) Member Access	How does **CMAP overall perform on primary care access indicators**? Are there gaps in Medicaid and/or statewide performance?
	• Access to PCPs
	• Utilization of primary care
	  • Primary care expenditures
	  • Prevention and treatment measures (e.g. preventive care visits, primary care screening, vaccinations)
		• **PCP supply in CT** compares favorably to other states and the nation (statewide; multi-payer)
		• **HUSKY member PCP access is near-universal,** as measured
		• **CMAP performs well on measures of *Primary Care Access and Preventive Care*** – CMAP scored above the national average for all measures in this Medicaid/CHIP Scorecard domain – and was in the top performance quartile for 82% of measures in this domain.
		• CMAP primary care spend appears to be **slightly below average as a share of total spend**
			Disparities identified in share of population with a personal care doctor, statewide.
			
			Disparities in performance by race/ethnicity on measures of ***Prevention and Screening*** **and** ***Access/ Availability of Care*** **identified** within CMAP population.

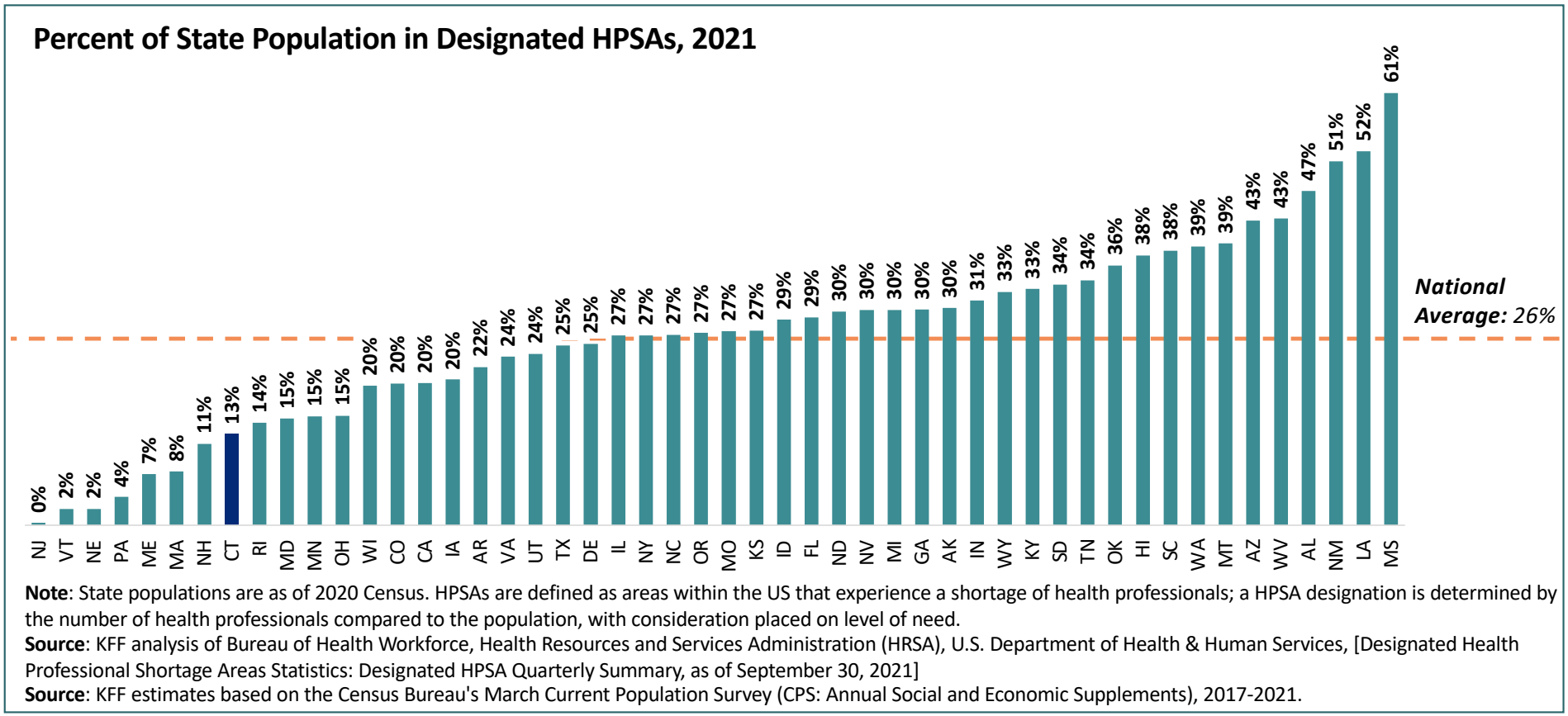
(2) Provider Participation	**How many members and providers and engaged in PCMH and PCMH+ and what are the characteristics of participating and non-participating providers?** • What share of HUSKY members and providers are participating in PCMH or PCMH+? • How has participation changed over time? Notable entries or departures? • Participation by provider type? • Barriers to participation?	**PCMH** • **Provider participation grew considerably in the initial years** of the program; growth has since leveled off • PCMH FFS rate increases **drove improvements in member access** **PCMH+** • **PCMH+ is FQHC dominated**; the majority of FQHC PCMHs are participating; very few non-FQHC PCMHs are participating in PCMH+ (and substantially left the program in Wave 3)	There are notable differences between the PCMH and PCMH+ program attributed member populations by race/ethnicity. PCMH+ attributed members are more likely to be Black or Hispanic and less likely to be White/Caucasian, as compared to PCMH attributed members.

(1) Member Access: Learnings

	Dimensions	Learnings	Equity
Member Access	**Access to PCPs**	**HUSKY member PCP access is near-universal as measured; PCP supply in CT compares favorably to other states and the nation** • **100% of HUSKY members are within defined distance** of a participating PCP or pediatric practice • **93% of HUSKY members have access to a PCP** or pediatric practice with an **open panel** Source: 2021 CHN Gap and Network Adequacy Analysis • **13% of adults statewide report not having a personal doctor**/ health care provider (compared to 20% nationally) • **13% of the state population lives in a designated primary care Health Professional Shortage Area** (compared to 26% nationally) Source: KFF Access Indicators	**Disparities identified** in share of population with a personal care doctor, statewide.
	Primary Care Access and Preventive Care Measures	**CMAP performs well on measures of *Primary Care Access and Preventive Care*** – CMAP scored above the national average for all measures in this Medicaid/CHIP Scorecard domain – and was in the top performance quartile for 82% of measures in this domain. Source: Medicaid/ CHIP Scorecard	**Disparities in performance by race/ethnicity** on measures of ***Prevention and Screening*** **and** ***Access/ Availability of Care*** **identified** within CMAP population.
	Primary Care Expenditures	CMAP primary care spend appears to be **slightly below average as a share of total spend** • Narrow Definition**: 5% Medicaid Expenditures** – Primary Care (compared to 6% nationally) • Broad Definition: **10% Medicaid Expenditures** – Primary Care (compared to 11% nationally) Source: Investing in Primary Care, A State-Level Analysis; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center *Note:* CT OHS Cost Growth Benchmark Program reported 7.8% CT Medicaid Expenditures – Primary Care; the multi-state analysis above to be used for benchmarking only.	Primary care expenditure data by race/ethnicity not available as of the date of report

Percent of State Population in Designated Primary Care HPSAs
(HPSA: Health Professional Shortage Area)

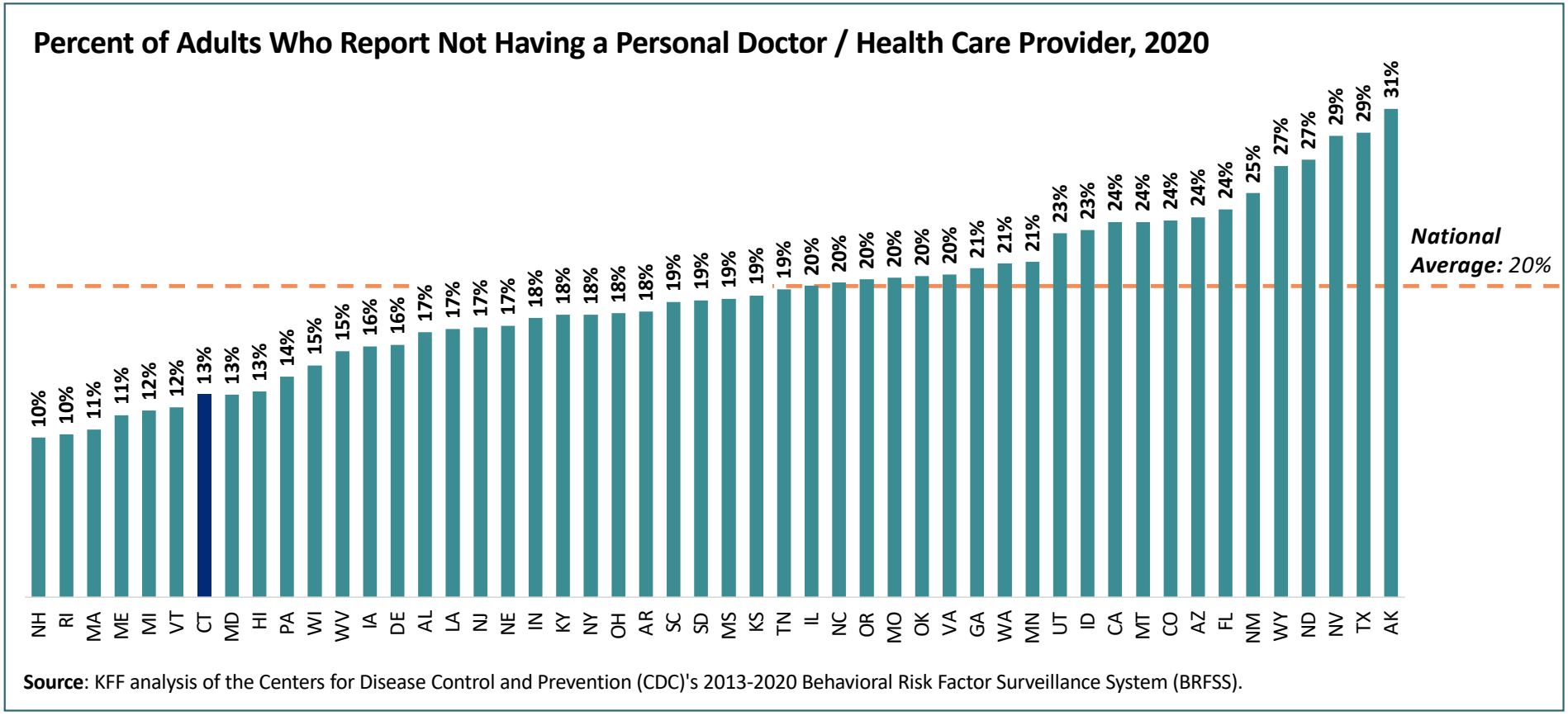
Access to PCPs



Note: State populations are as of 2020 Census. HPSAs are defined as areas within the US that experience a shortage of health professionals; a HPSA designation is determined by the number of health professionals compared to the population, with consideration placed on level of need.
Source: KFF analysis of Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, [Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2021]
Source: KFF estimates based on the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements), 2017-2021.

Percent Adults Lacking a Personal Doctor

Access to PCPs

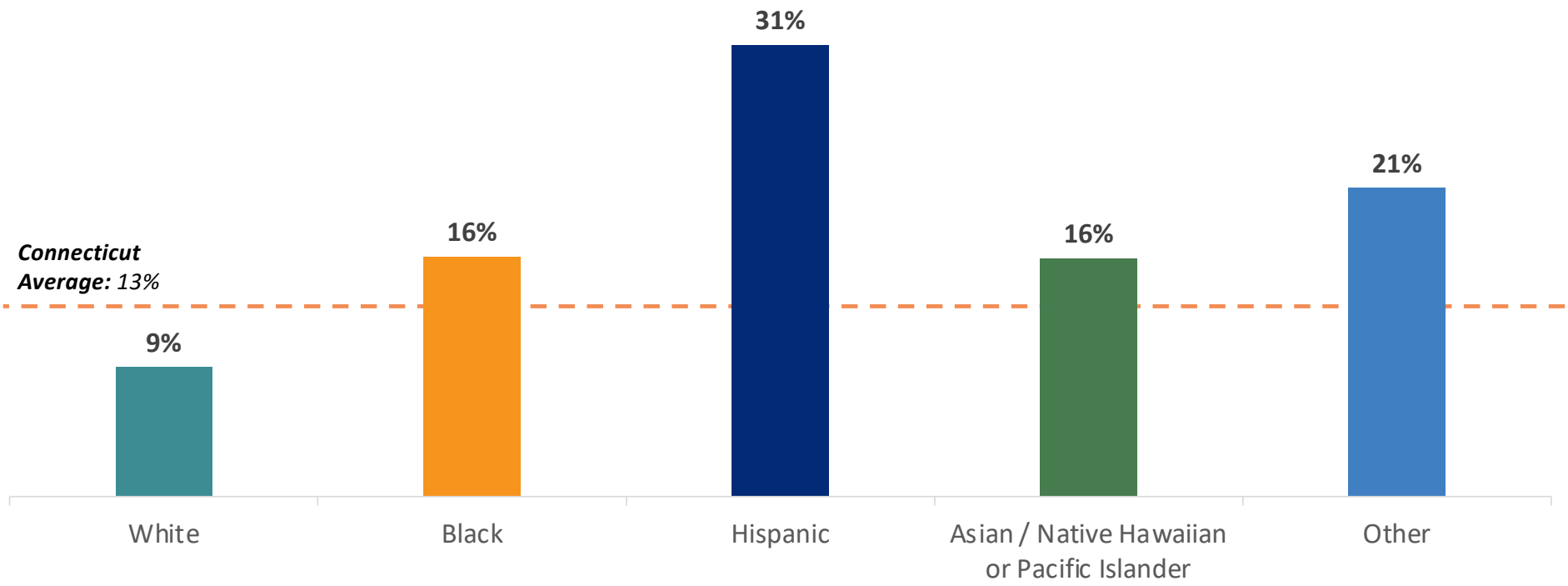


Source: KFF analysis of the Centers for Disease Control and Prevention (CDC)'s 2013-2020 Behavioral Risk Factor Surveillance System (BRFSS).

Percent Adults Lacking a Personal Doctor, by Race, CT

Access to PCPs

Percent of Adults Who Report Not Having a Personal Doctor / Health Care Provider by Race, Connecticut, 2020



Source: KFF analysis of the Centers for Disease Control and Prevention (CDC)'s 2013-2020 Behavioral Risk Factor Surveillance System (BRFSS).

Primary Care Access and Preventive Care Measures

Access and Preventive Care

CMAP performs well on measures of *Primary Care Access and Preventive Care* – CMAP scored above the national average for all measure components in this Medicaid/CHIP Scorecard domain – and was in the top performance quartile for 82% of measure components in this domain.

