Primary Care Program Advisory Committee

Meeting 5

August 3, 2023

Agenda

Topic	Timing
Opening Remarks and Welcome	10 Minutes
Goals for Today	10 Minutes
Topic 1: Primary Care Program Review and Discussion	35 Minutes
Topic 2: Data Review and Discussion	35 Minutes

New Committee Member Announcement

- Catherine John (Black and Brown United In Action)
- Carol Grabbe (Department of Developmental Services)
- Jossie Torres (Department of Developmental Services)

Meeting Schedule

	Primary Care Program Advisory Committee Meeting Topics
April	Background & Introductions
May	Primary Care Goals and Strategies
June	Scope of Primary Care Design and Prior Work
July	Listening Session: Strategies for Addressing Community Needs
August	Review of Primary Care Program Examples and Discussion of Supplementary Data
September	In Person Meeting: Key Primary Care Program Design Decisions

Goals for Today's Meeting

1. Be responsive to this Committee's request for additional data, and give Committee members an opportunity to discuss priority data topics

2. Discuss state and federal primary care programs that could inform DSS' primary care program design process, and support the transition to more targeted discussions about the role of primary care within a broader system of care that recognizes and addresses health-related social needs

Update on Public Act 23-171

DSS will work with the Office of Health Strategy, the Office of Policy and Management and other agencies and stakeholders to develop a strategy that improves health care outcomes, community health and health equity to support HUSKY Health members.

Excerpted from Public Act 23-171

- The strategy should both identify barriers and influences that impact health and health care outcomes for HUSKY Health members as well as recommending approaches for improvements, with the following goals:
  1. Improve health care access and outcomes;
  2. Increase adoption of interventions to support improved access to preventive care services;
  3. Identify and address social, economic and environmental drivers of health to advance long-term preventive health and health care outcomes;
  4. Explore innovative financing reforms that support high quality care, promote integration of primary, preventive and behavioral health care and address health-related social needs and long-term preventive outcomes;
  5. Improve collaboration and coordination among health care providers and cross-sector community partners;
  6. Improve Medicaid reimbursement and performance to achieve a sustainable health care delivery system and improve health care affordability for all.
- Not later than January 1, 2025, the Commissioner of Social Services shall submit recommendations for reform to MAPOC, including, but not limited to, recommendations for filing any state plan amendments or federal waivers with the federal Centers for Medicare and Medicaid Services.

See Section 17 (pgs. 39-41) of Public Act No. 23-171 for full text (https://www.cga.ct.gov/2023/ACT/PA/PDF/2023PA-00171-R00HB-06669-PA.PDF)

HRSN Listening Session: Key Themes

At the last meeting, we heard important feedback about opportunities for addressing members' health related social needs.

Key Themes

1. **Developing and Expanding SDOH/HRSN Initiatives**
2. **SDOH/HRSN Screening, Referral, and Outreach**
3. **Delivery System**
4. **Financing and Accountability**

The slides following provide an overview of key feedback within each of these themes.

HRSN Listening Session: Key Themes

Key Themes

Developing and Expanding SDOH/HRSN Initiatives

- **Encourage statewide, multi-agency partnerships:** Addressing SDOH requires cross-agency collaboration. DSS cannot and should not shoulder SDOH/HRSN work alone.
- **Integrate statewide resources:** Acknowledging that this is a work in progress, DSS should be cognizant of connecting HUSKY members to all Medicaid benefits (e.g., Veo – a free transportation benefit) and safety net programs/resources (e.g., SNAP, WIC, 211 line) that they are eligible for.
- **Expand pilot programs when successful:** It is important to both pilot SDOH/HRSN initiatives and pursue statewide coverage when initiatives are successful.

SDOH/HRSN Screening, Referral, and Outreach

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

HRSN Listening Session: Key Themes

Key Themes

Delivery System

- **Pursue community-based HRSN strategies:** SDOH/HRSN are broader structural and public health issues which require community-based strategies beyond the scope of primary care.
- **Consider utilizing regional hubs:** Regional entities can provide more flexibility than centralized delivery systems (e.g., they can offer better tailored community-informed interventions and support).
- **Encourage upstream prevention**: This work should apply a public health approach aimed at upstream prevention, in contrast to the medical system's downstream focus.

Financing and Accountability

- **Support existing community-based collaboratives**: To improve infrastructure and overall capacity, fund and build off existing CBOs and faith-based organizations that already operate programs aimed at streamlining HRSN referrals for high need members.
- **Promote a whole person financing and accountability model:** Create financing and accountability structures that enable participation of a broad range of actors in the community and healthcare system who are critical in addressing HRSN.

Topic 1: Primary Care Program Review and Discussion

Today, we will review a selection of existing primary care programs and discuss learnings that could inform DSS' primary care program design process.

We'll provide a brief overview of:

(1) Core elements of primary care programs launched at the state and federal level

(2) The role of primary care in addressing health-related social needs within these programs

We'll ask for your feedback on:

(1) Program elements or design features you're interested in exploring further as part of DSS' primary care program design process

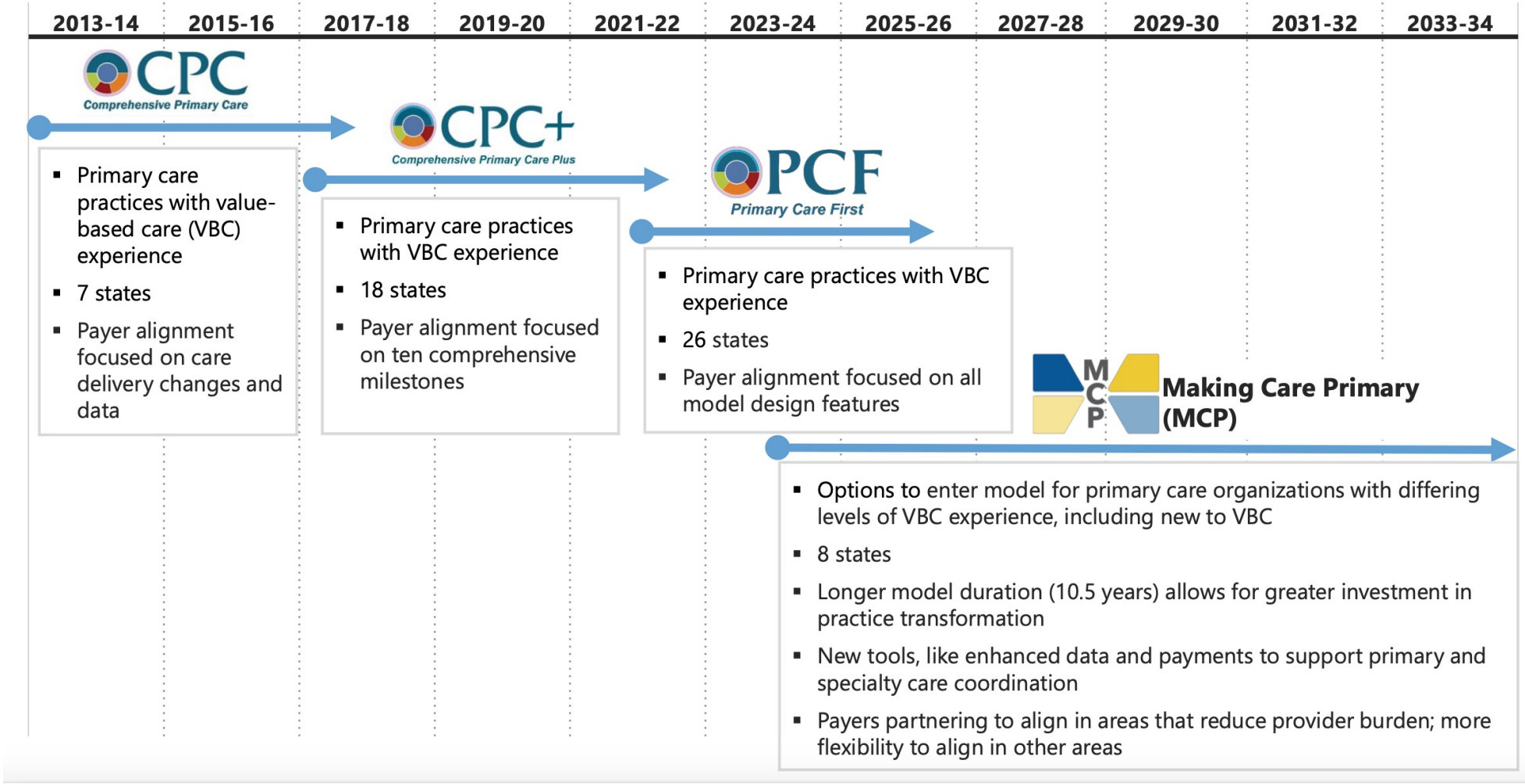
(2) The role primary care should play in a broader system of care that seeks to address health-related social needs as an important driver of biopsychosocial member health

CMS Innovation Center Primary Care Programs

The CMS Innovation Center (CMMI) has designed and launched a series of notable primary care programs nationally.

