Primary Care Program Advisory Committee

Meeting 6

October 5, 2023

Agenda

Topic	Timing
Opening Remarks and Welcome	5 Minutes
Goals for Today	5 Minutes
Topic 1: Process and Timeline Check In	40 Minutes
Topic 2: Medicaid Delivery System and Payment Reform Examples	40 Minutes

Goals for Today

1. Check in on the overall timeline and process for primary care program design – review what has been accomplished during Phase 1 and discuss where we are headed in Phase 2

2. Review and discuss a range of primary care delivery system and payment reform strategies that have been implemented by state Medicaid programs to inform upcoming discussions about program design

Topic 1: Timeline for Primary Care Program Design

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

Phase 1: Activities and Accomplishments

Phase 1 focused on giving committee members the background and context that will lay the groundwork for more in-depth primary care program design discussions.

As part of Phase 1, this committee has:

- Reviewed DSS' goals and aligned on an overarching goal: *Improve the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members and in a way that reduces inequities and racial disparities.*
- Acknowledged that primary care is one part of a comprehensive system of care oriented towards improving biopsychosocial health and discussed other efforts underway to address social determinants of health/health related social needs
- Participated in a listening session and provided feedback to inform the development of broader strategies to address social determinants of health/health related social needs
- Reviewed quantitative and qualitative data related to access, quality, utilization, cost, experience, and equity
- Received supplementary data in response to requests for additional information
- Reviewed examples of federal and state primary care models and programs addressing health related social needs

Phase 2: Primary Care Program Design Components

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

Care Delivery	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, specialty, behavioral health and oral health integration, identifying and addressing health related social needs, and promoting equity.
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.
Payment Model	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.

Phase 2: Primary Care Program Design Components

During Phase 2, we will discuss key primary care program design components that will define the structure of the primary care program.

Care Delivery	• Identifying and Addressing Health Related Social Needs • Integration with Specialty Care, Behavioral Health, and Oral Health Care • Care Team and Care Coordination Enhancements • Care Transformation Infrastructure • Practice Recognition and Technical Assistance
Performance Measurement	• Quality Measurement • Data Sharing • Monitoring Strategy
Payment Model	• Base Payment • Care Delivery Redesign Payment • Performance Based Payment

Equity Strategy

Proposed Meeting Schedule

The meeting schedule below is a starting point – this process will be iterative and flexible.

		Primary Care Program Advisory Committee Meeting Topics
Phase 1	**April 6**	Background & Introductions
	May 4	Primary Care Goals and Strategies
	June 1	Scope of Primary Care Design and Prior Work
	July 13	Listening Session: Strategies for Addressing Community Needs
	August 3	Review of Primary Care Program Examples and Discussion of Supplementary Data
	August 24	Supplementary Data Review Meeting
Phase 2	**October 5**	Process Check In and Review of Program Examples
	October 26	In Person Meeting: Care Delivery Redesign
	November 2	Payment Model
	December 7	Performance Measurement
	January 4	Equity Strategy Review *(cross-cutting elements to be discussed within each topic area)*
	February 1	Program Structure Review

For Discussion – Phase 2: Program Design

During Phase 2, we will discuss key primary care program design components that will define the structure of the primary care program.

- Are there other program design components we should be including?

Topic 2: Medicaid Delivery System and Payment Reform Models

State Medicaid programs have implemented a range of delivery system and payment reform initiatives that aim to address gaps in traditional delivery and payment systems.

The Kaiser Family Foundation (KFF) tracks the adoption of different delivery system and payment reform initiatives across Medicaid programs.

- Common delivery and payment reform models include:
  - Patient-centered medical homes (PCMHs)
  - ACA health homes
  - Accountable care organizations (ACOs)
  - Episodes of care

- There is variation in which models are most widely used, how states combine and implement these models, and how long states have been engaged in efforts to transform payment and delivery systems.