Medicaid/CHIP Scorecard Performance Summary

FY 2020 Child and Adult Core Set Performance

Domain	Number of Measure Components Reported	Performance Quartile (CT vs. All Reporting States)							
		1st (Best)	2nd	3rd	4th (Worst)	1st (Best)	2nd	3rd	4th (Worst)
		#	#	#	#	%	%	%	%
Behavioral Health Care	31	11	11	6	3	**35%**	**35%**	**19%**	**10%**
Care of Acute and Chronic Conditions	14	5	3	3	3	**36%**	**21%**	**21%**	**21%**
Dental and Oral Health Services	2	1	1	0	0	**50%**	**50%**	**0%**	**0%**
Maternal and Perinatal Health	15	10	4	1	0	**67%**	**27%**	**7%**	**0%**
Primary Care Access and Preventive Care	**17**	**14**	**3**	**0**	**0**	**82%**	**18%**	**0%**	**0%**
Total	**79**	**41**	**22**	**10**	**6**	**52%**	**28%**	**13%**	**8%**

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Equity Lens: Primary Care Access and Preventive Care

Access and Preventive Care

For the CMAP population, there were identified disparities by race/ethnicity on measures of *Prevention and Screening* and *Access/ Availability of Care.*

Summary of Quality Performance Disparities by Race/Ethnicity

Source: 2021 HUSKY Health Program Health Equities Report; MY 2019 Performance

Domain	Total Measures	CMAP Overall (#/% Measures with Identified Disparities)		PCMH Practices (#/% Measures with Identified Disparities)		FQHCs (#/% Measures with Identified Disparities)	
		#	%	#	%	#	%
Prevention and Screening	**10**	9	**90%**	8	**80%**	8	**80%**
Access/ Availability of Care	**8**	7	**88%**	8	**100%**	7	**88%**

***Identified Disparities**: the rate for one or more of the 3 non-white populations (Black/ African American Non-Hispanic, Asian Non-Hispanic, Hispanic) was worse than the overall rate for the measure*

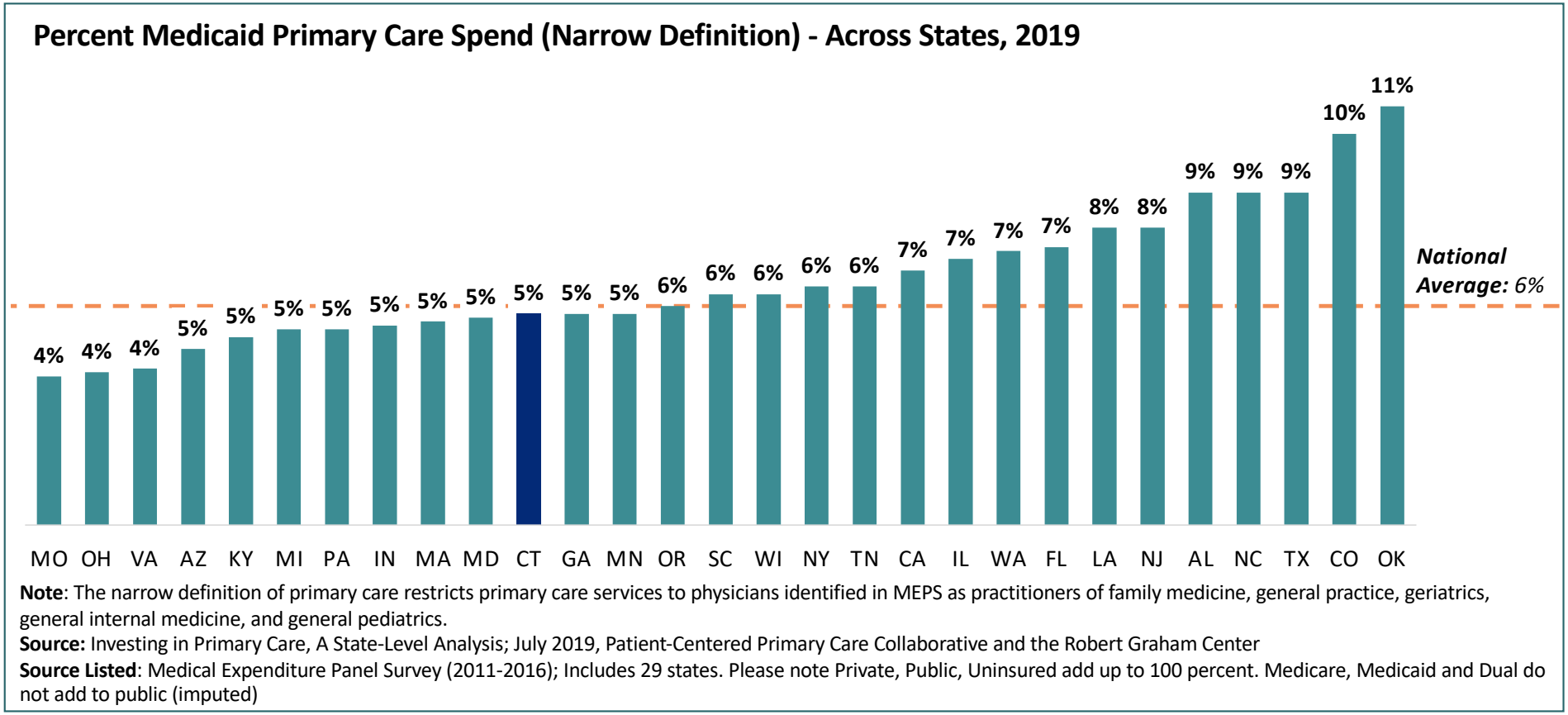
Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Race/ethnicity data completion: data is unknown for 33% of HUSKY Health members overall; rates of completion vary by measure based on measure population

Percent Medicaid Primary Care Spending (Narrow Definition) Across States

Primary Care Expenditures



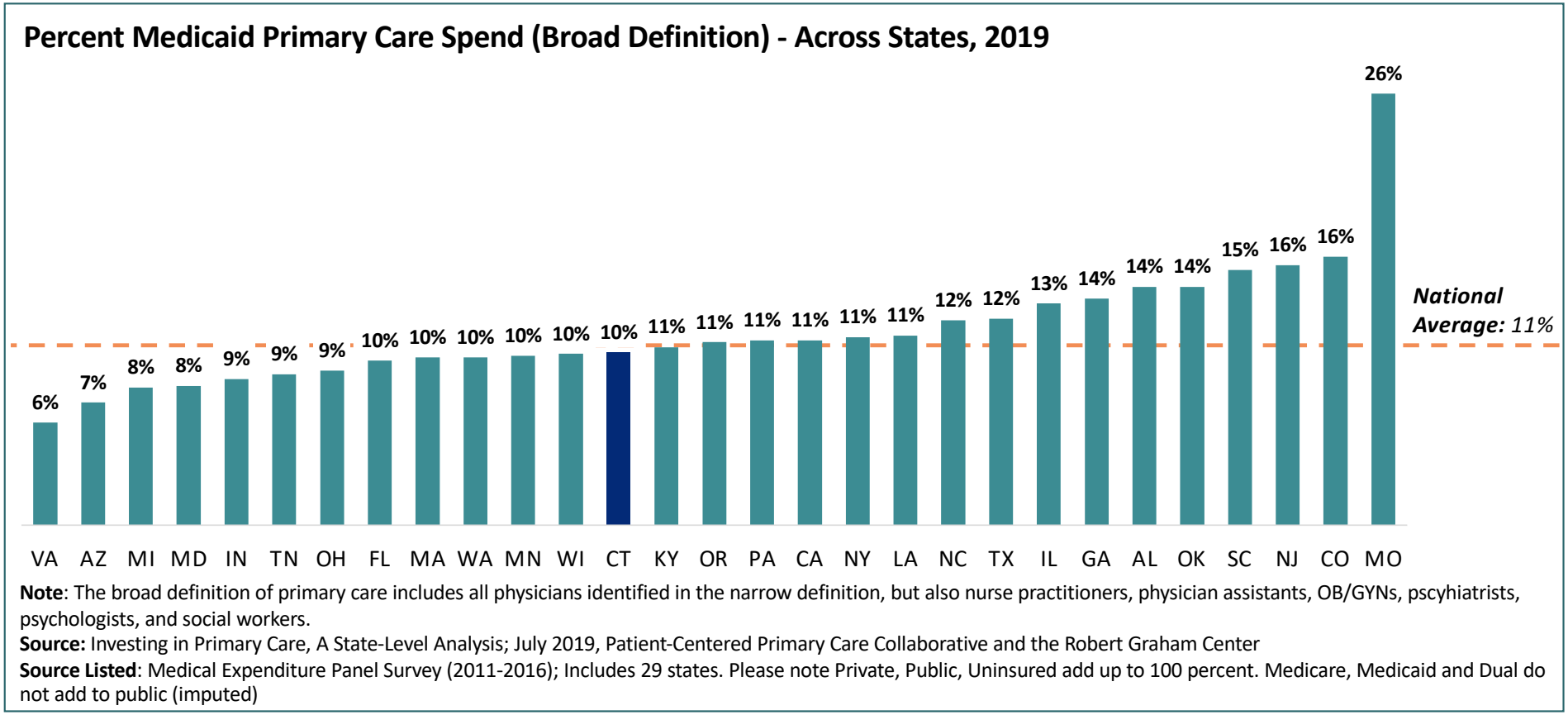
Note: The narrow definition of primary care restricts primary care services to physicians identified in MEPS as practitioners of family medicine, general practice, geriatrics, general internal medicine, and general pediatrics.

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

Source Listed: Medical Expenditure Panel Survey (2011-2016); Includes 29 states. Please note Private, Public, Uninsured add up to 100 percent. Medicare, Medicaid and Dual do not add to public (imputed)

Percent Medicaid Primary Care Spending (Broad Definition) Across States

Primary Care Expenditures



Note: The broad definition of primary care includes all physicians identified in the narrow definition, but also nurse practitioners, physician assistants, OB/GYNs, pscyhiatrists, psychologists, and social workers.

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

Source Listed: Medical Expenditure Panel Survey (2011-2016); Includes 29 states. Please note Private, Public, Uninsured add up to 100 percent. Medicare, Medicaid and Dual do not add to public (imputed)

(2) Provider Participation: Learnings

	PCMH	PCMH+	Equity
Provider Participation	**Current Participation** • **Members: 55% HUSKY members attributed to a PCMH**; 80% of those attributed to a PCP (Dec 2020) • **Providers: 56% CMAP participating PCPs** participating in PCMH (MY 2020) **Participation Over Time** • Provider participation grew considerably at the beginning of the program; **program growth has leveled off and may be nearing saturation** (remaining providers are mostly smaller entities that are less likely to invest in PCMH core capabilities/ infrastructure) **Improving member access** to primary care was a key focus at the start of the program- • Increased FFS rates for PCMHs **drove significant improvements in member access**	**Current Participation** • **Members: 17% HUSKY members attributed to a PCMH+** practice; 25% of those attributed to a PCP (Dec 2020) • **Providers: 18% CMAP participating PCPs** participating in PCMH+ (MY 2020) **Participation Over Time** • **Substantial drop in AN (non-FQHC) provider participation for Wave 3:** 3 of the 4 ANs participating in Wave 2 dropped out for Wave 3; 1 new AN came on for Wave 3 (Year 1) • **Some entities were not selected for participation in Wave 3**/ could not meet the more intensive requirements CT implemented (e.g. coordinated EHRs); this was intentional, CT intended to make expectations tougher and more specific over time • **Some ANs left the program after they did not get shared savings**; hard to justify the additional administrative burden (ANs don't get a prospective PMPM, and most did not get shared savings; though some got payments for quality through the challenge pool) **Participation by Provider Type** • **FQHC dominated program:** 10 of 12 participating providers in Wave 3 (Year 1) are FQHCs • **FQHCs have a strong incentive to participate** since they are eligible for the **care coordination PMPM** under PCMH+, but are not eligible for financial incentives thru PCMH • **The state intended for PCMH+ to be equalizing for the FQHCs** (and to use the program to focus on stepping up quality and requiring care coordination for FQHCs) **Participation Barriers** • **Population size requirement** (2,500 member threshold) is a barrier to entry for smaller providers; PCMH practices can partner to meet the threshold but only a couple have (and it was not successful long-term) • **PCMH recognition** – PCMH recognition is a pre-requisite for PCMH+ participation	There are notable differences between the PCMH and PCMH+ program attributed member populations by race/ethnicity. PCMH+ attributed members are more likely to be Black or Hispanic and less likely to be White/Caucasian, as compared to PCMH attributed members.

Source: CHN MY 2020 Annual Provider Profiling Report; CHN PCMH Longitudinal Review

Provider Participation: Detail

The majority of FQHC PCMHs are participating in PCMH+ (and have continued to do so over time), while very few non-FQHC PCMHs are participating in PCMH+ (and substantially left the program in Wave 3).

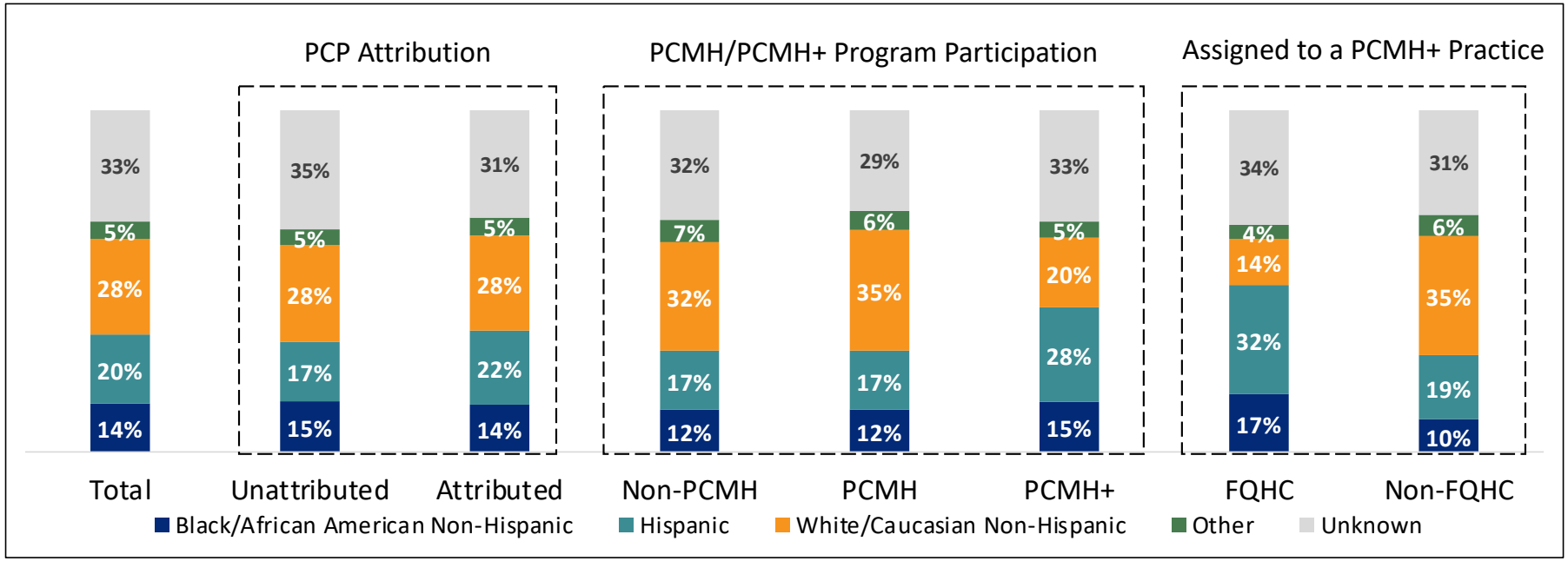
	PCMH+ Participating Entities by Wave	Wave 1 (Year 1)	Wave 2 (Year 2)	Wave 3 (Year 1)	Initial Observations
AN	Connecticut Children's Medical Center			X	• **Substantial drop in AN provider participation for Wave 3:** 3 of the 4 ANs participating in Wave 2 dropped out for Wave 3
AN	Hartford Healthcare Medical Group, Inc.		X	X	
AN	Prospect CT Medical Foundation, Inc. AN		X		
AN	St. Vincent's AN	X	X		
AN	Northeast Medical Group AN	X	X		
	Total AN	2	4	2	
FQHC	Charter Oak Health Center	X	X	X	• **FQHC dominated program**: 10 of 12 participating providers in Wave 3 (Year 1) are FQHCs • **FQHCs have continued to participate** in the program; the number participating has only grown over time
FQHC	Community Health Center, Inc.	X	X	X	
FQHC	Cornell Scott-Hill Health Corporation	X	X	X	
FQHC	Fair Haven Community Health Clinic, Inc.	X	X	X	
FQHC	First Choice Health Center		X	X	
FQHC	Generations Family Health Center, Inc.	X	X	X	
FQHC	Optimus Health Care, Inc.	X	X	X	
FQHC	Southwest Community Health Center, Inc.	X	X	X	
FQHC	United Community and Family Services, Inc.		X	X	
FQHC	Wheeler Clinic, Inc.		X	X	
	Total FQHC	7	10	10	
	Total PE	9	14	12	

Source: Mercer Annual PCMH+ Reports

Data Request: *Share of eligible non-FQHC practices participating in PCMH+*

Equity Lens: PCMH/PCMH+ Member Attribution by Race/Ethnicity

There are notable differences between the PCMH and PCMH+ program attributed member populations by race/ethnicity. PCMH+ attributed members are more likely to be Black or Hispanic and less likely to be White/Caucasian, as compared to PCMH attributed members.



