Primary Care and Related Reforms Workgroup Meeting

November 24, 2020

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Welcome and Agenda Review	Vicki Veltri, OHS	1:00 PM
Public Comment	Public	1:02 PM
Approval of October 27th Meeting Minutes	Vicki Veltri, OHS	1:08 PM
Vote on Adoption of Revised Charter and Bylaws	Vicki Veltri, OHS	1:09 PM
Appointment of Chair & Solicit Nominations for Vice Chair	Vicki Veltri, OHS	1:16 PM
PCRRWG Subgroups Process	Craig Hostetler, CedarBridge Group	1:23 PM
Moving to Value Alliance Model Presentation	Jeff Hogan, Rogers Benefit Group	1:32 PM
Medicaid PCMH and PCMH+ Models Presentation	Kate McEvoy, Dept. of Social Services	2:02 PM
Primary Care Modernization (PCM) Care Delivery Principles	Elsa Stone, American Academy of Pediatrics	2:22 PM
Facilitated Discussion - Exploring PCM Integration and Other Concepts for Roadmap Development	All - Facilitated by Craig Jones, CedarBridge Group	2:42 PM
Meeting Adjournment	All	3:00 PM

Public Comment

(2 minutes per person)

Approval of October Meeting Minutes

Adoption of PCRRWG Charter and Bylaws

Appointment of Chair

Vice Chair Nominations

PCRRWG Learning Health Network and Subgroups Process

Craig Hostetler,
CedarBridge Group

Process

- Level set understanding of the work that was accomplished through the SIM grant at the November and December PCRRWG meetings
- Introduce new models and innovations, including those impacted by the COVID-19 pandemic at the November and December PCRRWG
- Subgroups will identify and bring forward:
  - Aspects of the HEC, PCM, and other SIM recommendations to consider or modify for the Roadmap
  - Other innovative models and concepts for the Roadmap
  - Potential and actual barriers to implementation
  - Methods and considerations for overcoming and avoiding barriers
  - Implications for various stakeholders (patients and families, various types of health care providers, community organizations, governments, and insurance providers)
  - Glide path strategies to meet various stakeholders where they're at in their readiness for models and concepts proposed

PCRRWG Subgroups

Population Health & Health Equity Design Group

Practice Transformation Design Group

Why these subgroups?

- In recognition of the significant progress already accomplished through the Population Health Council and Practice Transformation Task Force
- Consistent areas of interest and focus among work group members
- Two subgroups keeps our process agile; more feasible for members with subject matter expertise or interest in both areas to participate
- Allows for more in-depth discussion on these critical areas with the intent of bridging to action sooner than later

Topics for Consideration

- **Population health and health equity**
  - Health Enhancement Communities
  - Community information exchange
  - Braided funding strategies

- **Practice transformation**
  - Clinical innovations in primary care
  - Pediatric models
  - Safety-net clinic and FQHC models
  - Behavioral health models and integration with primary care
  - Chronic medication optimization and management models

- **Included in both**
  - Integrating the patient perspective and needs
  - Payer led models
  - Data informed coordination and HIE
  - Healthcare and community-based organization workforce capacity
  - Integration of population health with clinical practice transformation

Moving to Value Alliance

Jeff Hogan,
Rogers Benefit Group

Medicaid PCMH and PCMH+ Models

Kate McEvoy,
Department of Social Services

Overview of HUSKY Health Primary Care Initiatives

November 2020

A Snapshot of the Program

- Connecticut HUSKY Health (Medicaid and CHIP) serves over 850,000 individuals (21% of the state population)

- Connecticut is a Medicaid expansion state, and optimized use of many other aspects of the Affordable Care Act (preventive services, health homes, Community First Choice, Balancing Incentive Program, State Innovation Model Test Grant)

- By contrast to many other Medicaid programs that rely on capitated managed care, Connecticut uses a self-insured, managed fee-for-service approach in partnership with three Administrative Services Organizations (medical, behavioral health dental)

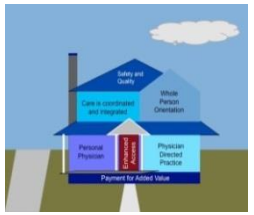
Primary Care Foundation

Our view is that primary care is a foundation on which to meet needs of people with complex health profiles and life circumstances, so we have made many investments there, taking a layering approach:

- expansion of coverage (e.g. smoking cessation, family planning, fluoride varnish)
- Electronic Health Record payments
- maintenance of ACA primary care “rate bump” for many codes
- reimbursement for behavioral health and developmental screenings
- PCMH supports: free practice coaching, enhanced rates, performance and year-over-year improvement payments
- PCMH+ supports: supplemental care coordination payments and upside-only shared savings arrangements

Our Roadmap

On a foundation of



Person-Centered Medical Homes

ASO-based Intensive Care Management (ICM)

Pay-for-Performance (PCMH, OB)

Data Analytics/ Risk Stratification

we have built in

Community-based care coordination through expanded care team (health homes, PCMH+)

Supports for social determinants (ICM, transition/tenancy sustaining services)

PCMH+

with the desired result of creating

Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods

PCMH Overview

The Person-Centered Medical Home (PCMH) initiative, which includes limited embedded care coordination, extended hours and use of Electronic Health Records:

- has grown and matured, now including 120 practices, over 550 sites and more than 2,300 providers (internal medicine, family medicine, pediatricians, geriatricians)
- is supporting half of HUSKY Health members, who have chosen to receive their care at those practices
- has consistently been associated with strong positive scores through mystery shopper (measuring access) and CAHPS (measuring consumer experience of care)

- has demonstrated strong outcomes:
  - PCMH practices' quality measure results show a linear trend and improvement in all measures except post admission follow-up and the readmission measure
  - Emergency department utilization trend over time shows a significantly better outcome in PCMH practices that have received performance payments, although there have been fluctuations
- has incentivized practices to improve and maintain high quality care
- is a prerequisite to participation in our shared savings initiative, PCMH+