***CPC**, **CPC+**, and **PCF** were launched in sequence as voluntary, multi-payer advanced primary care model demonstrations in select states*

***MCP** was recently announced and will launch on July 1st, 2024, in eight states*



CMS Innovation Center Primary Care Programs

The CMMI primary care programs share common program elements.

SHARED PROGRAM ELEMENTS

Care Delivery Requirements	*To ensure that patients receive comprehensive primary care that is integrated, coordinated, person-centered and accountable*	• Implementing chronic and episodic **care management programs** • **Using data and team-based care** to proactively identify the needs of patients and efficiently manage their care • Identifying specialty, behavioral health, and health-related social needs and **assisting patients with navigating and coordinating resources** to meet those needs
Payment Model	*To enable practices to deliver comprehensive primary care*	• Additive **funding for care management** to support augmented staffing and historically nonbillable services • **Transition from fee-for-service to population-based payment** to provide greater flexibility in care delivery and allow practices to deliver an enhanced array of comprehensive services
Performance Measurement	*To monitor and hold providers accountable to improving quality of care and health outcomes of patients*	• Defined **quality measure slate** and scoring methodology • **Incentive payments or penalties** tied to quality, patient experience, utilization, and/or cost metrics • **Reporting requirements and data collection** to support monitoring and evaluation strategy

CMS Innovation Center Primary Care Programs

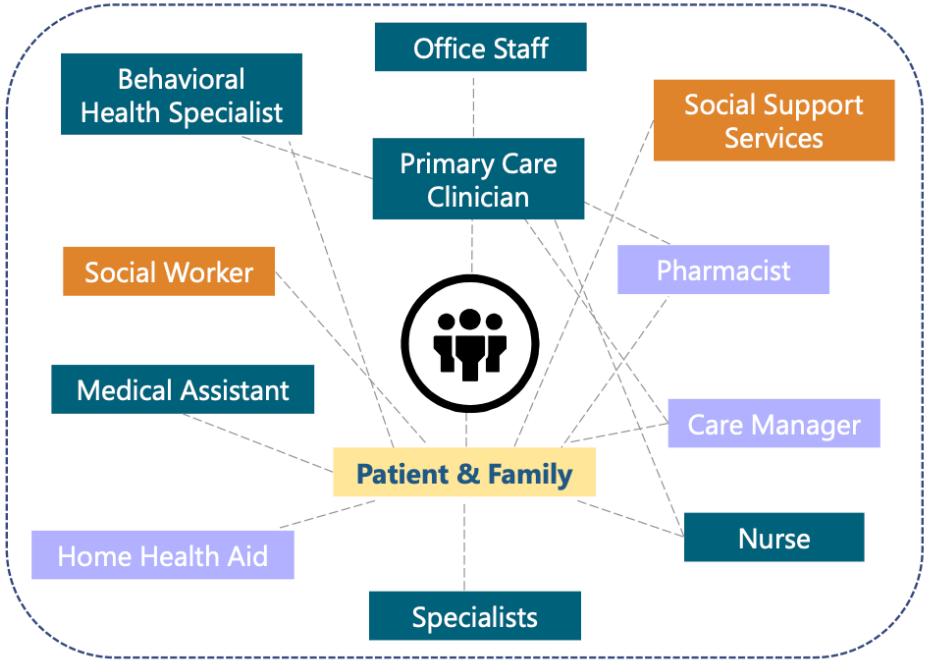
	CPC+	Primary Care First	Making Care Primary
Care Delivery Priorities	• Focus on five **Comprehensive Primary Care Functions:** Access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, planned care and population health • **Focus on practice infrastructure, "wrap-around" primary care services, flexibility** to support delivery of nonbillable services through the primary care payment	• Focus **on promoting flexibility in care delivery and reducing the need to bring patients into the office** (supports services by email, phone, patient portal, etc.)	• Focus on **care management**, especially for chronic conditions, **care integration** with specialty and behavioral health, and **community connection** to identify and address HRSNs and connect patients to community supports and services
Payment Model	• For Track 2, a transition from FFS to **hybrid primary care population-based payment, with FFS reduction** – upfront payment for % of expected payments for E&M services for attributed members; practice selected hybrid payment ratio • **Care management fee** (PMPM) – supports augmented staffing/training and historically nonbillable services	• A **flat visit fee** that compensates practices for in-person treatment; • A **primary care population-based payment,** practice risk group adjusted, including funding for care management services	• **Primary care population-based payment** to support a gradual progression from FFS payment to 50/50 hybrid FFS/population-based to full population-based payment • An **upfront infrastructure payment** to support smaller organizations in Track 1; • An **enhanced services payment** (PMPM) to reflect the attributed population's risk level • Two payment types to encourage **specialty care integration**
Performance Measurement	• **Pay for performance** (PMPM) - incentive tied to patient experience, clinical quality, and hospital/ED utilization	• **Performance-based adjustment (with downside):** up to 50% upside; 10% downside incentive tied to Acute Hospital Utilization or Total Per Capita Cost, with a quality gateway	• Upside-only **pay for performance** incentives for improvements in patient outcomes and quality metrics

CMS Innovation Center Primary Care Programs and HRSN

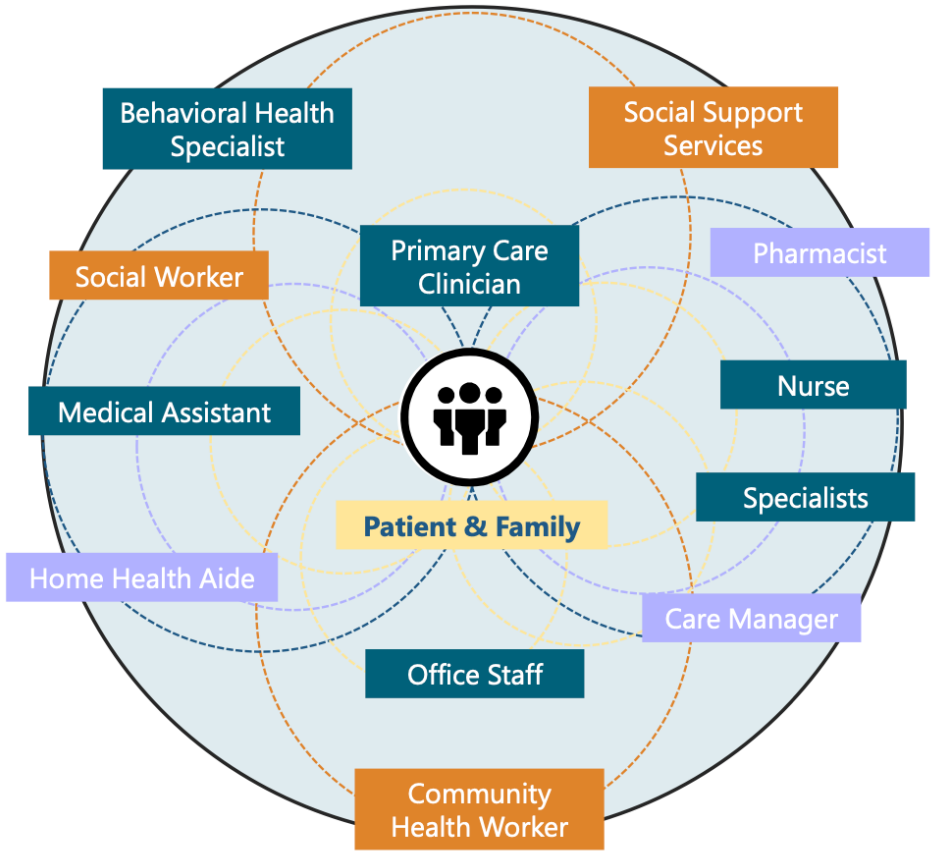
Making Care Primary aims to encourage care coordination and reduce patient challenges navigating their health care.