Source: CHN Member Attribution data request; attribution as of 1/1/2022; excludes dual Medicare/Medicaid members; PCMH category includes Glide Path practices
Other combines categories that represent <3% of members each: Asian Non-Hispanic, Multiple Races Non-Hispanic, Native American/Pacific Islander Non-Hispanic.

Initial Observations: Details by Dimension

A. Member Access and Provider Participation

B. Cost

C. Quality

D. Member and Provider Experience

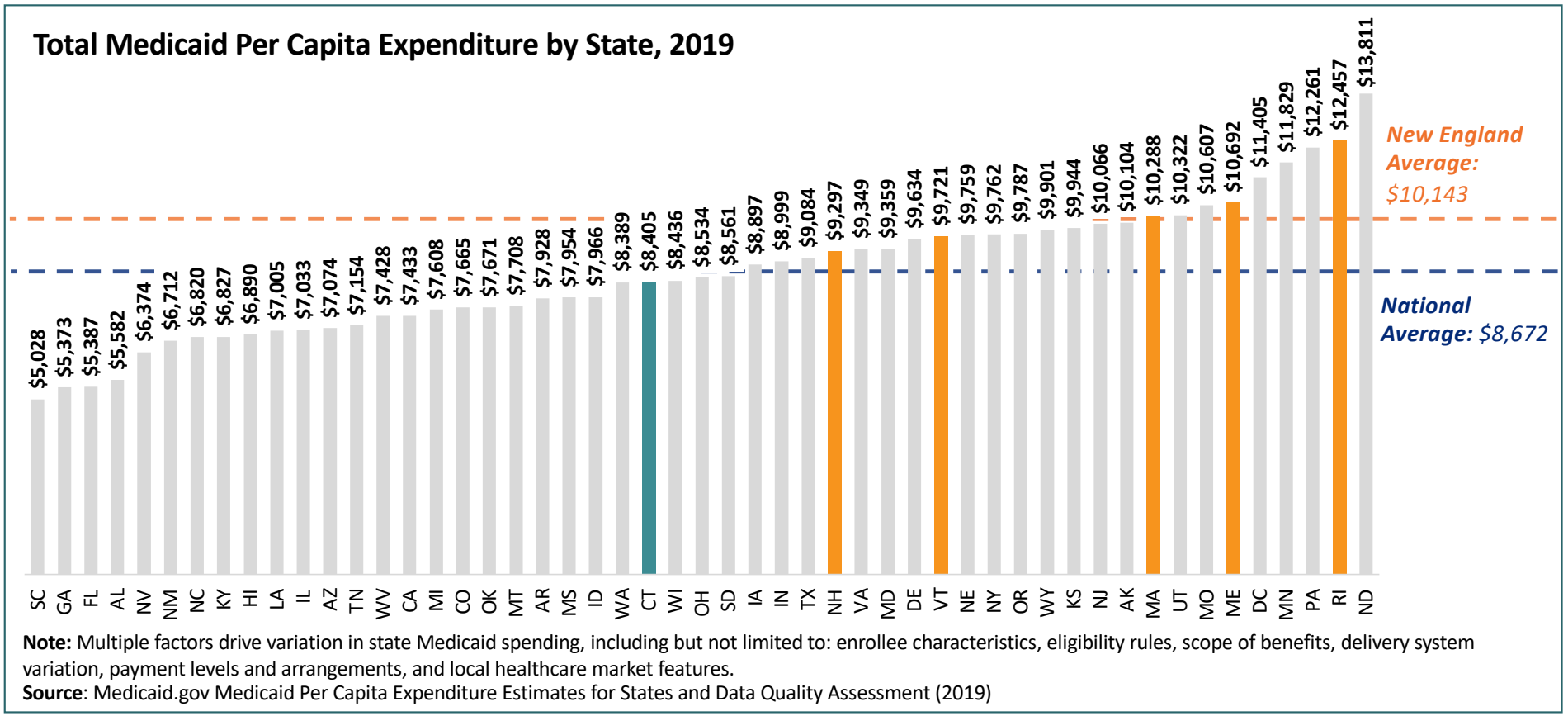
(B) Cost

	Dimensions	Key Questions	Learnings	Equity Lens
Cost	**(1) Overall CMAP Costs**	• How do **overall Medicaid cost trends** in CT compare to other states? • Does CMAP have **identifiable areas of opportunity to lower costs**?	• **CT Medicaid appears to be relatively low cost overall** – CT has the lowest per capita Medicaid expenditure amongst New England states ($8,400 in CT vs. $10,100 New England average) • **There may be an opportunity with certain populations** - CT Medicaid per capita expenditures for People with Disabilities substantially exceed the New England and national averages	

	(2) Distribution of Costs and Avoidable Hospital Use	• How does CMAP compare on **inpatient/ ED** spending/ utilization **vs. primary care** spending/ utilization?	• While overall costs are comparatively low, initial assessment suggests **opportunities for CMAP to**
			  • **invest more significantly in primary care and**
			  • **reduce inpatient/ ED utilization**
				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

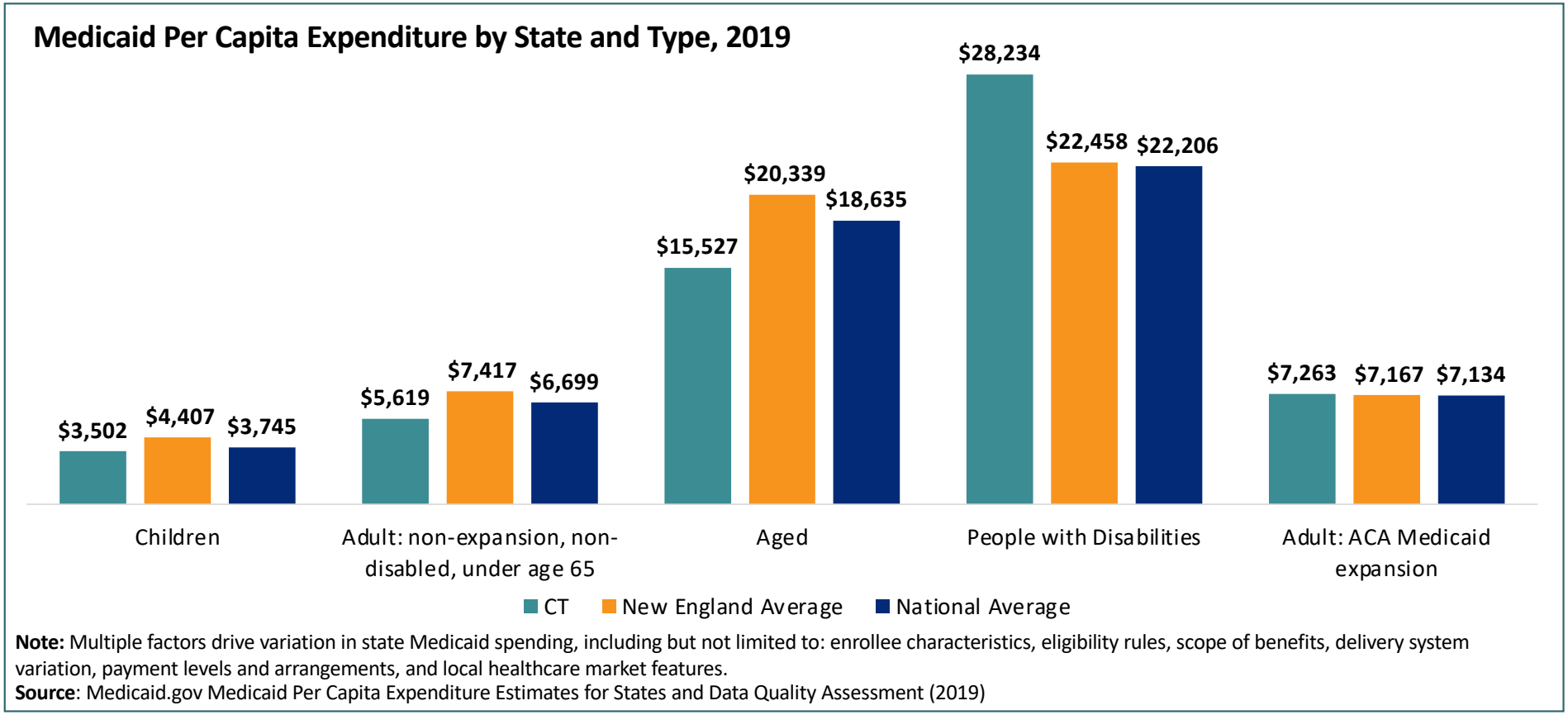
	(3) PCMH+ Program Performance	• Have **PCMH+ providers made an impact on total cost of care**? • How many **PCMH+ providers have generated shared savings**?	• PCMH+ has **demonstrated success** in generating statistically significant **decreases in spending and acute care utilization** and **controlling cost trend.** • Although PCMH+ has impacted cost trend in aggregate, **shared savings performance has varied by provider** – many providers have not achieved shared savings. • Small scale of program limits the impact of PCMH+ on overall CMAP costs.	Disparities in hospital utilization by race/ ethnicity persist within PCMH+ practices
	(4) PCMH Program Performance	• Has CT's PCMH program **impacted costs/ reduced acute care utilization**?	• Generally, PCMHs have demonstrated success in controlling costs and reducing acute care utilization – **has this been the case in CT?**	Disparities in hospital utilization by race/ ethnicity persist within PCMH practices

(1) Overall CMAP Costs: Medicaid Per Capita Expenditure by State



Note: Multiple factors drive variation in state Medicaid spending, including but not limited to: enrollee characteristics, eligibility rules, scope of benefits, delivery system variation, payment levels and arrangements, and local healthcare market features.
Source: Medicaid.gov Medicaid Per Capita Expenditure Estimates for States and Data Quality Assessment (2019)

(1) Overall CMAP Costs: Medicaid Per Capita Expenditure by State



Note: Multiple factors drive variation in state Medicaid spending, including but not limited to: enrollee characteristics, eligibility rules, scope of benefits, delivery system variation, payment levels and arrangements, and local healthcare market features.
Source: Medicaid.gov Medicaid Per Capita Expenditure Estimates for States and Data Quality Assessment (2019)

(2) CMAP Distribution of Costs and Avoidable Hospital Use

While overall costs are comparatively low, there does appear to be an opportunity for CMAP to invest more significantly in primary care and reduce inpatient/ ED utilization.

Inpatient/ ED Utilization	**Medicaid/CHIP Scorecard Measures**	**Population**	**CT Score**	**National Average**	**Directionality**	**State Rank/ Total Reporting States**
	Ambulatory Care: Emergency Department (ED) Visits: Ages 0 to 19	**Medicaid Children**	**46.2**	**43.2**	**Lower is better**	**29 / 46 (bottom quartile)**
	Adult Emergency Department Visits	***Forthcoming***				
	PQI 01: Diabetes Short-Term Complications Admission Rate: Age 18 and Older	**Medicaid Adults**	**15.2**	**20.1**	**Lower is better**	**9 / 36 (top quartile)**
% Medicaid FFS Acute Care Spending *(excludes Pharmacy)*	**Kaiser Family Foundation, FY 2020**	**Population**	**CT Score**	**National Average**	**Directionality**	**State Rank/ Total Reporting States**
	Inpatient	**FFS Medicaid**	**38%**	**38%**	**Lower is better**	**31 / 51 (bottom half)**
	Outpatient (Outpatient hospital/clinic, FQHC)	**FFS Medicaid**	**30%**	**19%**		
	All Other (Physician, Lab, Other)	**FFS Medicaid**	**32%**	**43%**	**Higher is better**	**44 / 51 (bottom quartile)**
% Medicaid Primary Care Spend*	**Patient-Centered Primary Care Collaborative Study (for Multi-State Benchmarking)**	**Population**	**CT Score**	**National Average**	**Directionality**	**State Rank/ Total Reporting States**
	Percent Medicaid Primary Care Spend (Narrow Definition), 2019	**Medicaid**	**5%**	**6%**	**Higher is better**	**19 / 29 (bottom half)**
	Percent Medicaid Primary Care Spend (Broad Definition), 2019	**Medicaid**	**10%**	**11%**	**Higher is better**	**17 / 29 (bottom half)**

*CT OHS Cost Growth Benchmark Program - CT Specific Data (2019): 7.8% Medicaid Primary Care Spending

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

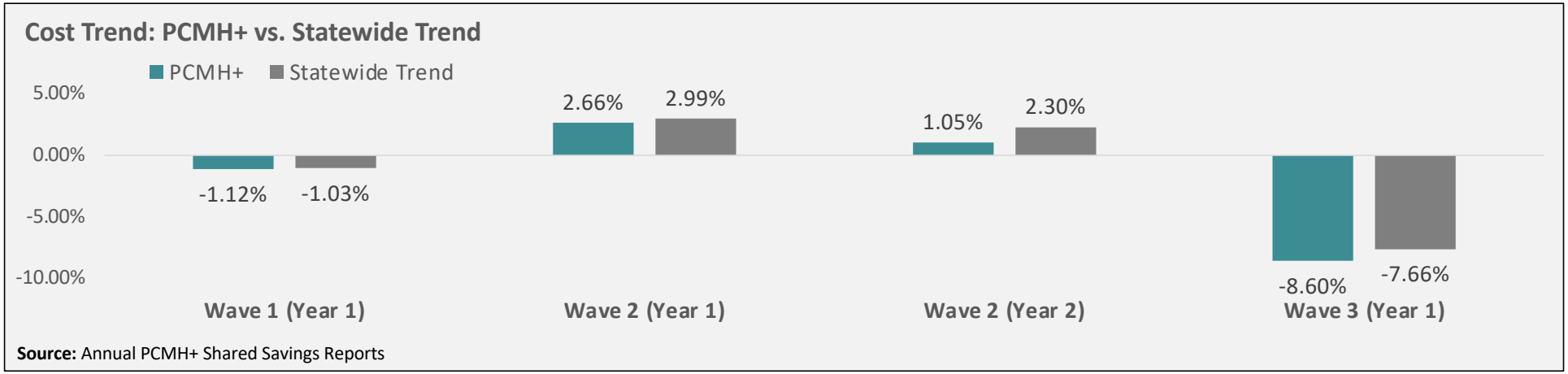
Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(3) PCMH+ Provider Shared Savings Performance

PCMH+ has demonstrated success in generating statistically significant decreases in spending and acute care utilization and controlling cost trend.

CT PCMH+: SIM Round 2 Final Evaluation Report Findings		
Decreased Spending	Total Spending PBPM	Statistically significant decrease
Decreased Acute Care Utilization	Emergency Department Visits	Statistically significant decrease
	Inpatient Admissions	Not statistically significant
	30-day Readmissions	Statistically significant decrease

Source: RTI, *Evaluation of the State Innovation Models (SIM) Initiative Round 2: Model Test Final Report*, June 28, 2021



Source: Annual PCMH+ Shared Savings Reports

(3) PCMH+ Provider Shared Savings Performance

Although PCMH+ has impacted cost trend in aggregate, shared savings performance has varied by provider – many providers have not achieved shared savings, and the limited number of participating providers limits the program's ability to impact overall costs.

PCMH+ Provider Awards	Wave 1 (Year 1)	Wave 2 (Year 1)	Wave 2 (Year 2)	Wave 3 (Year 1)
Participating Providers	**9**	**14**	**14**	**12**
Providers Earning **Shared Savings** Payments	**2**	**4**	**6**	**3**
% Providers Earning **Shared Savings** Payments	**22%**	**29%**	**43%**	**25%**
Total **Shared Savings** Award	$915,033	$1,855,536	$3,903,942	$2,011,370

Source: Annual PCMH+ Shared Savings Reports

Input Session Learnings

Barriers to Achieving Shared Savings

- **The 2% MSR is a challenge -** there are always providers who generate savings that aren't determined meaningful (CMS originally wanted a 4-6% savings rate — CT negotiated it down to 2% using the same population over 2 years)
- **Low-cost providers that have already achieved efficiencies have a harder time generating savings** ("trimming muscle is harder than trimming fat")

Wave 3 Shared Savings Design

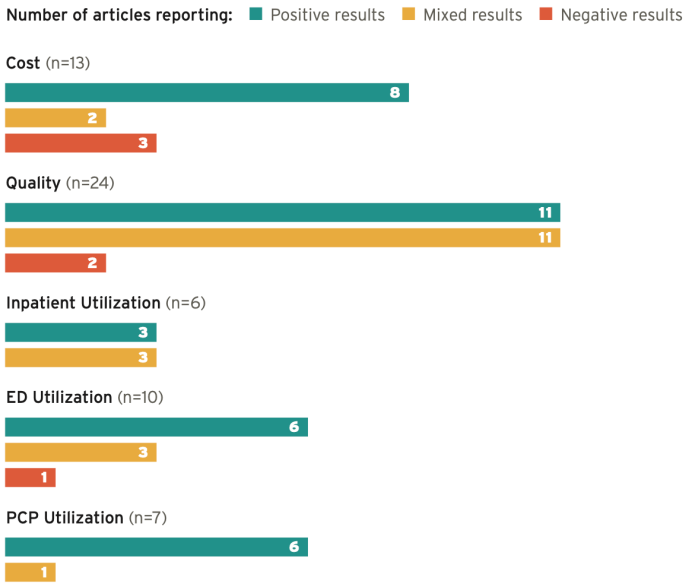
- **Year-over-year improvement on Avoidable ED Visits and Avoidable Hospitalizations** were added as gates for both the Individual and Challenge pools in Wave 3 (1 of 4 PEs that achieved savings in Wave 3 Year 1 was disqualified by the improvement requirement)

Note: Program design implications to be discussed further as part of payment model conversation.