PCMH+ Overview

The Person-Centered Medical Home + (PCMH+) initiative, which includes enhanced features of care coordination, supplemental care coordination payments to FQHCs, and an upside-only shared savings approach:

- has completed a first (one-year period) and second wave (two-year period) and is currently in a third (two-year period)
- is supporting over 180,000 Medicaid members, who have chosen to receive their care at those practices
- has showed very low opt-outs and complaints, and has been associated with strong positive scores through mystery shopper and CAHPS surveys

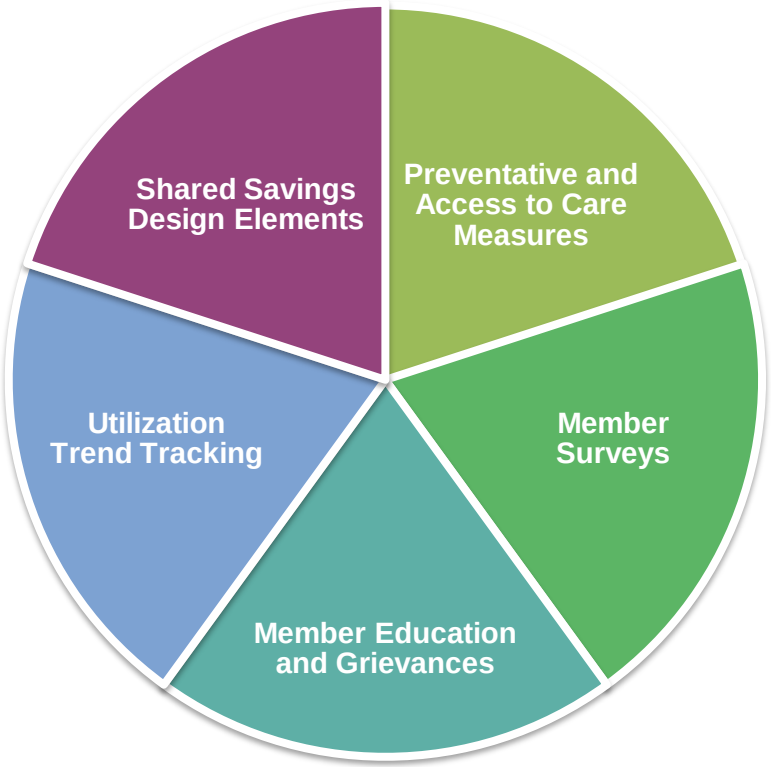
PCMH+ features the following enhanced care coordination activities:

Enhanced Care Coordination Category	Activities Required for Both FQHCs and Advanced Networks
Behavioral health/physical health integration	• Employ a behavioral health care coordinator • Screen for behavioral health conditions • Use psychiatric advance directives for adult and transition age youth • Use WRAP or other recovery planning tools
Culturally competent services	• Provide training and incorporate elements related to culture within care plan • Comply with CLAS standards
Children with Special Health Care Needs	• Perform advance care planning
Disability competence	• Expand health assessment to include questions regrading needs • Provide accommodations

See this link for more detail: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/Wave-2/Enhanced-Care-Coordination-Guide-4_18_18.pdf?la=en

- PCMH+ uses the **five-pronged approach** depicted at right to identify indicators of under-service

- DSS regularly assesses these to ensure that access to and quality of care for Medicaid members is not adversely affected by the shared savings approach - there is no indication to date that PCMH+ has had any adverse impacts



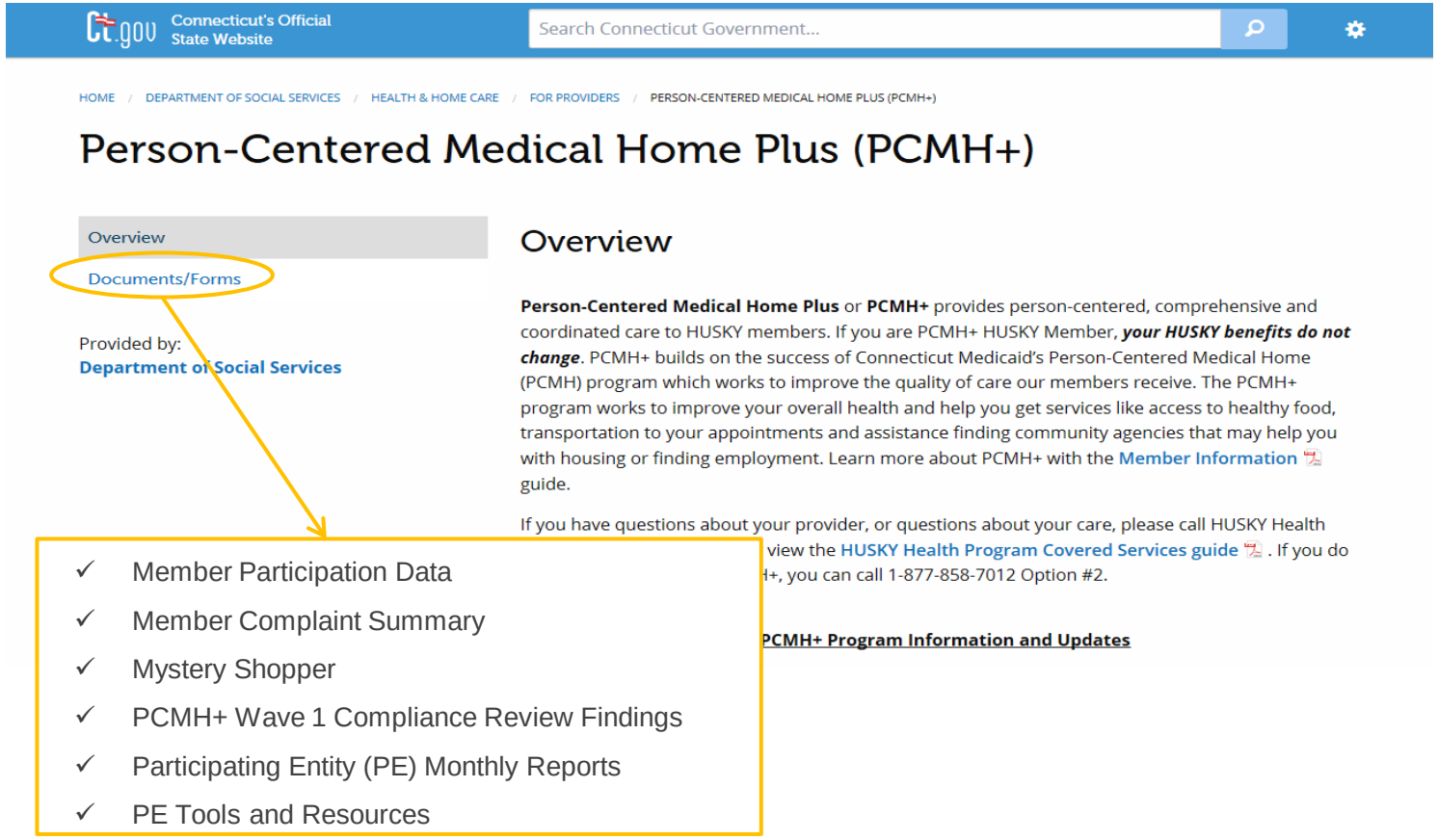
- PCMH+ is competitively procured and in its third wave includes ten Federally Qualified Health Centers (FQHCs) and ten "advanced networks" as Participating Entities (PEs)

