

Population health payment models for kids in Medicaid

DSS needs a pediatric replacement for PCMH+

The State's PCMH+ initiative is scheduled to end on December 31, 2025. The Connecticut Children's Care Network (the Care Network) has participated in PCMH+ since 2020 and generated \$56.3 million in cumulative savings for the State's Medicaid program. Without the opportunity of PCMH+ shared savings payments, there will be no funding stream to support the investments that the Care Network has made to achieve quality outcomes for kids while controlling costs. We strongly recommend that DSS implement a pediatric population health model to replace PCMH+ and we offer below recommendations about key design elements for a future program.

Background: What is the Care Network?

The Care Network was established in 2019 to improve patient care for children and adolescents around the region. It operates as a primary care pediatrician-led organization that includes both pediatric subspecialists and community-based primary care physicians. Currently, the Care Network includes 40 community-based pediatric practices that represent 253 primary care providers working in 55 locations throughout the state.



How has the Care Network performed in PCMH+?

Since joining PCMH+ in 2020, the Care Network practices have generated a total of **\$53.6 million in savings for the State**. The Care Network is completely self-sustaining and does not receive funding from Connecticut Children's Medical Center. When the Care Network received PCMH+ shared savings payments from the State, a portion was retained to reinvest in future improvement activities. The opportunity to earn shared savings payments is an essential component of PCMH+--without them, the Care Network could not sustainably invest in this infrastructure that supports improvements in quality and the cost effectiveness of care.

How have the Care Network practices pursued continual improvement?

By focusing on shared learning and community building strategies including:

- Establishing Quarterly Learning Communities on primary care pediatrics topics
 - Often focused on quality metric topics and/or cost management strategies (e.g., ED utilization, behavioral health)
 - Providing continuing education credits for clinical providers
- Convening "Meet and Eats" throughout the year
- Distributing biweekly Network updates
- Offering Practice Manager meetings to build sense of community across the Network

The Care Network has effectively managed costs by investing in:

- population health management tools that analyze data to identify actionable clinical issues and trends
- centralized care coordination where nurses focus on hospital discharges, high emergency room utilizers, and patients with chronic or complex disease

The Care Network has improved quality by:

- using the limited available data from the State to identify actionable gaps in care
- sharing that gap analysis with practices and estimating their quality performance metrics
- convening quarterly mandatory quality meetings with all practices

How could we design a future pediatric alternative payment model in Medicaid?

Key components for a pediatric replacement for PCMH+ include but are not limited to:

- Up front PMPM payment that supports the infrastructure costs of population health improvement
 - e.g., Care coordination, technology systems, pediatric prevention efforts that are not currently paid for by insurers (e.g., Reach Out and Read, etc)
- Offer incentive payment based on quality performance that must:
 - be based on pediatric quality metrics
 - make data available on performance throughout the year on the attributed population
 - allow for supplemental data submission to correct errors on performance calculations
- Offer incentive payment based on cost management that:
 - include upside-only shared savings
 - do not include downside risk that could result in practices owing money back