In this model, primary care is envisioned to play an important role in integrating a patient's system of care, inclusive of social support services.

Current State:
A Disjoined System



Desired Future State:
Integrated, High-Quality Primary Care



CMS Innovation Center Primary Care Programs and HRSN

The CMMI primary care programs envision a role for primary care in screening for health-related social needs and connecting patients to community supports and services.

		CPC+	PCF	MCP
HRSN Care Delivery Requirements	Screen for HRSN	✓	✓	✓
	Maintain an inventory of services and supports in the community	✓	✓	
	Develop and implement referral workflows			✓
	Partner with social service providers	✓		✓
	Utilize CHW or equivalent professional with shared lived experience to deliver services to higher need patients			✓

CMS Innovation Center Primary Care Programs and HRSN

HRSN related care delivery expectations are supported by the program's payment model and performance measurement standards.

		CPC+	PCF	MCP
HRSN Payment Model	Additive funding for care management to support augmented staffing and historically nonbillable services	✓	✓	✓
	Population-based payment structure to provide greater flexibility in care delivery	✓	✓	✓
HRSN Performance Measurement	HRSN screening performance incentive measure			✓
	HRSN data collection to evaluate health disparities			✓

Medicaid Primary Care Programs and HRSN: MassHealth Example

Some state Medicaid programs have taken a similar approach to defining the role of primary care in addressing HRSN.

	MassHealth Primary Care Accountable Care Organization HRSN Strategy
HRSN Care Delivery Requirements	**Screen:** Conduct a universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool
	Refer: Provide a regularly-updated inventory of relevant community-based resources to those with positive HRSN screens
	Coordinate: Participate in formalized practice-driven and/or ACO-driven care coordination that includes connection to community-based services, state agencies, federal programs (e.g., SNAP or WIC), and/or other supports
	Integrate Team-Based Staff: At least 1 CHW, Peer, Social Worker, or Nurse Care Manager dedicated to the primary care site (to qualify for Tier 2 or 3 payment)
HRSN Payment Model	**Tiered add-on payment:** Additive funding to support new care delivery requirements
	Primary Care Sub-Capitation Payment: Per member per month payments for primary care services are structured to increase flexibility for providers and enable the integration of team-based staff
HRSN Performance Measurement	**HRSN Screening Measure:** Included in the ACO Quality Performance Score
	Health Equity Score: ACO Health Equity Incentive payments can be earned based on collection of member-level social risk factor data, reporting on quality measures stratified by social risk factors, and reduction of identified disparities in performance

Medicaid Primary Care Programs and HRSN: Additional Examples

State Medicaid primary care programs have adopted a variety of other design elements as part of their HRSN strategies.

	Other Notable Features of Medicaid Primary Care Program HRSN Strategies	
HRSN Care Delivery Requirements	Statewide Referral Systems	• **Arizona:** CommunityCares statewide closed-loop referral system integrated with existing EHRs, patient portals, and care management systems • **North Carolina, Rhode Island:** statewide referral systems that can be leveraged to connect members with identified needs to community resources
	Standardized HRSN Screening Tools	• **North Carolina:** standardized screening tool focused on four priority domains; MCOs can add supplemental questions
	Approval of HRSN Screening Tools	• **Massachusetts, New York:** HRSN screening tool can be selected, with approval by the state
	CBO Partnership Requirements	• **Rhode Island:** Medicaid Accountable Entities required to establish partnerships with CBOs as part of infrastructure building
HRSN Payment Model	Infrastructure Funding for CBO Partners	• **Rhode Island:** Medicaid Accountable Entities required to allocate 10% of infrastructure funding to CBO partners as part of infrastructure building
HRSN Performance Measurement	HRSN Screening Performance Measures	• **Massachusetts, Rhode Island:** Pay-for-performance measure associated with HRSN screening; tied to ACO shared savings/loss calculations

Discussion

Having heard about these primary care programs and their approaches to addressing health-related social needs:

(1) Are there program elements or design features you're interested in exploring further as part of DSS' primary care program design process?

(2) Do you see primary care playing a similar or different role in addressing health-related social needs in CT?

Topic 2: Data Review and Discussion

Today, we will review a selection of data topics prioritized by Committee members for review.

Data Request	Data Available?	Where to Find	Priority Order (from pre-meeting poll)
Utilization and Cost by Population	Yes	**(5) Utilization, Cost, and Prevalence** (PDF)	1
Measures of Access: By Different Geographical Areas in the State	Yes	**(4) Measures of Primary Care Access** (PDF)	2
Unattributed Member Data	Yes	**(2) Data Compendium** (Excel)	3
Member Experience Metrics	Yes	**(3) Member Experience Metrics** (PDF)	4
Pediatric Data: Quality and Outcomes	Yes	**(2) Data Compendium** (Excel)	5
Prevalence of Chronic Conditions	Yes	**(5) Utilization, Cost, and Prevalence** (PDF)	5
Pediatric Data: Cost and Utilization	Yes	**(2) Data Compendium** (Excel)	6
Measures of Access: By Practice Setting	Yes	**(4) Measures of Primary Care Access** (PDF)	6
Prevalence of Health-Related Social Needs (HSRN)	Yes	**(1) PCPAC Meeting 4 Deck**	*Reviewed last meeting*
Measures of Access: By Subpopulations (DD, noncitizens)	No		
Measures of Access: By Member Preferences for Providers	No		

Today, we'll review topics 1 & 3 with a focus on the unattributed, and topics 2 & 4 with a focus on access.

An optional supplementary meeting has also been scheduled on **August 24th from 1 - 2pm** to review data related questions or comments that we are unable to review today.

Unattributed Member Data

2022 Member Months	Unattributed	% of Total	Attributed	% of Total
Asian Non-Hispanic	135,924	2.7%	250,112	3.2%
Black/African American Non-Hispanic	724,019	14.4%	1,131,400	14.3%
Hispanic	851,555	16.9%	1,761,819	22.3%
Multiple Races Non-Hispanic	73,726	1.5%	145,056	1.8%
Native American/Pacific Islander Non-Hispanic	18,907	0.4%	28,508	0.4%
Unknown Non-Hispanic	1,716,433	34.1%	2,277,355	28.9%
White/Caucasian Non-Hispanic	1,516,093	30.1%	2,293,769	29.1%
Total Population	**5,036,657**	**100.0%**	**7,888,019**	**100.0%**
Adult	3,881,562	77.1%	4,100,825	52.0%
Child	1,155,095	22.9%	3,787,182	48.0%
Total Population	**5,036,657**	**100.0%**	**7,888,007**	**100.0%**
Female	2,469,146	49.0%	4,391,997	55.7%
Male	2,567,511	51.0%	3,496,022	44.3%
Total Population	**5,036,657**	**100.0%**	**7,888,019**	**100.0%**

Key Takeaways:

Race/Ethnicity

- A higher proportion of unattributed members are in the Unknown category
- Hispanic members are more likely to be attributed to a provider

Age

- Children are more likely to be attributed compared to adults

Sex

- Females are more likely to be attributed compared to males

Utilization and Cost by Population

Key Takeaways:

