CT Medicaid primary care redesign: What the evidence says

Part 4: Better, safer reform options

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Connecticut Medicaid is considering reforms to primary care delivery and payment. The CT Health Policy Project is collecting evidence from other states and programs to help inform that planning. Part 1 focused on Connecting with community services to improve health. Part 2 explored primary care payment reform, especially value-based reforms that move financial risk to providers.

While primary care in Connecticut's Medicaid program is doing well, better than other states and in some cases better than private insurance plans, there is room for improvement, especially to improve health equity. There is wide agreement across stakeholders to **Do No Harm**; that any reforms should do nothing to undermine the progress Connecticut has made.

Below are some options to further improve primary care in Connecticut's Medicaid program, many with supporting evidence, that carry less risk of unintended harm. The lengthy list of options below address accountability, patient support and education, primary care practice support, technology and new care delivery innovations, access to care, care management, population health, data, and information, efficiently targeting resources, and improvements for people with disabilities.

Adoption of these options will promote health equity, but monitoring, team-based care, engaging trusted messengers, access options, targeting resources, data, and diversity in provider recruitment and retention are critical.

All options require investment, in money and time, which carries opportunity costs. While primary care payment rates should be sufficient to sustain practice, we describe the evidence that increasing payment rates alone does not improve access or quality of care. It is important to consider any option's costs in comparison to other opportunities. Investment in proven public health initiatives have demonstrated higher Returns on Investment (ROI) (net to the state) than the federal government's Medicaid matching rate for medical costs. We drill deeper into the evidence on competing opportunities for investment.

This list of options was informed by the evidence, the experience of other states, and input from Connecticut advocates. However, most reviews acknowledge that there is not enough evidence to evaluate many options that are being tried. Before wide-scale adoption, any policy change should be piloted and evaluated[i] in Connecticut's context by an independent entity for both benefits and consequences. The options are in no particular order.

This list offers a place to begin discussions of real-world options to improve primary care in Connecticut's Medicaid program while preserving hard-won progress.

Accountability

- Develop a robust monitoring system for unintended consequences of any reform, especially for any change in incentives and for impact on disparities.
    - Create a plan to address these effects when found and attach significant penalties if it continues in any form.
    - Do not use the inadequate PCMH Plus scheme
- Tie Primary Care Provider (PCP) payment to accountability for improved access and quality.
    - Balance accountability for performance outcomes with the realities of practice and what PCPs can/should control, respecting consumers' decisions.
- Do not pay providers based on outcomes or other metrics outside PCP control.
    - This leads to resentment, gaming of the system, discourages referrals to specialists, and diverts effort away from essential primary care.
- Hold-backs on payments are also deeply resented by PCPs and add to the financial uncertainty of running primary care practices.[ii]
- Set primary care access and ED rates as payment-linked quality measures, with meaningful dis/incentives, similar to Medicare readmission rates.
- Require practices to use data (and supply it) to identify population health needs of their patients, with special attention to underserved communities – and to craft, partner with, and support resources to address needs in the community.
- Consider non-financial incentives which are often more salient for professionals.

Patient support and education

- To build patient trust in providers, use best practices in patient-centered communications documents and skills (e.g., make an effort to understand their experiences, communicate clearly, work in partnership).[iii]
    - Communications must be culturally sensitive
    - Communications must be in plain language; patients can't use or benefit from information that isn't understandable
- Create user-friendly, regularly updated systems for patients to find nearby primary care providers with open appointments, taking new patients that meet their needs (e.g., language access, wait times when at appointments, quality measures, patient satisfaction ratings).
- Provide every treatment option to patients with recommendations and risks, to ensure truly informed consent.[iv]
- Ensure all patients are aware of provider payment incentives, and their rights if they feel they have been inappropriately denied care.[v]
- Provide consumers with balanced, culturally sensitive materials on chronic illnesses.
    - Either identify valid sources that are independent of conflicted interests or develop them.

