

Healthcare Benchmark Initiative Stakeholder Advisory Board

December 8, 2021 Meeting



Agenda

| <u>Time</u> | <u>Topic</u> |
|-------------|---|
| 2:00 p.m. | I. Call to Order |
| 2:05 p.m. | II. Public Comment |
| 2:10 p.m. | III. Welcome New Members |
| 2:15 p.m. | IV. Approval of March 25 th Meeting Minutes - Vote |
| 2:20 p.m. | V. Healthcare Benchmark Initiative Steering Committee |
| 2:25 p.m. | VI. Highlights from Mathematica Cost Driver Analysis |
| 3:25 p.m. | VII. Overview of Primary Care Roadmap |
| 3:55 p.m. | VIII. Wrap-Up and Next Steps |
| 4:00 p.m. | IX. Adjourn |

Call to Order

Stakeholder Advisory Board Members

- **Rebecca Andrews, UCONN Health**
- **Pareesa Charmchi Goodwin – CT Oral Health Initiative**
- **Reginald Eadie – Trinity Health of NE**
- **Tekisha Everette – Health Equity Solutions**
- **Howard Forman – Yale University**
- **Jonathan Gonzalez-Cruz - patient rep.**
- **Hector Glynn – The Village for Families & Children**
- **Angela Harris, Phillips Health Ministry**
- **Sal Luciano – CT AFL-CIO**
- **Rick Melita – SEIU CT State Council**
- **Susan Millerick - patient rep.**
- **Fiona Mohring – Stanley Black and Decker**
- **Lori Pasqualini – Ability Beyond**
- **Luis Perez, Mental Health Connecticut**
- **Theresa Riordan- Anthem BCBS of CT**
- **Richard Searles – Merritt Healthcare Solutions**
- **Kelly Sinko Steuber- Office of Health Strategy**
- **Marie Smith – UConn School of Pharmacy**
- **Kristen Whitney-Daniels - patient rep.**
- **Jill Zorn- Universal Health Care Foundation**

Public Comment

Approval of Previous Meeting Minutes

Healthcare Benchmark Initiative Steering Committee

Healthcare Benchmark Initiative Steering Committee: Overview

- Previously, the Stakeholder Advisory Board advised a **Technical Team** consisting of 10 state agency executives and outside stakeholders, excluding insurers and large health systems.
- The Technical Team was replaced this fall with a new **Steering Committee** in order to involve leading provider and payer organizations who were not previously represented in order that they might participate in the design of cost growth mitigation strategies.

Highlights from the Latest Mathematica Analysis

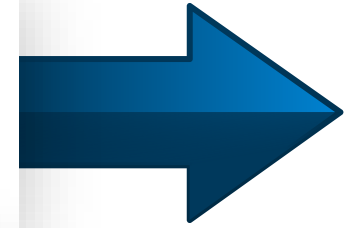
Connecticut Benchmarks and Target Program

1



Cost Growth Benchmark

Develop recommendations for a cost growth benchmark that covers all payers and all populations for 2021-2025.

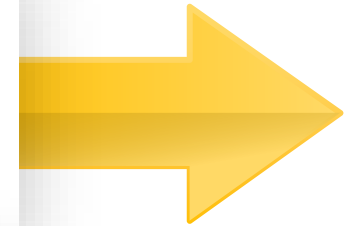


2



Primary Care Target

Develop recommendations for getting to a 10% primary care target that applies to all payers and populations as a share of total health care expenditures for CY 2021-2025.

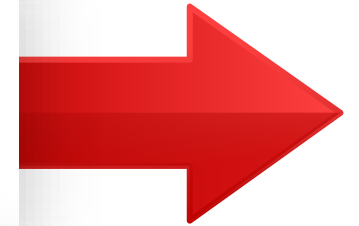


3



Data Use Strategy

This is a complementary strategy to the cost growth benchmark that leverages the state's APCD to analyze cost and cost growth drivers.



4



Quality Benchmarks

Beginning in CY 2022, quality benchmarks are to be applied to all public and private payers. This work will be coordinated through OHS, DSS and the OHS Quality Council.

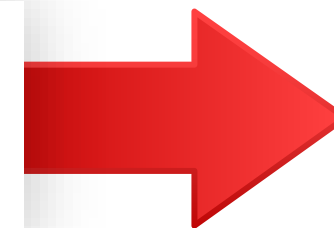


3



Data Use Strategy

This is a complementary strategy to the cost growth benchmark that leverages the state's APCD to analyze cost and cost growth drivers.



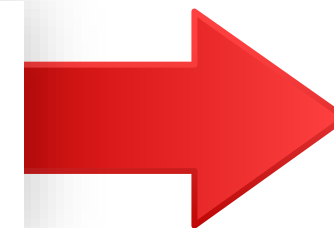
- OHS hired Bailit Health to support the Executive Order work. Bailit Health's partner, Mathematica, produced an initial analysis last winter in order to **understand patterns in Connecticut health care spending**, and thereby perhaps **identify potential opportunities to slow spending growth** and meet the benchmark (3.4% for 2021).
- This summer Mathematica performed additional analyses at OHS' direction. Today we will review some of the latest findings.

3



Data Use Strategy

This is a complementary strategy to the cost growth benchmark that leverages the state's APCD to analyze cost and cost growth drivers.