- PCMH+ has shown progress in the following:
  - **local adoption of enhanced care coordination** features
  - **connections between primary care practices and community-based organizations** through formal agreements and feedback loops
  - **use of Medicaid claims and ADT data** that is being provided via portal
  - **hiring of community health workers**
  - various, locally informed applications of **behavioral health integration**
  - **great collaboration with peers** via an ongoing provider collaborative, related to clinical practice
  - **positive results on some quality measures**, while others have not yet improved

- PCMH+ has incentivized FQHC PEs with supplemental care coordination payments in support of behavioral health integration and expansion of care teams to include community health workers (CHWs)
  - these are Medicaid payments that are made up of state funds and federal match
  - these payments are recouped in the shared savings calculation

- PCMH+ has achieved Medicaid savings – in Wave 2:
  - the program saved $8.2 million in total
  - 12 out of 14 PEs received a payment from either the Individual Savings Pool or the Challenge Pool

Extensive information is publicly available on the DSS PCMH+ website: portal.ct.gov/dss/Health-and-Home-Care/PCMH-Plus



Impact of and Response to PHE

- DSS recognizes that the COVID public health emergency (PHE) caused:
  - stress and anxiety, access barriers, challenges around continuity of care and support with chronic conditions, and economic insecurity for Medicaid members, in general;
  - stark, disparate impacts for Medicaid members of color; and
  - operational and financial stressors and constraints for providers

- Specific to primary care providers, DSS has:
  - covered:
    - COVID testing and treatment for both symptomatic and asymptomatic members, and also antibody testing
    - a new Medicaid coverage group for testing of uninsured people
    - a broad portfolio of telehealth authorities for primary medical and behavioral health care, at parity with in-person visits and via videoconference and (in identified cases) audio-only
  - promoted opportunities around federal Provider Relief Fund assistance (early distributions favored Medicare providers, but advocacy yielded a specific distribution for Medicaid providers)

- Please see the Appendix for more detail on DSS activities

Appendix: Actions Taken by DSS to Support Members and Providers During Public Health Emergency

Member Supports

To support members during the PHE, HUSKY Health:

- Is covering COVID-19 testing and treatment with no cost share
- Extended coverage to 90-day periods for prescription drugs, medical surgical supplies, hearing aid batteries, parenteral/enteral supplies, respiratory equipment and supplies
- Through CHNCT, is maintaining a 24/7 nurse care line, supporting referrals to providers, and using data to identify and connect people who are at high risk with Intensive Care Management

- Through Beacon Health Options, has implemented a peer staff warm line
- Expanded home and community-based long-term services and supports under the waivers
- Is ordering and distributing Personal Protective Equipment (PPE) to consumer employers who participate in self-directed care under Community First Choice
- Recently implemented a specialized Non-Emergency Medical Transportation (NEMT) service for COVID-positive people




Provider Supports

HUSKY Health has supported providers by . . .	• Implementing coverage for telemedicine at the same rates that are paid for in-person visits • Providing administrative flexibilities (e.g. removal of prior authorization) in where and how care can be provided • Continuing to pay 100% of clean claims on a timely, bi-weekly basis • Making payment advances and provider relief payments • Advocating at the federal level for further financial relief

OHS CONNECTICUT Office of Health Strategy

Primary Care Modernization: Unlocking the Potential of Primary Care to Improve Health and Affordability

OUR SHARED CHALLENGE

The highest performing health systems spend 10 to 12% of health care dollars on primary care. In Connecticut, primary care spending is 5% or less. The result is underuse of high value services, overuse of low value services, higher overall spending and worse outcomes.

Connecticut ranks…

- At the bottom of a 29 state analysis of health care spending on primary care, at 3.5%[1]
- 32nd worst in the nation in avoidable hospital use and costs, largely driven by avoidable ED use[2]
- 6th highest private health insurance spending per capita and 5th highest for Medicare[3]
- 43rd worst in the nation in health disparities[4]
- 39th worst in the nation in deaths from drug use[5]

The United States ranks last in primary care providers per 1,000 among developed countries[5]. Connecticut is projected to require a 15% increase by 2030 to keep pace with current utilization[6].