(4) PCMH Program Performance

Generally, PCMH programs have been successful in reducing costs and controlling acute care utilization.

Impact of PCMH on Cost Quality and Utilization 2016-2017: Summary of Peer-Reviewed Articles

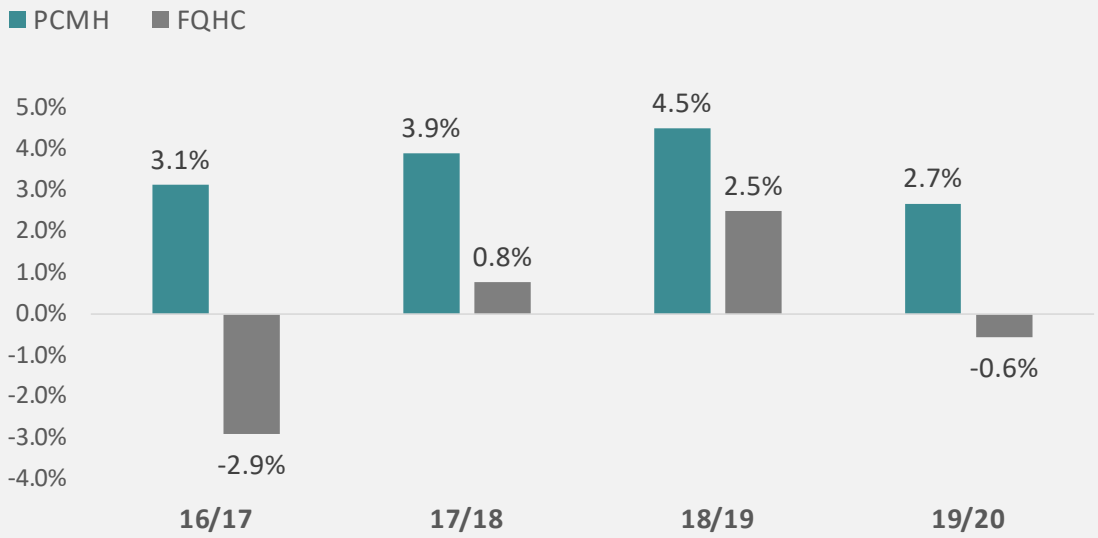


Source: Investing in Primary Care, A State-Level Analysis; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center

Has the CT PCMH program had an impact on cost/ acute care utilization?

Our preliminary look at year-over-year PMPM cost trend suggests that PCMH practices have had a much less significant impact on cost as compared to FQHCs (i.e., PCMH+ practices).

Cost Trend: PCMH vs. FQHC PMPM Year over Year Trend



Source: CHN, PCMH Longitudinal Review

Equity Lens: Disparities in Hospital Utilization by Race/ Ethnicity

Hospital/ ED Utilization is higher amongst CMAP's Black/ African American Non-Hispanic and Hispanic populations.

- The Black CMAP population had a higher-than-overall rate of hospital/ED utilization on 4 out of 4 measures
- The Hispanic CMAP population had a higher-than-overall rate on 3 out of 4 measures.

	HEDIS Measures of Hospital/ED Utilization						
	MY 2019 Performance	**Overall**	**White/ Caucasian Non-Hispanic**	**Black/ African American Non-Hispanic**	**Asian Non-Hispanic**	**Hispanic**	**All Other Races / Unknown / Multiple Races**
CMAP Total	Ambulatory Care - ED Visits per 1000 MM	**58.79**	49.24	65.26	26.23	72.49	57.76
	Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)	**8.8%**	5.2%	11.5%	6.7%	9.0%	9.4%
	Readmissions within 30 Days - Physical Health and Behavioral Health	**12.8%**	16.8%	15.2%	8.9%	12.2%	9.8%
	Readmissions within 30 Days - Physical Health Only	**11.8%**	15.5%	15.1%	7.9%	11.9%	8.8%

Source: CHN 2021 Health Equity Report

Red shading indicates rate is worse than the Overall population rate

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Equity Lens: Disparities in Hospital Utilization by Race/ Ethnicity

These disparities persist within the population served by PCMH practices, and to a lesser extent within the population served by FQHCs.

	HEDIS Measures of Hospital/ED Utilization						
PCMH Practices, Excluding FQHCs	**MY 2019 Performance**	**Overall**	**White/ Caucasian Non-Hispanic**	**Black/ African American Non-Hispanic**	**Asian Non-Hispanic**	**Hispanic**	**All Other Races / Unknown / Multiple Races**
	Ambulatory Care - ED Visits per 1000 MM	**57.24**	48.16	69.30	29.13	70.73	57.94
	Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)	**7.6%**	4.3%	10.8%	4.8%	8.0%	8.2%
	Readmissions within 30 Days - Physical Health and Behavioral Health	**12.9%**	16.3%	16.7%	11.5%	13.4%	8.9%
	Readmissions within 30 Days - Physical Health Only	**11.8%**	15.5%	15.1%	7.9%	11.9%	8.8%

	HEDIS Measures of Hospital/ED Utilization						
FQHCs	**MY 2019 Performance**	**Overall**	**White/ Caucasian Non-Hispanic**	**Black/ African American Non-Hispanic**	**Asian Non-Hispanic**	**Hispanic**	**All Other Races / Unknown / Multiple Races**
	Ambulatory Care - ED Visits per 1000 MM	**81.88**	87.77	80.53	37.38	87.75	77.00
	Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2-20)	**10.5%**	7.6%	12.1%	8.1%	9.8%	11.4%
	Readmissions within 30 Days - Physical Health and Behavioral Health	**15.0%**	22.2%	15.7%	6.7%	12.5%	11.7%
	Readmissions within 30 Days - Physical Health Only	**13.6%**	20.7%	15.4%	6.0%	12.4%	10.1%

Source: CHN 2021 Health Equity Report

Red shading indicates rate is worse than the Overall population rate

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Initial Observations: Details by Dimension

A. **Member Access and Provider Participation**

B. **Cost**

C. **Quality**

D. **Member and Provider Experience**

(C) Quality

	Dimensions	Key Questions	Learnings	(4) Equity Lens
Quality	**(1) CMAP Overall Performance**	• How does CMAP compare to other Medicaid programs on 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 • CMAP has **more opportunity for improvement** in the *Behavioral Health Care* and *Care of Acute and Chronic Conditions* domains • CMAP performs worse than CT commercial plans on half of the quality measures for which comparison data is available.	Overall, there were observable disparities in quality performance by race/ethnicity for **83% of measures**.
	(2) PCMH Program Performance	• Has the PCMH program driven quality improvement over time? • How do PCMH practices compare to non-PCMH practices on quality performance?	• PCMH practices **overall have improved performance on quality measures – performance on 7 of the 11 measures on the PCMH quality slate improved** between 2016 and 2019, and performance on the remaining 4 measures was essentially unchanged. • PCMH practices **outperformed non-PCMH practices on 63% of measures.** • PCMH practices performed better than non-PCMH practices especially in ***Prevention and Screening*** **and chronic conditions care** (*Diabetes*, and *Respiratory Conditions*)	For PCMH practices, there were observable disparities in quality performance by race/ethnicity for **83% of measures**.
	(3) PCMH+ Program Performance	• Has the PCMH+ program driven quality improvement over time? • How do PCMH+ practices compare to non-PCMH practices on quality performance?	• PCMH+ practices **overall have improved performance on quality measures – performance on 7 of the 9 measures** on the PCMH+ quality slate (with history) improved between Wave 2 (CY 18) and Wave 3 (CY 19). • FQHCs **outperformed non-PCMH practices on 65% of measures.** • FQHCs performed better than non-PCMH practices especially in ***Prevention and Screening***, ***Overuse/ Appropriateness,*** and ***Behavioral Health***	For FQHCs, there were observable disparities in quality performance by race/ethnicity for **90% of measures**.

(1) CMAP Overall Performance

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
- CMAP demonstrated **strongest performance** in *Primary Care Access and Preventive Care*, followed by *Maternal and Perinatal Health*
- CMAP has **more opportunity for improvement** in the *Behavioral Health Care* and *Care of Acute and Chronic Conditions* domains

Medicaid/CHIP Scorecard Performance Summary

FY 2020 Child and Adult Core Set Performance

Domain	Number of Measure Components Reported	Performance Quartile (CT vs. All Reporting States)							
		1st (Best)	2nd	3rd	4th (Worst)	1st (Best)	2nd	3rd	4th (Worst)
		#	#	#	#	%	%	%	%
Behavioral Health Care	31	11	11	6	3	35%	35%	19%	10%
Care of Acute and Chronic Conditions	14	5	3	3	3	36%	21%	21%	21%
Dental and Oral Health Services	2	1	1	0	0	50%	50%	0%	0%
Maternal and Perinatal Health	15	10	4	1	0	67%	27%	7%	0%
Primary Care Access and Preventive Care	17	14	3	0	0	82%	18%	0%	0%
Total	**79**	**41**	**22**	**10**	**6**	**52%**	**28%**	**13%**	**8%**

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(1) CMAP Overall Performance vs. Commercial

CMAP performs worse than CT commercial plans on half of the quality measures for which comparison data is available.

HUSKY Health Quality Performance vs. CT and National Commercial Averages

Source: 2021 HUSKY Health Program Health Equities Report (MY 2019); NCQA Quality Compass 2020 (MY 2019)

Measure Name	MY 2019 CT Commercial Average	MY 2019 National Commercial Average	MY 2019 HUSKY Health Overall Rate	Better is:	HUSKY Vs. CT Commercial	HUSKY Vs. National Commercial
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	37.25	40.21	43.80	Higher	Better	Better
Adults' Access to Preventive/Ambulatory Health Services (Total)	93.98	94.22	80.71	Higher	Worse	Worse
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	0	39.35	58.95	Higher	Better	Better
Antidepressant Medication Management - Effective Acute Phase Treatment	73.86	72.37	58.30	Higher	Worse	Worse
Asthma Medication Ratio (Total)	81.59	78.89	64.26	Higher	Worse	Worse
Breast Cancer Screening	73.56	71.62	59.70	Higher	Worse	Worse
Cervical Cancer Screening	75.64	74.18	59.75	Higher	Worse	Worse
Comprehensive Diabetes Care - Eye Exams	55.7	50.27	56.89	Higher	Better	Better
Chlamydia Screening in Women (Total)	63.72	47.2	67.68	Higher	Better	Better
Appropriate Testing for Pharyngitis (Total)	78.97	75.94	81.08	Higher	Better	Better
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation of AOD - Total - Total	37.32	36.35	44.97	Higher	Better	Better
Immunizations for Adolescents - HPV	21.53	27.17	29.49	Higher	Better	Better
Use of Imaging Studies for Low Back Pain	74.71	76.18	77.79	Higher	Better	Better
Prenatal and Postpartum Care - Timeliness of Prenatal Care	81.28	74.11	67.41	Higher	Worse	Worse
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	72.03	59.74	24.12	Higher	Worse	Worse
Use of Opioids at High Dosage	9.12	5.79	9.05	Lower	Same	Worse
Use of Opioids from Multiple Providers - Multiple Prescribers	15.53	14.57	24.38	Lower	Worse	Worse

Better	8	47%	8	47%
Same	1	6%	0	0%
Worse	8	47%	9	53%
Total	**17**	**100%**	**17**	**100%**

Note: Performance comparison is based on reported rate only (Same = performance w/in a +/-2% corridor); no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(2) PCMH Program Performance – Over Time

PCMH practices overall have improved performance on quality measures.

- Performance on 7 of the 11 measures on the PCMH quality slate improved between 2016 and 2019, and performance on the remaining 4 measures was essentially unchanged
- PCMH practices improved most substantially on screenings, HPV immunizations, and use of imaging studies for low back pain

PCMH Practice Performance Over Time

Source: CHN PCMH Longitudinal Review

Quality Measures	CY 16	CY 17	CY 18	CY 19	CY 20	Directionality (Better is:)	Performance Improvement CY 19/16	
							(Y/N)	(%)
Asthma Patients with One or More Asthma-Related Emergency Room Visits (2-20)	7.5%	7.5%	7.1%	7.6%	4.3%	Lower	N	0.8%
Behavioral Health Screening (Ages 1-18)	**29.8%**	**36.8%**	**44.1%**	**45.3%**	**48.1%**	**Higher**	**Y**	**52.1%**
Breast Cancer Screening (HEDIS® MY2016-MY2020)	69.7%	69.9%	69.9%	69.3%	66.7%	Higher	N	-0.5%
Adolescent Well-Care Visits - ages 12-21 (HEDIS® MY2016-MY2019) Child and Adolescent Well-Care Visits – ages 12-21 (HEDIS® MY2020)	78.9%	80.1%	80.4%	78.5%	73.0%	Higher	N	-0.5%
Chlamydia Screening in Women (HEDIS® MY2016-MY2020)	**60.5%**	**65.4%**	**66.8%**	**66.9%**	**62.4%**	**Higher**	**Y**	**10.6%**
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed (HEDIS® MY2016-20)	57.7%	61.0%	62.0%	60.9%	55.9%	Higher	Y	5.6%
Comprehensive Diabetes Care - HbA1c Testing (HEDIS® MY2016-MY2020)	88.2%	89.5%	87.3%	88.6%	84.3%	Higher	Y	0.5%
Developmental Screening in the First Three Years of Life	**57.5%**	**62.6%**	**66.8%**	**67.7%**	**68.8%**	**Higher**	**Y**	**17.8%**
Immunizations for Adolescents - HPV (HEDIS® MY2016-MY2020)[3]	**12.7%**	**21.4%**	**24.5%**	**26.0%**	**27.2%**	**Higher**	**Y**	**104.9%**
Post-Admission Follow-up Within Seven Days of an Inpatient Discharge - PH & BH	44.8%	45.5%	44.1%	43.8%	46.1%	Higher	N	-2.2%
Use of Imaging Studies for Low Back Pain (HEDIS® MY2016-MY2020)	**68.7%**	**74.0%**	**71.6%**	**75.7%**	**75.8%**	**Higher**	**Y**	**10.2%**

Green shading indicates better performance; **bolded font indicates pre/post improvement of 10% or more**

CY 2020 is not included in longitudinal view (not representative)

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(3) PCMH+ Program Performance – Over Time

PCMH+ practices overall have improved performance on quality measures.

