Primary Care Program Advisory Committee
Meeting Minutes
4/4/2024 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 Phase 2 materials
- Introduce and discuss high-level payment model structure and key design elements
- Discuss stakeholder engagement plans for Phase 3
- Wrap up

Part 1: Phase 2 Review

- The meeting commenced with DSS reviewing the committee's decisions and key takeaways from Phase 2 regarding care delivery priorities, performance measurement, payment model design, and the cross-cutting equity strategy.
- Members provided additional context and nuance around some of the Phase 2 feedback:
    - **Payment Model Design Feedback:**
        - Practice size alone does not define practice capability; some large providers don't have experience with VBP models and risk while some small providers do.
        - Need a robust base payment model that includes protections and prevention against cherry picking and lemon dropping.
    - **Equity Strategy Feedback:**
        - Educate providers and patients on the importance of the collection of RELD data AND social determinants of health and heath related social needs more generally.
        - Need to acknowledge social services providers are often groups that don't have FFS systems and are reliant on philanthropy to accomplish their work. It's one thing to give patients choice of their providers, but these providers also need infrastructure support.
- The committee also provided feedback on the "DSS Supports" strategies, suggesting DSS streamline access to social services within the DSS portfolio (e.g., SNAP, WIC, Veyo), pursue Medicaid coverage of HRSN services, and provide flexible funding directly to members to enable them to address social needs.
    - In response to member questions regarding DSS involvement in broader state efforts, DSS elaborated on examples including collaboration with NASHP on housing supports, work with an interagency council on homelessness, and coordination with the state comptroller's office.

Part 2: Payment Model Structure and Key Design Elements

- DSS acknowledged budget constraints and federal limitations that will impact the payment model design, but noted the goal is to design a program that improves care delivery and outcomes for Medicaid members, even with budget constraints, by focusing on *how* we are paying rather than *how much* for this conversation.

- DSS introduced a high-level payment model structure for the committee to react to, noting many of the details will need to be further defined in the next phase of work. Below is a non-exhaustive summary of comments and considerations raised by members organized by theme or payment model component:

Cross-Cutting Concerns

- Acknowledging budget constraints, a member suggested that DSS focus on allocating available funds to approaches that can be tested that lead to better quality care and outcomes.
    - DSS agreed and noted the state was recently awarded a grant from Arnold Ventures to bolster analytic capacity.
- Members pushed for more attention to **dual eligible populations** – within or beyond the scope of this work.
    - DSS responded that there was a desire to include dual-eligible members, but there are significant data integration challenges that have prevented this so far.
    - Members noted that providers are accountable to Medicare for the quality outcomes of duals and members receive care management through Medicare.
    - One member noted that MAPOC has spent significant time researching and reporting on dual eligible beneficiaries and would be a good resource for more information.
- Members expressed **concerns regarding the future of the PCMH+ program** and funding for 2025 and beyond, noting that some practices are developing their budgets now.
    - In response, DSS stated that they do not expect there to be a large gap between programs and that the funding is allocated for existing programs. They clarified that this process is to determine what comes after PCMH/PCMH+. Further discussion of the transition and additional timeline guidance is forthcoming.
- Members revisited the interest in more **comprehensive strategies** (e.g., regional accountability and/or AHEAD model participation) and highlighted the importance of developing this program with attention to alignment.
    - One member suggested that it would be difficult to move forward with primary care program design without knowing where the AHEAD model is going, and questioned whether DSS was limiting the thinking about primary care reform by not embedding it within a broader conversation.
    - In response to requests for broader strategies, one member noted that the existing model is stagnant and there is an urgency to do something, highlighting tweaks to the existing model would do a lot of good. Suggestions included a multi-year glidepath and effective incentives for core care delivery priorities.
    - DSS agreed that there would need to be attention to how this program aligns with the AHEAD model but maintained that the possibility of AHEAD should not prevent the committee from moving forward with primary care program design.
- One member requested that patients be able to opt out of this program, noting that they need to know their provider has no incentive to not provide the right care.
- There were recommendations to differentiate between the terms "PMPM" and "capitation" to avoid confusion.

Provider Tracks

- Members expressed a preference for track options aligned with practice capabilities rather than practice size, suggesting providers should be able to choose whichever track is most beneficial to them.
- Members recommended the payment model include a risk-free track.