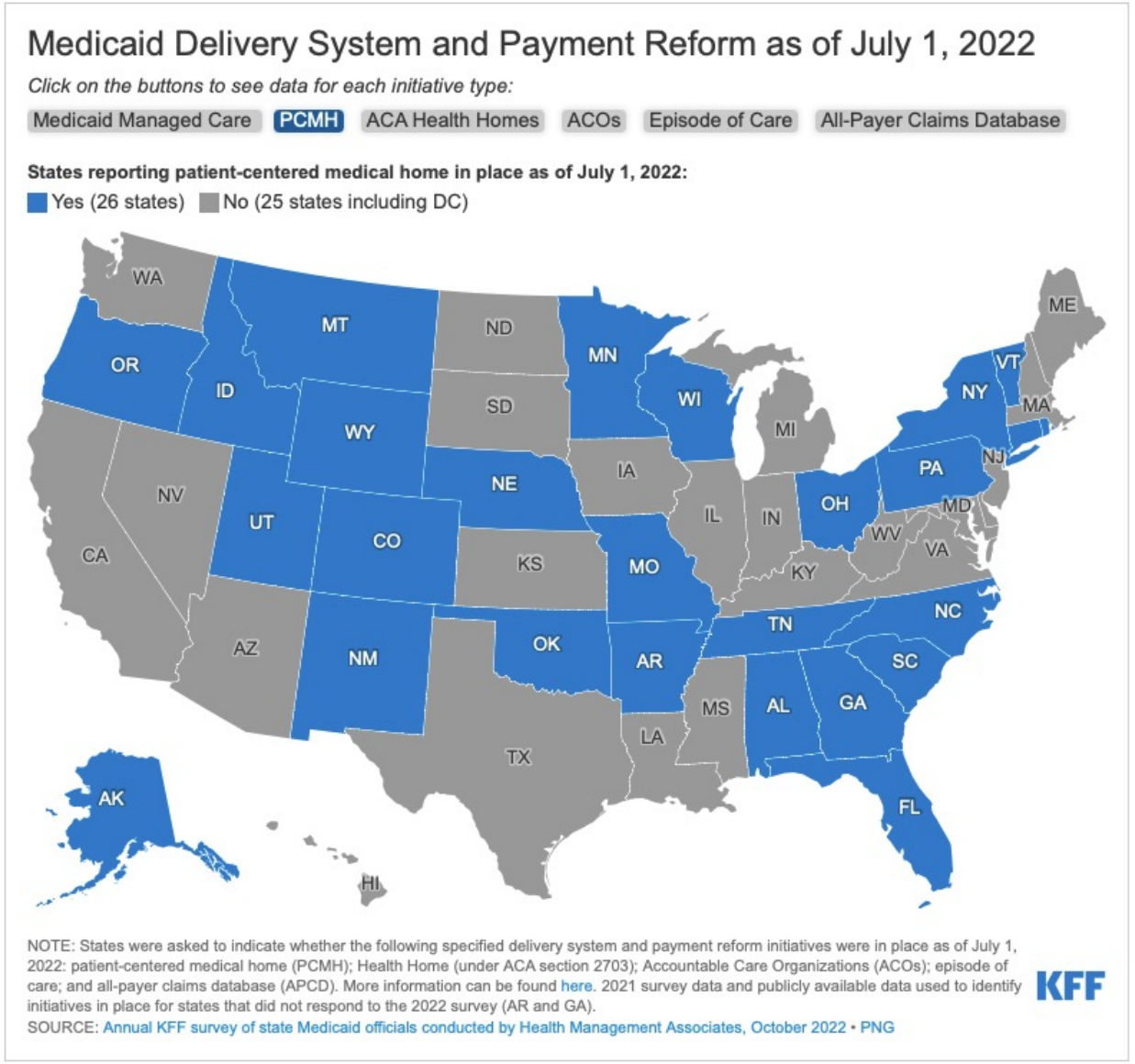
- The literature about delivery and payment reform models is not conclusive regarding the impact of these initiatives and more research is needed, states have seen successes and many models have evolved over time in response to state experience and evaluation finding.

