Primary Care Subgroup Meeting
July 27, 2021

OHS
CONNECTICUT
Office *of* Health Strategy

Roll Call

Public Comment (2 minutes/person)

Approval of June Meeting Minutes

Agenda

Welcome and Roll Call	Office of Health Strategy	1:00 PM
Public Comment	Members of the Public	1:05 PM
Approval of June Meeting Minutes—Vote	Members of the PCSG	1:15 PM
June Subgroup Meeting Recap	Bailit Health	1:20 PM
Continuation of Roadmap Development	Bailit Health	1:30 PM
Next Steps and Wrap-up	Bailit Health	2:55 PM
Meeting Adjournment	All	3:00 PM

June Subgroup Meeting Recap

Recap of decisions and discussion from June meeting (1 of 2)

1. Final edits were made to the 11 core practice team functions based on Subgroup and stakeholder feedback
   - Updated, redlined version distributed to the Subgroup on 7/22

2. Discussion resumed on supports to help practice teams implement and maximize core functions. Feedback from the Subgroup included:
   - A continued clinician preference for a unified approach to practice coaching that includes centralized coaches instead of multiple coaches provided by different health plans
   - A recommendation for a multi-pronged approach to practice coaching that addresses different needs of practices and provides an option for practices and insurers to maintain existing relationships if preferred
   - Varied experiences with learning collaboratives

Recap of decisions and discussion from June meeting (2 of 2)

3. Options for confirming practice adoption of core practice team functions were reviewed. Feedback from the Subgroup included:
   - Concerns from small practices regarding added costs of recognition
   - Mixed responses to full NCQA recognition
   - Agreement that complete self-attestation is not a viable option
   - Preference for a hybrid approach involving self-attestation with limited review and a state-developed recognition process

Continuation of Roadmap Development

Today's focus: Revisit #3 and #4, introduce #5

Process Step	Description
1. Establish highest priority objectives for a strengthened primary care system	This should be a listing of only the highest priorities, such as those identified in the "Guiding Principles." It should not be all-inclusive.
2. Adopt an advanced primary care practice model	This should describe core, essential practice functionalities.
3. Decide how practices will be supported in adopting the practice model, and by whom	For example: learning collaborative, practice coaching, self-taught with learning aids, or a combination
4. Adopt a program for confirming practice model adoption	This is necessary for payers to support investment.
5. Adopt a payment model(s)	The payment model(s) should support the care model, sustain practices and align with objectives for high-value.
6. Adopt an implementation plan	The plan describes who will be responsible for doing what, and by when. Involved stakeholders should support the plan; commercial payers must commit to it.
7. Define a measurement and evaluation plan	To determine that the highest priority objectives were achieved, without any unintended adverse consequences.

New!

Today we present a revised proposal for practice team supports based on Subgroup feedback

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

1. **Practice coaches are primarily provided by an OHS-contracted third party**
   - Practice teams seeking enhanced payments are required to work with a practice coach
   - Some practice teams may receive coaching by a commercial insurer
   - The third party is funded by large commercial carriers on a pro rata basis
2. **A learning collaborative is provided by an OHS-contracted third party**
   - Participation is voluntary and offered to all practices seeking or that have already obtained OHS recognition
   - The learning collaborative is contingent on state funding

Practice team coaching proposal

1. Practice teams seeking enhanced payments are required to work with a practice coach until the practice team has demonstrated mastery of all 11 core functions
2. Each practice team undergoes an initial and then a periodic assessment to evaluate practice team functionality relative to the 11 core functions
3. Practice teams are required to work earnestly, and with demonstration of commitment to quality improvement, with an OHS-recognized practice coach
4. Practice coaching is primarily provided by an OHS-contracted third party, with shared funding provided on a pro rata basis by the state's largest commercial insurers*. Some practice teams may instead receive practice coaching by a commercial insurer:
   - if the practice team expresses a preference for doing so, and
   - the insurer demonstrates a commitment and plan for addressing the 11 core practice team functions in its coaching.

* DSS has been excluded because of its investment getting 100's of CT practices NCQA-certified.

