Primary Care Program Advisory Committee
Meeting Minutes
2/8/2024 9:30 – 11:00am

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 progress to date
- Discuss and collect feedback on Performance Based Payment
- Wrap up and next steps

Part 1: Review of Progress to Date

- At the previous in-person/hybrid meeting on January 18th, DSS reviewed goals and preliminary decisions related to care delivery and performance measurement; provided an overview of payment models and examples from state and federal programs; discussed base payment options and collected directional feedback from the Committee.
- In response to Committee feedback, DSS incorporated members' recommendations to explicitly include Behavioral Health Integration within the Opportunities and Care Delivery Priorities this Committee has aligned on.
    - Members welcomed and applauded this update as it signals the importance of behavioral health.
- DSS also acknowledged the need for further discussion about the approach to HRSN screening/referral and community supports, which the Committee will revisit at the March meeting.

Part 2: Performance Based Payment

- In continuation of initial payment model discussions, the goal of this meeting was for the Committee to provide directional feedback on performance based payments.
    - Specifically, DSS aimed to collect input on the following question: How should DSS use financial incentives or incremental payments to drive performance and ensure measures and requirements are met?
    - DSS noted that more discussions will be needed to design and implement a payment model that enables broad-based participation.
- To ground the discussion, DSS provided an overview and program examples of two types of performance based payments: Shared Savings/Risk and Pay for Performance.
- In terms of the strengths and limitations of performance based payments, members expressed the following comments:
    - In shared savings models, guardrails will never be perfect, so DSS should be mindful that there's potential to increase harm.

        - Another member replied that there are several shared savings programs that reward providers for both cost and quality performance, which can be complimentary.
        - DSS also acknowledged that any payment model, if done poorly, has a risk of increased harm to patients, gaming, and cherry picking (e.g. the FFS system does not incentivize access for people with disabilities).
    - Shared savings models typically prioritize high value care that can be quickly achieved. For example, Medicare ACO models focus on the near-term opportunities (e.g., hospital utilization).
    - Pay for Performance payments enable narrow accountability, which would allow DSS to target money and accountability for distinct priorities.
    - Pay for Performance payments that are geared toward clinical outcomes and utilization may be preferrable for smaller providers, who tend to be more challenged in total cost of care models.
        - Another member commented that it has become standard for small providers to access shared savings programs through a larger network. However, there is still room for more partnership.
- *Proposal for an upstream, preventive care model:* One member proposed creating a payment model that rewards upstream prevention in health care, which traditional shared savings programs do not incentivize. Investment in community assets and infrastructure is critical for achieving biopsychosocial health.
    - Since the cost benchmark is based on the population's health, programs tend to reward practices with sicker patient panels (e.g., practices are rewarded if they have more diabetic patients in their panel). DSS could come up with a cost benchmark without frequent rebasing or downward adjustments that rewards providers for savings to accrue from prevention.
    - The model could also enable cost accountability across many entities, not just primary care providers, and a portion of savings could be reinvested with the community and behavioral health providers.
    - This primary care design should complement a broader systemic solution, in which primary care focuses on chronic diseases but sets the stage for participation in a more systems-oriented model.
    - A handful of members expressed interest and support for a model that focuses on upstream prevention and community collaboration, adding that savings should be directed to both the community/patients (with their input on how to reinvest funds) and the healthcare system. Another member highlighted that primary care is only one piece of the puzzle within a broader systemic solution (i.e., primary care should not be expected to solve all problems).
    - DSS noted that there are opportunities to promote preventive care through quality metrics that are tailored toward preventive care (e.g., cancer screenings). In addition, DSS considered how the proposed model may be difficult for small and medium sized practices to implement. DSS also requested clarification regarding how patients and community should provide input on how savings are spent.

