Primary Care Program Advisory Committee
Meeting Minutes
1/18/2024 9:00am – 12:00pm

For all meeting materials (agendas, presentations, meeting minutes, and links to meeting recordings) to date, please see the **Primary Care Redesign Meeting website**.

Agenda

- Opening remarks
- Review of opportunities and progress to date
- Discuss and collect feedback on:
    - Topic 1: Base Payment
    - Topic 2: Performance Based Payment *(moved to next meeting)*
- Wrap up and next steps

Opening Remarks

- The committee was welcomed and reminded of their overarching goal to design a primary care system that *improves the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members and in a way that reduces inequities and racial disparities*.

Part 1: Review of Progress to Date

- DSS reviewed six opportunities identified by the PCPAC.
    - One member raised that behavioral health integration should be explicitly named as an opportunity/priority, so its importance is obvious to others outside the committee.
    - DSS acknowledged the importance of behavioral health integration and committed to revisiting the care delivery priorities with this comment in mind.
- DSS provided a recap of the committee's progress so far, including identifying the top five care delivery priorities and discussing measures to drive and track performance on these priorities.
    - The top five care delivery priorities include: **1)** Chronic Condition & Targeted Care Management, **2)** Accessibility of Care, **3)** HRSN Screening & Community Supports, **4)** Data Infrastructure & Data Sharing, and **5)** Team Based Care
- Committee members raised the following considerations regarding the care delivery priorities:
    - **Health Related Social Needs (HRSN):** Several committee members raised concerns about the current HSRN definition of success. Common concerns included a lack of support and investment in community-based organizations (CBOs) that are providing HSRN services, a need to craft unique solutions that meet the needs of various communities, and provider capacity and tools needed to conduct screenings and successful referrals. Below is a non-exhaustive list of specific comments and recommendations.

        - *Medicaid members who are referred for services are going to be on waiting lists.* We need funding for CBOs so that all communities can access health care. When we talk about marginalized communities, we cannot come up with one solution – each community needs a distinct solution. There is a huge need to address HRSN outside of the primary care context and resources outside of primary care are essential.
        - *High need members will need CHWs and care coordinators to help them access these services.* Screening and referral on their own aren't effective for these members, we need to embed care coordinators in practices so they can work in the communities and with families.
        - In response to questions about alignment with broader community investment efforts and the potential for blending and braiding sources of funds, DSS acknowledged the importance of alignment and noted an intent to connect these conversations.
        - DSS committed to revisiting the approach to HSRN Screening & Community Supports at an upcoming meeting.
    - **Data Infrastructure & Data Sharing:** Committee members raised the following considerations regarding this care delivery priority:
        - *Electronic Health Records (EHRs) are creating additional burden on clinicians and taking time away from patients*, we need appropriate provider supports given the administrative burden resulting from electronic record/data requirements.
        - *Please let's not forget to include a centralized portal for patients to see their own health information*. Various practitioners are branching off from using MY CHART to other unconnected systems, requiring multiple log ins for patients to access their own health records. This also will allow patients to provide visibility to CHW's and visiting nurses and therapists, who don't traditionally have access.
- One committee member asked if the group should take a step back and talk about structural racism and how the system being designed will impact these communities.
    - DSS stated that structural racism and broader inequities (education, socioeconomic status, rural/urban, etc.) and their impact on care delivery have been a continued topic of conversation internally, considered in the development of DSS materials, and will be fundamental in the development of this primary care model.
    - DSS asked the committee to bring an equity lens to the discussion.

Part 2: Payment Model Overview and Examples

- DSS provided an overview of base and incremental payment model types to ground the group's discussion. The committee was advised to think about population based payment (PBP) in the context of payment for primary care providers. Below is a non-exhaustive list of committee comments/questions during this part of the discussion.

    - *DSS should only hold providers accountable for what is within their control.* One member noted that specialists are largely in control of care for members with chronic conditions.
    - *Doing anything that puts access at risk is a problem.* We need to consider how providers are held accountable (e.g., for hospitalizations) to ensure the payment model selection does not risk access.
    - *In the Integrated Care for Kids (InCK) program various criteria are being used to place patients into risk tiers*; this is an example of tiering that is already in use.
- DSS noted that the payment model types being presented should be viewed as a framework and that the committee is encouraged to work outside of the box and outside of existing models.

Part 3: Weighing Options and Collecting Directional Feedback

- When asked about resources devoted to this initiative, DSS advised the committee to consider an ideal model, noting that the level of investment will need to be considered and we will need to determine what we can realistically do.
- DSS emphasized that this discussion is about paying in a way that enables primary care providers to contribute to improving member outcomes.
- There was some discussion amongst committee members about Medicaid's performance on the state's primary care spend target and how that compares to Medicare and commercial.

Topic 1: Base Payment

Design Question: *How should DSS pay primary care providers to enable them to deliver care in a way that improves member health and well being and drives a focus on the care delivery priorities we have established?*

- DSS outlined starting point considerations for base payment including strengths and limitations of different models, examples of existing programs, and an assessment of alignment between models and the top five care delivery priorities.