[1] PCPCC Evidence Report Investing in Primary Care: A State-Level Analysis, 2019, https://www.pcpcc.org/sites/default/files/resources/PCPCC%202019%20Evidence%20Report%20Presentation.pdf
[2] Commonwealth Fund Scorecard on State Health System Performance, 2018, https://interactives.commonwealthfund.org/2018/state-scorecard/files/Connecticut.pdf
[3] Kaiser Family Foundation State Health Facts, 2017, https://www.kff.org/other/state-indicator/per-capita-state-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[4] America's Health Rankings 2018 Annual Report, https://www.americashealthrankings.org/
[5] Organisation for Economic Cooperation and Development, https://stats.oecd.org/Index.aspx?QueryId=30173
[6] Connecticut: Projecting Primary Care Physician Workforce, https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Connecticut.pdf

TRANSFORM CARE ACROSS THE DELIVERY SYSTEM

PCM aligns Connecticut around proven capabilities and flexible payment model options that support patient-centered, convenient care delivered effectively and efficiently.

GOALS

- IMPROVE ACCESS
- IMPROVE PATIENT EXPERIENCE
- IMPROVE QUALITY
- REVITALIZED PRIMARY CARE
- IMPROVE OUTCOMES

INPUTS

- PATIENTS AND FAMILIES
- CARE TEAMS
- PRIMARY CARE CAPABILITIES
- HEALTH NEIGHBORHOOD
- POPULATION HEALTH MANAGEMENT

ENABLERS

- FLEXIBLE PAYMENTS
- COST ACCOUNTABLE PAYMENT
- CONSUMER SAFEGUARDS
- QUALITY MEASUREMENT
- PEFORMANCE ACCOUNTABILITY

IMPACTS

- REDUCTION IN UNNECESSARY HOSPITAL, ED, AND SPECIALTY CARE
- GREATER USE OF HIGH VALUE SERVICES
- PREVENTIVE CARE AND CHRONIC CONDITION OUTCOMES IMPROVE
- PROVIDER RECRUITMENT AND RETENTION IMPROVES
- AFFORDABILITY IMPROVES

MEET DR. NEIL

Dr. Neil is a primary care physician trying to provide good care. She feels overwhelmed by billing, coding and other administrative hassles. She wishes she had more clinical support too.

MEET DR. NEIL'S PATIENTS

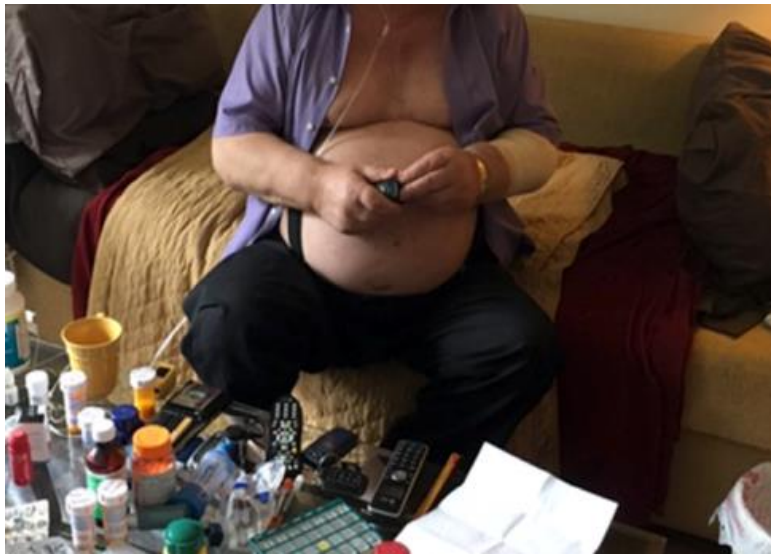
Chris and Mr. Jones need more support than Dr. Neil can provide alone. They are frustrated and worried. They want to feel well again.

MR. JONES' STORY

Mr. Jones has a complex medical history including heart failure, stroke, diabetes, and kidney disease. Recently, he began having serious complications.

Mr. Jones' Needs

- Help managing prescriptions for diabetes, congestive heart failure, kidney disease
- More frequent and closer monitoring of changes in condition
- Fewer avoidable trips to the doctor due to mobility challenges related to a stroke



Dr. Neil's Practice Solutions

- Home visit by part-time pharmacist
- eConsult with cardiologist
- Video check-ins with PCP and/or RN care manager
- Remote patient monitoring for congestive heart failure
- CHW or nutritionist provides coaching on diet
- Frequent communication with care team through phone and email

CHRIS' STORY

Chris was diagnosed with Crohn's disease in her teens. Lately, her condition has been flaring up more often and its affecting her work and her mental health.

Chris' Needs

- Help managing her Crohn's flare-ups
- Support for her depression
- More coordinated care to reduce the number of specialists she is seeing
- Fewer days of missed work and fewer trips to the emergency room