Source: Kaiser Family Foundation, Mapping Medicaid Managed Care Models & Delivery System and Payment Reform, Mar 6 2023, https://www.kff.org/report-section/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform-definitions/

Patient-Centered Medical Home (PCMH)

Model Description

- Under a PCMH model, a physician-led, multi-disciplinary care team holistically manages the patient's ongoing care, including recommended preventive services, care for chronic conditions, and access to social services and supports.
- Generally, providers or provider organizations that operate as a PCMH seek recognition from organizations like the National Committee for Quality Assurance (NCQA).
- PCMHs are often paid (by state Medicaid agencies directly or through MCO contracts) a per member per month (PMPM) fee in addition to regular FFS payments for their Medicaid patients.



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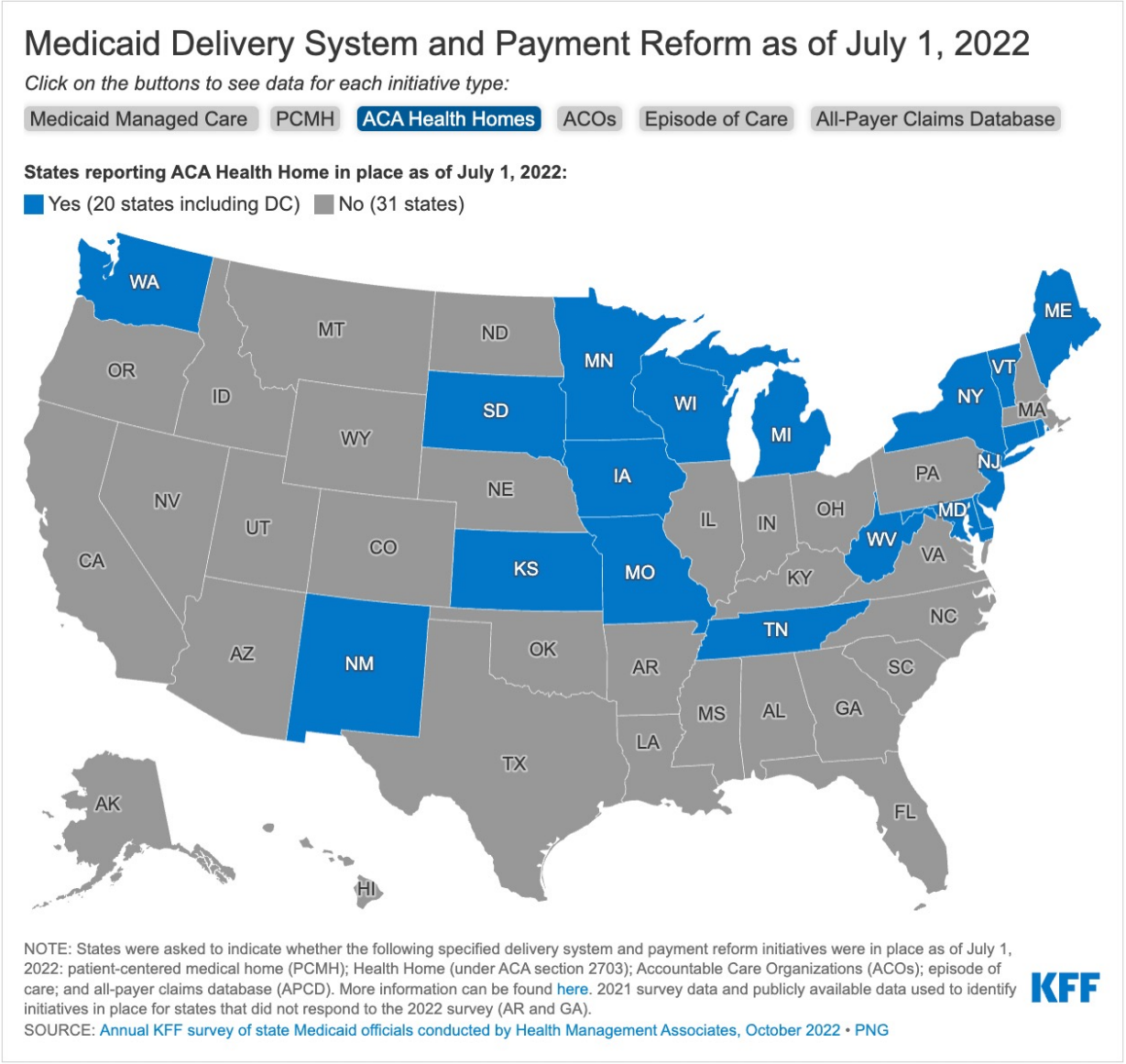
ACA Health Homes