    - Give trustworthy sources for more information.
    - Use as the basis for shared decision-making.
    - Distribute through primary care practices and integrate with the care plan.
- Ensure all patient notices are consumer-friendly and culturally sensitive -- include the reason for the notice, clear description of patient rights, an independent place to call or email if they have questions, at middle school reading level or lower, and links to more information.
    - This is especially critical for new payment models.
- Create a state-wide, culturally sensitive patient education campaign, including:
    - Patient-centered medical homes – e.g. don't go to the ER for small things, communicate any changes in your health to your PCP.
    - Why you need to show up for your appointment or cancel it. Explain the financial burden of no-shows on providers and the impact on care including double booking and longer wait times.
    - Make very clear to patients the expectations for their care and their rights and responsibilities.
    - Explain they shouldn't ignore health problems and delay care; if a treatment didn't work, call the office.
    - How to file a grievance, where to get help filing.
- Patient communications options include orientation statements and videos, phone prompts, mailed reminders, automatic appointments, patient contracts, connecting to trusted messengers including social service and community organizations, and sharing best practices.
- Increase supports and incentives for PCMH certification, and the demonstrated benefits, to all Connecticut primary care practices, particularly in underserved areas
    - Make it worth the effort.

Primary care practice support

- **Shift successful PCMH program from higher visit payment rates to per member per month payments**, for patient convenience/safety and to free up more slots for unmet primary care need.
    - In other states, paying per member per month has improved primary care practice sustainability and allowed practices to see more Medicaid patients.[vi]
- Support and expand team-based care -- there is good evidence that team-based care improves health outcomes, quality, and reduces provider burn out.[vii] There is some evidence of improved access.[viii]
- There is evidence of lower ED rates for patients in practices with evening hours[ix], smaller panels, and relevant equipment at the practice (e.g., peak flow meters, nebulizers).
    - These practice characteristics had more effect on ED use than patient characteristics.[x]
- Reduce paperwork/report time burdens for PCPs.
- Equalize payment for behavioral health care to ensure sufficient resources for integration and referrals.

- Include behavioral health peer support in integration but not linked to billable codes
    - Due to stigma and medical discrimination, some patients will not access care from traditional medical providers and settings, but will engage with peer support
- Minimize program changes for PCPs -- only change policies when completely necessary, group them in time, ensure clear communication with adequate lead time before changes are effective, provide resources for more information and to resolve transition issues, and, most importantly, explain why the policy is changing and make clear the goal of the change.
- DSS should routinely get input from practicing, real world PCPs and administrative staff for all state policy changes, big and small, to avoid unintended consequences or increased burdens.
    - Get input in provider-friendly ways - electronic, evening/early morning meetings, local/regional meetings.
    - Have regular meetings with open agendas of practicing, real world PCPs with policymakers and payers.[xi]
- Expand capacity in CHNCT's successful ICM program to monitor, engage, and address patients' problems.
- Build on CHNCT's trusted support for practices to innovate and adjust to policy changes.
- Adopt and pay for proven AI innovations that reduce providers' transactional administrative burdens.
- Support new, creative roles and pilot projects for staff, clinical and non-clinical, based on patient and provider needs.
    - Potentially to include academic projects at CT schools
    - Share successful projects across the state
- Primary care provider student loan forgiveness/scholarships if they practice in underserved communities.[xii] Tailor awards to actual debt owed rather than flat amounts spread too thin.[xiii]
- Support educational opportunities/learning collaboratives/continuing education for practice staff – clinicians and non-clinicians – related to diversity, Medicaid members' health, or improved practice.[xiv]
    - Support mentorships and collaborations across settings.
- Provide support and funding for provider safety and to counter workplace violence.
    - Fund mental healthcare for providers when needed.
- Engage pharmacists in new primary care and care management roles, ensure connections to primary care practice.
- Engage PCPs in care transitions – discharge planning, child to adult care – not just notify but engage PCPs in decision-making.

Technology, new delivery innovations

- Implement and pay for proven, FDA-approved new technologies and practice methods that allow patients to manage their own conditions and lower PCP and consumer burdens and time loss.

