Primary Care Program Advisory Committee

Meeting 1

April 6, 2023

Agenda

Topic	Timing
Opening Remarks	10 Minutes
Context for Primary Care Program Design	20 Minutes
Stakeholder Process Overview and Upcoming Meetings	15 Minutes
Committee Member Introductions	30 Minutes
Questions/Comments	15 Minutes

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

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

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

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

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

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

Federal Priorities

CMS Strategic Priorities

A HEALTH SYSTEM THAT ACHIEVES EQUITABLE OUTCOMES THROUGH HIGH QUALITY, AFFORDABLE, PERSON-CENTERED CARE

- DRIVE ACCOUNTABLE CARE
- ADVANCE HEALTH EQUITY
- SUPPORT INNOVATION
- ADDRESS AFFORDABILITY
- PARTNER TO ACHIEVE SYSTEM TRANSFORMATION

### Innovation Center Strategic Objective 1: Drive Accountable Care

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

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

DRIVE ACCOUNTABLE CARE

Presidential COVID-19 Health Equity Task Force

Health Care Access and Quality
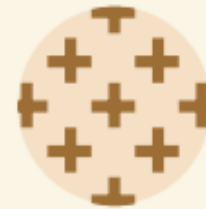
Everyone has equitable access to high-quality health care.

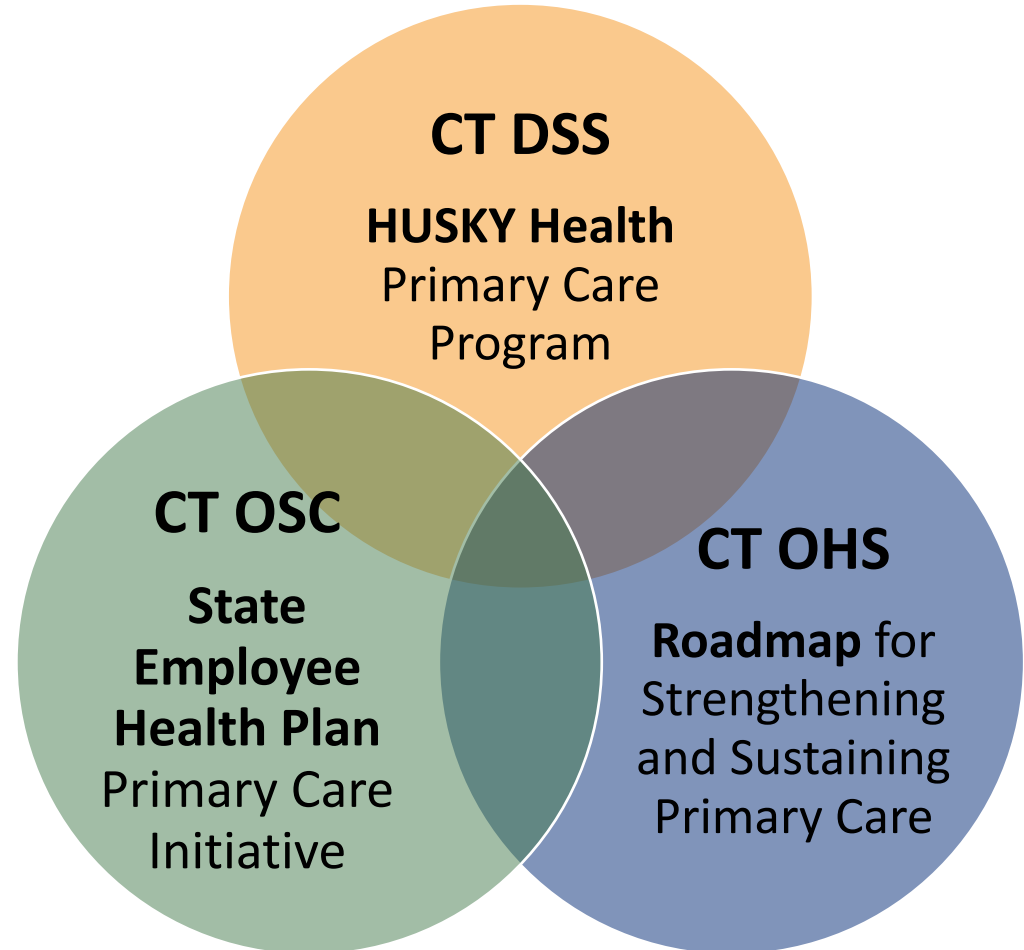**Improve health equity through measurement and incentives.**