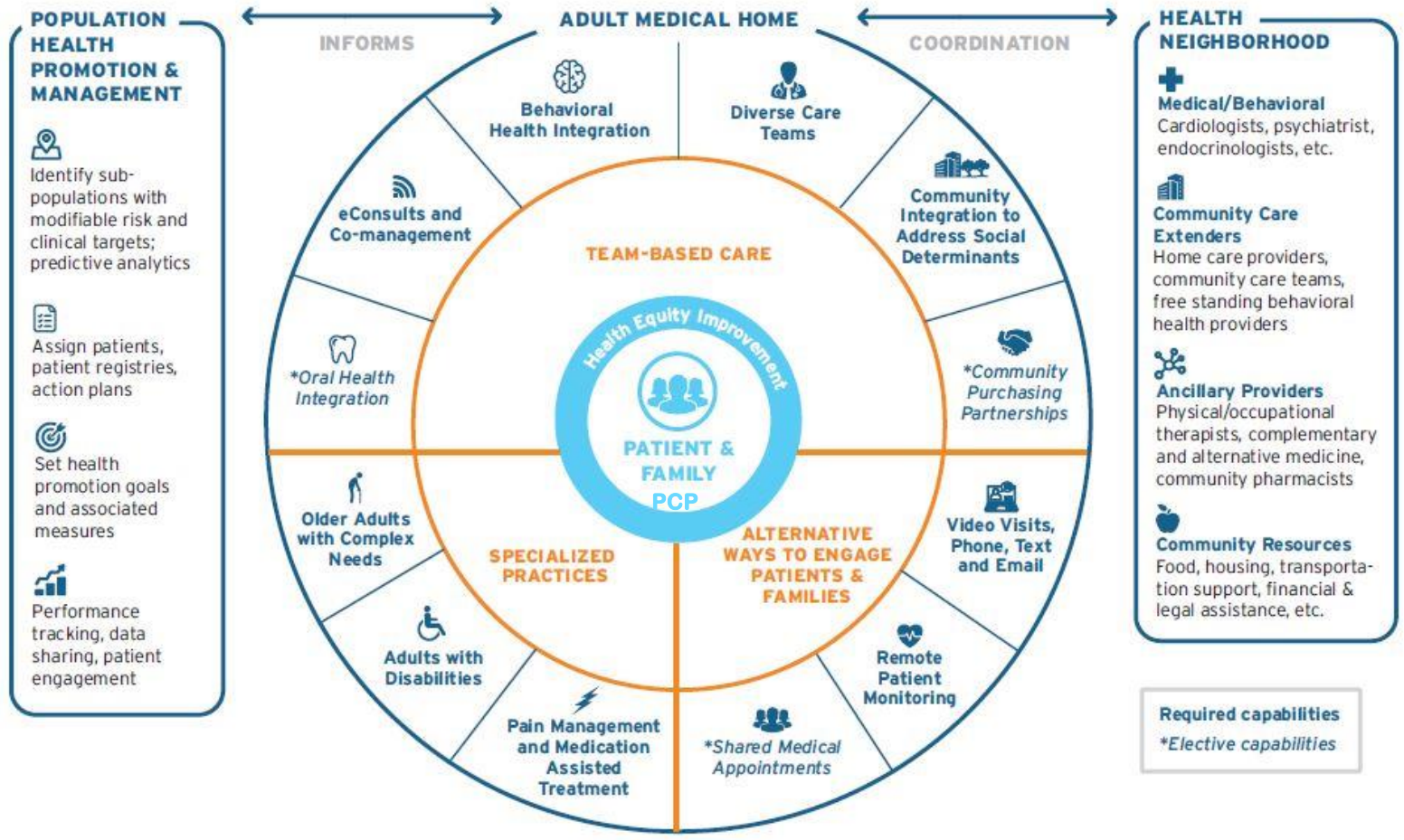
Dr. Neil's Practice Solutions

- Part-time LCSW identifies behavioral health needs, makes referrals, and provides monthly support
- Coordinated care between the gastroenterologist, PCP, and LCSW
- eConsult addresses new skin problem
- Nutritionist counsels Chris on changes to her diet such as limiting fiber and dairy

DRAW SHARED FOCUS TO PROVEN CAPABILITIES

Practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, convenient and responsive to patients' needs while improving health equity.