- The additional analyses focused on two areas of inquiry:
 1. how increases in hospital payments have been driving spending growth in the employer-sponsored coverage (“commercial”) market, and
 2. why ED utilization is so much higher among communities with higher proportions of people of color and lower income persons with commercial coverage.
- OHS seeks your ideas about how to leverage this type of analysis to address cost drivers and help CT meet our cost growth benchmark.

Overview of Analytic Population and Framework

- CT residents under age 65, as indicated, in 2015 - 2019
- Commercial (fully insured, and State employees and retirees)
- Exclusions (about 7% of members and claim lines per year):
 - Non-CT residents
 - Secondary payers, vision-only, and some student plans
 - Denied, reversed, and non-primary claim lines
 - Claim lines with negative payment or cost-sharing
 - Payments after runout period (after June 30th of following year)
- Also missing: non-claims-based payments, drug rebates, and retail pharmacy

PMPM Commercial Spending

Out-of-Pocket Commercial Spending

Medical spending PMPM increased 21%, 2015-19

| Payer | 2015 | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 | Total change (%) |
|-------------------------------|----------|----------|----------|----------|----------|------|------|------|------|------------------|
| All-payer (unadjusted) | \$375.47 | \$407.64 | \$421.05 | \$431.19 | \$454.19 | 8.6% | 3.3% | 2.4% | 5.3% | 21.0% |

Notes:

- 1) The average annual increase was 4.9%
- 2) Average wage growth in CT for the same time period was 2.6%.
- 3) Limited to CT residents under age 65.
- 4) Excludes retail pharmacy spend, a major contributor to spending growth in other states.

Out-of-pocket spending increased much faster than total spending

| Payer | OOP spending for insured medical services (PMPM) | | | | | Annual OOP change (%) | | | | Average annual change (%) | | Total change (%) | |
|-------------------------------|--|---------|---------|---------|---------|-----------------------|-------|------|------|---------------------------|------|------------------|-------|
| | 2015 | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 | OOP | PMPM | OOP | PMPM |
| All-payer (unadjusted) | \$44.26 | \$47.82 | \$53.83 | \$55.25 | \$56.70 | 8.0% | 12.6% | 2.6% | 2.6% | 6.5% | 4.9% | 28.1% | 21.0% |

Note:

- 1) The average annual increase in out-of-pocket spending was 6.5%.
 - This includes patient co-insurance, deductible, and co-payment obligations. It does not include premium contributions.
- 2) This finding reflects changes in employer decisions on plan design, and employee plan selection.

PMPM Commercial Spending, by Service

Relative Impact of Price and Utilization

Between 2015 and 2019 per capita spending growth varied significantly by service type

| Service Category | 2015 | | 2018 | | 2019 | | 2018-2019 change (%) | Average annual change (%) | Total change (%) | Change in category as percent of total PMPM change |
|------------------------|----------|-------|----------|-------|----------|-------|----------------------|---------------------------|------------------|--|
| | PMPM | % | PMPM | % | PMPM | % | | | | |
| All services | \$375.46 | 100.0 | \$431.19 | 100.0 | \$454.18 | 100.0 | 5.3 | 4.9 | 21.0 | 100.0 |
| Professional | \$167.77 | 44.7 | \$182.65 | 42.4% | \$188.01 | 41.4 | 2.9 | 2.9 | 12.1 | 25.7 |
| Inpatient acute | \$77.79 | 20.7 | \$93.32 | 21.6% | \$98.52 | 21.7 | 5.6 | 6.2 | 26.8 | 26.4 |
| Outpatient | \$124.40 | 33.1 | \$150.44 | 34.9% | \$162.96 | 35.9 | 8.3 | 7.0 | 31.0 | 49.0 |
| Other | \$5.59 | 1.5 | \$4.78 | 1.1% | \$4.69 | 1.0 | -2.0 | -4.3 | -16.2 | -1.2 |
| ED* | \$26.77 | 7.1 | \$32.63 | 7.6 | \$35.60 | 7.8 | 9.1 | 7.5 | 33.0 | 11.2 |

*ED includes both professional and outpatient ED claims if delivered in an ED, thus an overlap of professional and OP.

Notes: 1) Recall that Rx spending is not included in the analysis. It often represents around 25% of commercial spend. 2) Annual hospital spending growth is particularly high. By comparison, in RI insurer-reported data showed 2018-19 trends in per capita commercial hospital spending of 1% for IP services and 7% for OP (including ED) services.

Spending per service unit drove spending growth

| Service Category | 2019 Volume | 2019 Spending per unit | Percent change in spending per unit | | | | Total 4-year | 4-year percent change in volume |
|--------------------|----------------|------------------------------|-------------------------------------|------|------|------|--------------|--|
| | | | 2016 | 2017 | 2018 | 2019 | | |
| Inpt. acute stay | 33,683 | \$28,015 | 9.5 | 7.3 | 7.0 | 9.3 | 37.4 | -10.2 |
| Outpatient claim | 1,011,124 | \$1,544 | 6.2 | 4.8 | 8.5 | 8.3 | 30.7 | -2.4 |
| Professional claim | 8,270,885 | \$218 | 1.6 | 2.3 | 0.9 | 1.9 | 6.8 | 2.1 |
| ED visit* | 179,072 | \$1,904 | 10.0 | 7.9 | 9.1 | 11.4 | 44.3 | -10.3 |

- Changes in spending per unit may be affected by changes in service mix and in service-level prices
- Categories of services derived from the CT APCD Data Dictionary claim type detail.
- Includes CT residents under age 65. Results are not age/gender adjusted.
- Inpatient stay units defined as discharges, which can include multiple claims. “Other” category of service units defined as individual claims.