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

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

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Connecticut's Coordinated Primary Care Reform Effort

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

DSS is aiming to develop a primary care program that:

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

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

CT DSS
HUSKY Health Primary Care Program

CT OSC
State Employee Health Plan Primary Care Initiative

CT OHS
Roadmap for Strengthening and Sustaining Primary Care

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.
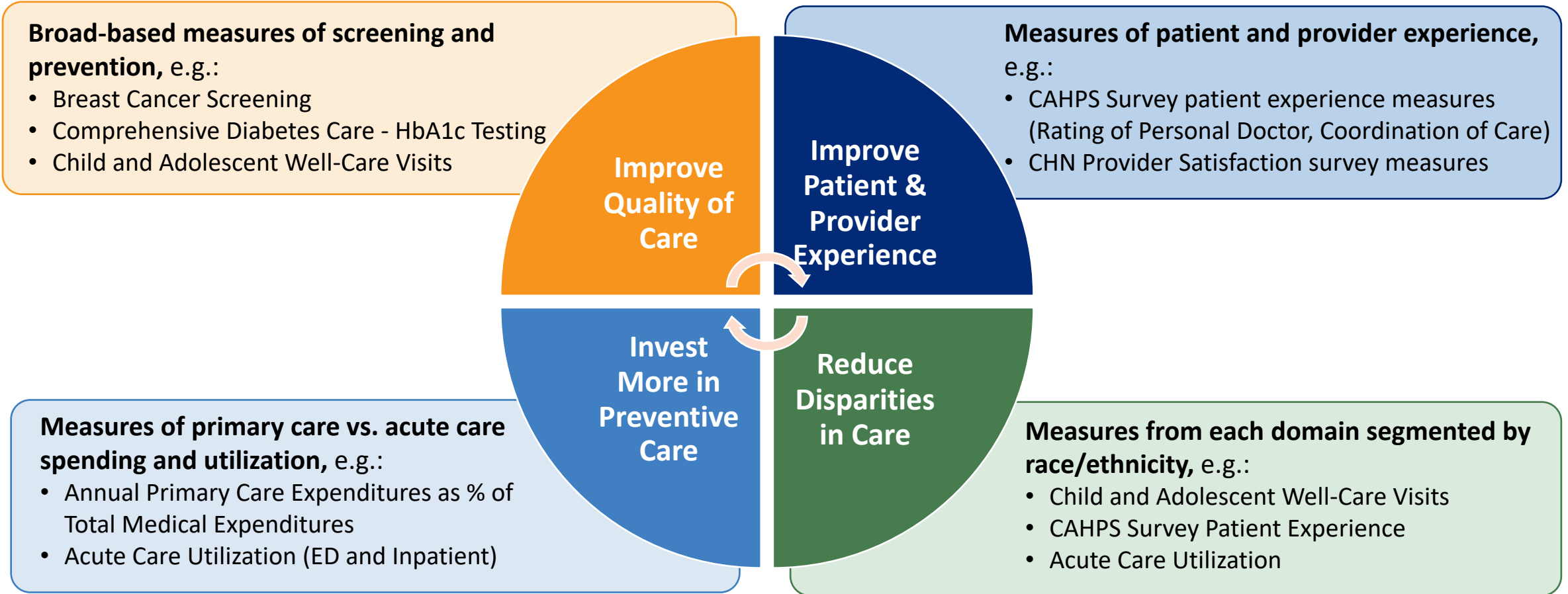
Strategies

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.

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Defining Success

Primary care program redesign should improve quality of care and patient/provider experience, reduce disparities in care, and result in more health care resources being expended on preventive care instead of acute care.