Adult Primary Care Capabilities



OHS CONNECTICUT Office of Health Strategy

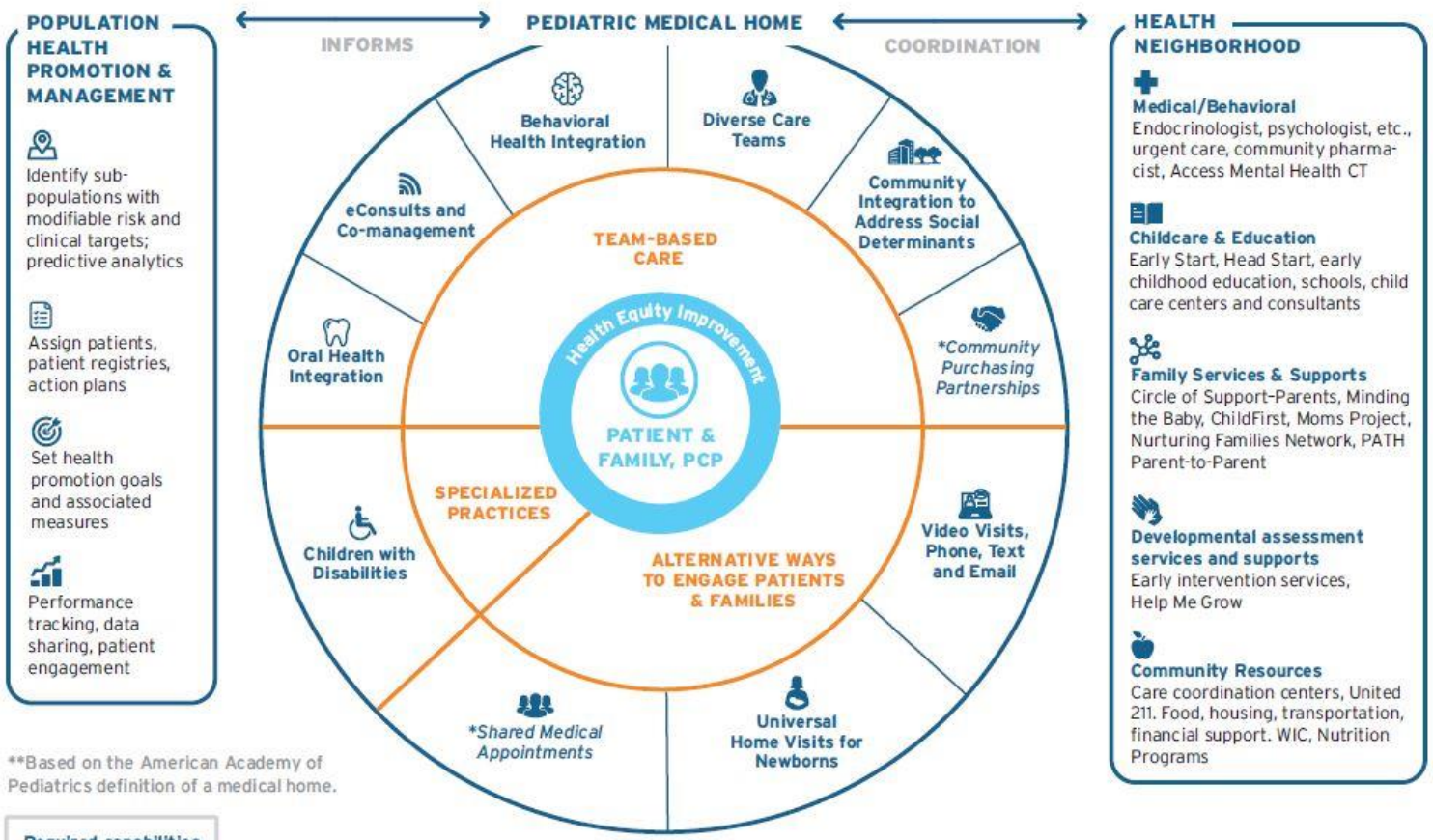
DRAFT FOR DISCUSSION ONLY

SIM connecticut state innovation model

ADDRESS SPECIFIC NEEDS OF PEDIATRICS

Pediatric practices participating in PCM will develop care delivery capabilities that aim to make care more accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Pediatric Primary Care Capabilities



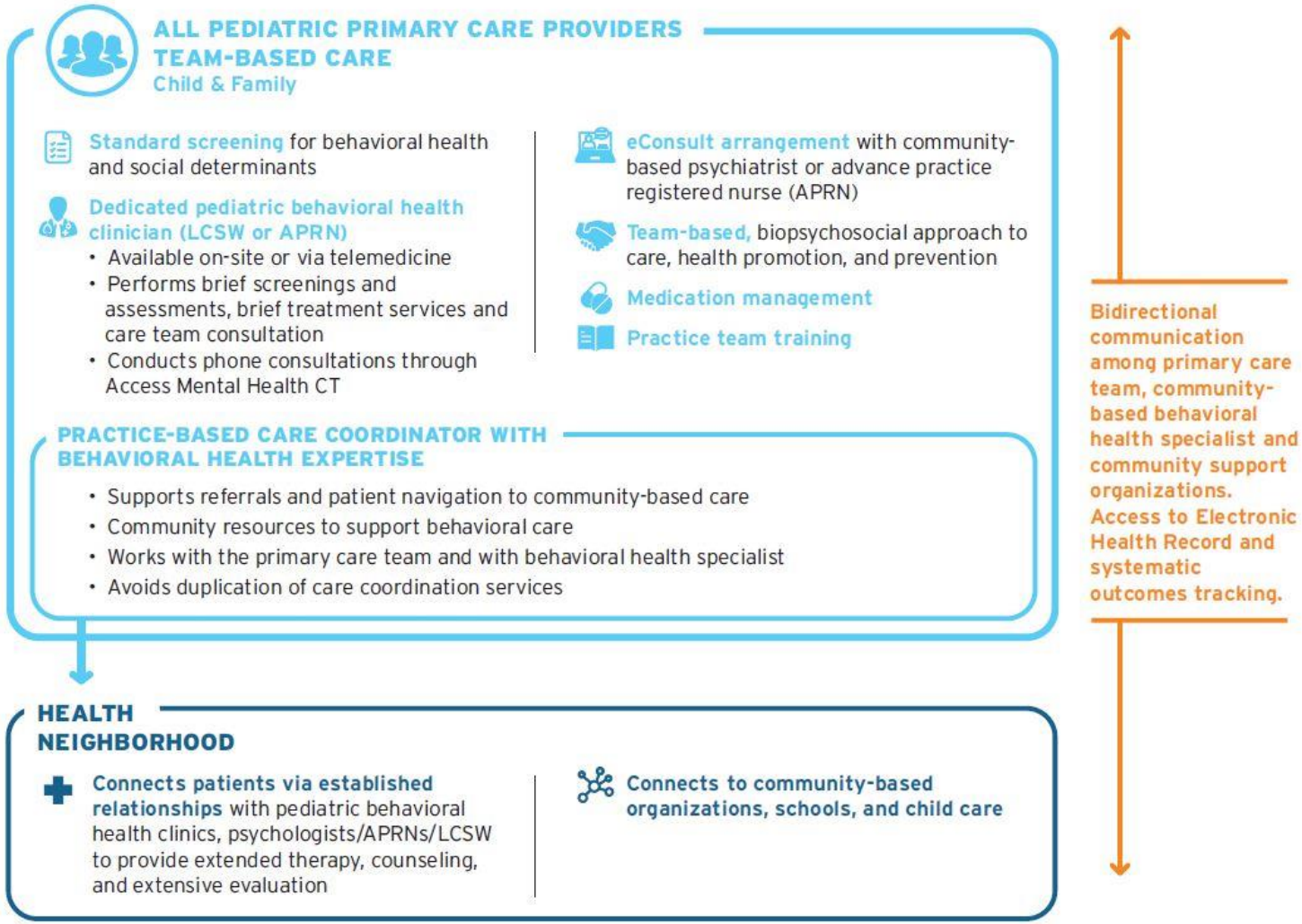
OHS CONNECTICUT Office of Health Strategy

DRAFT FOR DISCUSSION ONLY

SIM connecticut state innovation model

PEDIATRIC BEHAVIORAL HEALTH INTEGRATION

A team-based approach to prevention, early identification and promotion of developmental, socio-emotional, and mental health for children and families within the pediatric medical home and community.