Model Description

- Health homes must target beneficiaries who have at least two chronic conditions, or one and risk of a second, or a serious and persistent mental health condition
- Health homes provide a person-centered system of care that facilitates access to and coordination of primary and acute physical health services, behavioral health care, and social and long-term services and supports (e.g., comprehensive care mgmt., referrals to community/social support services, and use of health information technology to link services).
- States receive a 90% federal match rate for qualified Health Home service expenditures for the first 8 quarters under each Health Home SPA



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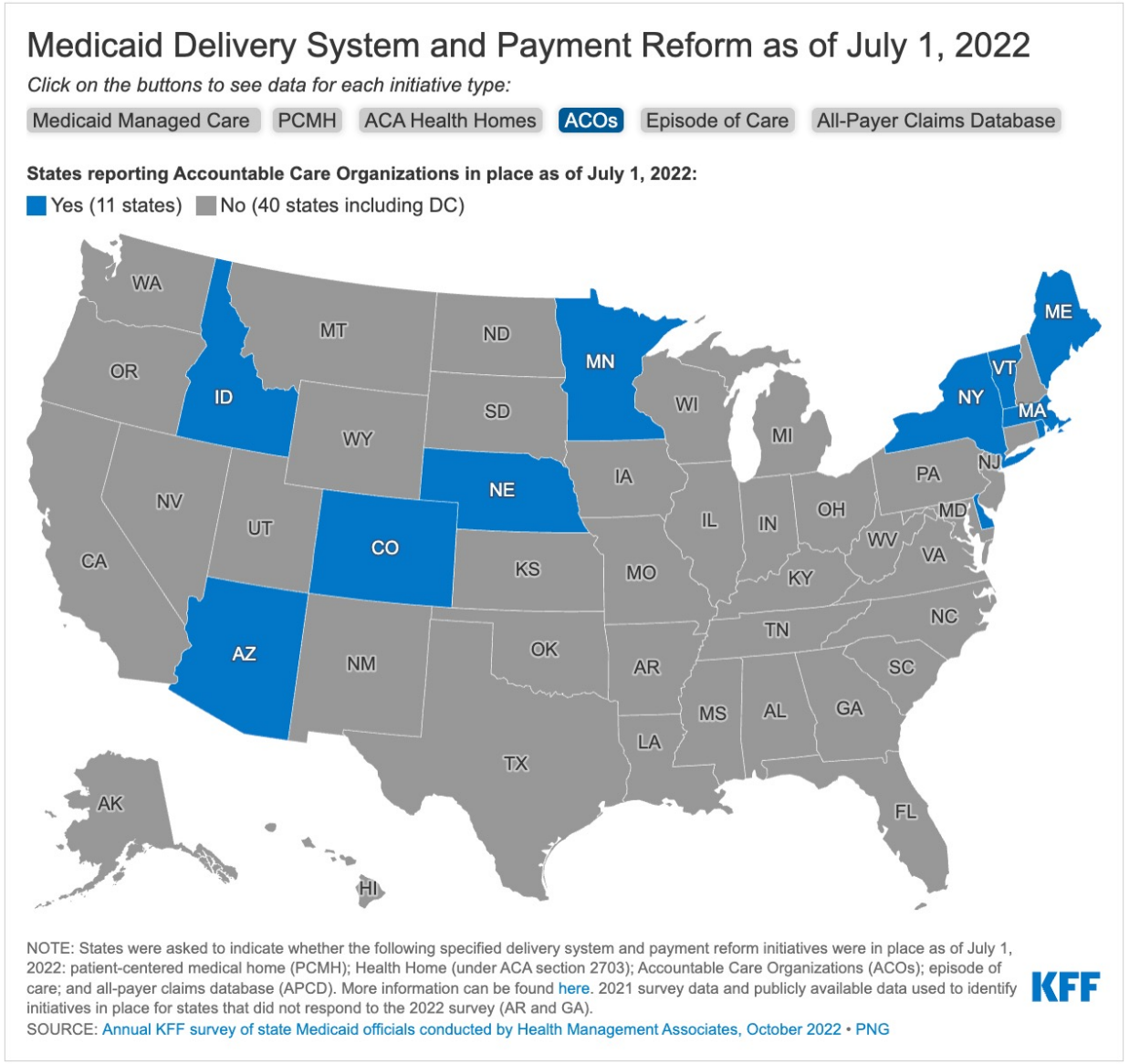
Accountable Care Organization (ACO)