Example measures for each domain are shown; measure selections will be refined with stakeholders

Broad-based measures of screening and prevention, e.g.:
- Breast Cancer Screening
- Comprehensive Diabetes Care - HbA1c Testing
- Child and Adolescent Well-Care Visits

Measures of patient and provider experience, e.g.:
- CAHPS Survey patient experience measures (Rating of Personal Doctor, Coordination of Care)
- CHN Provider Satisfaction survey measures

Improve Quality of Care

Improve Patient & Provider Experience

Invest More in Preventive Care

Reduce Disparities in Care

Measures of primary care vs. acute care spending and utilization, e.g.:
- Annual Primary Care Expenditures as % of Total Medical Expenditures
- Acute Care Utilization (ED and Inpatient)

Measures from each domain segmented by race/ethnicity, e.g.:
- Child and Adolescent Well-Care Visits
- CAHPS Survey Patient Experience
- Acute Care Utilization

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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.
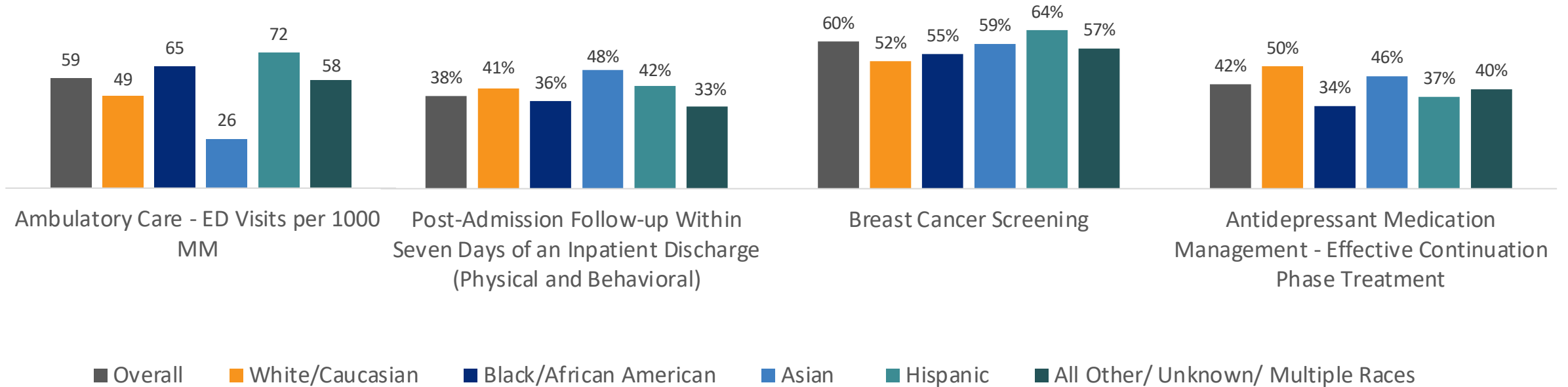
	Objective	2022
Phase 1 *Initial Evaluation*	• Review existing program documentation	**Mar**
	• Interview state team for background/ context	**Apr**
	• Complete preliminary program assessment	**May**
Phase 2 *Primary Data Collection*	• Conduct focus group interviews with members, providers, and other 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

Key Deliverables:
Preliminary Program Assessment

Focus Group Learnings

Primary Care Program Recommendations

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.

Work to Date: Opportunities for Improvement

Within the HUSKY Health program, there are disparities in quality of care and member outcomes by race/ethnicity.

HUSKY Health Program Health Equity Benchmark Measures, MY 2019

Legend:
- Overall
- White/Caucasian
- Black/African American
- Asian
- Hispanic
- All Other/ Unknown/ Multiple Races

Ambulatory Care - ED Visits per 1000 MM: 59, 49, 65, 26, 72, 58

Post-Admission Follow-up Within Seven Days of an Inpatient Discharge (Physical and Behavioral): 38%, 41%, 36%, 48%, 42%, 33%

Breast Cancer Screening: 60%, 52%, 55%, 59%, 64%, 57%

Antidepressant Medication Management - Effective Continuation Phase Treatment: 42%, 50%, 34%, 46%, 37%, 40%

| **ED Utilization** *(lower is better)* | **Access/ Availability of Care** *(higher is better)* | **Prevention and Screening** *(higher is better)* | **Behavioral Health** *(higher is better)* |

Source: 2021 HUSKY Health Program Health Equities Report, MY 2019

Work to Date: Opportunities for Improvement

In focus group discussions, members, providers, and advocates identified barriers that impact the equitable delivery of care and opportunities for improving the primary care system.