*ED includes both professional and outpatient ED claims if delivered in an ED

Notes: 1) Hospital price increases appear to be the primary driver of cost growth. 2) Professionals appear to have experienced very small annual fee increases. 3) This analysis does not isolate the impact of new services substituting for older ones at different price points, or for changes in site of service, e.g., surgery moving from inpatient to outpatient.

Emergency Department Utilization

Methods: ED Utilization Analysis

- 2016 – 2019*
- Focus on disparities by age, gender, income, and race
- Deciles are based on resident zip code** and derived from Census data
 - Income Decile 1 is lowest income; Decile 10 is highest income
 - Race decile is defined by the percentage of people of color in the community; Race decile 1 is the highest portion of people of color; race decile 10 is lowest portion of people of color
- Professional and outpatient ED claims for the same member on the same date were grouped into ED visits

* 2015 excluded from most ED analyses because (1) the analysis used ICD-10 codes, which were introduced in late 2015 or (2) at least 1 lookback year was required to assign a chronic condition

** Zip codes mapped to Zip Code Tabulation Areas

ED utilization and PCP visits

- Members with ED visits were *more likely* to have had a PCP visit than those members without an ED visit (76% vs. 55%). Nothing changed in this respect between 2015 and 2019.
- Members in communities with higher proportions of people of color were less likely to have had a PCP visit. Nothing changed in this respect between 2015 and 2019.

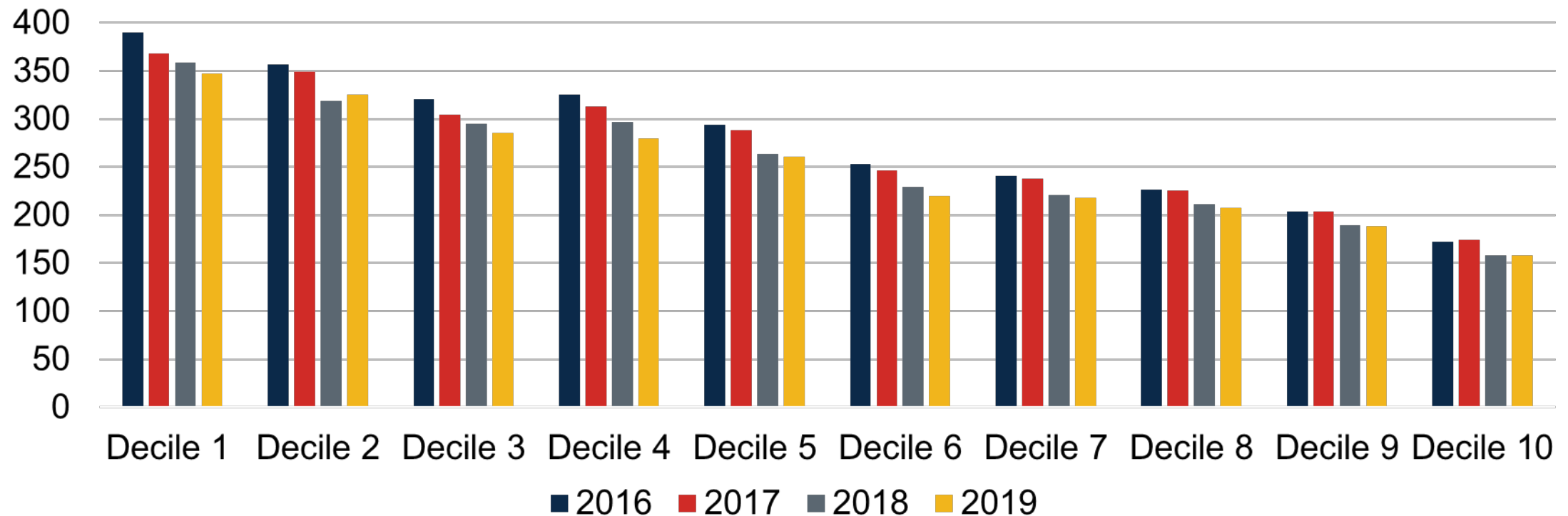
Rates of ED use are especially high in six communities; Most are majority Black and Hispanic/Latino.

| Zip Code | Town | Median Household Income | Percent Black | Percent Hispanic/Latino | ED visits per 1,000 members |
|---------------|------------|-------------------------|---------------|-------------------------|-----------------------------|
| All CT | | \$ 86,945 | 9.4 | 13.8 | 976 |
| 06120 | Hartford | \$ 27,324 | 51.7 | 43.0 | 1,802 |
| 06519 | New Haven | \$ 29,332 | 35.0 | 45.1 | 1,731 |
| 06704 | Waterbury | \$ 40,625 | 25.5 | 45.5 | 1,726 |
| 06226 | Windham | \$ 37,339 | 5.6 | 44.6 | 1,721 |
| 06380 | Norwich | \$ 38,319 | 10.6 | 17.8 | 1,710 |
| 06607 | Bridgeport | \$ 42,103 | 48.0 | 43.2 | 1,681 |

- Communities are defined by zip code.
- Limited to adults 18-64 and communities with >10,000 adult member months in sample.
- Includes four years of data, 2016-2019.