Model Description

- While there is no uniform, commonly accepted federal definition of an ACO, an ACO generally refers to a group of health care providers or, in some cases, a regional entity that contracts with providers and/or health plans, that agrees to share responsibility for the health care delivery and outcomes for a defined population.
- An ACO that meets quality performance standards that have been set by the payer and achieves savings relative to a benchmark can share in the savings.
- States use different terminology in referring to their Medicaid ACO initiatives, such as Regional Accountable Entities in Colorado and Accountable Entities in Rhode Island.



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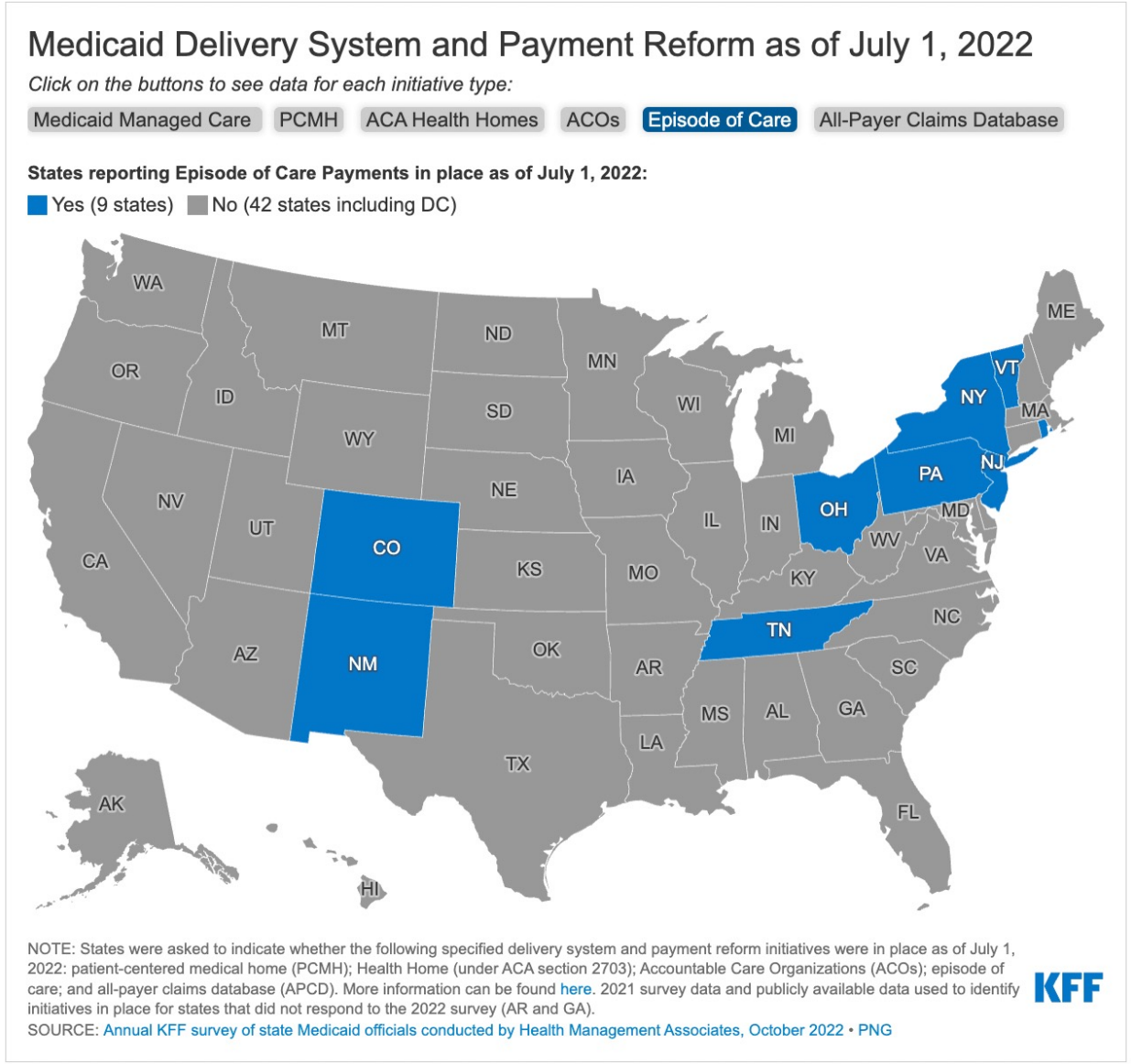
Episodes of Care