Opportunities to improve the primary care system and advance health and equity.

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

- Access to transportation
- Housing security
- Food security
- Translation supports
- Technology enabled care
- Behavioral health access
- Extended care hours
- Disability access
- Cultural competency
- Workforce diversity

(1) Identify and address health related social needs

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)

(2) Enhance care coordination through expanded care teams, inclusive of community and peer-based health workers

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)

(3) Ensure members have easy and timely access to care, including through technology enabled care options

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)

Work to Date: Primary Care Program Recommendations

The primary care program assessment established a set of program design recommendations and key program components responsive to identified goals and opportunities.

Primary Care Program Recommendations **Key Program Components**

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

Care Delivery Redesign

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

- Care Coordination
- Care Transformation Infrastructure
- SDOH Supports
- Practice Recognition
- Technical Assistance

Performance Measurement

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

- Quality Measurement
- Data Sharing

Payment

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

- Funding for Care Delivery Redesign
- Funding for Performance
- Aligned Incentives

Pursue multi-payer alignment on select design features

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Starting Point: Program Scope

DSS is aiming to develop a broad-based program that maximizes program impact and ensures program benefits are widely distributed.

|	Approach	Rationale
Providers	• **Design a program that enables broad-based provider participation** • Tailor program design to **ensure that FQHCs and small providers can participate**, utilizing tracks with different requirements as needed	• Broad-based provider participation **maximizes program impact and ensures program benefits are widely distributed**
Members	• **Include HUSKY members attributed to a PCP**, exclude dual Medicare-Medicaid eligible members initially • **Take a phased approach to tailoring** core program design for other special populations, e.g., pediatrics	• Phasing in customized design elements for special populations **allows DSS to focus first on the development of a core program model**, before tailoring the program to include more targeted measures and incentives (e.g., pediatric focused quality measures)

Next Steps: Program Design Timeline

Program design is being conducted towards a targeted program launch in July 2024.

	2023										2024					
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

Equity Framework
Develop and apply an equity framework throughout program design

Stakeholder Engagement
Ongoing stakeholder engagement with a diverse array of stakeholders to inform program design

Program Model and Quality Measurement Program Design
Program model development, technical design and specifications

Authority and Budget
State budget and regulatory authority; SPA development

Implementation Support
Technical implementation

New Primary Care Program Launch

Key Program Milestones (target date):

- **Program design complete** (Aug 2023)
- **Technical design complete** (Oct 2023)
- **State budget request submitted** (Sep 2023)
- **State plan amendment submitted** (Jan 2024)

