SustiNet Patient-Centered Medical Home Advisory Committee
Issues/Questions/Decision points for Committee consideration
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1. Payment options – how to reimburse PCMHs
    a. Need to risk adjust payments
        i. Include demographic indicators, psycho-social risk factors? i.e. literacy, income levels
        ii. Include patient history of compliance with diagnosis/age/etc?
        iii. Individually rate based on that patient's history eventually?
    b. Options used in other systems:
        i. Fee for service + per member per month (pmpm) flat fee i.e. PCCM
            1. Higher pmpm for higher NCQA tiers option – i.e. OK
        ii. Fee for service + per member per month flat fee + quality incentive (i.e. P4P, improvement rewards, process vs. outcomes, patient experience)
        iii. Higher fee for service rate – simplest, but does nothing to reduce over-utilization or promote efficiency
        iv. Shared savings, with or without pmpm fee – payments linked to practice performance, but reimbursement is delayed – may inhibit investment
        v. Pay based on menu of services offered by practice, i.e. AL Medicaid
        vi. Need upfront payments in addition to ongoing fees? I.e. PA; Is this fair to those who have already invested?
        vii. Global cap rates – as for surgery and OB – could be linked to reinsurance and/or insurance to cover insurance risk vs. performance risk, i.e. MA
        viii. Tier and steer – no rate increases, but limit or encourage patients to PCMHs with lower copays, increases volume but most CT primary care practices are too busy now
    c. Pay more for ancillary services (group appointments, patient education, secure email, websites) or expected in the model? Do they pay for themselves? For all practices?
2. How to begin?
    a. Chronically ill/ medically complex patients first – where the money and the need is,
    b. or
    c. Recognize that providers will not treat their patients differently and provide to all patients in practice, beginning with the practices that are most eager to change
    d. How to choose where to begin?
        i. Competition/application
        ii. Geographic areas of greatest need – primary care shortages
        iii. Target practices that are already there or close
        iv. Practices that serve under-served groups, large numbers of chronic illness admissions or other red flags
        v. Large vs. small practices
        vi. Medicaid vs. state employee providers
        vii. Teaching sites – to maximize dissemination
3. Support for practice transformation – various options for varying needs, need to ensure fairness to practices that have already invested in care coordination and quality

    a. Offer a menu of services from a set of approved providers – i.e. for small practices that cannot hire a new care manager, they can share some of their fees with a service to deliver parts of that care, allows specialization (asthma, diabetes, etc.) and flexibility
    b. Require contracting with one network for a defined set of services, i.e. NC or let the market decide?
    c. Develop approved referral networks? – Dieticians, behavioral health services, dental care, etc.
    d. Learning collaborative – i.e. PA
    e. Coaches on-site, mentoring?
    f. Patient education materials, programs and best practices
    g. How to share best practices?
    h. Approved list of consultants to help with NCQA certification?
    i. How to engage patients in design of new system for each practice? And keep surveying consumers about their experience? How to incorporate their input and test solutions?
    j. How to collect and organize feedback and input from providers – primary care and others
4. Communications and coordination across the care continuum –
    a. How to develop virtual teams? How to incorporate/link to other professions? Feedback loops and communication – esp. with providers and community contacts that will never have an EMR
    b. How to receive info on care from other providers and timeliness of the information, i.e. ER, specialists, pharmacies – PCP and care coordinator need to know immediately when a patient enters urgent care system
    c. How to share decision making with patient 1st, then with primary care provider, care coordinator and then other providers
5. Evaluation
    a. How to recognize excellence?
    b. How to evaluate care coordination?
    c. How to evaluate patient satisfaction? Secret shopper studies?
    d. Focus on outcomes over process
    e. How to ensure provider satisfaction? That primary care is attractive again, physicians are enjoying their jobs again, other staff satisfaction
    f. How to generate and pilot new ideas – create a learning system
    g. How to disseminate what is learned
    h. How to track savings – to which stakeholders – payers, providers, hospitals,
6. Multipayer cooperation
    a. Critical to have all payers use similar standards, data elements, evaluation, focused studies, disease management, compatible data systems, audit and compliance processes
    b. Must have coordinated incentives – if fragmented (i.e. $ for asthma for one set of patients, for diabetes for another payer) will not be salient to invest in transformation or feasible to track
    c. Must have Medicare at the table
7. NCQA certification
    a. Appears to be “gold standard” for payers, highlighted at federal level
    b. Require it or just pay more for it?
    c. Reasonable timelines for progress
    d. Expect all to reach Level 3 eventually?

    e. How to support and encourage practices to become certified
    f. How to coordinate carrots and sticks across payers, transparent process
8. What is included in care coordination? Options:
    a. Patient satisfaction measurement
    b. Risk assessment and individual care plan for every patient, approved by patient
        i. Ability to identify high utilizers of care, or those at risk, and intervene
        ii. Transition planning for discharge and other events
    c. Patient self-management tools, support
    d. Standards for timeliness of appointments for PCMH patients – well and sick visits
    e. After hours care – standards/requirements
    f. On-call services—24/7
    g. Cultural competence
    h. Team model of care – everyone working at the top of their license
    i. Hospital admitting privileges, prescribing authority required
    j. Prescription, referral and test/lab tracking
    k. Patient prevention reminder system
    l. Population health tracking, drives practice decisions, services offered
    m. Billing, data collection and reporting requirements
    n. Ability to communicate with other providers – hospitals, pharmacy, behavioral health, dental care, dieticians, etc.
    o. Referral networks – diversity in geography, race/ethnicity, price
    p. Patient complaint process
    q. Clear practice guidelines, staff training and evaluation, continuing education
        i. Use of evidence-based guidelines for care
9. State support and oversight – options:
    a. Research – best practices CT and elsewhere
    b. Dissemination
    c. Technical assistance
    d. Support pilots
    e. Convene payers, facilitate collaboration – anti-trust exemption
    f. Tie to licensure – i.e. based on PCMH performance increase license tenure, reduce fees
    g. Public education about patient responsibilities and benefits of medical homes
    h. As payer – SustiNet – Medicaid, state employees/retirees/dependents, small business, uninsured
        i. Pay for PCMH
        ii. Create one option for practice support, maybe allowing others at provider discretion, or provide loans to create support networks?
        iii. Approve/license entities for contracting services i.e. support, health care services?
        iv. Create a referral network?
10. How to merge Medicaid PCMH (PCCM) and state employee plan PCMH?
    a. While it is beyond the scope of this committee, it bears recognizing that requiring higher standards for Medicaid providers than now exist must be coupled with equity in payment rates
    b. An important principle – that every CT resident deserves high quality, coordinated care regardless of their health care payer source – providers must be held to the same standards of care for Medicaid and state employee plan patients

c. It is also important to recognize that Medicaid and the state employee plan serve very different populations with very different needs
d. Both plans include comprehensive coverage packages
e. NCQA?

Medicaid/PCCM	State employee plan
Lower income, less education	Higher income, more education
Few participating providers – lots of public provider	Many participating providers – mainly private
Lots of patient churning	Very stable patient population
Not used to easy access to care	Used to high levels of access
Not used to long-term relationship with individual providers	Very used to long term relationships
Cultural competence critical	Less important
Health literacy low	Less of an issue
Low utilizers of care	High utilizers of care
Comprehensive package	Comprehensive package
Need for transportation, other supports	No non-urgent transportation
Great need for community network of referrals – housing, hunger, heat assistance	Less need
High use of ER	Lower ER use
Little familiarity with a usual source of care	Less familiarity than there should be
High pediatrics, OB/GYN	More adult medicine
High chronic care needs	High chronic care needs