- Attributed members are utilizing more preventive services – the attributed population has a utilization rate that is approximately 4x greater for FQHC Services, 2.5x greater for Physician Services, and 2x greater for Clinic Services
- HUSKY C and D members are more often unattributed compared to HUSKY A and B members – differences in the cost and utilization profile of the unattributed reflect this (e.g., higher utilization and cost for Hospice and Medicare Crossover claims for dual eligible members)

	Unattributed Members 2022, Pd thru May 2023					Attributed Members 2022, Pd thru May 2023					Variance (Attributed over Unattributed) 2022, Pd thru May 2023					
COE Description	**Util**	**Util/1000**	**Paid**	**UnitCost**	**PMPM**	**Util**	**Util/1000**	**Paid**	**UnitCost**	**PMPM**	**Util/1000**	**%**	**Unit Cost**	**%**	**PMPM**	**%**
Totals	**7,079,956**	**16,868.2**	**2,972,490,715**	**419.85**	**590.17**	**27,488,283**	**41,817.8**	**6,561,754,654**	**238.71**	**831.86**	24,949.5	147.9	-181.13	-43.1	241.69	41.0
All Other	1,753,120	4,176.9	1,639,285,668	935.07	325.47	4,866,365	7,403.2	1,915,416,208	393.60	242.83	3,226.3	77.2	-541.46	-57.9	-82.64	-25.4
Clinic Services	449,482	1,070.9	47,519,854	105.72	9.43	1,273,875	1,937.9	147,735,989	115.97	18.73	867.0	81.0	10.25	9.7	9.29	98.5
Dental	186,755	444.9	32,952,767	176.45	6.54	743,560	1,131.2	129,867,310	174.66	16.46	686.2	154.2	-1.79	-1.0	9.92	151.6
Durable Medical Equipment	59,673	142.2	14,950,066	250.53	2.97	349,901	532.3	64,762,436	185.09	8.21	390.1	274.4	-65.45	-26.1	5.24	176.6
FQHC – Dental	18,723	44.6	2,838,344	151.60	0.56	92,982	141.5	14,288,623	153.67	1.81	96.8	217.1	2.07	1.4	1.25	221.4
FQHC – Medical	118,993	283.5	19,425,035	163.25	3.86	739,206	1,124.6	121,076,358	163.79	15.35	841.0	296.7	0.55	0.3	11.49	298.0
FQHC – Mental Health	72,131	171.9	13,443,468	186.38	2.67	508,514	773.6	96,351,377	189.48	12.21	601.7	350.1	3.10	1.7	9.55	357.6
Home Health Services	87,143	207.6	82,981,277	952.24	16.48	324,755	494.0	154,068,727	474.42	19.53	286.4	138.0	-477.83	-50.2	3.06	18.6
Hospice	652	1.6	2,902,094	4,451.06	0.58	916	1.4	3,508,623	3,830.37	0.44	-0.2	-10.3	-620.69	-13.9	-0.13	-22.8
Hospital Inpatient	41,123	98.0	430,513,678	10,468.93	85.48	53,726	81.7	766,442,028	14,265.76	97.17	-16.2	-16.6	3,796.83	36.3	11.69	13.7
Hospital Outpatient – All Other	247,796	590.4	104,447,904	421.51	20.74	1,152,133	1,752.7	541,857,920	470.31	68.69	1,162.4	196.9	48.80	11.6	47.96	231.3
Hospital Outpatient – Emergency Room	140,466	334.7	91,121,992	648.71	18.09	442,928	673.8	274,340,092	619.38	34.78	339.2	101.3	-29.33	-4.5	16.69	92.2
Independent Lab	271,758	647.5	15,431,503	56.78	3.06	932,993	1,419.4	44,581,450	47.78	5.65	771.9	119.2	-9.00	-15.9	2.59	84.5
Independent Radiology	3,720	8.9	229,773	61.77	0.05	7,883	12.0	1,269,903	161.09	0.16	3.1	35.3	99.33	160.8	0.12	252.9
Medicare Crossover	372,970	888.6	46,315,555	124.18	9.20	579,972	882.3	65,722,220	113.32	8.33	-6.3	-0.7	-10.86	-8.7	-0.86	-9.4
Other Practitioner	470,293	1,120.5	44,785,996	95.23	8.89	1,795,071	2,730.8	180,054,527	100.30	22.83	1,610.3	143.7	5.07	5.3	13.93	156.7
Pharmacy	1,608,284	3,831.8	261,871,646	162.83	51.99	9,063,021	13,787.5	1,596,199,069	176.12	202.36	9,955.7	259.8	13.30	8.2	150.36	289.2
Physician Services – All	1,104,196	2,630.8	114,170,799	103.40	22.67	4,286,543	6,521.1	416,073,223	97.06	52.75	3,890.3	147.9	-6.33	-6.1	30.08	132.7
Vision	72,678	173.2	7,303,295	100.49	1.45	273,939	416.7	28,138,571	102.72	3.57	243.6	140.7	2.23	2.2	2.12	146.0

Measures of Access: Primary Care Network Adequacy

Key Takeaways:

- 100% of HUSKY members are within 15 miles of a HUSKY Health PCP or Pediatrician

Methodology Notes:

- GeoAccess reports assess the distance to any HUSKY Health provider, regardless of the provider's panel status (open or closed)

EX E Gap and Network Adequacy Analysis # 10 - Draft — July 28, 2023

HUSKY GEO ACCESS by LOB	HUSKY A 1:15	HUSKY A 1:20	HUSKY A 1:25	HUSKY B 1:15	HUSKY B 1:20	HUSKY B 1:25	HUSKY C 1:15	HUSKY C 1:20	HUSKY C 1:25	HUSKY D 1:15	HUSKY D 1:20	HUSKY D 1:25
PCPs (Adult)	100%						100%			100%		
Pediatricians (Child)	100%			100%			100%			100%		

Measures of Access: Primary Care Network Adequacy

Key Takeaways:

- Currently, 7% of HUSKY members are within 15 miles of a HUSKY Health PCP or Pediatrician with a closed or limited panel

Methodology Notes:

- This table considers provider panel status (open vs. closed or limited)
- This data has been updated; the most recent data is shown below (as of July 28th)

EX E Gap and Network Adequacy Analysis # 10 - Draft — July 28, 2023

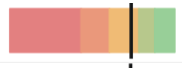
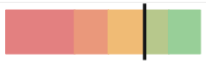
Program Name	Total Membership	Number of attributed and unattributed members included with access to a PCP/Pedi with an open panel	Number of attributed members excluded with access to a PCP/Pedi with a closed or limited panel	Percentage of membership included with access to a PCP/Pedi with an open panel	Percentage of membership excluded with access to a PCP/Pedi with a closed panel
HUSKY A	561,944	513,228	48,716	91.33%	8.67%
HUSKY B	12,786	10,775	2,011	84.27%	15.73%
HUSKY C	77,044	71,606	5,438	92.94%	7.06%
HUSKY D	370,065	350,907	19,158	94.82%	5.18%

Member Experience Measures Related to Access: Summary

Key Takeaways:

- CAHPS measures provide important insight into the member experience of accessing care

Note that these measures are not PCP-specific

MEASURE	SUMMARY RATE 2021	SUMMARY RATE 2022	CHANGE	National Vendor Client Sample PERCENTILE DISTRIBUTION (0 20 40 60 80 100)	PERCENTILE RANK	BoB SRS
2022 Medicaid Adult – HUSKY A/C/D *(277 completed surveys; 16.0% response rate)*						
Getting Needed Care *% Usually or Always*	82.1%	83.3%	1.2		52nd	82.3%
Getting Care Quickly *% Usually or Always*	82.5%	83.2%	0.7		66th	80.9%
2022 Medicaid Child – HUSKY A/C/D *(379 completed surveys; 17.8% response rate)*						
Getting Needed Care *% Usually or Always*	84.0%	82.5%	-1.5		37th	84.4%
Getting Care Quickly *% Usually or Always*	89.9%	84.3%	-5.6		30th	86.7%
2022 Medicaid Child – HUSKY B *(347 completed surveys; 16.5% response rate)*						
Getting Needed Care *% Usually or Always*	86.7%	80.4%	-6.3		24th	84.4%
Getting Care Quickly *% Usually or Always*	91.1%	86.3%	-4.8		44th	86.7%