ED visits are declining, but remain higher among residents in lower income communities

ED visits per 1,000 members by Income Decile



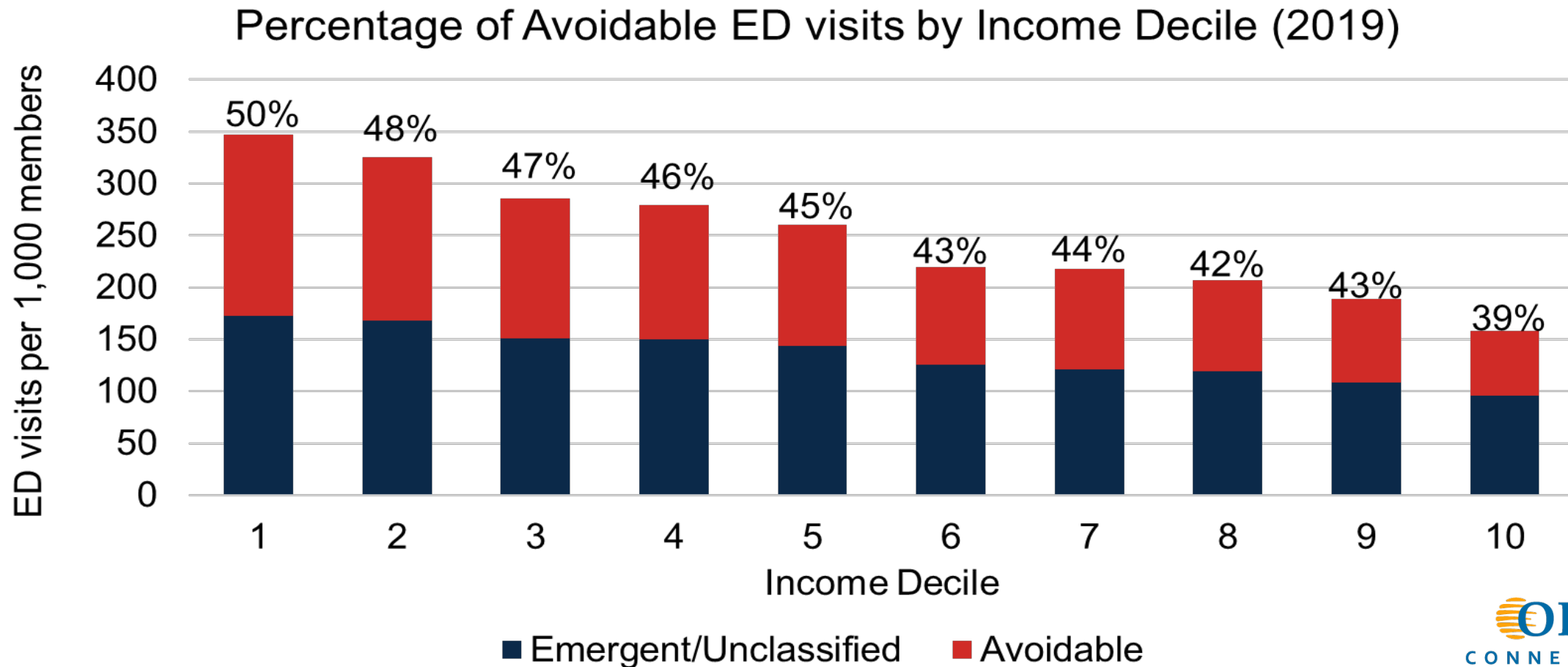
- Includes CT residents ages 65 and under
- ED claims include professional and outpatient claims located in the emergency department. Multiple ED claims for the same member on the same date are grouped into one ED visits.