- Performance on 7 of the 9 measures on the PCMH+ quality slate (with history) improved between Wave 2 (CY 18) and Wave 3 (CY 19)
- PCMH+ practices improved most substantially on screenings, prenatal and postpartum care, and readmissions

PCMH+ Practice Performance Over Time *(showing 9 of 20 measures with sufficient history to assess over time performance)*

Source: CHN PCMH Longitudinal Review

Quality Measures	CY 2018 Wave 2	CY 2019 Wave 2	CY 2019 Wave 3	CY 2020 Wave 3	Directionality (Better is:)	Performance Improvement Wave 3/2	
Individual Saving Pool Quality Measures						(Y/N)	(%)
Ambulatory Care - ED Visits per 1000 MM (HEDIS® MY2018-MY2020)[2]	80.14	76.96	75.28	50.24	Lower	Y	-6.1%
Child and Adolescent Well-Care Visits 12-21 Years (HEDIS® MY 2018-MY2020)	74.2%	73.4%	72.2%	54.5%	Higher	N	-2.7%
Developmental Screening In the First Three Years of Life	**63.1%**	**68.0%**	**76.6%**	**73.3%**	**Higher**	**Y**	**21.3%**
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing (HEDIS® MY2018-MY2020)	88.1%	89.2%	89.2%	79.0%	Higher	Y	1.2%
Challenge Pool Quality Measures							
Behavioral Health Screening 1-18	**38.0%**	**45.9%**	**53.3%**	**49.8%**	**Higher**	**Y**	**40.4%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS® MY2018-MY2020)	43.0%	40.4%	39.2%	31.7%	Higher	N	-8.7%
Prenatal and Postpartum Care (PPC) - Postpartum Care (HEDIS® MY2018-MY2020)[6]	**46.4%**	**58.1%**	**60.9%**	**58.8%**	**Higher**	**Y**	**31.3%**
Prenatal and Postpartum Care -Timeliness of Prenatal Care (HEDIS® MY2018-MY2020)[6]	75.0%	75.1%	77.8%	77.8%	Higher	Y	3.7%
Readmissions within 30 Days[2]	**15.2%**	**15.2%**	**11.7%**	**15.4%**	**Lower**	**Y**	**-22.8%**

Green shading indicates better performance; **bolded font indicates pre/post improvement of 10% or more**

CY 2020 is not included in longitudinal view (not representative)

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(2/3) PCMH and PCMH+ Program Performance – Comparative

PCMH and FQHC practices outperformed non-PCMH practices on the majority of measures.

- PCMH practices outperformed non-PCMH practices on 63% of measures; FQHCs outperformed on 65% of measures.
- Performance in the *Prevention and Screening* domain was especially strong for both PCMH practices and FQHCs vs. non-PCMH practices.

Summary of Comparative Program Performance by Domain

Source: 2021 HUSKY Health Program Health Equities Report; MY 2019 Performance

Domain	Total Measures	PCMH Comparative Performance (#/% Measures Outperforming Non-PCMH Practices)		FQHC Comparative Performance (#/% Measures Outperforming Non-PCMH Practices)	
		#	%	#	%
Prevention and Screening	10	10	**100%**	9	**90%**
Diabetes	2	2	**100%**	1	**50%**
Respiratory Conditions	3	2	**67%**	1	**33%**
Overuse/ Appropriateness	7	4	**57%**	5	**71%**
Access/ Availability of Care	8	4	**50%**	5	**63%**
Behavioral Health	7	3	**43%**	5	**71%**
Utilization	3	0	**0%**	0	**0%**
Total	**40**	**25**	**63%**	**26**	**65%**
		Top Performance Domains: • Prevention and Screening • Diabetes • Respiratory Conditions		**Top Performance Domains:** • Prevention and Screening • Overuse/ Appropriateness • Behavioral Health	

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(2/3) PCMH vs. PCMH+ Program Performance – Comparative

Comparative measure performance was split evenly between PCMHs and FQHCs.

- FQHCs outperformed PCMH practices on 50% of measures, with stronger performance in Behavioral Health, Access/ Availability of Care, and Overuse/ Appropriateness.

Summary of Comparative Program Performance by Domain

Source: 2021 HUSKY Health Program Health Equities Report; MY 2019 Performance

Domain	Total Measures	FQHC vs. PCMH Comparative Performance (#/% Measures FQHCs Outperformed PCMH Practices)	
		#	%
Prevention and Screening	10	5	**50%**
Diabetes	2	1	**50%**
Respiratory Conditions	3	0	**0%**
Overuse/ Appropriateness	7	4	**57%**
Access/ Availability of Care	8	5	**63%**
Behavioral Health	7	5	**71%**
Utilization	3	0	**0%**
Total	**40**	**20**	**50%**
			Top Performance Domains (where FQHCs outperformed PCMHs): • Behavioral Health • Access/ Availability of Care • Overuse/ Appropriateness

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

(4) Equity Lens: Disparities in Quality by Race/Ethnicity

Overall, there were identified disparities on quality performance by race/ethnicity for 83% of measures.

- This rate was consistent for PCMH practices (83%), and slightly higher for FQHCs (90%).
- Disparities were identified most consistently in the Utilization domain.

Summary of Quality Performance Disparities by Race/Ethnicity

Source: 2021 HUSKY Health Program Health Equities Report; MY 2019 Performance

Domain	Total Measures	CMAP Overall (#/% Measures with Identified Disparities)		PCMH Practices (#/% Measures with Identified Disparities)		FQHCs (#/% Measures with Identified Disparities)	
		#	%	#	%	#	%
Prevention and Screening	10	9	**90%**	8	**80%**	8	**80%**
Diabetes	2	2	**100%**	1	**50%**	2	**100%**
Respiratory Conditions	3	2	**67%**	3	**100%**	2	**67%**
Overuse/ Appropriateness	7	5	**71%**	6	**86%**	7	**100%**
Access/ Availability of Care	8	7	**88%**	8	**100%**	7	**88%**
Behavioral Health	7	5	**71%**	4	**57%**	7	**100%**
Utilization	3	3	**100%**	3	**100%**	3	**100%**
Total	**40**	**33**	**83%**	**33**	**83%**	**36**	**90%**
***Identified Disparities**: the rate for one or more of the 3 non-white populations (Black/ African American Non-Hispanic, Asian Non-Hispanic, Hispanic) was worse than the overall rate for the measure*		**Disparity Domains:** • Diabetes • Utilization		**Disparity Domains:** • Respiratory Conditions • Access/ Availability of Care • Utilization		**Disparity Domains:** • Diabetes • Overuse/ Appropriateness • Behavioral Health • Utilization	

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Race/ethnicity data completion: data is unknown for 33% of HUSKY Health members overall; rates of completion vary by measure based on measure population

(4) Equity Lens: Disparities in Quality by Race/Ethnicity - Detail

Disparities in quality performance were most prevalent in the Black/ African American Non-Hispanic population - quality performance rates were worse than the overall rate for 70% of measures.

Summary of Quality Performance Disparities by Race/Ethnicity

Source: 2021 HUSKY Health Program Health Equities Report; MY 2019 Performance

Domain	Total Measures	CMAP Overall (#/% Measures with Identified Disparities)		White/ Caucasian Non-Hispanic		Black/ African American Non-Hispanic		Asian Non-Hispanic		Hispanic	
		#	%	#	%	#	%	#	%	#	%
Prevention and Screening	10	9	**90%**	7	**70%**	6	**60%**	7	**70%**	2	**20%**
Diabetes	2	2	**100%**	2	**100%**	2	**100%**	0	**0%**	0	**0%**
Respiratory Conditions	3	2	**67%**	1	**33%**	2	**67%**	1	**33%**	1	**33%**
Overuse/ Appropriateness	7	5	**71%**	3	**43%**	4	**57%**	2	**29%**	1	**14%**
Access/ Availability of Care	8	7	**88%**	3	**38%**	7	**88%**	2	**25%**	2	**25%**
Behavioral Health	7	5	**71%**	5	**71%**	4	**57%**	2	**29%**	3	**43%**
Utilization	3	3	**100%**	2	**67%**	3	**100%**	0	**0%**	2	**67%**
Total	**40**	**33**	**83%**	**23**	**58%**	**28**	**70%**	**14**	**35%**	**11**	**28%**
Identified Disparities: *the rate for one or more of the 3 non-white populations (Black/ African American Non-Hispanic, Asian Non-Hispanic, Hispanic) was worse than the overall rate for the measure; by race/ethnicity category, the rate was worse than the overall rate*				**Disparity Domains:** • Diabetes		**Disparity Domains:** • Diabetes • Utilization		**Disparity Domains:** • Prevention and Screening		**Disparity Domains:** • Utilization	

Green shading indicates better performance

Note: Performance comparison is based on reported rate only; no statistical significance testing has been performed, and no additional clinical or social risk adjustment has been applied

Race/ethnicity data completion: data is unknown for 33% of HUSKY Health members overall; rates of completion vary by measure based on measure population

Initial Observations: Details by Dimension

A. Member Access and Provider Participation

B. Cost

C. Quality

D. Member and Provider Experience

(D) Member and Provider Experience

Participant experience information is expected to come primarily from primary research (member/provider focus groups) – only learnings from state team input sessions and available data reports are included in this preliminary look:

	Dimensions	Key Questions	Learnings	Equity Lens
Provider Experience	**PCMH Provider Engagement**	• How have providers responded to the PCMH program? • In what ways, and to what extent, did providers engage?	• PCMH had a **substantial impact on primary care provider participation** and generally **improved DSS' relationship with providers and fostered provider confidence** in the ASO model	There was a concerted effort to address equity goals and incorporate CLAS standards through the **Equity Toolkit** for providers; equity goals could be more fully integrated into the measure set
	PCMH+ Provider Engagement	• How have providers responded to the PCMH+ program? • In what ways, and to what extent, did providers engage?	• PCMH+ engaged providers **in care delivery redesign and substantially changed the way FQHCs looked at and targeted member needs.**	Some of the **changes catalyzed by the PCMH+ model were very well aligned with equity goals** – e.g. screening for and targeting non-medical member needs, connecting with community orgs, hiring CHWs
Member Experience	**CT DSS Member Experience Overall**	• How does CT DSS perform on member experience overall – compared to other state Medicaid programs?	• **CAHPS data for CMAP overall is broadly consistent** with the results of other Medicaid programs collecting CAHPS data.	CAHPS data for CMAP overall shows **variation by race/ethnicity on a small number of measures**, with higher ratings mostly occurring within the Hispanic population.
	PCMH/ PCMH+ Member Experience	• Are there differences in member experience across practice settings?	• Appears CT CAHPS data collection does not segment members by practice setting – **potential area for refinement**	By practice setting, by race/ethnicity data not available – **potential area for refinement**

Member Experience: CAHPS Data Learnings

CAHPS data for CMAP overall is broadly consistent with the results of other Medicaid programs collecting CAHPS data.

Comparison of CMAP Medicaid Adult and Child CAHPS Results vs. Other Medicaid Programs

Source: SPH Analytics, 2020 Medicaid Adult and Child At - A - Glance Reports

"Above" or "Below" indicates statistically significant difference at the 95% significance level

	CMAP Medicaid Adult Score vs.:		CMAP Medicaid Child Score vs.:	
	SPH Analytics Medicaid Adult Book of Business	2019 Quality Compass All Plans	SPH Analytics Medicaid Adult Book of Business	2019 Quality Compass All Plans
Getting Needed Care*				
Getting Care Quickly*				
How Well Doctors Communicate*				
Customer Service*			Below	
Coordination of Care				
Ease of Filling out Forms				
Rating Items (% 8, 9, or 10)				
Rating of Health Care				Above
Rating of Personal Doctor				
Rating of Specialist				
Rating of Health Plan			Above	Above
Effectiveness of Care Measures (Current Year)				
Flu Vaccinations				
Advising Smokers and Tobacco Users to Quit				
Discussing Cessation Medications				
Discussing Cessation Strategies				

**Composite measure score*

The 2020 SPH Analytics Book of Business contains all Medicaid samples that conducted surveys with SPH Analytics in 2020 and submitted data to NCQA

The 2019 Quality Compass® All Plans is the mean summary rate from the Medicaid plans who submitted to NCQA in 2019

[Equity Lens] Member Experience: CAHPS Data Learnings

CAHPS data for CMAP overall shows variation by race/ethnicity on a small number of measures, with higher ratings mostly occurring within the Hispanic population.

Breakout of CMAP Medicaid Adult and Child CAHPS Results by Race/Ethnicity

Source: SPH Analytics, 2020 Medicaid Adult and Child Final Reports

"Above" or "Below" indicates statistically significant difference vs. comparison population shaded in red

	CMAP Medicaid Adult Score					CMAP Medicaid Child Score				
	Race			Ethnicity		Race			Ethnicity	
	White	Black or African-American	Other	Hispanic	Not Hispanic	White	Black or African-American	Other	Hispanic	Not Hispanic
Getting Needed Care*										
Getting Care Quickly*										
How Well Doctors Communicate*										
Customer Service*										
Coordination of Care										
Ease of Filling out Forms										
Rating Items (% 8, 9, or 10)										
Rating of Health Care				Above	Below					
Rating of Personal Doctor				Above	Below					
Rating of Specialist				Above	Below					
Rating of Health Plan				Above	Below	Above	Below		Above	Below
Effectiveness of Care Measures (Current Year)										
Flu Vaccinations										
Advising Smokers and Tobacco Users to Quit										
Discussing Cessation Medications										
Discussing Cessation Strategies										

**Composite measure score*

Appendix 2: VBP Model Evidence Base

(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: VBP 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

See Appendix 2 for details

(3) Primary Data Collection: Focus Group Learnings

Collect qualitative feedback from members, providers, and other key stakeholders

Outreach to Participants
Broad-based outreach

Conduct Focus Groups
Facilitate discussion around a set of prompts

Categorize & Synthesize
Complete thematic analysis and summarize key learnings

VBP Model Evidence Base: Approach

This literature review aims to catalog and summarize VBP model results to date and lessons learned, across payers and payment model type.

(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 (see Appendix for details)

Source	Focus Area	Key Findings

(3) Categorize and synthesize key findings across sources

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

VBP Model Evidence Base: Sources

	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.

Results to Date: VBP Model Evidence Base

			Summary of Key Findings
Base Payment	**Activity-Based**		
	Population-Based		**Practices that receive primarily capitated payment have similar or better quality, lower total costs, and a greater incentive to increase the delivery of team and non-visit based primary care, if capitated payment levels are sufficiently high.** • Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high. [8] • Patients are more likely to receive education if their primary care providers receive primarily capitated payment. [9] • Capitated reimbursement was not associated with differences in hypertension, diabetes, or CKD quality indicators. [7] • Physicians in highly capitated environments had similar or better quality compared with physicians in other environments across most measures. [10] • Physicians in highly capitated practices had the lowest total costs and intensity of care, suggesting that these physicians develop an overall approach to care that also applies to their FFS patients. [11]
Incremental Payments	**Non-visit Functions**		**This payment mechanism is not typically evaluated distinctly against outcomes but may be necessary at the beginning of the transformation process, particularly for small practices.** • Particularly for small practices, up-front payments or higher payments at the beginning of the transformation process may be necessary to support hiring care management staff, upgrading practice health IT capabilities, and changing treatment protocols. [15]
	Pay-for-Performance		**Evidence of effectiveness is mixed and modest; programs utilizing penalties could be more effective than those utilizing rewards.** • The strength of evidence on the effectiveness of pay for performance VBP programs on improving health delivery and patient outcomes is mixed and modest. [4] • The published evidence regarding improvements in performance from the P4P experiments of the past decade is mixed (i.e., positive and null effects); where observed, improvements were typically modest. [5] • P4P programs utilizing penalties could be more effective than those utilizing rewards or a combination of both to improve the quality of surgical care. [3]
	Shared Savings	**ACO**	**Evidence of effectiveness is mixed but encouraging; these is little evidence of negative impacts on quality or outcomes.** • Although findings on ACO impacts are mixed, the reviewed studies suggest that ACOs reduce costs without reducing quality. [1] • With their substantial heterogeneity in approaches to financing and delivering healthcare, our findings that ACO impacts are mixed is both encouraging and expected. The findings suggest that quadruple–aim improvements are possible with ACO models. [1] • 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. [2]
	Shared Risk		