Member Experience Measures Related to Access

Sample Size Details

2022 Medicaid Adult – HUSKY A/C/D *(277 completed surveys; 16.0% response rate)*

	2022 Valid n	2020	2021	2022	2022 SPH BoB	2021 QC
Getting Needed Care *(% Usually or Always)*	**167**	**83.3%**	**82.1%**	**83.3%**	**82.3%**	**83.6%**
Q9. Getting care, tests, or treatment	193	85.6%	85.8%	85.0%	85.0%	85.5%
Q20. Getting specialist appointment	141	81.1%	78.3%	81.6%	79.6%	81.8%
Getting Care Quickly *(% Usually or Always)*	**131**	**85.5%**	**82.5%**	**83.2%**	**80.9%**	**81.8%**
Q4. Getting urgent care	86^	89.0%	85.1%	88.4%	81.7%	83.1%
Q6. Getting routine care	177	82.0%	80.0%	78.0%	80.0%	79.9%

2022 Medicaid Child – HUSKY A/C/D *(379 completed surveys; 17.8% response rate)*

	2022 Valid n	2020	2021	2022	2022 GP SPH BoB	2021 GP QC
Getting Needed Care *(% Usually or Always)*	**171**	**86.5%**	**84.0%**	**82.5%**	**84.4%**	**85.7%**
Q10. Getting care, tests, or treatment	248	92.3%	89.3%	89.1%	89.2%	90.3%
Q41. Getting specialist appointment	95^	80.6%	78.7%	75.8%	79.5%	81.9%
Getting Care Quickly *(% Usually or Always)*	**166**	**88.6%**	**89.9%**	**84.3%**	**86.7%**	**86.9%**
Q4. Getting urgent care	78^	88.9%	94.8%	87.2%	90.5%	91.0%
Q6. Getting routine care	254	88.3%	85.0%	81.5% ↕	82.9%	83.0%

2022 Medicaid Child – HUSKY B *(347 completed surveys; 16.5% response rate)*

	2022 Valid n	2020	2021	2022	2022 GP SPH BoB	2021 GP QC
Getting Needed Care *(% Usually or Always)*	**152**	**89.6%**	**86.7%**	**80.4%** ↕	**84.4%**	**85.7%** ▼
Q10. Getting care, tests, or treatment	225	94.2%	94.4%	85.8% ↓↕	89.2%	90.3%
Q41. Getting specialist appointment	80^	84.9%	79.0%	75.0%	79.5%	81.9%
Getting Care Quickly *(% Usually or Always)*	**145**	**91.0%**	**91.1%**	**86.3%**	**86.7%**	**86.9%**
Q4. Getting urgent care	80^	91.7%	97.0%	92.5%	90.5%	91.0%
Q6. Getting routine care	211	90.3%	85.3%	80.1% ↕	82.9%	83.0%

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (↕/↕) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

Reading this Report: Detailed Measure Reporting

Drilling Down Into Composites And Ratings This section is designed to give your plan a detailed report on the performance of each Star Rating measure as well as a few other key metrics. The measure analysis section contains:

Rating & Composite level information including…
- Percentile ranking and benchmark performance
- Historic scores
- Market performance

Attribute level information for composites including...
- Gate questions
- Percentile ranking and benchmark performance
- Summary rate score trending

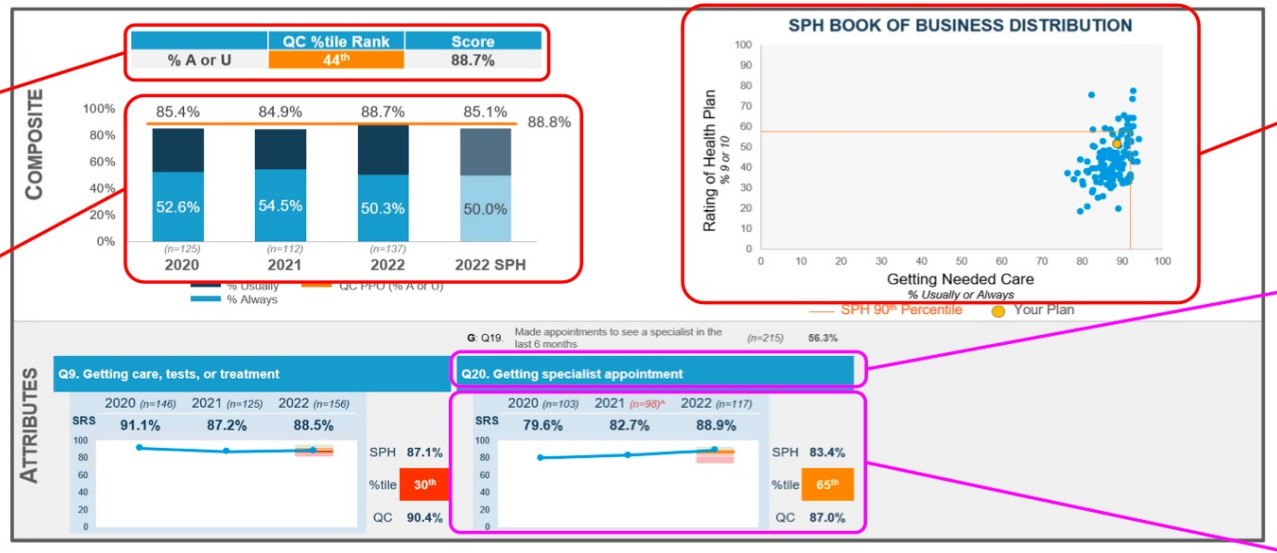
All scores displayed in this section are summary rate scores (notated with 'SRS').

More info.

Percentile Bands
≥90th
67th – 89th
33rd – 66th
10th – 32nd
<10th

Your plan's performance ranking along with **Summary Rate Score** are displayed at the top for quick reference.

Your plan's current year **Summary Rate Score** and base size along with previous two years, SPH BoB and Quality Compass national data are displayed.



Your plan's **Summary Rate Score** is plotted against the SPH Book of Business to provide a visual representation of market performance. The orange line represents the SPH 90th percentile.

Gate questions (indicated by "**G:**") for attributes are displayed above attributes – scores displayed are % Yes

For composites – all corresponding attributes that roll-up into the composite score are displayed:
- Historic bases and **Summary Rate Scores** along with significant changes in trend notated
- Benchmark comparisons along with significant differences notated
- Percentile ranking against **Quality Compass**
- Graphic representation of trend and 2021 **Quality Compass** percentile bands

Member Experience Measures Related to Access

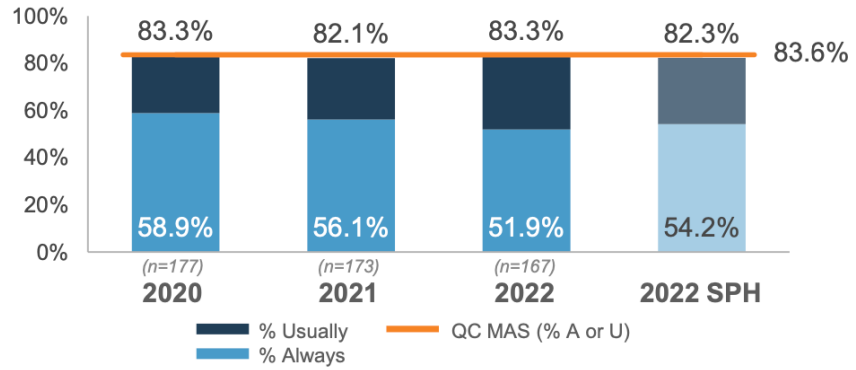
HUSKY Health program (A/C/D)