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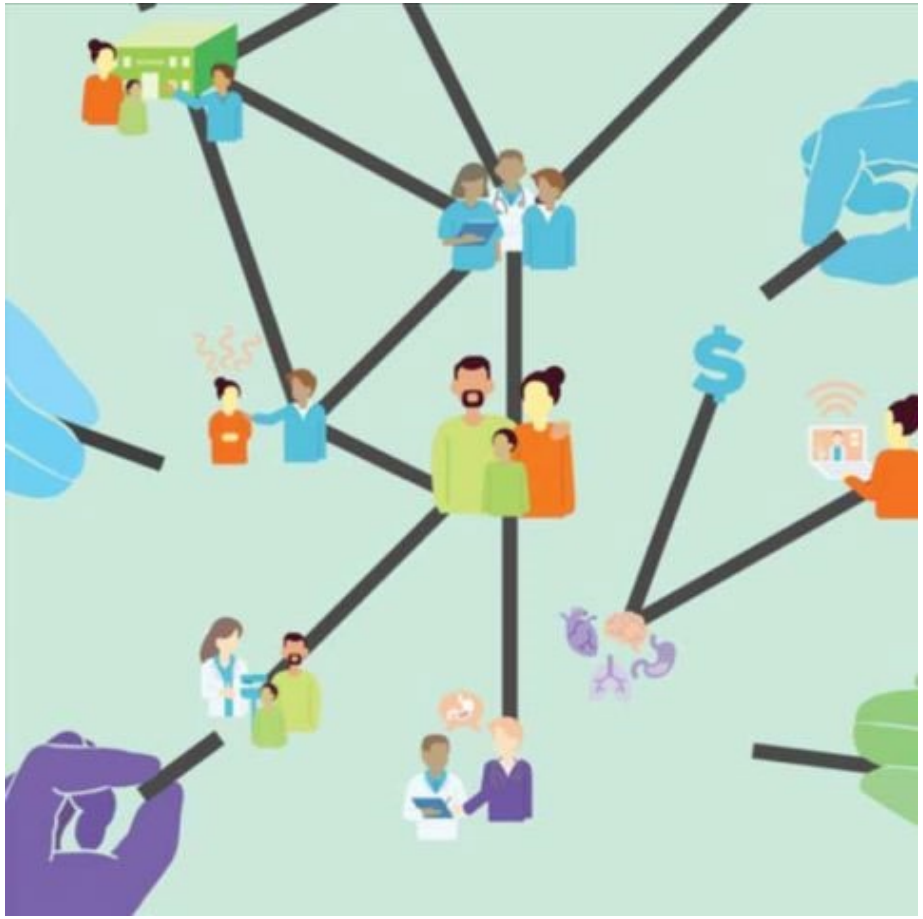
Learning collaborative proposal

1. The learning collaborative is provided by an OHS-contracted third party, contingent on state funding
2. Learning collaborative participation is offered to every practice that is seeking or has obtained OHS practice team recognition
3. Learning collaborative participation is *voluntary* and not linked to OHS recognition of primary care practice teams
   - Only practice teams with clinician leadership committed to collaborative participation are encouraged to apply to participate
4. Separate learning collaboratives are organized around care of children and adolescents and around care of adults
   - Family practices may elect to participate in either

For discussion

- Will these supports help practices implement and maximize the core functions?
- Do these revised proposals appropriately balance practice concerns and payer preferences?
- What questions and feedback does the group have?
- Are there any suggested modifications?

A practice's demonstration it has mastered the core functions is indicative of high performance



- **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 relapse can seek recognition
- **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**

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Practice team recognition program proposal (1 of 3)

1. Practices currently recognized by NCQA as a PCMH, including all DSS PCMH+ recognized practices, qualify for recognition with some limited additional requirements. Practice teams must:
   - Demonstrate embedded care management, care coordination and behavioral health functionality within two years
   - Identify how additional investment (enhanced payments) will be allocated to support improved patient care
   - Work earnestly, and with commitment to quality improvement, with an OHS-recognized practice coach until demonstrating mastery of all 11 core practice team functions to OHS's satisfaction

Practice team recognition program proposal (2 of 3)

2. Practices not recognized by NCQA or were recognized but let the recognition relapse, can seek recognition. Practice teams must:
   - Attest to, and in some cases demonstrate, mastery of the 11 OHS core practice team functions:
     - Six functions at the outset
     - Nine functions after one year
     - 11 functions after two years
   - Demonstrate embedded care management, care coordination and behavioral health functionality within two years
   - Identify how additional investment (enhanced payments) will be allocated to support improved patient care
   - Work earnestly, and with commitment to quality improvement, with an OHS-recognized practice coach until demonstrating mastery of all 11 core practice team functions to OHS' satisfaction