OHS CONNECTICUT Office of Health Strategy

DRAFT FOR DISCUSSION ONLY

SIM connecticut state innovation model

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

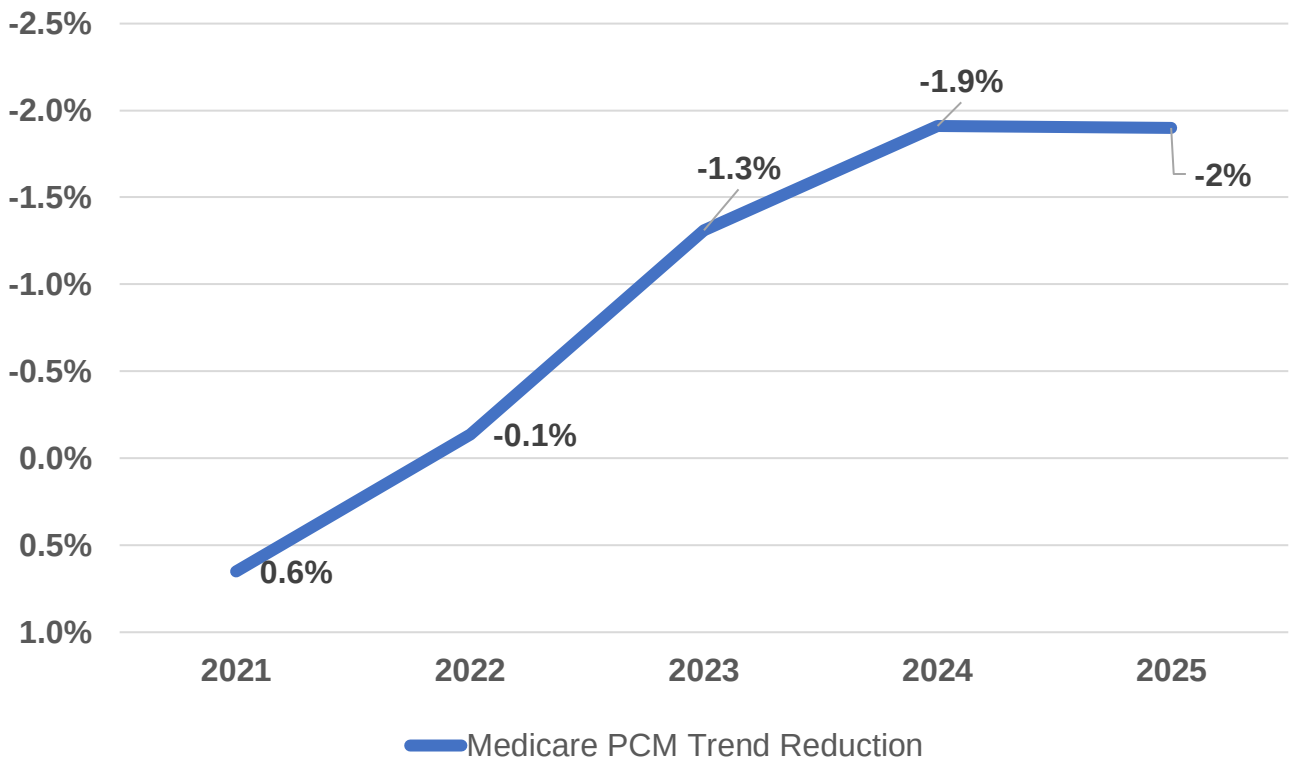
PMPM savings reflects the estimated per member, per month savings across the entire Medicare population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Medicare Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%, inpatient costs decrease 10%. *(PWC 2016)*	$32.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$4.03
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 6%. *(Strumpf, 2016; The Commonwealth Fund March 2012)*	$2.70
Specialized Practices: Pain Management/MAT	Total medical expense decreases 45%. *(Duke 2017)*	$2.10
Specialized Practices: Older Adults with Complex Needs	Skilled nursing facility utilization decreases 16%. *(Gross 2017)*	$15.03
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$1.47
Remote Patient Monitoring	Avoidable readmission costs decrease 50%. *(Broderick 2013)*	$0.33

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year two.

PCM Impact on Medicare Total Cost of Care



PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for Medicare
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Approximately 4.7% spend redeployed to primary care