45% of ED visits were non-emergent or avoidable

Of these, nearly half (18-19% of all ED visits) were non-emergent

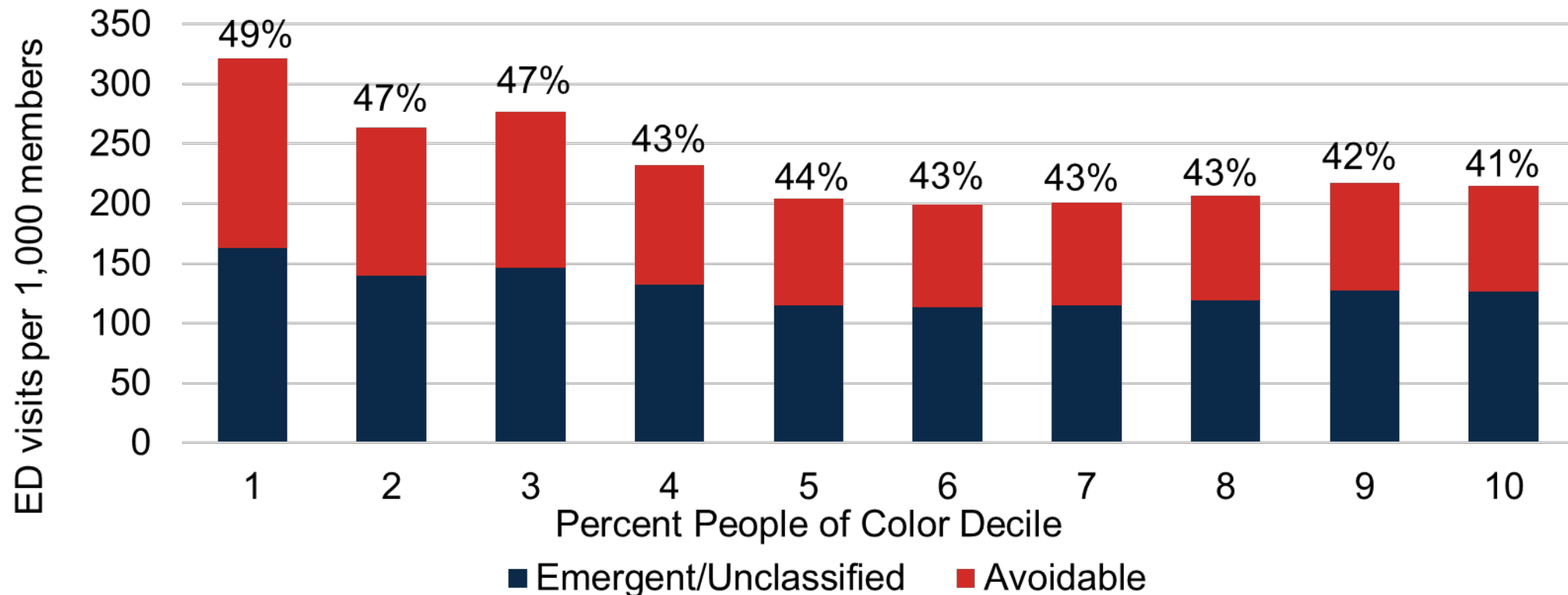
| ED visit type (<i>subtype</i>) | Percentage of ED visits | | | |
|---|-------------------------|-------|-------|-------|
| | 2016 | 2017 | 2018 | 2019 |
| Behavioral Health | 3.5% | 3.5% | 3.7% | 3.9% |
| All non-Behavioral Health | 85.4% | 84.2% | 83.9% | 83.3% |
| <i>Emergent, ED needed, non-preventable</i> | 16.9% | 16.9% | 17.7% | 17.7% |
| <i>Emergent, injury</i> | 23.5% | 23.0% | 21.5% | 21.5% |
| <i>Emergent, ED needed, preventable</i> | 5.1% | 5.0% | 5.0% | 4.9% |
| <i>Emergent, primary care treatable</i> | 21.2% | 21.1% | 21.4% | 21.1% |
| <i>Non-Emergent</i> | 18.7% | 18.3% | 18.2% | 18.0% |
| Unclassified | 11.1% | 12.3% | 12.3% | 12.8% |
| <i>All preventable ED visits</i> | 45.0% | 44.4% | 44.7% | 44.1% |

A higher number and percentage of ED visits are avoidable for residents of lower income communities relative to higher income communities



Residents of communities with higher percentages of people of color were more likely to have avoidable ED visits

Percentage of Avoidable ED visits by Race Decile (2019)



Certain diagnoses have notably higher ED rates in low-income communities

- **All ages**

- Asthma (2.4x)*

- Complications in pregnancy (2.3x)

- Low back pain (2.1x)

- Musculoskeletal pain, not low back pain (1.9x)

- Viral infection (1.8x)

- Interpretation for asthma:
(Rate in deciles 1&2)/(State rate) = 2.4.

- **Children (0-17)**

- Asthma (2.7x)

- Other specified upper respiratory infections (1.8x)

- Otitis media (1.8x)

- Respiratory signs and symptoms (1.8x)

- Nausea and vomiting (1.7x)

- **Special interest (all ages)**

- Influenza (All) (1.5x)

- Non-traumatic dental (1.7x)

In 2019, 70% of ED visits were by members with a chronic condition and nearly half by members with multiple chronic conditions

| Chronic condition | Percent of population | Percent of ED visits | Number of ED visits | ED visits per 1,000 mbrs | Ratio 1:10 | |
|------------------------|-----------------------|----------------------|---------------------|--------------------------|------------|------|
| | | | | | Income | Race |
| One or more conditions | 34.9% | 70.3% | 74,531 | 336.2 | 2.1 | 1.5 |
| Two or more conditions | 18.6% | 47.0% | 49,793 | 421.5 | 2.0 | 1.5 |
| No condition | 38.0% | 29.7% | 31,439 | 130.1 | 1.7 | 1.2 |

Other ED visit disparity observations...

- Bottom income decile members were 2x more likely to have a chronic condition and were 2x as likely to have two chronic conditions, compared to top income decile members. Disparities were greatest for glaucoma and ischemic heart disease. There was not a great deal of variation by chronic condition.
- Members in the decile with the highest % of people of color were 1.5x more likely to have one chronic condition and two or more chronic conditions, compared to decile with the lowest %. There was not a great deal of variation by chronic condition.
- There is certain correlation between income and race. These data suggest that income is more explanatory than race.