GETTING NEEDED CARE

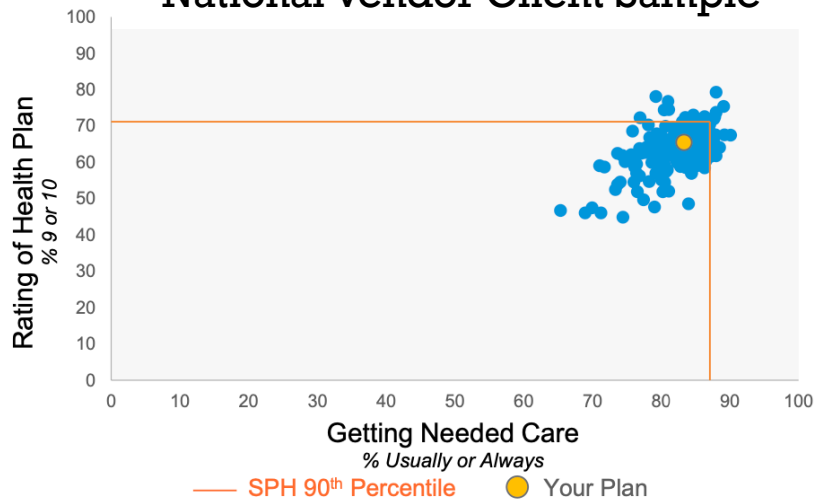
MEDICAID ADULT

	QC %tile Rank	Score
% A or U	40th	83.3%

COMPOSITE



National Vendor Client Sample

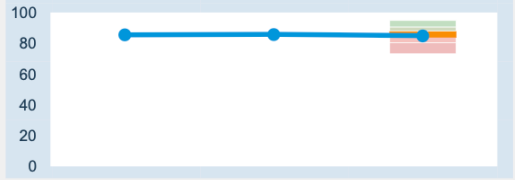


ATTRIBUTES

G: Q19. Made appointments to see a specialist in the last 6 months (n=274) 52.2%

Q9. Getting care, tests, or treatment

	2020 (n=222)	2021 (n=204)	2022 (n=193)
SRS	85.6%	85.8%	85.0%



SPH 85.0%
%tile 43rd
QC 85.5%

Q20. Getting specialist appointment

	2020 (n=132)	2021 (n=143)	2022 (n=141)
SRS	81.1%	78.3%	81.6%

SPH 79.6%
%tile 37th
QC 81.8%

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

Member Experience Measures Related to Access

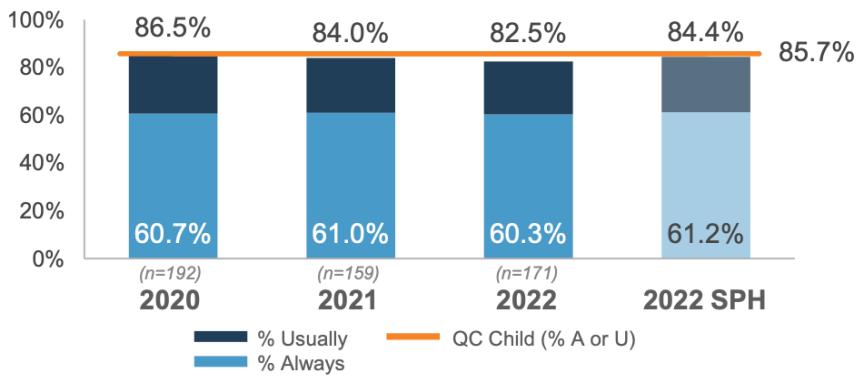
HUSKY Health program (A/C/D)

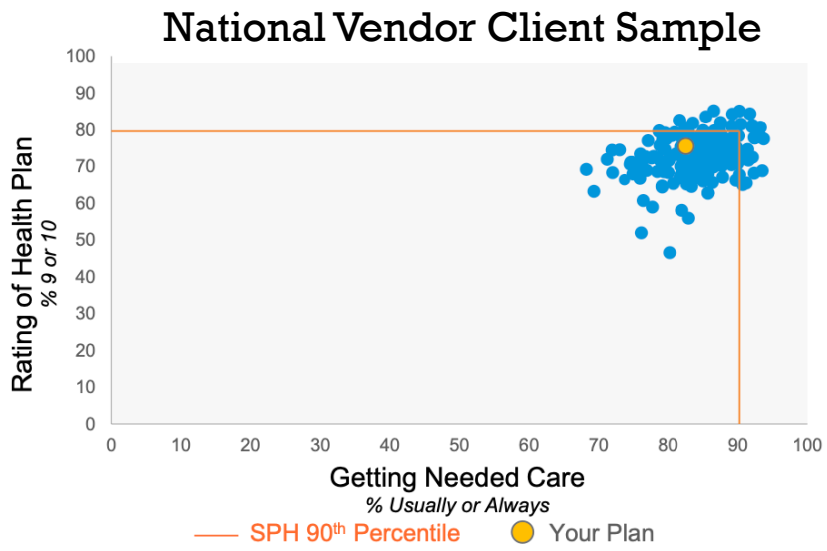
GETTING NEEDED CARE

MEDICAID CHILD: GENERAL POPULATION

	QC %tile Rank	Score
% A or U	23rd	82.5%

COMPOSITE





ATTRIBUTES

G: Q40. Made appointments to see a specialist in the last 6 months (n=377) 25.2%

Q10. Getting care, tests, or treatment

	2020 (n=286)	2021 (n=224)	2022 (n=248)
SRS	92.3%	89.3%	89.1%

SPH 89.2% | %tile 36th | QC 90.3%

Q41. Getting specialist appointment

	2020 (n=98)^	2021 (n=94)^	2022 (n=95)^
SRS	80.6%	78.7%	75.8%

SPH 79.5% | %tile 11th | QC 81.9%

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

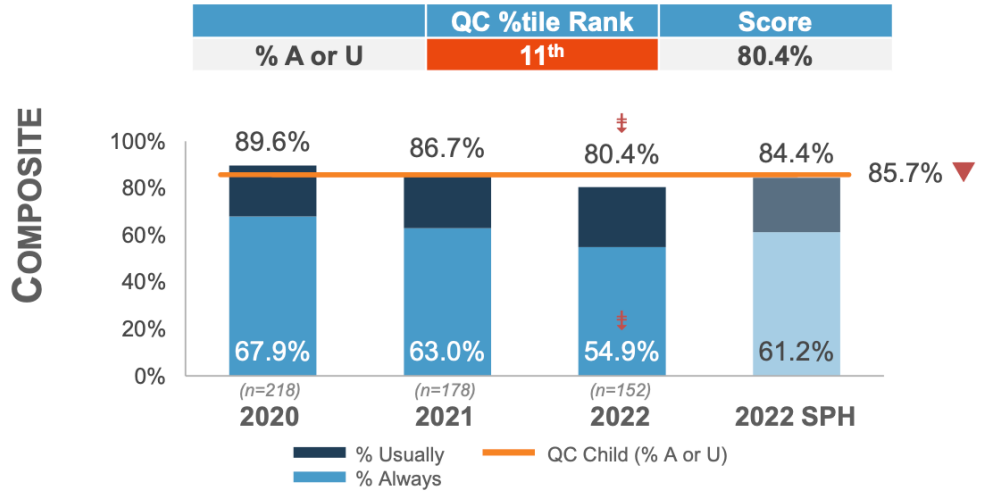
^Denominator less than 100. NCQA will assign an NA to this measure.