EVIDENCE SHOWS PCM CAPABILITIES SAVE MONEY

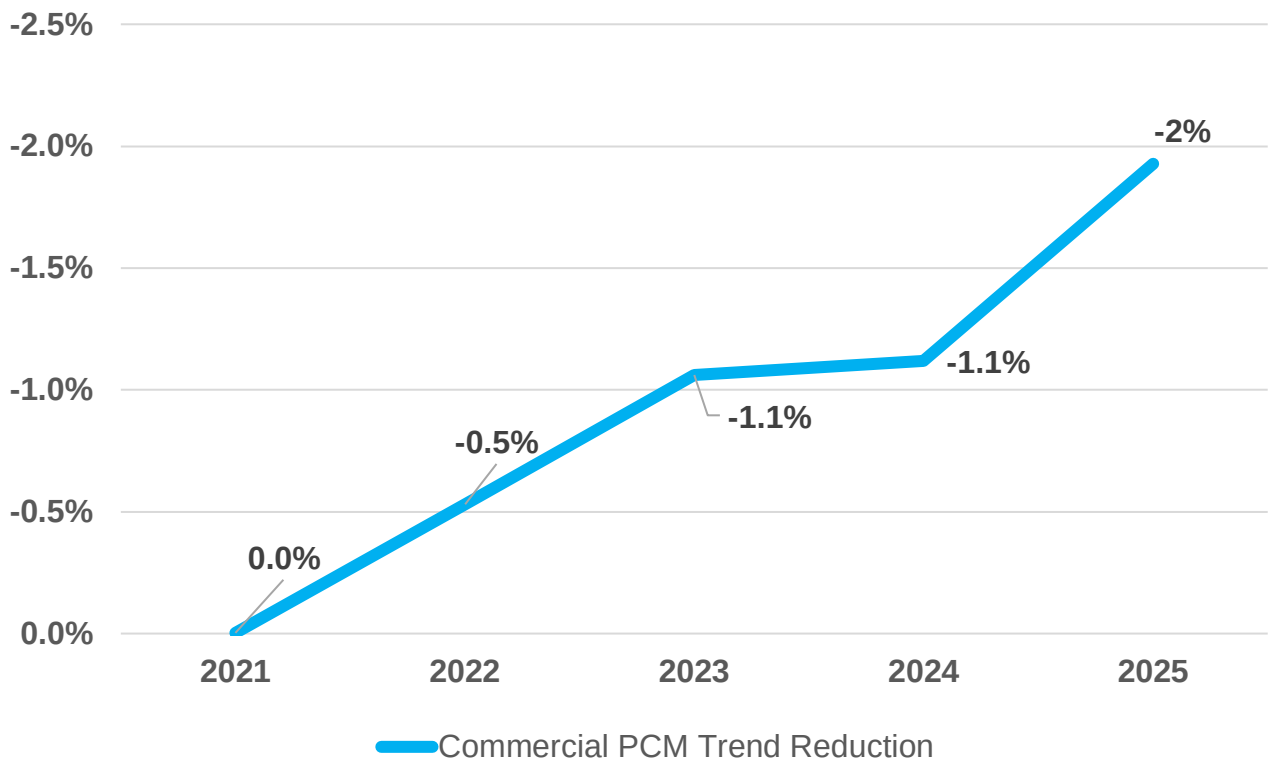
PMPM savings reflects the estimated per member, per month savings across the entire Commercial population. Therefore, this figure is smaller than the estimates for those benefiting from the capability.

Capability	Estimated Savings for Commercial Patients Benefiting from the Capability	Savings Applied to Entire Population (PMPM)
Diverse Care Teams	Emergency department costs decrease 20%; inpatient costs decrease 10%. *(PWC 2016)* Other outpatient facility costs decrease 12% *(NEJM, 2014)*	$19.00
Behavioral Health Integration	Total medical expense decreases 10%. *(Unützer 2008)*	$1.27
Phone, Text, Email and Telemedicine	Avoidable specialist costs decrease 3.6-6%. *(Strumpf, 2016;* The Commonwealth Fund March 2012)	$2.00
eConsult and Co-management	Based on 590 referrals by 36 primary care clinicians, eConsults replaced face-to-face specialty visits 69% of the time. *(The Annals of Family Medicine, 2016)*	$1.20

SAVINGS INCREASE AS CAPABILITIES IMPROVE OUTCOMES

Based on an extensive review of the evidence, modeling shows PCM would drive immediate reductions in avoidable utilization and those savings would more than cover the cost of the program by year two.

PCM Impact on Commercial Total Cost of Care



PCM IMPROVES AFFORDABILITY

- Immediate reductions in avoidable utilization
- Return on investment in year 2 for commercial payers
- Nearly 2 percent annual reduction in total cost of care by year 5
- Less spending on low value services and more spending on high value services
- Four percent of spend redeployed to primary care, similar to successful BCBS MA program (NEJM, 2016)
- Aligned with value-based insurance design
- Ability to reduce consumer cost share for commercial members, if desired

IMPACT
HEALTH EQUITY

Through capabilities focused on identifying and addressing health disparities and payment model options that recognize social factors impact cost, PCM would improve health equity in Connecticut.

People from communities of color, non-English speakers, and other underserved populations have higher rates of disease, less access to quality care, and poorer health outcomes. Disparities are largely driven by systemic barriers.

By creating new systems and employing care teams that reflect the patients and communities they serve, PCM capabilities work together to address barriers such as:

- Language differences
- Culture
- People with disabilities, including physical, intellectual, and mental health impairment
- Lack of transportation, childcare, food security, housing stability
- Difficulty taking time off work
- Literacy

CHARTING A COURSE TO MODERNIZATION

Practices will have the freedom to design their own implementation plan to achieve the required capabilities within five years.

The timeline below is aspirational and dependent on funding allocation. This offers an example of how practices might choose to rollout the new capabilities.

YEAR 1

CARE TEAM EXPANDS. Pilot practices include multi-disciplinary care teams that should include community liaisons. Care transitions are a focus.

PCPs and care team receive technical assistance to support workflow redesign.

Phone, text, email upgraded for better patient experience.

eConsult, remote patient monitoring offered.

YEAR 2

INTEGRATED BEHAVIORAL HEALTH PILOTED with hiring of LCSW.

Patients connected to community resources after analysis of social determinants data.

Care team expands to additional practices; new care team roles introduced. Technical assistance continues.

YEAR 3

FORMAL PARTNERSHIP LAUNCHED with local housing referral service.

Integrated behavioral health expanded to all practice sites.

Care team expansion and technical assistance continues.

YEAR 4

TWO SPECIALIZED PRACTICES DEVELOPED. One supports older adults with complex medical needs. Another focuses on chronic pain management.

Existing capabilities refined and expanded.

YEAR 5

ALL PRACTICES ACHIEVE ALL CORE CAPABILITIES.

Technical assistance continues.

Two additional partnerships with community-placed resources launch.

OHS CONNECTICUT Office *of* Health Strategy

DRAFT FOR DISCUSSION ONLY

SIM connecticut state innovation model

Exploring PCM Integration and Other Concepts for Roadmap Development

Facilitated by Craig Jones, MD
CedarBridge Group

Meeting Adjournment