    - Use research evaluating the effectiveness of new digital therapies[xv] and any structural biases.[xvi]
- Offer patients a suite of virtual and asynchronous services such as phone, text messages (that take more than a couple of minutes and require medical expertise), video, patient portal Q & A, eConsults, apps for 24-7 emergency virtual care, and secure email communications, connected to EHRs and clinical systems, to reduce disruption and costly, unnecessary trips to the office or ED.[xvii]
- Remote monitoring when appropriate with patient consent.
- Ensure new technologies are voluntary for practices and patients. Not all are appropriate or helpful for every patient or PCP's practice.
- Home-base primary care is promising, but there has been little study to date.[xviii]
- Implement and pay for home visiting when appropriate, with the patient's consent. Allow patients to choose who comes to their home and what organization they work for. Provide options including culturally diverse, geographic, and other relevant preferences. Visits should be informed by and provide feedback to the clinical team.
- Expand medication management.
    - Allow consumers to choose who provides this service.
    - Connect the results of the service back to the PCP and the medical record, with details about patient preferences and how decisions were made.
    - Implement evidence-based drug therapy support programs and supports.
- Support behavioral health integration with primary care but ensure independent options as well to protect patient choice.
    - Some consumers do not want to access behavioral health care where they see their doctors, or from large health systems.
    - That cannot be the barrier to getting care for mental health or substance abuse problems.[xix]

Access

- Create telehealth/audio programs tailored to the needs of specific communities, especially those less comfortable with technology. Address technology, digital literacy, and internet access barriers.[xx]
- State efforts to increase residency slots in underserved areas and paying hospitals to create programs have been effective at increasing capacity in other states. Sometimes these programs are more effective than incentives to retain PCPs.[xxi]
- State pipeline programs to increase the diversity in the primary care workforce are too new to evaluate but offer important potential to increase patient trust of medical care.[xxii]
- Programs to recruit and support young residents of underserved areas to train as PCPs and return to their neighborhoods have been successful in other states.[xxiii]
- There is limited research on state efforts increasing primary care residency pay to encourage more residents to choose primary care, but the option has potential.[xxiv]
- Other states are making a considered effort to get in-state medical school graduates to remain in the state for residency training, sometimes bypassing the national resident match.[xxv]

- Maximizing and coordinating applications for federal funds to bring primary care providers to underserved areas is supported by evidence. They tend to stay and practice in those communities.[xxvi]
- Engaging more foreign-trained physicians through federal waiver programs can also improve access, especially in urban areas.[xxvii]
- Polices encouraging and rewarding nurse practitioners and physician associates to work at the top of their license, especially at the same payment rate as physicians, can also improve access to care.[xxviii]
- Collaborate with local colleges and local employers to pay for medical support staff, medical assistant, and technician training, and ensuring pay is sufficient ,can address shortages and reduce administrative burdens on PCPs.[xxix]
- One study found improved access to care using alternative scheduling practices such as group appointments and flip appointments (where nurses handle most appointments and physicians check in toward the end).[xxx]
- Ensure new FQHC sites open in the highest-need areas. Recent evidence found efforts to scale up FQHCs between 2001 and 2011, did not effectively reach underserved areas.[xxxi]
- Scale up school-based health centers[xxxii] and connect them to primary care practices as necessary.
- Look for ways to encourage retail clinics in underserved areas. However, Massachusetts has had difficulty getting FQHCs to do this.[xxxiii]
- Enhanced payment for after-hours care is critical.[xxxiv] Connecticut has a troubled history implementing this policy in the past. There must be no deterrent to providers accessing the higher funding.[xxxv]
- Ensure all consumers have no-cost access to their medical records in a format compatible with all EHR systems.
    - Providers should encourage and facilitate independent second opinions.

Efficiently targeting resources

- Target resources to underserved areas based on community-level assessments of need. Build capacity not at the aggregate level (i.e., rural vs urban vs suburban or even geographic), but in specific communities where people are experiencing gaps in care, and for services they are missing.[xxxvi] Otherwise, there will be costly duplications and gaps.
    - Encourage, incentivize new primary care delivery sites and services in those areas.
    - Encourage existing primary care sites in the area to accept or take more HUSKY patients.
    - An important goal of targeting resources should be to reduce disparities.

Care Management

- Create standards for person-centered care planning across payers, especially for people with chronic conditions.
    - See Complex Care Committee recommendations (Care plan best practice recommendations to DSS, January 2018).