Committee Discussion

- *Committee members expressed mixed preferences for a base payment model*; some advocated that DSS use a FFS model, some spoke to the value of a PMPM model, many highlighted the benefits of a hybrid model with FFS payment and add-on PMPM. Members expressed:
    - If we want to address disparities, ensure access, and provide more primary care to offset unnecessary utilization of acute care, FSS is the way to go.
    - FFS is not necessarily an incentive to overserve if providers are being underpaid.
    - There is an opportunity to update the FFS payment amounts and structure to add new billable codes enabled by other payers (e.g., codes for coordination of care, e-consults, transitions of care, and complex care management).

    - A PMPM model would promote partnerships with community providers; this is an easier way to bill and guarantees hiring. A PMPM would support a collaborative process with the community.
    - The shortest step for the private practices is to harmonize with other payer methodologies and include core reimbursement for primary care FFS, with new capabilities which could be reimbursed through a PMPM.
        - This is similar to Medicare Advantage and the State Employee Health Plan
        - Add-on incremental payments are valuable for services that are not FFS reimbursable (e.g., navigation or referral programs, data infrastructure, care navigators, digital outreach, remote monitoring)
- *Practices should have freedom within a framework*. Several members spoke to the importance of building in flexibility for broad based participation with tiers/tracks or a glide path, similar to the CMMI models.
    - A couple members noted that mandatory graduation from one tier/track to the next should not be a requirement of the DSS model.
    - Provider participation in value based payment (VBP) arrangements and the range in provider readiness was discussed.
        - A few members spoke to experiences in VBP models with other payers (e.g., Medicare), noting that there is already a significant amount of commitment and infrastructure at the provider level, and a provider base that is interested in partnering in more complex models. There is an opportunity to integrate Medicaid members into existing population health/VBP approaches.
        - Another member cautioned that smaller practices have less experience with VBP models, especially risk based payments.
        - One member cautioned that serving Medicaid members requires changes in how groups practice; others suggested that wasn't universally true, and there are things being done that could have immediate value/benefit to Medicaid members.
    - One member noted that all population health programs start small and work incrementally to build over time – groups that are more experienced have been building this out for 10+ years. DSS should consider a long-term strategy for how we get to a more advanced program.
    - One member stated that a key success factor is a stepwise process – the need to manage populations over time at various levels of risk; starting at lower levels of risk and progressing into more complex models.
- Committee members raised the importance of aligning the DSS model with what other payers are doing to enable provider participation (e.g., Medicare and the State Employee Health Plan). The State Employee Health Plan (SEHP) model is a good example of a program that chose a familiar chassis and then enhanced - they use a stable base FFS payment with an augmented PMPM payment and shared savings; the program is then tailored to the SEHP population.

- Several committee members voiced the importance of measuring and tracking quality and member outcomes – including through measures that move outside of the medical model (e.g., patient activation, absenteeism, employment).

- *Chronic Condition & Targeted Care Management:* The committee continued the discussion of a base payment model in the context of its alignment with the first care delivery priority, Chronic Condition & Targeted Care Management. Below is a summary of committee member considerations.
    - *Accessibility and logistics are at the center of the problem.* Multiple members highlighted the critical impact that logistical barriers have on chronic condition management and overall patient health.
        - One member shared their experience with an existing chronic conditions management strategy, noting that the care wasn't the issue, rather it was the logistics they had to solve to start achieving improved patient outcomes. Supports for virtual care, self-management, and remote patient monitoring helped with these issues, but support staff and financial resources were needed.
        - One member emphasized the need to address the inequities and systemic racism that prevents people from getting access, stating once people are connected, they do well.
    - *Members debated how much to focus the program on chronic conditions management.*
        - One member suggested that a focus on chronic conditions prevalent in the Medicaid population (e.g., diabetes, hypertension, asthma) could provide a lens for functionalities like care coordination and HRSN screening and supports.
        - Another member cautioned against an overly narrow focus on chronic condition management, voicing concerns about ignoring the pediatric population – and favoring supporting provider tools that allow practices to address the needs of their populations.
            - DSS noted that the state may need to develop specialized programs for defined populations like pediatrics, but first needs to develop a broad-based primary care model.

- *How do we enable primary care providers to do all of this?* The committee moved beyond chronic condition management to discuss how to create the proper supports to enable providers to deliver on all care delivery priorities.
    - *Providers need support from CBOs across the continuum*. Several members highlighted the need for support from CBOs, noting that some practices without the internal capacity will need more of these partnerships than others.
    - *DSS should be thoughtful about the administrative complexity in this program design.* Members cautioned that the level of complexity in the PCMH+ program was substantial, and creating a simpler model should be a priority.

- *Patient choice is really important*. One member expressed that one size is not going to fit all and cautioned not to take choice away from the patients or providers.

The committee agreed to postpone the Topic 2 discussion on performance based payment to the next PCPAC meeting.

DSS Wrap Up & Next Steps:

- DSS commended the committee's progress in the discussion of specific care delivery priorities and base payment models.
- The committee will continue its payment discussion at the next meeting on February 8th. The meeting will be held virtually.