Base Payment

- Members expressed some concerns about the proposed hybrid base payment approach, with some voicing support for a **FFS foundation to promote access and simplicity**. Specific recommendations regarding FFS rates included:
    - Acknowledging funding challenges, we need to make sure the base FFS rates are adequate. With the primary care bump and PCMH bump we're being paid equivalent to 2014 Medicare rates. The best we can do through success in PCMH is 50 cents PMPM, which is not enough to support the interventions needed.
    - Fixing the FFS rate structure will help bring in more providers to serve Medicaid patients and will help with simplicity, as it's easy for practices to understand when they are thinking about joining. We need to keep things simple to improve access.
    - The FFS base payment needs to be reinforced and put in a schedule to be updated regularly.
        - DSS provided an update regarding the ongoing rate study, noting it is currently in Phase 2 and additional information is expected in January.
- Members also recommended the base payment be simple and clear about what it is for. Providers need to be held accountable by tying rate increases to specific capabilities and expectations for services – e.g. you need to do x, y, z to get this specific payment.
- One member acknowledged they were once an advocate for partial capitation (hybrid population based payment) but found that physicians were largely uninterested. In a model like CPC+, converting some revenue to population based payment means that physicians still must see the same number of patients to generate the FFS part of payment.

Flexible Funds

- There was **general support for including flexible "nonvisit" payments** to support activities like care coordination and behavioral health integration.
    - One member noted that BH services can contribute enormously to health and welfare through an integrated care approach. It's really important to remember that BH is in some ways a primary care delivery model – if you add primary care to BH services we have high impact on engaging (for example) the 50-year-old father who hasn't gone to the doctor in a long time. We won't get the outcomes we want without merging these (primary care and behavioral health).
- Some highlighted the importance of distinguishing base payment from add-on payments, recommending a guaranteed, adequate **base payment plus an add-on payment tied to specific expectations** and accountability standards.
    - When we think about asking providers to provide new services, specifically those that require added infrastructure – we need funds that aren't tied to performance-based risk. In a program where rates are barely enough – without this funding, programs will not succeed.
    - The separation between base and performance payment needs to be clear. Utilization metrics and access are what should be rewarded but we can't underpay providers, or they won't provide the access.

- One member recommended using the PMPM for developing a workforce inclusive of CHWs that primary care can leverage but does not need to build.

Performance Based Payment

- Members highlighted the role of specialists, hospital systems, and community providers in impacting outcomes and raised **concerns about primary care providers' ability to impact total cost of care (TCOC)**. Specific comments included:
    - There is now over a decade of history that says primary care has limited ability to influence outcomes. We think primary care should be a player and share in risk and rewards with other players in the health care system, including hospitals.
    - As soon as you enter total cost of care shared savings arrangements, expecting primary care to deliver is unrealistic. Chronic disease management is more anchored in specialist care. If we focused on how to incentivize primary care to deliver on the capabilities that are helpful, that will improve outcomes.
    - While it's true all parts of the system play a role in managing cost, evidence from the Medicare Shared Savings Program (MSSP) shows that non-hospital affiliated practices have had similar if not better performance generating shared savings than hospital affiliated practices.
    - PCPs contribute, as do specialists and care coordination all around. We can't have groups fighting for the same dollar, that's where outcomes are jeopardized.
    - PCPs need a base of specialists to provide care to complex patients with comorbidities – this will help improve overall care.
    - In a world where we recognize the constraints and we're not thinking about large systemic transformation we need to be realistic about what we can expect from PCPs, especially with respect to TCOC. If patients have social needs and PCPs cannot have those addressed– that's an issue. While talking about what goes into the shared savings model, we need to think about what is outside of the PCPs control.
- The committee emphasized the importance of aligning incentives across the healthcare system, rather than just focusing on primary care's ability to impact total cost of care.
    - Multi-payer alignment of incentives and resources can significantly improve outcomes. When we married PCMH money with the MSSP process, we improved from the lowest to highest quality quadrant.
- Need to pay PCPs sufficiently to fulfill the additional requirements we are asking of them and create appropriate accountability mechanisms.
- Members highlighted the importance of adequate base rates and recommended that program design consider the **potential impact of rate increases** (e.g., in the context of shared savings benchmark development). Specific comments included:
    - If we're offering shared savings, what is the confidence in setting benchmarks with rates expected to move? Changing rates could impact utilization. Without a historic baseline we're confident in – we may not have an accurate budget for several years.
    - Almost every VBP lives in an environment where fee schedules fluctuate over time. There is a path to solve this issue.

Stakeholder Engagement for Phase 3 & Wrap Up

- DSS announced they are forming a subcommittee for technical design and are looking to identify participants from the PCPAC who would like to participate. The Technical Design

Subcommittee will begin meeting on a monthly cadence and report back to PCPAC and the MAPOC care management committee – additional details are forthcoming.

- Committee Feedback:
    - There are different domains of expertise – quality measures vs financial modeling, while these pieces end up intersecting there may be different flavors of technical expertise required along the journey. Think about that as we build this group or subgroups.
    - Suggest this group continue to engage through implementation to give feedback and tweak the program along the way to improve success.
    - In response to concerns regarding payment model components that lack consensus among committee members, DSS clarified their goal is to collect valuable feedback and make decisions acknowledging that full consensus may not be reached.