Results to Date: VBP Model Evidence Base – Equity Lens

				Summary of Key Findings
Equity Lens	**Incremental Payments**	**Pay-for-Performance**		**Pay-for-performance programs have typically been designed for a general population and have not been found to decrease racial/ethnic of socioeconomic disparities in care. There is some evidence-based concern that some P4P program designs could exacerbate health disparities by penalizing organizations with large disadvantaged populations.** • Pay-for- performance programs have mostly been designed for the general population, and systematic reviews indicate that these incentives have usually not improved disparities. [22] • Many P4P studies have commented about possible unintended effects for patients of low socioeconomic status (SES) and the providers that serve these populations (e.g., safety net clinics and hospitals). […] Among the four studies that evaluated U.S. P4P programs, *three found no effects related to increasing or decreasing racial/ethnic or SES disparities* while one poor-quality study found very small significant differences in baseline performance for hospitals (between –0.5 percent and –1.1 percent lower performance for high DSH-index hospitals versus non-high- DSH-index hospitals). [5] • It has been suggested that [P4P] programs could exacerbate health disparities by penalizing organizations with large disadvantaged populations already less likely to receive recommended care due to factors including lower health literacy, resource constraints of both patients and facilities, and cultural norms. This concept was supported by Chien and colleagues who geocoded quality data of 12,000 practices in the California IHA program, and found a significant association between higher socio-economic areas and higher performance scores, despite outliers. [4]
		Shared Savings **Shared Risk**	**ACO**	**Medicare ACO models have been less likely to reach historically disadvantaged members, and within Medicare ACO programs, better performance on quality measures has not been consistently associated with smaller racial disparities in care. ACO model designs have generally not directly incorporated disparities reduction into incentives; new payment arrangements may be required for ACOs to promote greater equity in care.** • Recent evaluation results from the Next Generation ACO model showed that aligned Medicare beneficiaries were more likely to be white and less likely to be either dually eligible or to live in rural areas relative to other FFS beneficiaries in the same market areas. Internal Innovation Center analysis of Medicare beneficiaries aligned to participants in other models, including CPC+, PCF, and Global and Professional Direct Contracting yielded similar findings. […] The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models to date. [12] • Larger provider group size and better performance on quality measures were not consistently associated with smaller racial disparities in care for Medicare beneficiaries with cardiovascular disease or diabetes. […] Our findings are consistent with concerns that quality improvements achieved by Medicare ACO programs may not be associated with substantial reductions in health disparities, and may even be associated with larger disparities nationally if these programs disproportionately engage physicians and hospitals serving fewer minority patients. […] ACO incentives rewarding better quality for minority groups and payment arrangements supporting ACO development in disadvantaged communities may be required for ACOs to promote greater equity in care. [23] • Accountable care organizations have also not directly incorporated disparities reduction into incentives. [22]

Results to Date: Underutilization

	Summary of Key Findings
Results to Date	**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.** • 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. [14] • 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. [2] • Although findings on ACO impacts are mixed, the reviewed studies suggest that ACOs reduce costs without reducing quality. [1]

Monitoring quality and member experience measures and utilization patterns is foundational to monitoring for adverse effects that could result from the incentive to increase efficiency or lower costs – a broad based review of recent studies of ACO and capitation models finds little evidence of detrimental effects on quality, member experience, or utilization.

			Quality	Member Experience	Utilization
Base Payment	**Population-Based**		• No difference in chronic disease management quality indicators [7] • Physicians in highly capitated environments had similar or better quality [10]	• Patients more likely to receive education [9]	
Incremental Payments	**Shared Savings**	**ACO**	• Met majority of measures and performed better than FFS counterparts [1] • Some evidence of improvement – especially in adult preventive care and chronic disease management [2]	• ACOs do not reduce and may even improve some measures of patient satisfaction and perceived quality of care [2]	• Most consistent outcomes associated with Medicare ACOs are reduced inpatient and ED use [2]
	Shared Risk				

Summary of Lessons Learned/ Recommendations

Payment Model Design

- Consider making **participation mandatory** [12, 13]
- Ensure **benchmarks and risk adjustment are accurate** [13]
- **Reduce complexity** [12, 16]
- **Pursue multi-payer alignment** to facilitate the adoption and sustainability of models [6, 13, 15]
- Recognize the need for **iterative learning and expect cost savings to be realized only over time** [16]

Incremental Payments	**Non-visit Functions**		• Weigh the **added cost of up-front payments** against the need for models to achieve net savings [13]
	Pay-for-Performance		• Recognize that P4Ps essentially remain FFS structures and ensure **incentives are large enough to compensate providers** for the effort required to obtain them [4, 5]
	Shared Savings	**ACO**	• Shared savings/risk models need to be designed with **appropriate guardrails and provider supports** to enable providers to bear risk [12, 15] • Recognize the **challenges efficient providers may have** in achieving additional savings over time [16] • Consider **member engagement strategies and benefit designs** that support ACO model goals [16]
	Shared Risk		

Program Implementation

- **Recognize key barriers to provider participation**, including but not limited to, significant infrastructure investments in health IT capabilities, integrating new staff and enabling a higher degree of collaboration and communication between providers, and developing operational capabilities such as budget development, accounting, and risk stratification to target interventions. [1, 12, 15, 16]
- **Invest in the IT infrastructure** to support program operations and **share data with participants**. [6, 13, 17]
- **Provide technical assistance to providers** through one-on-one assistance or learning collaboratives. [15, 17]
- **Engage interdisciplinary stakeholders** in program design and governance [5, 6, 17]

Lessons Learned: Payment Model Design

Lessons Learned/ Recommendations: Payment Model Design

Consider making participation mandatory

- Work to avoid adverse selection in voluntary models – be careful about creating too many options that increase the probability the model will be gamed; consider making models mandatory [13]
- Certain model design features, including in some cases voluntary participation, can limit potential savings and impede evaluation due to selection bias, as participants may opt in if they project that the financial incentives in the model (e.g., benchmarking) are in their favor and drop out when potential losses are projected. [12]

Ensure benchmarks and risk adjustment are accurate

- Ensure benchmarks are accurate – when possible, use retrospective benchmarks; and if using prospective benchmarks, create guardrails that allow for benchmarks to be automatically adjusted if they prove inaccurate [13]
- Work to avoid gaming of risk adjustment, while keeping in place accurate risk adjustment [13]

Reduce complexity

- Complexity of financial benchmarks have undermined model effectiveness: Many financial benchmarks and risk adjustment methodologies have created opportunities for potential gaming and upcoding among participants — and reduced savings for Medicare. [12]
- Complexity of model design impedes scalable transformation. [12]
- Innovation is not always about creating new models; sometimes it is about better integrating and coordinating existing models. [16]

Pursue multi-payer alignment to facilitate the adoption and sustainability of models

- Alignment of commercial and public-sector value-based payment models can facilitate the adoption and sustainability of these models, particularly among providers in markets with numerous payers [6]
- Work to align models across payers. [13]
- When feasible, a multi-payer design provides better support for practice transformation. [15]

Recognize the need for iterative learning and expect cost savings to be realized only over time

- In retrospect, this iterative learning made it unrealistic to assume that any new model or combination of models would rapidly achieve the Triple Aim. Given the size, complexity, and competing interests in health care, the expedited timetable for demonstrating cost savings and system transformation was too ambitious. [16]

Lessons Learned: Payment Model Design – Model-Specific

Payment Model-Specific			Lessons Learned/ Recommendations: Payment Model Design
Incremental Payments	**Non-visit Functions**		**Weigh the added cost of up-front payments against the need for models to achieve net savings** • Be especially thoughtful when launching models with new up-front payments to providers that are greater than fee-for-service payments, since these additional payments make it very difficult for models to achieve net savings [13]
	Pay-for-Performance		**Recognize that P4Ps essentially remain FFS structures and ensure incentives are large enough to compensate providers for the effort required to obtain them.** • Sizable incentives: Incentives that were large enough to compensate providers for the effort required to obtain them was identified as one characteristic associated with more successful programs in a study of P4P in five Medicaid plans. [5] • [P4P] programs essentially remain fee-for-service structures of payment, sustaining all the negative incentives of that system. [4]
	Shared Savings	**ACO**	**Shared savings/risk models need to be designed with appropriate guardrails and provider supports to enable providers to bear risk** • Accepting downside risk is challenging if providers lack: care management tools, sufficient protection against the financial impact of beneficiaries with unpredictably high-costs, and appropriate payment and regulatory flexibilities. [12] • Shared savings incentives were problematic because their uncertainty and retrospective timing creates substantial financial risk for practices at the early stages of transformation. This is a particular problem for smaller practices that are less able or willing to bear risk. Financial support that combines shared savings with PBPM payments can overcome some of these challenges. [15] **Recognize the challenges efficient providers may have in achieving additional savings over time** • Entities that started with efficient utilization patterns may struggle to continuously achieve additional savings. [16] **Consider member engagement strategies and benefit designs that support ACO model goals** • It is difficult to manage care, absent strong incentives for beneficiaries to engage with providers and their recommendations: CMS continues to struggle with constraints on how it can offer beneficiaries lower cost sharing for obtaining services from ACO providers, and cannot reduce benefits to implement benefit designs aligned with the goals of the model. [16]
	Shared Risk		

Lessons Learned: Program Implementation

Lessons Learned/ Recommendations: Program Implementation

Recognize key barriers to provider participation, including but not limited to, significant infrastructure investments in health IT capabilities, integrating new staff and enabling a higher degree of collaboration and communication between providers, and developing operational capabilities such as budget development, accounting, and risk stratification to target interventions.

- Significant infrastructure investments are often needed to participate in models, including electronic health record (EHR) enhancements, new staff, and data analytic support especially for safety net providers and those serving Medicaid beneficiaries. [12]
- We identified three major practice-level challenges to practice transformation: (1) a practice's inexperience with transformation activities, (2) limited health IT capabilities, and (3) difficulty integrating new care management staff into clinical activities. [15]
- Some practices had steep learning curves for operational capabilities such as budget development, accounting, and risk stratification to target interventions and resources to patients with the greatest need and utilization patterns. [16]
- Participants face difficulty in joining or continuing in models due to investments required for care transformation, complexity of model payment and/or participation parameters, administrative burden, and lack of clarity on long-term strategy for models. [12]
- Mechanisms that enabled the delivery of high-quality primary care include supplemental care coordination staff, development of ACO-wide electronic medical records, and a higher degree of collaboration and communication among providers in the ACO network [1]

Invest in the IT infrastructure to support program operations and share data with participants.

- Invest in centralized operations and technology infrastructure to decrease errors in model implementation, increase consistency and lower the cost of operations. [13]
- Increase the amount of data shared with participants – provide standardized data analyses and build APIs. [13]
- Invest heavily in health IT and data analytics to help ACOs and their providers access and use clinical and claims data to manage high utilizers and identify patients with gaps in evidence-based care. [17]
- Factor reported amongst important contributors to success: provide technical assistance to establish a data infrastructure; disseminate web-based, real- time performance reports on outcomes; and provide opportunities for shared learning [6]

Provide technical assistance to providers through one-on-one assistance or learning collaboratives.

- We found that technical assistance provided by the initiatives had favorable effects on all outcomes except hospital admissions, although the relevant type of assistance differed by outcome. [15]
- Provide some level of technical assistance to clinical providers participating in the ACO, as well as to ACO administrators, to help them meet performance expectations. Provide practice transformation assistance to ACO-participating practices through one-on-one assistance or learning collaboratives. [17]

Engage interdisciplinary stakeholders in program design and governance

- Engage providers from multiple service sectors to ensure that the behavioral health, long-term care, and social service needs of medically and socially complex Medicaid beneficiaries could be met under an ACO arrangement. [17]
- A few studies have identified the involvement of key stakeholders in the P4P system design and implementation as important. [5]
- Factor reported amongst important contributors to success: involve interdisciplinary stakeholders in program design and governance. [6]

Appendix: Catalog of Key Findings by Source

Faulkner CONSULTING GROUP

VBP Model Systematic Reviews

Source 1

Source	Focus Area	Key Findings / Lessons Learned

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.	Rapid review of 59 private or public ACO model evaluations/ primary studies; US
	
	Two research objectives:
	(1) identify the impacts of accountable care organizations on improving the quadruple aim goals
	(2) determine how and why such impacts have been achieved
		Results to Date
		• Although findings on ACO impacts are mixed, the reviewed studies suggest that ACOs reduce costs without reducing quality:
		  • There are positive trends across the quadruple aim outcomes for ACOs as compared to Medicare FFS or group physician FFS models
		  • ACOs produced modest cost savings, which are largely attributable to savings in outpatient expenses among the most medically complex patients and reductions in the delivery of low-value services; however, cost savings didn't produce enough savings to receive bonuses in many cases
		  • ACO models met the majority of quality measures and perform better than their fee-for-service counterparts; although quality indicators may improve post-ACO implementation, changes were small and some metrics, such as hospital readmission, may not be affected
		  • There is relatively little evidence about the impact of ACOs on provider experience
		• With their substantial heterogeneity in approaches to financing and delivering healthcare, our findings that ACO impacts are mixed is both encouraging and expected. The findings suggest that quadruple–aim improvements are possible with ACO models.
		• While evidence suggests ACOs reduce costs and may improve quality, more research is needed to determine whether ACOs result in better patient experience of care and population health. The available research generally supports the continued piloting and close monitoring of ACOs.
		
		Lessons Learned
		1. Mechanisms that enabled the delivery of high-quality primary care include supplemental care coordination staff, development of ACO-wide electronic medical records, and a higher degree of collaboration and communication among providers in the ACO network
		2. Be cautious with the bureaucratic requirements that ACOs impose, including referral restrictions, quality monitoring and reporting
		3. ED strategies to support the achievement of ACO goals include use of case management and information technology to reduce costs and admissions
		4. To integrate mental health (MH) in ACOs, track MH quality metrics; integrate MH in bundled funding; encourage interprofessional consultation through remote consultation and co-location; foster informal provider relationships; and develop shared resources including online resource libraries

VBP Model Systematic Reviews

Source 2

Source	Focus Area	Key Findings/ Lessons Learned
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.	Systematic review of 42 studies of ACO impact on care and outcomes across payer types; 24 studies focus on Medicare ACOs; US	**Results to Date** • In this review, 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. • The most consistent outcomes associated with Medicare ACOs are reduced inpatient and ED use, as well as improved measures of adult preventive care and chronic disease management. • Non-Medicare ACOs also found some evidence of improvement in care quality metrics. • The finding that ACOs do not reduce and may even improve some measures of patient satisfaction and perceived quality of care suggests that ACOs have not prompted the patient frustration associated with the HMO model, potentially due to the preservation of patient choice in providers in the ACO model among other differences • Similar to ACOs, P4P programs have been associated with small positive effects on the process measures targeted; however, neither model has demonstrated consistent effects on health outcomes. • More data and research is needed into non-Medicare ACOs as well as financial and quality data for commercial ACOs. • More time may be needed to determine the impact of ACOs on patient outcomes. • To improve population health and outcomes, ACO programs may need to incentivize measures of quality that are more closely tied to outcomes. • Current trends in ACO contracts including increasing risk for provider groups and provider experience, may magnify any impacts of ACOs on care processes and outcomes over time.

VBP Model Systematic Reviews

Source 3

Source	Focus Area	Key Findings/ Lessons Learned
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.	Systematic review of surgical care P4P programs – review of 22 studies to assess if penalty-based P4P programs are more effective in improving quality and cost outcomes compared to two other payment strategies (i.e., rewards and a combination of rewards and penalties)	Recently, programs using penalties have gained in popularity, because of their potential to affect behavioral change more effectively than reward-based programs. This is due to evidence showing that individuals, and perhaps organizations, tend to be more sensitive to losses than gains. **Results to Date** • Five out of 10 studies reported positive effects of penalty-based programs, whereas evidence from studies evaluating P4P programs with a reward design or combination of rewards and penalties was little or null. • Results of this systematic review suggest that P4P programs utilizing penalties could be more effective than those utilizing rewards or a combination of both to improve the quality of surgical care.

VBP Model Systematic Reviews

Source 4

Source	Focus Area	Key Findings/ Lessons Learned
Chee, Tingyin, et al. "Current State of Value-Based Purchasing Programs." Circulation, 133;22, May 31 2016.	Pay-for-performance models, defined as providers being paid fee-for-service with payment adjustments up or down based on value metrics; includes discussion of public and private models; outpatient and inpatient; US and International	**Results to Date** • The strength of evidence on the effectiveness of pay for performance VBP programs on improving health delivery and patient outcomes is mixed and modest. • VBP programs have been implemented widely, and their impact has been marginal thus far. **Lessons Learned** • The effectiveness of VBP programs stems not only from the process of implementation, but also from specifics of program design and incentive structure. VBP programs essentially remain fee-for-service structures of payment, sustaining all the negative incentives of that system. • Opportunities to enhance the performance of VBP programs include improving the quality measurement science, strengthening both the size and design of incentives, reducing health disparities, establishing broad outcome measurement, choosing appropriate comparison targets, and determining the optimal role of VBP relative to alternative payment models. • As healthcare payment models increasingly move towards risk and accountability, there needs to be greater understanding of the individual design levers in creating a VBP program as well as responsiveness to the incentives of individual providers and provider organizations. **Equity/ Disparities Learnings** • It has been suggested that VBP programs could exacerbate health disparities by penalizing organizations with large disadvantaged populations already less likely to receive recommended care due to factors including lower health literacy, resource constraints of both patients and facilities, and cultural norms. This concept was supported by Chien and colleagues who geocoded quality data of 12,000 practices in the California IHA program, and found a significant association between higher socio-economic areas and higher performance scores, despite outliers. • Clearly the potential for unintended consequences, such as the exacerbation of healthcare disparities, requires consideration in program design and close ongoing monitoring and evaluation.