Inpatient Spending

Spending per unit, not number of units, drove growth in hospital spending

| Category of Service | Volume (2019) | Spending (2019) | Spending per unit (2019) | Change (2015-2019) | |
|-----------------------------|---------------|-----------------|--------------------------|--------------------|-------------------|
| | | | | Volume | Spending Per Unit |
| Inpatient Discharges | 33,683 | \$943,616,109 | \$28,015 | -10% | 37% |
| Professional | 8,270,885 | \$1,800,756,932 | \$218 | 2% | 7% |
| Outpatient | 1,011,124 | \$1,560,864,030 | \$1,544 | -2% | 31% |
| Other Services Combined | 106,503 | \$44,882,590 | \$421 | -12% | -7% |
| Emergency Department Visits | 179,072 | \$340,982,098 | \$1,904 | -10% | 44% |

- Changes in spending per unit may be affected by both changes in service mix and changes in service-level prices.
- Includes CT residents under age 65. Results are not age/gender-adjusted.
- Inpatient stay units defined as discharges, which can include multiple inpatient claims. ED units defined as visits which can include multiple outpatient and/or professional claims.
- “Other” category of service units defined as individual claims.

Methods: Factors driving inpatient spending per unit

Method 1: Hold MS-DRG distribution constant to isolate price factor

Price factor – spending per discharge, if MS-DRG distribution is held constant at 2015 level

Service mix factor – remainder

Requires large sample size; appropriate for state-level analysis

Method 2: Calculate spending per case-mix adjusted discharge

Price factor - spending per case-mix adjusted discharge (CMAD)

$$= \frac{\text{Total Inpatient Claims Payments}}{(\text{Case Mix Index} * \text{Number of Discharges})}$$

Service mix factor = case mix index = average MS-DRG weight

Accommodates smaller sizes; appropriate for state- and hospital-level analysis

Method 1: For adults, spending per discharge grew 37 percent in 4 years; 28/37 percentage points (**76%**) were due to within-DRG changes in spending (price factor)

Method 2: Spending per discharge grew 37 percent in 4 years; 25/37 percentage points (**68%**) were due to changes in spending per CMAD (price factor)

But...

The Massachusetts Health Policy Commission(HPC) recently completed an analysis of change in inpatient case mix over time and concluded that there was no change in case mix – change in *coding practice* accounted for all of the increased case mix scores.

OHS has yet to attempt to replicate the HPC analysis but will attempt to do so.

Case mix scores grew, discharges dropped and spending per case mix-adjusted discharge grew

| Hospital | Number of discharges | | | CMI | | | Spending per CMAD | | |
|--------------------|----------------------|--------|--------|------|------|--------|-------------------|----------|--------|
| | 2015 | 2019 | Change | 2015 | 2019 | Change | 2015 | 2019 | Change |
| State total | 27,946 | 25,062 | -10.3% | 1.40 | 1.54 | 9.8% | \$14,115 | \$17,598 | 24.7% |

During a future meeting we will review how these changes vary by hospital and hospital system.

Hospital discharges were concentrated in a few systems; discharge volume changes were variable

- Two health systems represented **57%** of 2019 inpatient discharges. The two next largest systems represented 10% and 9% of 2019 inpatient discharges respectively. Together, these four systems represented **76%** of 2019 inpatient discharges.
- While discharge volume per 1000 members dropped 9% between 2015 and 2019, there was considerable variation across systems. Two systems had declines of only -0.4%, while two had a drop of -21.5% and -16.9% respectively.

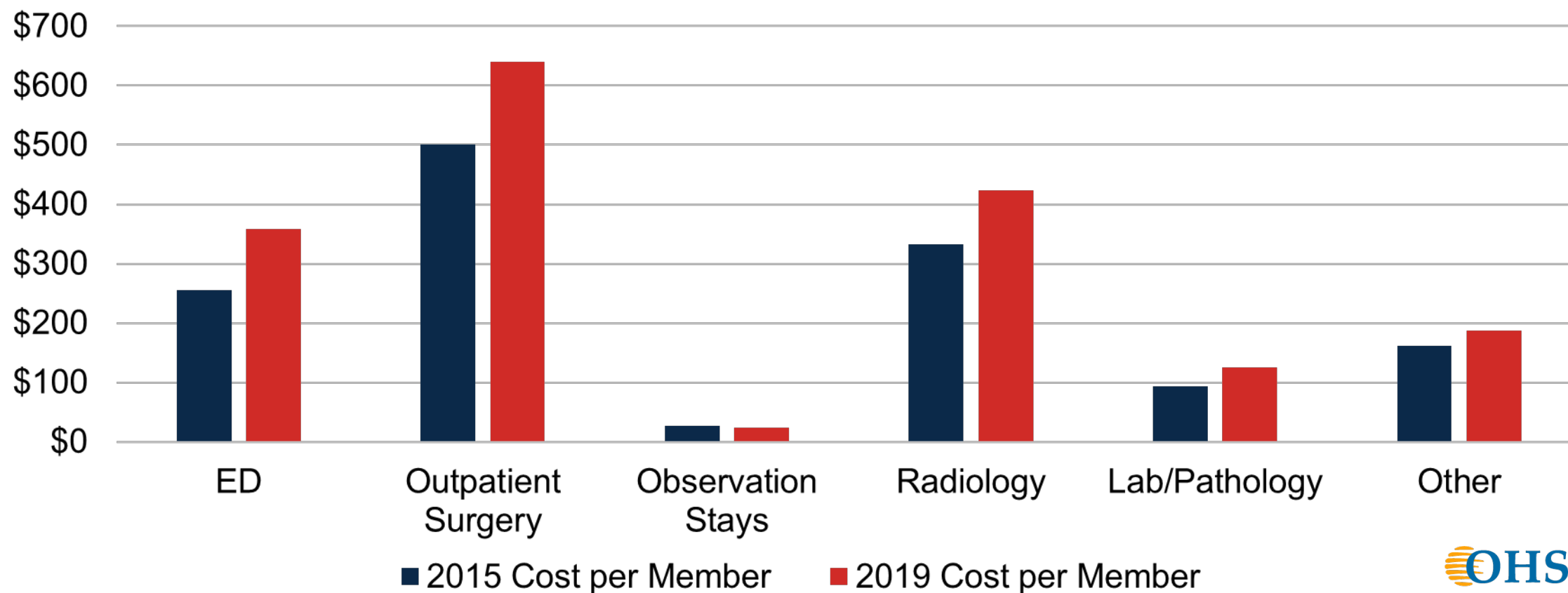
Hospitals with the highest inpatient costs grew fastest, while those with the lowest grew slowest