Practice team recognition program proposal (3 of 3)

- All OHS-recognized practice teams must have their recognition renewed every two years by submitting satisfactory responses to an OHS survey:
  - NCQA-recognized PCMH practice teams: demonstration of current NCQA PCMH recognition and demonstration of continued embedded care management, care coordination and behavioral health functionality
  - OHS-recognized practice teams: attestation to, and in some cases demonstration of, mastery of the 11 OHS core practice team functions, including but not limited to demonstration of continued embedded care management, care coordination and behavioral health functionality

For discussion

- Does this proposal to recognize practices for demonstrating the core practice team functions appropriately balance practice concerns and insurer preferences?
- What questions and feedback does the group have?
- Are there any suggested modifications?

Introducing a primary care payment model for Subgroup consideration

- The model(s) should align with established priority objectives for a strengthened primary care system, support the agreed upon core practice team functions, and sustain practices.
- Stakeholder interviews have revealed mixed feedback about primary care payment model(s):
  - Some practices desire to move away from fee-for-service payment, especially after the financial hardships created by COVID-19
  - Other practices are uncomfortable moving towards prospective payment and fear decreased revenue
  - OHS' primary care strategy, including payment models, must work for practices of all sizes

Potential benefits to primary care practices of a prospective payment model

1. Provides practice teams with greater flexibility to deliver primary care that better meets the needs and preferences of patients, e.g., traditionally uncompensated time to coordinate care for medical and social needs outside of the practice, use of community health workers, etc.
2. Allows practice teams to provide team-based services using care modalities that aren't often compensated under traditional FFS models, and reduces the financial imperative to generate office visits
3. Provides a predictable monthly cash flow; COVID-19 revealed how important this can be
4. Because the payment only includes those services the practice team delivers, the model does not transfer significant financial risk to the practice

Proposed primary care payment model for Subgroup consideration

- Make a value-based prospective primary care payment model available to interested practices, while permitting continued FFS payments to others
- Practices are eligible for enhanced payments under either approach, so long as they are seeking or have obtained OHS-recognition for mastery of the 11 core practice team functions.
  - Practices begin receiving enhanced payments upon indicating intent to become OHS-recognized.

1. Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel
2. Insurers can elect to enhance payments to practices however they like in order to hit the primary care spend target; the mode is not specified in OHS' recommendations

Common parameters for prospective payment

- The proposed prospective payment model includes common parameters to protect practices and insurers from challenges and risks associated with such a model and to maximize its overall success.
- Some parameters are widely accepted in value-based payment contracting; others are proving successful in national and state primary care initiatives.
- Recommendations were derived from those established by a stakeholder work group commissioned by the Rhode Island Office of the Health Insurance Commissioner to facilitate stakeholder discussions towards adoption of a primary care capitation payment method.

Primary care payment model proposal (1 of 2)

1. Primary care practices are prospectively paid a fixed PMPM fee for most primary care payments in lieu of FFS payments, regardless of the services provided to the practice's defined patient panel. The model calls for:
    - Risk-adjusted payments based on clinical complexity or by age and gender
    - Prospective patient attribution
    - Measures and monitoring practices to protect against stinting of care and undesired adverse risks
    - Multi-payer alignment on contractual primary care quality measures
    - Practice eligibility for substantial incentive payments based on quality performance
    - Data sharing and education

Primary care payment model proposal (2 of 2)

2. Practices can otherwise choose to continue receiving FFS payments and still receive enhanced payment. The model requires:
   - Multi-payer alignment on contractual primary care quality measures
   - Practice eligibility for substantial incentive payments based on quality performance
   - Data sharing and education

For discussion

- What are the group's reactions to the proposed payment model?
- Is the approach responsive to practice feedback?
- Is the approach feasible for insurers?
- The proposed model links practice demonstration of core practice team function mastery to enhanced payments eligibility. Does the group agree with this approach?

Risk-adjusted payments based on clinical complexity or by age and gender

- Risk adjustment is intended to reflect the relative risk of the patient panel in the prospective payment rate, reducing the incentive for a practice to seek out healthier patients and discourage sicker patients.

Recommendation:

- Insurers should risk adjust their payments to account for variation in the health care conditions of different patient panels, age, and gender, or solely for age and gender.
- Insurers may implement the risk adjustment tool of their choice, but should provide a high level of transparency to practices about how the software is applied, including underlying parameters, assumptions applied by the insurer, and the impact of risk adjustment on payments.