    - Create realistic plans that patients and caregivers are comfortable with and revisit the plan regularly and when major health events happen
    - Include information for patients on how to participate to create a realistic plan they will comply with.
    - Ensure consumers approve the plan, sign off on it, and get a copy.
    - Support and encourage patients to develop a list all their care managers/navigators/care sites.
    - Collect, aggregate, and analyze care plan information for needs assessment and capacity planning.
- Ask patients to choose one person to be their lead care coordinator across payers and providers.
    - Ensure patients and caregivers have clear contact information through multiple means (phone, email, text, etc.) for identified, individualized care managers independent of payers.
    - Give the consumer's chosen lead care manager the authority and the ability to connect and coordinate care, according to patient preferences and PCP recommendations.[xxxvii]
- Develop systems to track and coordinate patient care across healthcare settings that promote patient safety and preserve privacy, and only with patient permission (opt-in).

Population Health

- Support development of local Community Care Teams.[xxxviii]
    - To address social determinants of health, reduce disparities, high-cost/high-need community members, public health and safety risks, clinical and social service needs, and capacity across communities and populations.
    - Not to share revenues, which would change the focus and culture of the collaboration.
    - Link to data reports on capacity for the area.
    - Ensure robust participation of practicing PCPs and primary care administrative staff with meeting times and formats (online vs. in person) that fit their needs.
    - Link to hospital and local public health needs assessment planning.[xxxix]
    - Share best practices between teams across the state.
- Reinvest savings from any innovation back into the community services that address Medicaid members' needs and generated the savings.[xl]
    - Do not funnel community services funds through medical providers or health systems – they are inefficient, may have conflicted interests, and are not set up for that.
    - Allow members to choose where they get community services.

Data, information

For patients –

- Easy way to find providers with openings/taking new patients in their area, with available supports at each practice (e.g., nutrition counseling, language access, behavioral health integration, telehealth).

    - Survey members to see what services/information to provide.
- Include quality, consumer satisfaction ratings by provider.
- Help getting independent second opinions.

For providers –

- More timely data on attributed patients – utilization, gaps in care, where else they are getting care.
- More population health data on the communities they serve – medical and social needs by subpopulation.
- Track data on patient needs, utilization by system and provider, to find positive and underperforming providers (e.g., high ED rates, high performers) for follow up by CHNCT for technical assistance or to share best practices across the state.
- Watch the risk condition and demographic profiles of practices, compared to other practices, and longitudinal changes within the practice over time, to identify adverse selection.
- Offer analytics capacity that large systems and management companies offer – on patient needs, disparities, quality gaps, back-office functions/administrative burden, gaps in care analysis.

For people with disabilities

- Attach funding to relevant codes sufficient to meet needs.
- Ensure the funding gets to the practice for care coordination, necessary accommodations, and sufficient visit time.
- Survey patients and caregivers to ensure the resources are getting through and needs are being met.
- Care management training and engagement with caregivers.
- Training for providers to increase knowledge and comfort.
- Centralized resources/ICM to support patients, caregivers, and providers.
- Include in quality and access ratings for all providers, tied to payment.

Raising primary care reimbursement rates

In contrast to the above options, **there is little evidence that increasing primary care payment rates improves access to care, quality, or reduces other more expensive care.**[xli] It is also important to note that Connecticut is among the few states that have sustained the Affordable Care Act's primary care rate bump to Medicare levels with state funds.

Multiple studies of Medicaid reimbursement rate increases have found small or no increases in the availability of primary care appointments[xlii] or in reducing other more expensive care such as ED, inpatient, or imaging.[xliii] One study found an association between increased primary care rates and behavioral health outcomes, but this may have resulted from allowing behavioral health providers to bill under the higher primary care codes.[xliv]

Raising primary care clinician pay rates to a meaningful level would be extremely expensive. Tying to budget neutrality and reducing specialty rates would be politically infeasible and potentially harm access to specialty care. Recent Medicare efforts to raise primary care clinicians pay at the expense of specialists has been controversial.[xlv] A study of Medicaid rates estimated that it would require a 50% increase in primary care clinician's pay and a decrease of 20% in cardiologists to achieve equity.[xlvi] As Connecticut Medicaid access to specialty care is arguably worse than to primary care, that cut could significantly harm patient access to specialty care.

Opportunity costs for any option

When choosing any option, it is critical to consider opportunity costs. Every dollar or staff hour in a practice devoted to one option is a loss to another option. **Proven public health initiatives have demonstrated strong returns on Investment** (median of 14.3 overall, 5.1 for healthcare public health interventions)[xlvii], including in Medicaid programs[xlviii]. Many far surpass the state's federal match on Medicaid spending on medical services.

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