- Of the ten hospitals with the **highest rates of growth in payment** per CMAD, five hospitals also had the highest cost per CMAD in 2019. Four of five were affiliated with the largest systems.
- Of the ten hospitals with the **lowest rates of growth in payment** per CMAD, five hospitals also had lowest cost per CMAD in 2019. Four of five were unaffiliated with the largest systems.

Outpatient Spending

ED, outpatient surgery, and radiology make up the majority of outpatient facility spending.

Outpatient spending by service type



Across all major outpatient service types, changes in outpatient spending were driven by spending per unit not units per person

| Service type | 2015 – 2019 Percent Change | | | |
|---------------------------|----------------------------|------------------|-------------------|-----------------------------|
| | Spending per person | Units per member | Spending per unit | Interaction of both factors |
| ED | 40.1% | -6.3% | 49.5% | -3.1% |
| Outpatient surgery | 28.1% | 2.3% | 25.2% | 0.6% |
| Radiology | 27.5% | 0.0% | 27.6% | 0.0% |
| Lab/pathology | 35.5% | -5.2% | 42.8% | -2.2% |

- For ED, spending per unit rose by almost 50 percent between 2015 and 2019.

Discussion

How can we leverage these analyses to:

- address the identified commercial market cost drivers?
- reduce the observed disparities in ED utilization?

Primary Care Roadmap

Improving Primary Care: Benefits for Patients



Increased access

More time and attention for individual patients
Convenience of various types of appointments
with increased access to practice



Whole-person care approach

Expanded care team (Community Health Workers,
Nurse Care Managers, Patient Navigators)
Improved collaboration across care providers
Early identification and intervention



Focus on prevention and wellness

Improved health and reduced illness burden

Improving Primary Care: Benefits for Practices



More time for patient care

Increased opportunities to understand patient goals and needs
Ability to focus on quality outcomes



Improved professional capabilities

Data analytics, collaborative relationships, quality improvement



Multi-payer alignment

Limited number of quality measures
Reduced administrative burden



Flexibility in practice design and workflow

Services to support patient needs
Team-based approach



Predictable financing

Reduces the financial imperative to generate office visits

Supporting Connecticut's primary care infrastructure (1 of 2)

- Primary care across the U.S. and in CT is in trouble. There are multiple indicators:
 - Fewer medical school students entering primary care
 - An aging primary care physician workforce
 - High levels of burnout causing clinicians to leave the workforce or convert to direct primary care models
 - Connecticut primary care organizations report staff shortages and enormous difficulty in recruitment

Supporting Connecticut's primary care infrastructure (2 of 2)

- Analysis completed by OHS in October 2021 found that:
 - In 2019, only 5.2 percent of the commercial payments in Connecticut went to primary care. This is below the New England states' mean rate and CT's primary care spending target of 10 percent, and less than half of RI's regulatory commercial insurer standard of 10.7 percent.
- For these reasons, and because primary care is the foundation of our delivery system, Governor Lamont has made sustaining CT's primary care infrastructure a policy priority.

Status of the *Roadmap for Strengthening and Sustaining Primary Care* (1 of 2)

- OHS began work in Spring 2021 with its Primary Care Subgroup to:
 1. Make recommendations for primary care spending targets, as required by Executive Order No. 5.
 2. Design a strategy (the “Roadmap”) to complement the primary care target for more effective and efficient primary care that will better meet the needs of patients and support primary care professionals.



Status of the *Roadmap for Strengthening and Sustaining Primary Care* (2 of 2)

- Learning from the SIM experience, OHS chose to pursue a strategy that is more modest and flexible in scope so that it can be implemented in a timely fashion and achieve the Governor's goals.
- OHS is finalizing the draft Roadmap, informed by input from the Primary Care Subgroup, for public comment release mid-December.
- The Roadmap will be finalized once public and stakeholder feedback has been reviewed and considered.
- OHS will begin implementation activities starting sometime in 2022.