VBP Model Systematic Reviews

Source 5

Source	Focus Area	Key Findings/ Lessons Learned

RAND Corporation, "Measuring Success in Health Care Value-Based Purchasing Programs," 2014.	Public and private VBP models* - assessment based on review of 91 P4P programs, published evaluation literature, and input from technical expert panel
	
	**Note: this study also reviewed ACO and bundled payment models, but the evidence base for those models was narrower at the time the study was done – excerpted findings relate specifically to pay-for-performance models*
		Results to Date (Pay-for-Performance)
		• The published evidence regarding improvements in performance from the P4P experiments of the past decade is mixed (i.e., positive and null effects); where observed, improvements were typically modest.
		• VBP programs are natural experiments and inherently difficult to evaluate because program sponsors rarely withhold the VBP intervention from a matched group of providers to see what would have occurred absent the intervention.
		• **Clinical Quality:** Overall, the results of the studies were mixed, and studies with stronger methodological designs were less likely to identify significant improvements associated with the P4P programs. Any identified effects were relatively small.
		• **Costs:** Few studies have investigated the impact of P4P on costs. The studies with the strongest study designs report mixed effects on costs in the physician or physician group setting.
		• **Disparities:**
		  • Many P4P studies have commented about possible unintended effects for patients of low socioeconomic status (SES) and the providers that serve these populations (e.g., safety net clinics and hospitals). Examinations of whether VBP programs work to reduce or increase disparities are challenged by the lack of information at the patient level on race, ethnicity, education, SES, and other markers of vulnerable populations prone to disparities.
		  • Among the four studies that evaluated U.S. P4P programs, three found no effects related to increasing or decreasing racial/ethnic or SES disparities while one poor-quality study found very small significant differences in baseline performance for hospitals (between –0.5 percent and –1.1 percent lower performance for high DSH-index hospitals versus non-high- DSH-index hospitals)
		
		Lessons Learned
		Based on the panelists' anecdotal evidence and the limited literature, we identified six features that appear to influence the success of VBP programs:
		• Sizable incentives: Incentives that were large enough to compensate providers for the effort required to obtain them was identified as one characteristic associated with more successful programs in a study of P4P in five Medicaid plans.
		• Measure alignment: A number of TEP members discussed the importance of measure alignment across VBP programs to give providers a clear signal of what is important.
		• Provider engagement: A few studies have identified the involvement of key stakeholders in the P4P system design and implementation as important.
		• Performance targets: TEP members discussed the importance of the methodology used to measure and reward performance. Members stressed the importance of rewarding both achievement and improvement…
		• Data and other quality improvement support: there was an extensive discussion among the TEP of the importance of support to help providers improve, particularly through the use of HIT and data registries.

VBP Model Systematic Reviews

Source 6

Source	Focus Area	Key Findings/ Lessons Learned

Milad, Marina, et al. "Value-Based Payment Models In The Commercial Insurance Sector: A Systematic Review." Health Affairs, 41;4, April 2022.	Systematic review of 59 studies of the impact of commercial VBP models on quality, spending, and utilization; US	**Results to Date**
		• More studies had positive results for quality outcomes (81 percent of studies) than for spending (56 percent) and utilization (58 percent).
		• Commercial VBP models have been somewhat successful in improving health care quality, but impacts on spending and utilization have been less conclusive.
		  • Quality of care improved or remained stable in P4P programs and bundled payment programs; Shared savings or shared risk models either improved quality or had no effect on quality; One population-based payment model evaluation found that quality improved
		  • Impacts on spending had mixed results for P4P programs, bundled payment programs, shared savings/risk models, and population-based payment models
		  • For utilization, P4P programs and bundled payment programs had mixed positive results, while shared savings/risk models and population-based payment models had both mixed positive results and mixed negative results
		
		Lessons Learned
		• Technical assistance and financial incentives should be deployed alongside support for providers; Program implementation factors that contributed to success: involve interdisciplinary stakeholders in program design and governance; provide technical assistance to establish a data infrastructure; disseminate web-based, real- time performance reports on outcomes; and provide opportunities for shared learning
		• Alignment of commercial and public-sector value-based payment models can facilitate the adoption and sustainability of these models, particularly among providers in markets with numerous payers

Base Payment Assessments

Source 7

Source	Focus Area	Key Findings/ Lessons Learned

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.	Cross-sectional analysis of visits in the United States' National Ambulatory Medical Care Survey (NAMCS) for patients with hypertension, diabetes, or chronic kidney disease (CKD). Our predictor was practice reimbursement type, classified as 1) majority capitation, 2) majority FFS, or 3) other reimbursement mix.	**Key Findings**
		• Prior research on the effect of capitated payments on chronic disease management has shown mixed results.
		  • Several factors may explain these mixed findings. First, the capitation payment amount should also be considered, which may differ substantially across Medicare, Medicaid, and commercial managed care settings. Second, practices are subject to different quality metrics and pay-for-performance initiatives depending on the payor arrangement, which incentivize quality of care improvements. Thus, the impact of not only capitation vs. FFS reimbursement type, but also quality metrics and other regulatory requirements, impact quality of care delivery and must be considered in evaluating new capitation models.
		• Practices with majority capitation revenue differed substantially from FFS and other practices in patient, physician, and practice characteristics, but were not associated with consistent quality differences.
		  • Capitated practices, compared with FFS and other practices, had lower visit frequency (3.7 vs. 5.2 vs. 5.2, p = 0.006), were more likely to be located in the West Census Region (55% vs. 18% vs. 17%, $p < 0.001$), less likely to be solo practice (21% vs. 37% vs. 35%, $p = 0.005$), more likely to be owned by an insurance company, health plan or HMO (24% vs. 13% vs. 13%, $p = 0.033$), and more likely to have private insurance (43% vs. 25% vs. 19%, $p = 0.004$) and managed care payments (69% vs. 23% vs. 26%, $p < 0.001$) as the majority of revenue
		  • Capitated reimbursement was not associated with differences in hypertension, diabetes, or CKD quality indicators

Base Payment Assessments

Source 8

Source	Focus Area	Key Findings/ Lessons Learned
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.	Using a microsimulation model incorporating data from 969 US practices, we sought to understand whether shifting to team- and non-visit-based care is financially sustainable for practices under traditional fee-for-service, capitated payment, or a mix of the two.	**Key Findings** Shifting to capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care, if capitated payment levels were sufficiently high. • Practice revenues and costs were computed for fee-for-service payments and a range of capitated payments, before and after the substitution of team- and non-visit-based services for low-complexity in-person physician visits. • The substitution produced financial losses for simulated practices under fee-for-service payment of $42,398 per full-time-equivalent physician per year; however, substitution produced financial gains under capitated payment in 95 percent of cases, if more than 63 percent of annual payments were capitated.

Base Payment Assessments

Source 9

Source	Focus Area	Key Findings/ Lessons Learned
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.	Cross-sectional analysis of patient visits to primary care providers to determine whether practice payment in the form of capitated payments is associated with patient education being included more frequently during office visits compared with other payment methods.	**Key Findings** • Patients are more likely to receive education if their primary care providers receive primarily capitated payment. • In an adjusted logistic model controlling for new patients (yes/no), number of chronic conditions, number of medications managed, number of previous visits within the year, and age and sex of the patients, the odds of receiving education were reported as odds ratios (95% confidence intervals): <25% capitation, 1.00 (1.00 –1.00); 26% to 50% capitation, 0.77 (0.38 – 1.58); 51% to 75% capitation, 0.81 (0.53–1.25); and >75% capitation, 3.38 (1.23–9.30). • This association is generally important for health policymakers constructing payment strategies for patient populations who would most benefit from interventions that incorporate or depend on patient education, such as populations requiring management of chronic diseases.

Base Payment Assessments

Source 10-11

Source	Focus Area	Key Findings/ Lessons Learned
Landon, Bruce, et al. "Physician Compensation Strategies and Quality of Care for Medicare Beneficiaries," American Journal of Managed Care, 20;10, 2014.	Cross-sectional analysis of physician survey data linked to Medicare claims.	**Key Findings** • Employed physicians with productivity and other incentives were more likely to deliver care of high quality when compared with salaried physicians. • Physicians in highly capitated environments had similar or better quality compared with physicians in other environments across most measures. • Increasing use of global payment strategies is not likely to lead to lower quality.
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.	Cross-sectional analysis of physician survey data linked to Medicare claims.	**Key Findings** • Financial incentives experienced by PCPs have a measurable impact on the costs of care, with most productivity-based payment systems leading to higher total costs and intensity of care. • Physicians in highly capitated practices had the lowest total costs and intensity of care, suggesting that these physicians develop an overall approach to care that also applies to their FFS patients. • The effect of practicing in a high-capitation environment appears to be a strong counter weight to other incentives (such as productivity-based incentives) to provide additional services. This finding is also consistent with a significant spillover effect as the Medicare patients we studied were all reimbursed using FFS payments.

CMS Innovation Center Models

Source 12

Source	Focus Area	Key Findings/ Lessons Learned

CMS Innovation Center Strategy Refresh, October 2021.	CMS Innovation Center review of lessons learned from the Center's first decade and 5 strategic objectives for moving forward	**Results to Date**
		• Over the last ten years, only six out of more than 50 models launched generated statistically significant savings to Medicare and to taxpayers and four of these met the requirements to be expanded in duration and scope.
		  • As of September 2021, the models that showed statistically significant savings include the Maryland All-Payer Model (MDAPM); Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model; the Home Health Value-Based Purchasing (HHVBP) Model; the ACO Investment Model (AIM); the Pioneer ACO Model; and the Medicare Care Choices Model (MCCM).
		  • As of September 2021, the Pioneer ACO, Medicare Diabetes Prevention Program (MDPP), RSNAT, and HHVBP model met the requirements under Section 1115A(c) of the Social Security Act (the Act) to be expanded in duration and scope.
		
		CMS Innovation Center – Key Learnings
		1. Ensure health equity is embedded in every model.
		• The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models to date.
		• Medicare-focused models have limited reach to Medicaid beneficiaries and safety net providers.
		• Models have not systematically evaluated impacts across beneficiaries with different demographic characteristics.
		
		2. Streamline the model portfolio and reduce complexity and overlap to help scale what works.
		• Complex payment policies and model overlap rules in CMS Innovation Center models can sometimes result in conflicting or opposing incentives for health care providers (e.g., multiple shared savings models operating in the same health system).
		• Participants face difficulty in joining or continuing in models due to investments required for care transformation, complexity of model payment and/or participation parameters, administrative burden, and lack of clarity on long-term strategy for models.
		• Complexity of model design impedes scalable transformation.

CMS Innovation Center Models

Source 12

Source	Focus Area	Key Findings/ Lessons Learned
(CONT'D) CMS Innovation Center Strategy Refresh, October 2021.	CMS Innovation Center review of lessons learned from the Center's first decade and 5 strategic objectives for moving forward	**CMS Innovation Center – Key Learnings (CONT'D)** **3. Tools to support transformation in care delivery can assist providers in assuming financial risk.** • Accepting downside risk is challenging if providers lack: care management tools, sufficient protection against the financial impact of beneficiaries with unpredictably high-costs, and appropriate payment and regulatory flexibilities. • Significant infrastructure investments are often needed to participate in models, including electronic health record (EHR) enhancements, new staff, and data analytic support especially for safety net providers and those serving Medicaid beneficiaries. **4. Design of models may not consistently ensure broad provider participation.** • Certain model design features, including in some cases voluntary participation, can limit potential savings and impede evaluation due to selection bias, as participants may opt in if they project that the financial incentives in the model (e.g., benchmarking) are in their favor and drop out when potential losses are projected. • Multi-payer models designed for Medicare providers have not consistently led to high levels of participation from Medicaid and commercial payers. **5. Complexity of financial benchmarks have undermined model effectiveness.** • Many financial benchmarks and risk adjustment methodologies have created opportunities for potential gaming and upcoding among participants — and reduced savings for Medicare. **6. Models should encourage lasting care delivery transformation.** • Model testing has been focused on meeting the statutory standards for certification and expansion. • Transformation can be limited to the duration of model test.

CMS Innovation Center Models

Source 12

Source	Focus Area	Key Findings/ Lessons Learned

(CONT'D) CMS Innovation Center Strategy Refresh, October 2021.	CMS Innovation Center review of lessons learned from the Center's first decade and 5 strategic objectives for moving forward	**Advanced Primary Care – Lessons Learned and Model Considerations**
		• Previous primary care models illustrated that practices can be effectively incentivized to broaden their care delivery capabilities, including making medical record and facilities more accessible after hours for patients in need.
		• Practices have also effectively increased usage of care managers, integrated behavioral health, and incorporated screening for social service needs at rates much higher than non-participating practices.
		• The latest CPC+ evaluation report indicates there have been slight decreases in emergency department and hospital utilization among beneficiaries attributed to participating CPC+ practices.
		• These models have also offered lessons for future model testing:
		  • There was limited participation among independent practices
		  • Beneficiaries in advanced primary care models were more likely to be white and less likely to be dually eligible
		  • These primary care models have not generated net savings for the Medicare program
		
		ACOs – Lessons Learned and Model Considerations
		CMS has learned significant lessons from its portfolio of ACO initiatives as it has grown and evolved over the last ten years – for example:
		• The Center is examining its benchmarking and risk adjustment approaches to provide incentives to encourage participation, especially among providers caring for underserved beneficiaries.
		• It is important to ensure that benchmarks and risk adjustors are appropriate for ACOs at varying levels of experience and that models are not resulting in inaccurate payments and potential upcoding among participants, both of which can reduce savings for Medicare.
		• The Innovation Center is also examining how beneficiaries can be better engaged in accountable care relationships through benefit enhancements and beneficiary engagement incentives, as well as voluntary alignment
		• ACOs must manage high-cost episodic and specialty care more effectively
		
		Advancing Health Equity – Lessons Learned
		• Recent evaluation results from the Next Generation ACO model showed that aligned Medicare beneficiaries were more likely to be white and less likely to be either dually eligible or to live in rural areas relative to other FFS beneficiaries in the same market areas.
		• Internal Innovation Center analysis of Medicare beneficiaries aligned to participants in other models, including CPC+, PCF, and Global and Professional Direct Contracting yielded similar findings

CMS Innovation Center Models

Source 13

Source	Focus Area	Key Findings/ Lessons Learned
Smith, Brad. "CMS Innovation Center at 10 Years – Progress and Lessons Learned." New England Journal of Medicine, 384;8, February 2021.	CMS Innovation Center payment models – overall lessons learned from the launch of 54 value-based payment models over 10 years	**Results to Date** • The vast majority of the Center's models have not saved money, with several on pace to lose billions of dollars • The majority of models do not show significant improvements in quality, although no models show a significant decrease in quality **Lessons Learned/ Recommendations** 1. Prioritize new models that are most likely to achieve savings or improve quality - be especially thoughtful when launching models with new up-front payments to providers that are greater than fee-for-service payments, since these additional payments make it very difficult for models to achieve net savings 2. Ensure benchmarks are accurate – when possible, use retrospective benchmarks; and if using prospective benchmarks, create guardrails that allow for benchmarks to be automatically adjusted if they prove inaccurate 3. Work to avoid adverse selection in voluntary models – be careful about creating too many options that increase the probability the model will be gamed; consider making models mandatory 4. Work to avoid gaming of risk adjustment, while keeping in place accurate risk adjustment 5. Work to better align the quality metrics for which participants are paid with the quality metrics that are evaluated 6. Invest in centralized operations and technology infrastructure to decrease errors in model implementation, increase consistency and lower the cost of operations 7. Increase the amount of data shared with participants – provide standardized data analyses and build APIs 8. Work to align models across payers

CMS Innovation Center Models

Source 14

Source	Focus Area	Key Findings/ Lessons Learned
Chernew, Michael, et al., "The Case For ACOs: Why Payment Reform Remains Necessary," Health Affairs, January 2022.	CMMI ACO model re-design process and launch of the Global and Professional Direct Contracting Model (GPDC)	**Lessons Learned** • The strength of ACO incentives to reduce unneeded care depends on the design of the models and varies by organizational structure. Incentives are stronger for physician groups than for hospital-based health systems. • 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. • That said, spending reductions achieved by ACOs have been modest and may not translate into savings for Medicare. For example, if benchmarks are set too high or not adjusted for coding effects, ACOs will prosper, not Medicare. Moreover, if programs are voluntary or if ACOs can adjust provider lists, non-random participation can result in higher Medicare spending even if ACOs succeed in reducing utilization. Similarly, if risk is one-sided, savings from lower use that arise by chance will lead to bonuses without offsetting penalties.