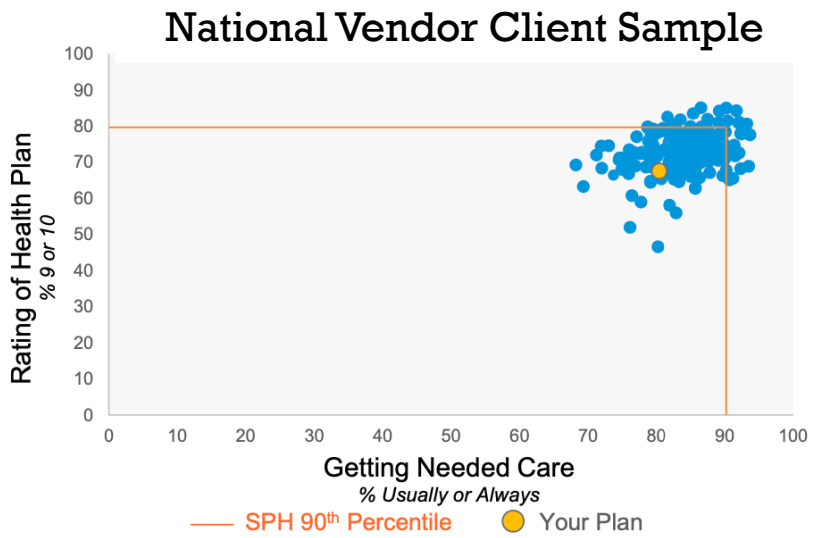
Member Experience Measures Related to Access

HUSKY Health program (HUSKY B)

GETTING NEEDED CARE

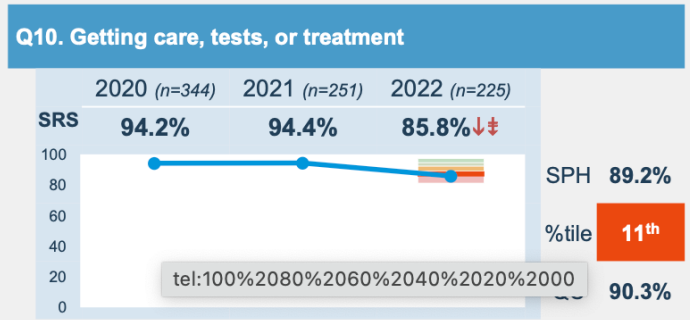
MEDICAID CHILD: GENERAL POPULATION





ATTRIBUTES

G: Q40. Made appointments to see a specialist in the last 6 months (n=346) 23.1%



Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

Member Experience Measures Related to Access

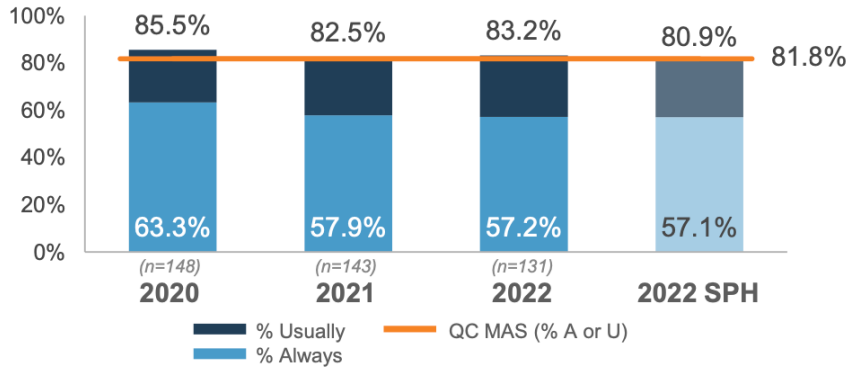
HUSKY Health program (A/C/D)

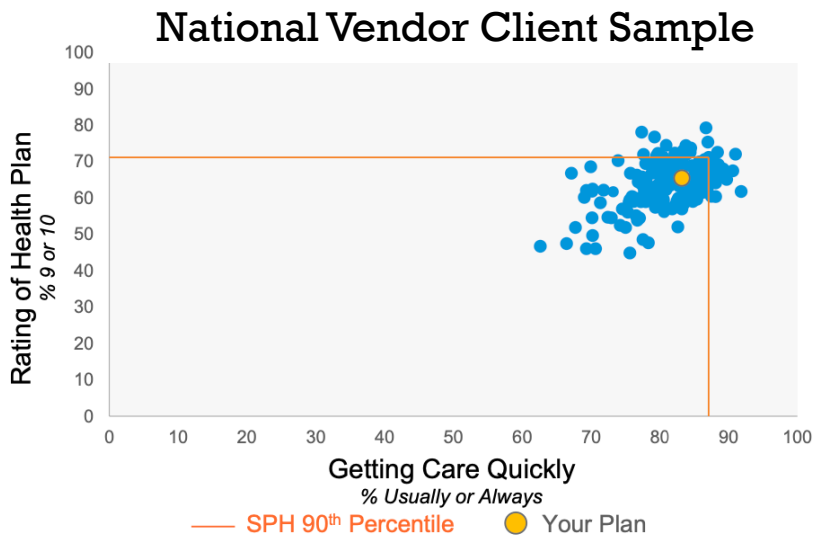
GETTING CARE QUICKLY

MEDICAID ADULT

	QC %tile Rank	Score
% A or U	59th	83.2%

COMPOSITE





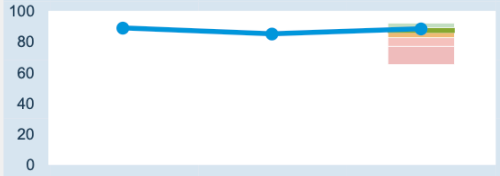
ATTRIBUTES

G: Q3. Had illness, injury or condition that needed care right away (n=270) 34.1%

G: Q5. Made appointments for check-ups or routine care at doctor's office or clinic (n=273) 68.1%

Q4. Getting urgent care

	2020 (n=91)^	2021 (n=87)^	2022 (n=86)^
SRS	89.0%	85.1%	88.4%



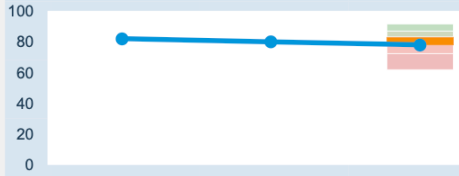
SPH 81.7%

%tile 86th

QC 83.1%

Q6. Getting routine care

	2020 (n=205)	2021 (n=200)	2022 (n=177)
SRS	82.0%	80.0%	78.0%



SPH 80.0%

%tile 34th

QC 79.9%

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

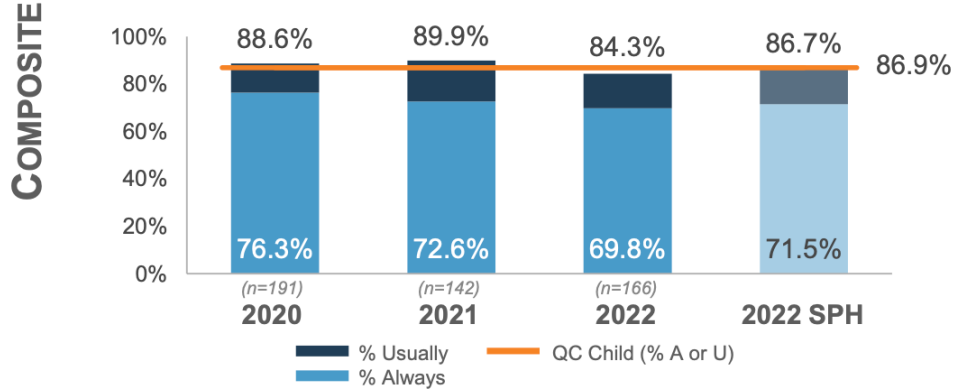
Member Experience Measures Related to Access