Prospective patient attribution

- A primary care practice that contracts on a prospective payment basis would be paid prospectively for those patients attributed to the practice.
- The practice would receive a FFS payment for the care of other patients and for non-prospectively paid services delivered to the attributed patients.

Recommendation:

- Insurers can utilize an attribution methodology of their choosing which may include attribution methodologies in current use, so long as they are transparent about the methodology with practices.
- Insurers should reattribute patients monthly, communicate these updates to practices in a timely manner, and use these updates when calculating capitation payments.

Measures and monitoring practices to protect against stinting of care and other undesired adverse risks

- As with any payment model, prospective models have some limitations, e.g.,
  - Practices could take on more patients than they can realistically care for, resulting in limited appointment availability
  - Practices could direct patients to unnecessary utilization of specialist and emergency care

Recommendation:

- Insurers should carefully monitor practice behavior to identify cases where access is decreasing or there are other signs of stinting on care.
- Insurers should use data available to them to monitor this problem to the extent possible, and take corrective action when performance measures indicate the need to do so.
- Insurers should identify and adopt measures that incentive practices to minimize inappropriate use of specialists and emergency departments.

Multi-payer alignment on contractual primary care quality measures

- Quality measurement and reporting are critical to improving patient care, outcomes, and experience.
- Quality reporting requirements are burdensome on practices, particularly for small practices that lack the support and infrastructure to effectively respond to the volume of requests for quality data. It consumes resources which would otherwise be directed to patient care.
- A quality measurement strategy for primary care aligned across insurers, with manageable reporting requirements, would help minimize the burden on practices.

Recommendation:

- OHS' Quality Council to define a subset of primary care measures, derived from OHS' Core Measure Set, that insurers use in all primary care practice contracts.

Practice eligibility for substantial incentive payments based on quality performance

- The primary care payment model should reward quality with an opportunity to earn substantial incentive payments based on practices' performance on certain measures.

Recommendation:

- OHS does not propose a specific incentive methodology at this time, but does recommend primary care quality measures from a new OHS primary care aligned measure set be employed in the methodology.

Data sharing and education

- High quality data exchange is necessary for insurers and practices to make the most of a prospective arrangement.
- Some practices will benefit from education and coaching about how to deliver patient care in a financially sustainable way in the context of a capitated payment methodology.

Recommendation:

- Insurers should supply providers with timely, high-quality data to allow more effective management of their patient panel and their revenue under a capitated arrangement. This includes data about a practice's panel, risk scores, and associated payment calculations. This also requires practices to provide accurate accounting of services rendered.
- Insurers should provide appropriate technical assistance and educational support to facilitate the transition to capitated payments.

For discussion

- What concerns, questions and feedback does the group have to the proposed payment parameters?
- Are there any suggested considerations or modifications?

Addressing practice barriers

- Many of you responded to the request to identify structural impediments and other barriers to the delivery of high-quality primary care that need to be reduced or removed. Thank you.
- There was significant alignment across the submissions.
- We synthesized your input and grouped the barriers into five identified themes: **payment**, **workforce**, **administrative burden**, **technology**, and **access**.
- Throughout the roadmap development process, our goal is to minimize or remove those barriers within our scope.

Identified structural impediments and other barriers to high-quality primary care (1 of 3)

Theme	Cited Examples
Payment	- Inflexible payment models - Inadequate payment for comprehensive care or time outside of direct care - Misaligned models across payers - Lack of support for staff training or coordination w/social service providers - Medicaid payment policies
Workforce	- Inadequate supply of PCPs - Underutilization of highly trained clinicians as expanded care team members - Market competition (hospitals hire away from practices with higher pay) - Working knowledge of special populations - Increased referrals to specialists - Inadequate training for Advanced Practice Providers (APPs)

Identified structural impediments and other barriers to high-quality primary care (2 of 3)

Theme	Cited Examples
Admin. Burden	- Paperwork and reporting requirements - Paperwork only a physician can sign - EMR documentation - Pre-authorizations - Chart review requirements
Technology	- Lack of broadband access across the continuum of care - Lack of access to all patient information - Lack of technology to administer electronic appointment check-ins - Lack of technology for telehealth

Identified structural impediments and other barriers to high-quality primary care (3 of 3)

Theme	Cited Examples
Access	- Access to what is ordered/prescribed by primary care and beyond the financial means of a patient - Transportation - Parking availability - Hours of operation - Limited access to behavioral health services and to some specialists