Upcoming Meetings

Each meeting of the Primary Care Program Advisory Committee will focus on defining a component of the program.
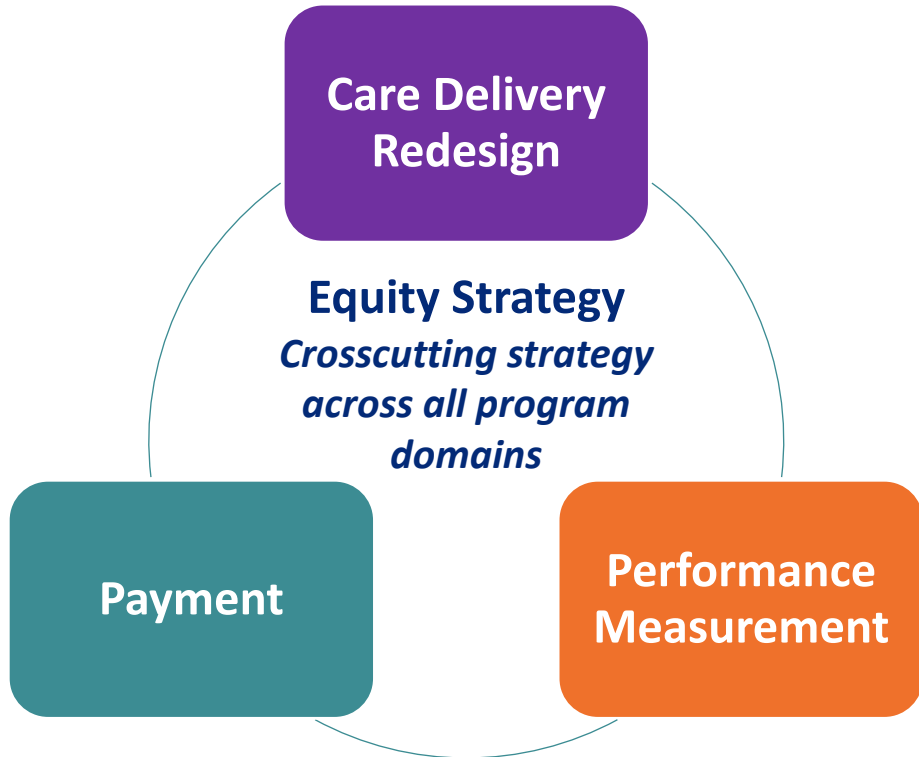
Upcoming Meetings

Month		Agenda Topic
April		Background & Introductions
May		Care Delivery Redesign Priorities
June		Primary Care Base Payment
July		Primary Care Performance Based Payment
August		Quality Measurement and Data Sharing
September		*Technical Design*: Primary Care Base Payment
October		*Technical Design*: Primary Care Performance Based Payment
November		Practice Recognition and Provider Technical Assistance
December		Equity Strategy Review*
January		*Technical Design*: Quality Measurement

(EQUITY STRATEGY spans May through January)

Care Delivery Redesign

Equity Strategy
Crosscutting strategy across all program domains

Payment

Performance Measurement

Note that equity considerations will be addressed throughout each meeting topic; the Equity Strategy Review is intended to provide an opportunity to assess the crosscutting equity strategy

Stakeholder Engagement Plan

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

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

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Committee Goals and Expectations

Committee Goals

- **Provide advisory support** to DSS throughout the different phases of primary care program design and development

- **Enable DSS to consider a diverse array of perspectives** in developing a program that aims to promote health equity and improve the biopsychosocial health and well-being of HUSKY Health members

Committee Member Expectations

We ask the following of committee members:

- **Please attend** monthly committee meetings

- **Engage critically** throughout the different phases of evaluation/development, devoting time to understand and digest conversations and information shared

- **Contribute your thoughts and perspectives** to help Connecticut develop a primary care program that promotes health equity and that is high quality for stakeholders throughout the state

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Committee Member Introductions

We would like to offer each committee member an opportunity to introduce themself and provide some context for their perspective, for example:

- Who do you represent?

- What are your priorities for this work?

Committee Member	Organization	Committee Member	Organization
Robyn Anderson	Ministers Health Fellowship Advocacy Coalition	**Yvette Highsmith Francis**	Community Health Center, Inc.
Ellen Andrews	CT Health Policy Project	**David Krol**	Connecticut Children's Care Network
James Cardon	Hartford Healthcare	**Nichelle Mullins**	Charter Oak Health Center, Inc. & Community Health Center Association of CT (CHCACT)
Stephanye Clarke	Health Improvement Collaborative of Southeastern Connecticut	**Doug Olson**	Optimus Health Care
Tiffany Donelson	Connecticut Health Foundation	**Joseph Quaranta**	Community Medical Group
Alice Forrester	Clifford Beers Community Health Partners	**Mark Schaefer**	Connecticut Hospital Association
Paul Grady	Alera Group	**Karen Siegel**	Health Equity Solutions
Angela Harris	Phillips Health Ministry	**Kelly Sinko**	CT Office of Health Strategy
		Polly Vanderwoude	Yale New Haven Health System
Josh Herbert	Stamford Health Medical Group	**Josh Wojcik**	Office of the State Comptroller

Questions? Comments?

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