OHS solicited broad input to make sure the Roadmap is feasible, implemented, and successful

OHS engaged a wide array of stakeholders, in addition to those represented on OHS' Primary Care Subgroup:

Consumer Advocates:

- CT Chapter of the National Association of Hispanic Nurses
- Department of Public Health Medical Home Advisory Council
- OHS Consumer Advisory Council
- OHS Community Health Subgroup and Health Enhancement Communities

Providers:

- Bristol Hospital
- Community Health Center Association of CT, Community Health Center Inc.
- CT State Medical Society – IPA
- Eastern CT Health Network Medical Group
- Hartford HealthCare Integrated Care Partners
- Medical Professional Services
- Northeast Medical Group
- SoNE HEALTH
- Starling Physicians
- Trinity Health of New England Medical Group
- Yale New Haven Health

OHS engaged a wide array of stakeholders, in addition to those represented on OHS' Primary Care Subgroup:

Medical Societies:

- Connecticut Chapters of Academy of Family Physicians
- Advanced Practice Registered Nurse Society
- American College of Physicians, American Academy of Pediatrics

State Agencies:

- Connecticut Insurance Department
- Department of Social Services
- Department of Public Health
- Office of the State Comptroller

Payers:

- Aetna
- Anthem
- Cigna
- ConnectiCare
- Harvard Pilgrim
- UnitedHealthcare

Roadmap strategies for sustainable primary care

The Roadmap initiative is multi-payer:

- Commercial market-focused
- Aligned with Medicaid



Key elements of Roadmap:



Payers will increase primary care spending up to the governor's target and take action to aid implementation of the Roadmap.



Primary care practices that choose to participate in the primary care Roadmap and adopt the prescribed core functions will receive enhanced primary care payments from payers for doing so.



Enhanced payments will go towards improving patient care and implementing high-quality primary care.

Roadmap strategies focus on:

1. Core function expectations of primary care practice teams
2. Resources and supports to help practice teams master the core function expectations
3. Methods to assess and recognize practice team performance
4. Voluntary primary care alternative payment models, beyond fee-for-service (FFS), to reimburse primary care

1. OHS adopted 11 core functions it believes will lead to high-quality primary care (1 of 2)

1. Care delivery is centered around the patient, including developing **trusted relationships...**
2. Care delivery is **team-based...**
3. Practices designate a **lead clinician** for each patient...
4. Practices **coordinate care** for its patients and are supported with **embedded clinical care management and non-clinical care coordination personnel...**
5. **Behavioral health** is integrated into the practice...
6. Practices deliver “**planned care**” at every visit...

1. OHS adopted 11 core functions it believes will lead to high-quality primary care (2 of 2)

7. Care is easily **accessible and prompt** ...and **culturally and linguistically competent**.
8. Care delivery follows **evidence-based** guidelines...
9. Practices **engage and support** patients...
10. Practices **use patient information and data** to identify care needs... and inform **quality and equity improvement** activities.
11. Practices identify **social risk factors** ...and are knowledgeable about **community resources** to address them.

2. OHS will support practices in mastering the 11 core functions

- A blend of supports to help practices implement and maximize the 11 core practice team functions:
 - Practice coaches
 - Learning collaborative



2. OHS will support practices in mastering the 11 core functions

1. Practice coaches are primarily provided by an OHS-contracted third party(ies).

- Because practices are required to demonstrate commitment to the mastery of all 11 core practice team functions to qualify for enhanced payments, practices will be offered access to practice coaching to help them master the 11 functions.
- Some practice teams may elect to receive coaching from a commercial insurer or its own resources.

2. OHS will support practices in mastering the 11 core functions

2. A learning collaborative is provided by an OHS-contracted third party(ies).

- Participation is voluntary and offered to all practices seeking or that have already obtained OHS recognition.
- The learning collaborative is contingent on state funding.

3. OHS will assess and recognize practice team performance

- There are two pathways for practices to become an OHS-recognized practice:
 1. Practices currently recognized by NCQA as a PCMH, including all DSS PCMH+ recognized practices, qualify for recognition with some limited additional requirements
 2. Practices not recognized by NCQA or that were recognized but let the recognition lapse can seek OHS recognition

3. OHS will assess and recognize practice team performance



Image courtesy of the National Academies of Science, Engineering, Medicine:
Implementing High-Quality Primary Care

- Requirement to renew OHS recognition every two years
- Practices may opt out of the OHS recognition process and forego enhanced payments specified by the primary care spend target

4. To support team-based care and balance interest from practices that want to move away from FFS, OHS asks insurers to make alternative, voluntary payment options available

- Make a value-based prospective primary care payment model available to interested practices, while permitting continued FFS payments to others
 - Primary care practices are prospectively paid a fixed PMPM fee for most primary care services in lieu of FFS payments.
 - Does not preclude other aligned primary care alternative payment models.
- Practices are eligible for enhanced payments so long as they are seeking or have obtained OHS-recognition for mastery of the 11 core practice team functions.

OHS parameters for any primary care alternative payment model to maximize overall success and ensure patients are not harmed

Common parameters require insurers to:

1. **Risk adjust payments** to account for variation in the health care conditions of different patient panels and for age and gender.
2. Provide **prospective notification** of those patients for whom they are receiving capitated payment.
3. Carefully **monitor practice behavior** to identify cases where access is decreasing or there are other signs of stinting on care or adverse impact.
4. Adopt for universal primary care contractual use an **aligned set of quality measures** that include equity-focused measures.
5. Offer and make payment related to **substantial quality incentives**.
6. Supply providers with **timely, high-quality data** to allow more effective management of their patient panel and their revenue under a capitated arrangement.

Wrap-up & Next Steps

Next Steps

- The next Stakeholder Advisory Board meeting will be held the first quarter of 2022.

Adjourn