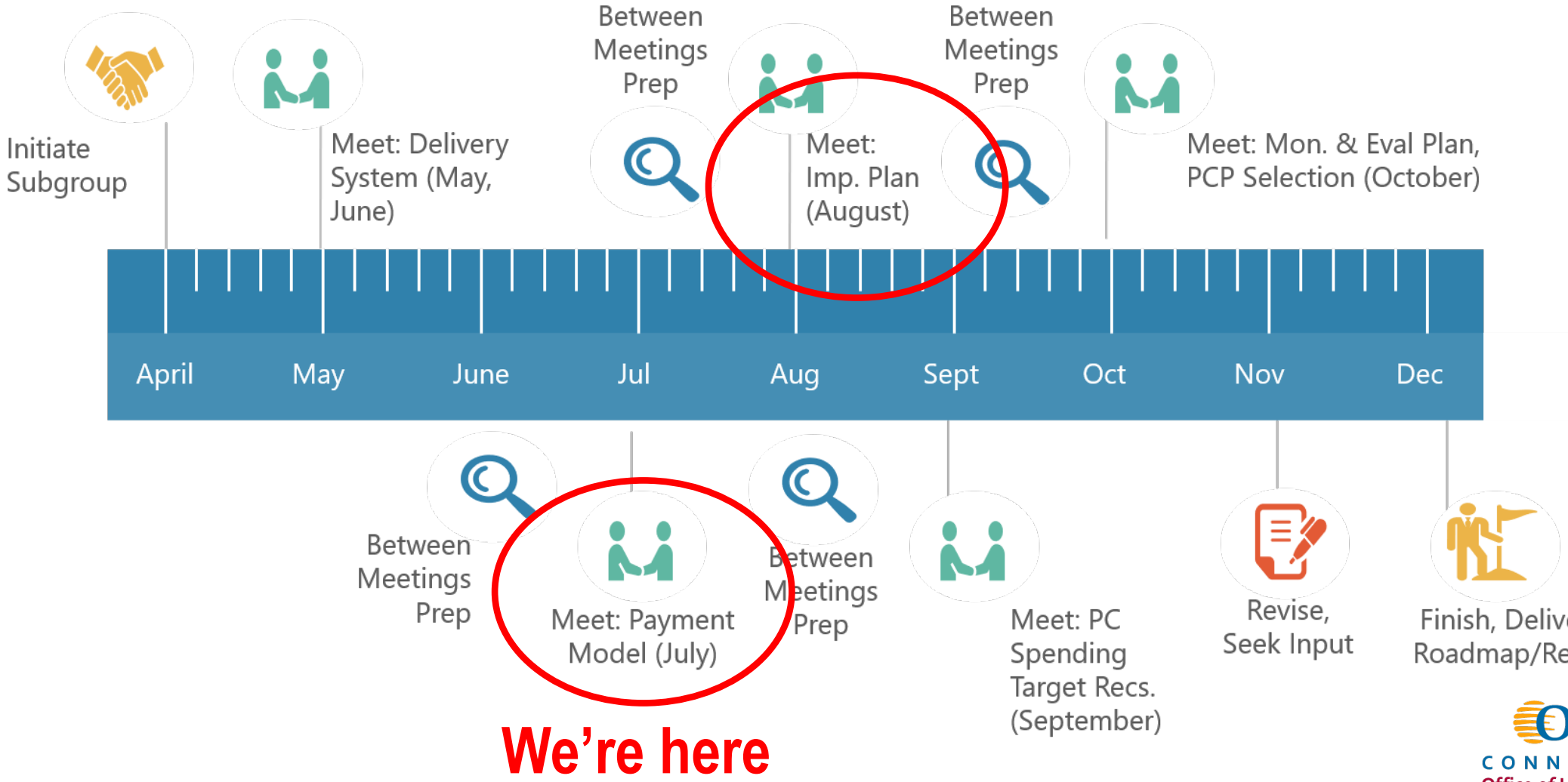
For discussion

- Are there any additional important barriers worth citing?
- Which barriers should we prioritize addressing because of their impact on practices *and* our ability to impact them?
- For those you prioritize, we will next ask you for ideas about how to address them.

Next Steps and Wrap-Up

Subgroup 2021 process and timeline

Next, we'll transition to implementation planning



We're here

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Next steps

- The next Primary Care Subgroup meeting is scheduled to take place August 24 at 1pm.


THANK
YOU