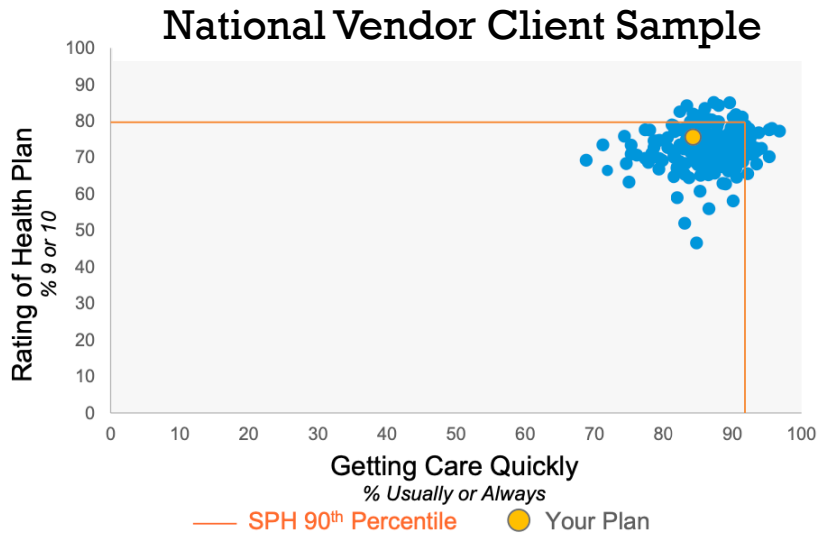
HUSKY Health program (A/C/D)

GETTING CARE QUICKLY

MEDICAID CHILD: GENERAL POPULATION

	QC %tile Rank	Score
% A or U	25th	84.3%



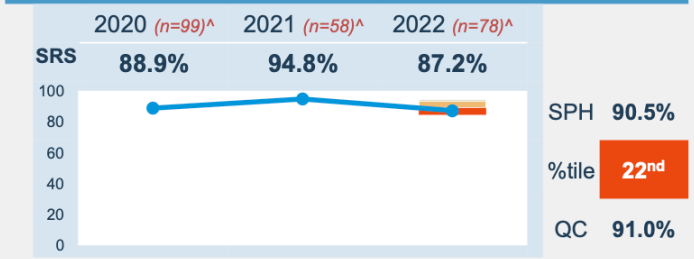


ATTRIBUTES

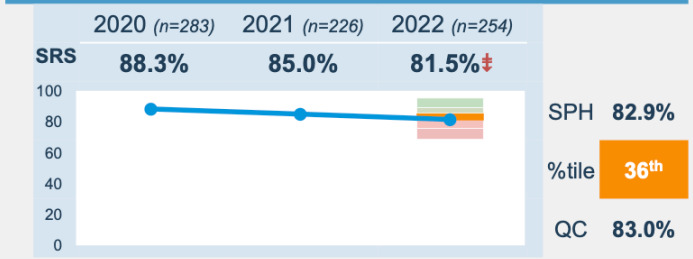
G: Q3. Had illness, injury or condition that needed care right away *(n=374)* **21.4%**

G: Q5. Made appointments for check-ups or routine care at doctor's office or clinic *(n=374)* **70.1%**

Q4. Getting urgent care



Q6. Getting routine care



Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

Member Experience Measures Related to Access

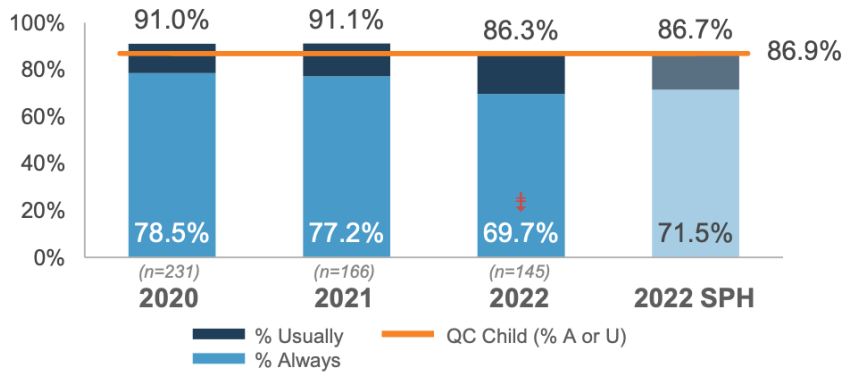
HUSKY Health program (HUSKY B)

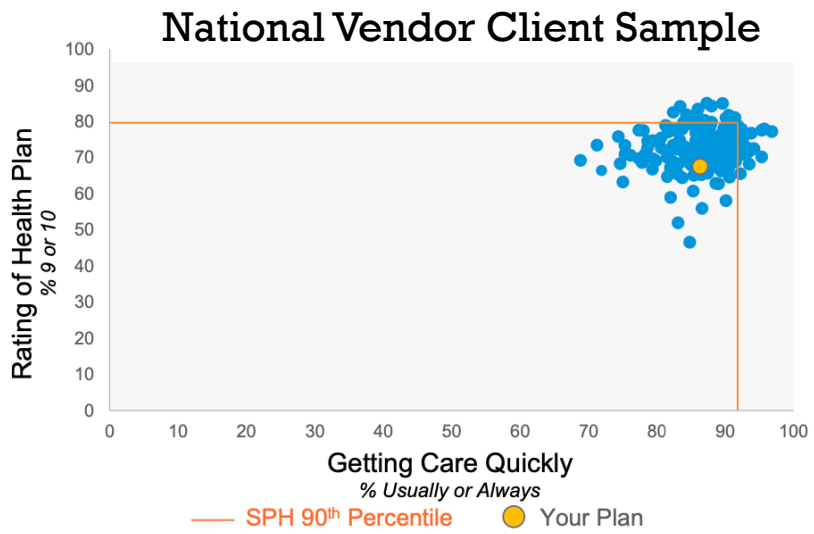
GETTING CARE QUICKLY

MEDICAID CHILD: GENERAL POPULATION

COMPOSITE

	QC %tile Rank	Score
% A or U	39th	86.3%





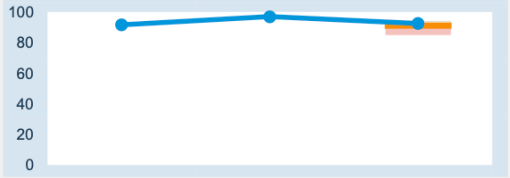
ATTRIBUTES

G: Q3. Had illness, injury or condition that needed care right away *(n=341)* **23.8%**

G: Q5. Made appointments for check-ups or routine care at doctor's office or clinic *(n=341)* **65.1%**

Q4. Getting urgent care

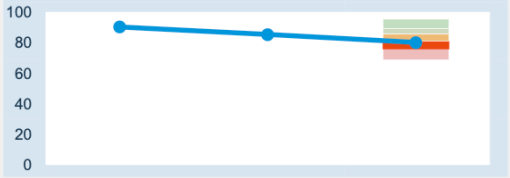
	2020 (n=132)	2021 (n=67)^	2022 (n=80)^
SRS	91.7%	97.0%	92.5%



SPH 90.5%
%tile 55th
QC 91.0%

Q6. Getting routine care

	2020 (n=330)	2021 (n=265)	2022 (n=211)
SRS	90.3%	85.3%	80.1%‡



SPH 82.9%
%tile 29th
QC 83.0%

Significance Testing: Current score is significantly higher/lower than the 2021 score (↑/↓), the 2020 score (‡/‡) or benchmark score (▲/▼).

^Denominator less than 100. NCQA will assign an NA to this measure.

Appendix: **CMS Innovation Center Primary Care Program Outcomes**

	CPC+	Primary Care First	Making Care Primary
Outcomes	***Program complete – evaluation data is available*** • CPC+ **reduced outpatient ED visits** (starting PY 1), **hospitalizations, and acute inpatient expenditures** (starting PY 3) and **improved some claims-based quality-of-care measures**. • A 1.5% reduction in total expenditures without enhanced payments emerged in PY 4 for Track 1 SSP practices.	***Program still in early years of implementation – only initial evaluation data is available*** • Based on a preliminary review of initial Quality Gateway measure data, **most Cohort 1 practices met benchmarks for quality measures related to diabetes control, high blood pressure control, and colorectal cancer screening**. • Future reports on improvements in quality of care and lower acute hospitalizations and total cost of care for Medicare beneficiaries are forthcoming.	***Program not yet launched – no evaluation data***