Model Description

- Unlike fee-for-service (FFS) reimbursements, where providers are paid separately for each service, or capitation, where a health plan receives a PMPM payment for each enrollee intended to cover the costs for all covered services, episode of care payments provide a set dollar amount for the care a patient receives in connection with a defined condition or health event (e.g., heart attack or knee replacement).
- Episode-based payments usually involve payment for multiple services and providers, creating a financial incentive for physicians, hospitals, and other providers to work together to improve patient care and manage costs.



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Starting Point: CT DSS Programs

CT DSS currently operates a PCMH program and a PCMH+ program.

CT PCMH (2012– Present)

- PCMH is based on the widely-adopted **national PCMH model.**
- Participating providers receive **FFS Payment with Enhanced Reimbursement Rate** (+24% on primary care services supplemental to the current Medicaid fee schedule) and **Per Member Per Month (PMPM) Performance-Based Payments** (earned based on performance and improvement on quality measures).

CT PCMH+ (2017– Present)

- PCMH+ **builds on PCMH with a more advanced payment model** and more intensive care coordination requirements.
- Participating providers receive **FFS Payment** and **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).
- Participating FQHC providers also earn **Care Coordination Add-on Payments** (prospective monthly payments for FQHCs only).

The state also has an ACA Health Home model – "Behavioral Health Homes" - operated by DMHAS.

- *Additional details on Behavioral Health Homes can be found on the DMHAS website and the CT Behavioral Health Homes website.*

For Discussion – Program Models of Interest

Moving forward, we intend to bring in examples from different programs to help frame options to consider.

- Are there specific state or federal program examples you would like to consider as part of program design discussions?
- Are there models (or components) that you think could be a good fit for CT's landscape and goals?

For Discussion – Program Scope: Population

There is substantial variation in how states design and implement these programs – but speaking generally, the different models we looked at can be characterized as broad or narrow in terms of the populations they typically include.

- Keeping in mind reform goals - improving the biopsychosocial wellbeing of members - and the advisory committee's interest in impacting HRSN through primary care, should DSS approach initial program design starting with a broad population or a more targeted population approach?