    - In response to DSS' comment about implementation for small/medium practices, the member proposed that DSS create a regional cost benchmark that spreads accountability between all providers in the region (small to large practices, including FQHCs). All practices would be measured together to drive quality improvement, and savings would be based on each practice's attribution and quality performance. Another member voiced support for shared, regional accountability as it reduces incentives for cherrypicking.
    - Another member suggested that DSS design a primary care model that closes the gap on unattributed members. The program should consider how to build and leverage community partners to build trusting relationships with member. The model should also enhance infrastructure to build enhanced care team models.
- *FQHC participation*: Given the federal reimbursement requirements around FQHC prospective payment system (PPS) payments, community health centers have the option to participate in alternative payment models, which need to ensure that FQHCs receive at least what they would have under PPS.
    - In response to a member's question about FQHC participation in the Rhode Island Accountable Entity (AE) model, DSS clarified that FQHCs can participate in the AE program without downside risk, while non-FQHC providers participate in the model with downside risk.
    - DSS emphasized the importance of designing a program that incentivizes FQHC participation. DSS has an FQHC-specific subcommittee as part of this work.
- *Food Insecurity:* Members also voiced concerns related to food access and its critical impact on health, noting that community investment is critical for making progress on the real underlying issues that affect health in our communities.
    - For example, one member shared the following comment in the Zoom chat: "Don't forget food insecurity and lack of access to quality, affordable food in areas with high rates of diabetes! Lack of grocery stores in urban centers in CT is Food Apartheid! What can DSS do to use its resources and influence to address this disparity and track progress on the improvement of health outcomes (if addressed at all)? Grocery stores with regular hours are preferred over more pantries with limited hours of operation and limited quality, fresh foods. Pantries often stock items that don't sell in grocery stores (expired canned goods and processed foods with high sodium, preservatives, sugar, fructose, corn syrup, etc.), which often can negatively impact chronic conditions like diabetes and high blood pressure."
    - Another member strongly urged that a portion of program savings be invested in multi-sector community coalitions and/or organizations that address social determinants of health.
    - In full agreement of the importance of food access and benefits of Food is Medicine programs, DSS requested that members share their thoughts and ideas on the role that DSS and primary care should play to address food insecurity at the next March meeting, which will revisit the health-related social needs conversation.

- *Tiered Model Design Considerations:* Program tiers for quality and savings may be helpful to meet providers where they are, especially to ensure that providers don't disenroll from Medicaid.
    - Practices should be able to choose their track/tier to maximize flexibility for practices. The tracks should allow for a glide path and broad program participation.
- *Infrastructure Investment:* It's important that providers get actionable data and tools to improve quality and efficiency. DSS should invest in improving data sharing infrastructure and provide more technical assistance and trainings to practices.
- *Behavioral Health Integration:* Many primary care practices have expressed the challenges of recruiting and retaining behavioral health providers. To ensure robust behavioral health integration, DSS and this Committee should think about what can be paid fee-for-service (FFS) vs. per-member-per-month (PMPM).
    - Providers strongly recommend that DSS ensure full behavioral health coverage through the full array of codes in the CPT manual since Medicare and commercial payers have aligned and expanded the use of these codes.
    - DSS should consider the rate adequacy and pricing model for behavioral health to ensure payment supports the workforce. FFS models can enable small practices to grow their behavioral health capabilities, while providing flexibility for small providers and large clinically integrated networks to adopt team-based care models that align with how they want to practice.
    - In addition, PMPM payments should be introduced to incentivize new, enhanced capabilities. Some services are difficult to reimburse FFS (e.g., care management/coordination and services related to treating substance use).
    - Behavioral health integration is especially difficult for pediatric practices (note that no pediatric practice serves 100% Medicaid members). For successful behavioral health integration, DSS and this Committee need to focus on reimbursing and training behavioral health providers to function within primary care practices.

Closing Remarks

- DSS reviewed feedback from the base payment discussion in January and previewed the topics of our upcoming meetings.
    - The next meeting (virtual) is March 7th to review a cross-cutting program equity strategy.
    - The next in-person meeting is April 4th to review Phase 2 design conversations and learnings.