CT SIM Primary Care Modernization: Proposed Charter and Composition

Project Name	Primary Care Modernization
Project Sponsor	Connecticut Office of Health Strategy: State Innovation Model (SIM)
Workgroup	Payment Reform Council

WORKGROUP CHARTER

Project Background and Scope

The goal of the Primary Care Modernization design process is to develop a primary care modernization program model that details: 1) new care delivery capabilities for Connecticut's primary care practices and 2) payment model options that support those capabilities. The program model is intended to increase primary care spending over a period of five years so that doctors can provide patients with more support. It will also introduce new payment methods that increase flexibility to make care more convenient, community-based and responsive to the needs of patients. Together, these changes must improve outcomes and health equity while reducing the total cost of care and increasing the joy of practice. The program model will be an option for consideration by the governor-elect during the transition period that begins soon after the November election.

Workgroup Goal:

Develop Primary Care Modernization payment model options that introduce new payment methods that increase flexibility to make primary care more convenient, community-based and responsive to the needs of patients

Workgroup Objectives:

- Recommend primary care payment model options for Medicare fee-for-service primary care practices that are participating in the Medicare Shared Savings Program (MSSP) leveraging the proposals of the Practice Transformation Task Force
- Recommend model design options for other payers for networks participating in shared savings arrangements based on stakeholder engagement in a model design process.
- Detail methodological component, including recommended specifications for each option.

The Workgroup scope will include:

- Convene four times between September and November to develop payment model options
- Convene design groups as needed to address specific aspects of the model, such as FQHC strategy, risk adjustment, attribution methodology, and safeguards against risks to consumers like underservice
- Maximize use of similar work from the federal government and other states, including best in class efforts and existing models. Adapt approaches for CT.
- Consider and incorporate stakeholder input from consumers, providers, payers and employers
- Define minimum requirements for provider participation, such as participation in MSSP or risk contract.
- Recommend minimally burdensome methods that are aligned across payers for comparable populations
- Collaborate with the PTTF on workgroup progress and recommendations
- May review results of actuarial analyses to evaluate the financial impact of the model

The Workgroup scope will not include:

- Considering model options not recommended in the primary care payment reform report to the PTTF.
- Implementation of the proposed model.

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Workgroup Deliverables

Recommendations for:

1. Services (at the CPT code level) to include in the comprehensive primary care bundles, which represents visits and potentially other services that have historically been the basis for practice revenue.
2. Staff, services, or investments that are intended to be covered by a supplemental "care management" bundle and which may cover the cost of additional care team members, new technology investments (e.g., telemedicine), promotion of socio-emotional development (in pediatrics) and other one-time or ongoing costs associated with the recommended capabilities.
3. Recommend attribution approach for payments
    - Review of attribution methodologies currently in use
    - Recommend leveraging current or new methodology
    - Document characteristics of approach (retrospective or prospective; timing; criteria (consumer choice, utilization history) and role of auto assignment (geographic)
4. Methods and frequency of risk adjustment to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.
5. Bundled payment model options in which primary care practices receive resources to provide routine outpatient mental health and/or substance use services and assume accountability for associated outcomes.
6. Performance measures (single measure set common to all payers or payer determined measure set aligned on specific parameters).
7. Performance incentives/penalties.
8. Minimum alignment requirements for other participating payers based on the proposed Medicare model.
9. Considerations for Federally Qualified Health Centers (FQHCs), which are currently paid via Prospective Payment System (PPS), and not currently participating in MSSP.
    - Develop recommendations that will apply to FQHC contracts and support engagement
    - Example: We recommend that the risk sharing thresholds in standard risk tracks be adjustable based on the FQHC's ability to assume financial risk. We do not recommend that any provider participate in just the bundles.
10. Strategy should support pediatric practices that are participating in accountable care, but not participating in MSSP through evaluation of codes used in pediatric primary care in the bundle and development of recommendations that will support engagement from pediatric practices.
11. Identify methods for monitoring under-service and patient selection that provide for rapid-cycle feedback to payers, providers and consumer stakeholders to enable continuous learning and improvement.

Workgroup Duration	The Council will meet four times between August and November

Workgroup Membership

TBD

Project Team Support:

- Mark Schaefer, SIM Director
- Laurie Doran, Payment Reform Council Facilitator
- Gail Sillman, ACO expert
- Pano Yeracaris, PCMH and CPC+ expert
- Linda Green, PTTF Facilitator
- Alyssa Harrington, Project Director
- Vinayak Sinha, Project Coordinator

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Payment Reform Council Proposed Composition

Representative	Qualifications
1. Payer	Commercial, experience in alternative payment models
2. Payer	Commercial, experience in alternative payment models
3. ACO	Hospital-anchored, experience in contracting, shared savings arrangements
4. ACO	Non-hospital based, experience in contracting, shared savings arrangements
5. Office of State Comptroller	State representative
6. Medicaid	State representative
7. FQHC	Experience with PCMH+ or other shared savings arrangement
8. FQHC	Experience with PCMH+ or other shared savings arrangement
9. Provider	Clinician with experience in ACO model, and at least one of the following: • Behavioral health • Long term social supports/post-acute communities • Social determinants, health equity
10. Consumer	Experience in alternative payment models, and at least one of the following: • Behavioral health • Long-term social supports • Social determinants, health equity
11. Consumer	Experience in alternative payment models, and at least one of the following: • Behavioral health • Long-term social supports • Social determinants, health equity
12. Employer	Self-insured, experience with value-based contracting, headquarters in CT