CMS Innovation Center Models

Source 15

Source	Focus Area	Key Findings/ Lessons Learned

Systematic Review of CMMI Primary Care Initiatives: Final Report, Prepared for CMS by Kennell and Associates, Inc., February 2018.	Systematic review of six CMMI initiatives launched from 2011-2013 to test whether advanced primary care models could increase quality and reduce costs, including:
	• Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration
	• Comprehensive Primary Care (CPC) initiative
	• Independence at Home (IAH) demonstration
	• Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
	• Primary care models included in the State Innovation Models (SIM) initiative
	• Health Care Innovation Awards Primary Care Redesign Programs (HCIA-PCR)
		Summary of Key Findings (pg. 89):
		• **Practices made substantial progress transforming to advanced primary care practices** - initiative practices made large strides toward becoming PCMHs or advanced primary care practices. For example, while less than 10 percent of initiative FQHCs had any PCMH recognition status prior to the initiative, 70 percent of initiative FQHCs achieved NCQA Level-3 recognition by the end of the initiative.
		• **These initiatives produced modest and mixed results in the available evaluation period** - did not find consistent impacts across the initiatives or by setting within initiatives **for any of the four core outcomes identified by CMS:** fee-for-service Medicare hospital admissions, 30-day readmissions, outpatient ED visits, and Medicare expenditures
		  • The pooled regression and meta-regression analyses across four initiatives (CPC, MAPCP, HCIA-PCR, and FQHC) both indicated that the **aggregate impacts of these four initiatives combined on the core outcomes were small and not statistically significant**.
		• **Across initiatives, certain population subgroups and practice types experienced more favorable outcomes.**
		  • We found that two beneficiary-level characteristics related to health status—**disability status and HCC risk score quartile**—both influenced the magnitude of the outcome effects, suggesting that the initiatives produced somewhat more favorable cost results for the sickest beneficiaries with the poorest health. Specifically, beneficiaries originally eligible for Medicare due to disability and beneficiaries with poor health (as reflected by being in the highest quartile of baseline HCC risk scores) experienced slower growth in Medicare expenditures.
		  • We also found slower growth in Medicare expenditures and lower rates of inpatient admissions and ED visits among **practices with fewer than six practitioners and also among practices that were not multispecialty practices**.
		  • We found that technical assistance provided by the initiatives had favorable effects on all outcomes except hospital admissions, although the relevant type of assistance differed by outcome.
		
		Conclusions
		• There are advantages to both state-convened and CMS-convened initiatives.
		• When feasible, a multi-payer design provides better support for practice transformation.
		• Practice-level factors are important in addressing transformation challenges.
		  • We identified three major practice-level challenges to practice transformation: (1) a practice's inexperience with transformation activities, (2) limited health IT capabilities, and (3) difficulty integrating new care management staff into clinical activities.
		• Initiative-level supports also helped practices meet transformation challenges.
		  • Particularly for small practices, up-front payments or higher payments at the beginning of the transformation process may be necessary to support hiring care management staff, upgrading practice health IT capabilities, and changing treatment protocols.
		  • Shared savings incentives were problematic because their uncertainty and retrospective timing creates substantial financial risk for practices at the early stages of transformation. This is a particular problem for smaller practices that are less able or willing to bear risk. Financial support that combines shared savings with PBPM payments can overcome some of these challenges.

CMS Innovation Center Models

Source 16

Source	Focus Area	Key Findings/ Lessons Learned

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.	Discussion of the design/ execution and resulting outcomes and lessons from CMMI's five initial models:
	• ACO (Pioneer and Advanced Payment)
	• BPCI (Bundled Payments for Care Improvement)
	• CPC (Comprehensive Primary Care)
	• PfP (Partnership for Patients)
	• HCIA (Health Care Innovation Awards, round 1)
		Overall Insights to Inform Future Efforts
		• First, CMMI created an organizing framework for iterative testing and learning. Target results were not achieved for every model, but the resulting learning would not have occurred as early, as fast, or at the same scale without public-sector leadership to synthesize the market's reactions and feedback and iterate based on this leadership and its influence in the market
		• Second, in retrospect, this iterative learning made it unrealistic to assume that any new model or combination of models would rapidly achieve the Triple Aim. Given the size, complexity, and competing interests in health care, the expedited timetable for demonstrating cost savings and system transformation was too ambitious.
		• Third, innovation is not always about creating new models; sometimes it is about better integrating and coordinating existing models.
		
		ACO Key Findings/ Results to Date
		• ACOs that had succeeded under Medicare Advantage's local benchmarking for cost and utilization faced challenges achieving the further efficiencies required to meet the Pioneer ACO national benchmarks. As a result, some ACOs struggled to deliver the degree of savings they had anticipated.
		• In 2015 the Office of the Actuary at CMS certified that the Pioneer ACO Model improved quality without increasing cost—required by statue if the Department of Health and Human Services wished to expand the model.
		• CMS's ACO initiatives, especially the Medicare Shared Savings Program, significantly accelerated the growth of commercial ACOs, from 75 in 2011 to 842 in 2016.
		• Challenges for ACOs remain:
		  • Entities that started with efficient utilization patterns may struggle to continuously achieve additional savings
		  • It is difficult to manage care, absent strong incentives for beneficiaries to engage with providers and their recommendations: CMS continues to struggle with constraints on how it can offer beneficiaries lower cost sharing for obtaining services from ACO providers, and cannot reduce benefits to implement benefit designs aligned with the goals of the model
		
		CPC Key Findings/ Results to Date
		• Within two years CPC yielded improved patient experience ratings and essentially resulted in the same amount of spending when the care management fee was factored in, although this result did not reach significance.
		• Some practices had steep learning curves for operational capabilities such as budget development, accounting, and risk stratification to target interventions and resources to patients with the greatest need and utilization patterns.
		• CMS did not receive sufficient, reliable EHR data to properly measure and report back to practices how they performed
		• In CPC, the market made clear that offering shared savings to an aggregation of small, unrelated practices did not provide sufficient motivation or financial incentives for practices to fully engage.
		  • CPC+ instead offers performance payments based on practice-specific utilization and quality metrics and on screening patients for unmet social needs.

State Medicaid Program Models

Source 17

Source	Focus Area	Key Findings/ Lessons Learned

Rutledge, Regina, et al. "Medicaid Accountable Care Organizations in Four States: Implementation and Early Impacts." The Milbank Quarterly, 97;2, 2019.	Medicaid ACOs in, Maine, Minnesota, Vermont and Massachusetts	• VT had the most promising results in reducing high-cost service use (inpatient admissions and ED visits) and Medicaid cost growth, followed by MN and ME
		  • Notably, VT's and MN's efforts to support ACOs were very focused, while ME's efforts were less intense
		  • Use of two-sided risk had minimal influence on study outcomes
		  • *Note*: MassHealth ACO program design and implementation factors were only analyzed as the program did not have sufficient implementation data available at the time
		• Factors that facilitated ACO development: Flexibility in model design, ability to build on existing reforms, provision of technical assistance to providers, and access to raw Medicaid claims data or aggregated claims data in a feedback report
		• The states sustained Medicaid ACOs due to provider support and early successes in generating shared savings, and states continue to modify their ACOs to include greater accountability and financial risk
		
		Lessons Learned/ Recommendations
		1. Build ACO models upon existing primary care health reforms (all states had prior experience with PCMH models)
		2. Provide some level of technical assistance to clinical providers participating in the ACO, as well as to ACO administrators, to help them meet performance expectations
		3. Invest heavily in health IT and data analytics to help ACOs and their providers access and use clinical and claims data to manage high utilizers and identify patients with gaps in evidence-based care
		  • ME and VT invested in existing health information exchanges, while MA and VT invested in inpatient and ED event notification systems to broaden providers' access to real-time clinical data
		4. Engage providers from multiple service sectors to ensure that the behavioral health, long-term care, and social service needs of medically and socially complex Medicaid beneficiaries could be met under an ACO arrangement
		5. Provide practice transformation assistance to ACO-participating practices through one-on-one assistance or learning collaboratives

State Medicaid Program Models

Source 18

Source	Focus Area	Key Findings/ Lessons Learned
McConnell, John, et al. "Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado." JAMA Internal Medicine, 177;4, April 2017.	Medicaid ACO programs in Oregon and Colorado	• In 2012, Oregon put the majority of its Medicaid enrollees into various Coordinated Care Organizations (CCOs). In 2011, Colorado began its Medicaid Accountable Care Collaborative (ACC). Data was analyzed from 2010 – 2014. • After adjusting for demographic differences and risk, there was no decrease in PMPM expenditure in Oregon. • Oregon's CCO program showed a decrease in primary care and avoidable ED utilization. While primary care utilization also decreased in Colorado, Oregon maintained or improved three out of four HEDIS access measures, relative to Colorado. **Lessons Learned** 1. Oregon's CCO program had a more ambitious scope and monetary investment when compared to Colorado, where Colorado took more cautious, incremental steps. Both states showed success in reducing utilization, although Oregon had a more significant rate of improvement. 2. The CCO program may need more time to show improvements in expenditure; Colorado's ACC model may be more accessible for other states to follow.

Primary Care Start-up Models

Source 19-20

Source	Focus Area	Key Findings/ Lessons Learned
Bates, Matthew. "Operationalizing Value-Based Primary Care: Lessons from the Field." KaufmanHall, February 2022.	Several emerging companies focused primarily or exclusively on primary care have pursued significant growth and touted promising, if early, performance results in recent years.	• ChenMed reported a 22% lower rate of stroke in patients who had been enrolled at least a year. The company's physicians also provide face time with patients more than 10 times that of the national average. • Oak Street Health reported a 51% decrease in hospital admissions, a 51% decrease in ED visits, and a 42% decrease in readmission rates (when compared to Medicare benchmarks in 2012, the year the company was founded). • One Medical, which acquired Iora Health in 2021, provides in-network primary care at 100+ offices nationwide, in addition to 42/7 virtual care. • Optum, which is part of UnitedHealth Group, report its plan to implement value-based arrangements for more than 500,000 new patients. The company also reported a 14% increase in revenue from 2020 to 2021.
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.	CareMore, a Medicare Advantage insurance plan originating in southern California, provides direct care for its frailest elderly patients and has developed an integrated patient care delivery system designed to surround patients with care.	• Early data from this system suggest better outcomes at lower costs: patients experience 42% fewer hospital admissions than the national average, an amputation rate among diabetic patients that is 60% lower than the national average, and a 4% pressure ulcer rate in institutionalized patients compared with a 13% rate for the entire state of California. • Per member per month spending is less than expected under a CMS model for similar risk patients. For patients in the intermediate risk category, the actual cost is $1000 versus an expected cost of $1500. For the high- risk group, the actual cost is $2250 versus an expected $3500.

Note: Evidence in this category is less reliable – pulled from industry publications that appear to include organization-reported outcome data

Driving Equity through Payment

Source 21

Source	Focus Area	Key Findings/ Lessons Learned
Michigan Department of Health & Human Services, *Medicaid Health Equity Project Year 8 Report (HEDIS 2018)*, January 2021	Medicaid Health Equity Project – 13 HEDIS measures reported by Medicaid Health Plans (MHPs) starting in 2011 and collected each year since – measures are reported by race/ethnicity	**CHCS Summary – Data from the 2021 report demonstrate:** • Strong improvements on disparities in cervical cancer screening, chlamydia screening, adolescent immunization, lead screening in children, diabetes eye exams, diabetes attention for nephropathy • Limited or lack of improvement on disparities for other 7 HEDIS measures included **Results to Date** • The data collection from 2012-2018 has shown the African American population consistently below (not necessarily significantly) the White reference population for ten measures: BCS, PPC, CIS, IMA, LSC, W34, CAP, AAP, CDC1 and CDC2. • In 2018, although all the thirteen measures exhibited racial/ethnic disparities, rates for African American Medicaid beneficiaries fell significantly below that of White beneficiaries for nine measures, an improvement compared to 2017 when ten measures were significantly below the White rates. In IMA, the significant disparity for the African American population in 2017 had become non-significant in 2018. Interventions include new payment methodologies in addition to changes in care delivery, including: • Performance improvement projects focused on reducing racial/ethnic health disparities in particular measures across MHPs • Contractual requirements for MHPs to develop a Health Equity Program with an annual work plan to narrow disparities • Contractual requirements for MHPs to implement a CHW program in collaboration with community-based organizations to reduce barriers to care and address member's needs

Driving Equity through Payment

Source 22

Source	Focus Area	Key Findings/ Lessons Learned
Anderson, Andrew, et al. "Promoting Health Equity and Eliminating Disparities Through Performance Measurement and Payment," Health Affairs, 37;3, 2018.	National Quality Forum road map to demonstrate how measurement and associated policies can contribute to eliminating disparities and promote health equity	**Findings:** • Pay-for- performance programs have mostly been designed for the general population, and systematic reviews indicate that these incentives have usually not improved disparities. • In addition, bundled payment and accountable care organizations have also not directly incorporated disparities reduction into incentives. **Recommendations – Nation Quality Forum:** 1. Identify and prioritize areas to reduce health disparities 2. Implement evidence-based interventions to reduce disparities 3. Invest in the development and use of health equity performance measures 4. Incentivize the reduction of health disparities and achievement of health equity A key recommendation of the road map presented in this article is to tie stratified performance measures to payment incentives and financial supports. Creation of a stronger business case for equity can encourage the leadership of health care organizations to prioritize equity and invest in the data infrastructure necessary for stratifying performance measures.

Driving Equity through Payment

Source 23

Source	Focus Area	Key Findings/ Lessons Learned
Anderson, Ryan, et al., "Quality of Care and Racial Disparities in Medicare Among Potential ACOs," Journal of General Internal Medicine, 29;9, May 2014.	Medicare ACO programs – study using 2009 Medicare claims for beneficiaries with cardiovascular disease or diabetes comparing racial differences in quality	**Key Findings** • Larger provider group size and better performance on quality measures were not consistently associated with smaller racial disparities in care for Medicare beneficiaries with cardiovascular disease or diabetes. • In this national study of Medicare beneficiaries with cardiovascular disease or diabetes, those served by provider groups sufficiently large to participate in ACO programs were more likely to be white and lived in more socioeconomically advantaged areas than beneficiaries served by smaller groups. • Our findings are consistent with concerns that quality improvements achieved by Medicare ACO programs may not be associated with substantial reductions in health disparities, and may even be associated with larger disparities nationally if these programs disproportionately engage physicians and hospitals serving fewer minority patients. **Lessons Learned** • ACO incentives rewarding better quality for minority groups and payment arrangements supporting ACO development in disadvantaged communities may be required for ACOs to promote greater equity in care.

Appendix 3: Focus Group Learnings

(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: VBP 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) Primary Data Collection: Focus Group Learnings

Collect qualitative feedback from members, providers, and other key stakeholders

Outreach to Participants
Broad-based outreach

Conduct Focus Groups
Facilitate discussion around a set of prompts

Categorize & Synthesize
Complete thematic analysis and summarize key learnings

See Appendix 3 for details

Primary Care Focus Groups: Approach

Qualitative feedback was collected through 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 with 5-10 participants per group 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 with 5-10 participants per group
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 with 5-10 participants per group

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

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

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)

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)

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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)

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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)