Primary Care Program Advisory Committee

January 18, 2024

Agenda

Topic	Time
Opening Remarks and Goals for Today's Meeting	10 Minutes
Part 1: Review of Progress to Date	10 Minutes
Part 2: Payment Model Overview and Examples	15 Minutes
Part 3: Weighing Options and Collecting Directional Feedback	5 Minutes
Topic 1: Base Payment	60 Minutes
Break	10 Minutes
Topic 2: Performance Based Payment	60 Minutes
Closing Remarks and Next Steps	10 Minutes

Reminder

Primary Care Program Design Goals

Primary Care Program Goal

Primary care program design is being conducted with the overarching goal to:

Improve 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.

While primary care is not the whole solution, it is a foundational piece of a high-functioning health care system that is oriented towards improving member health and well-being.

This Committee's Charge

This committee is charged with engaging critically to help DSS develop a primary care program that promotes health equity and improves the health and well-being of members.

- We appreciate your engagement in this process – as we move forward with program design, we will be thinking together about solutions that support primary care in improving member health and well-being

Opportunities Ahead

Reminder

1. **Address disparities** in quality of care and member outcomes.

2. **Ensure members have easy and timely access to care** and address the range of barriers that make it challenging for members to access care.

3. Acknowledge the role that social determinants of health play in member health and well-being and **better identify and address health related social needs.**

4. **Enhance team-based care** with a focus on improving the care experience and providing care coordination driven by person centered goals and needs.

5. **Improve chronic conditions management** with a focus on reducing unnecessary inpatient and ED utilization.

6. **Invest more in primary care as a percent of total spend** with the intent to increase preventive care spending and decrease acute care spending.

Note: Opportunity 4 has been updated based on committee feedback

Goals for Today

1. **Take stock of where we are** - orient towards goals and decisions to date on care delivery and performance measurement

2. **Provide an overview of payment model types to ground the discussion** – review models and examples from state and federal programs that are aligned with the goals and policy priorities this group has discussed

3. **Collect directional feedback** - discuss strengths and limitations of each model type and collect feedback from the committee on which options are well suited to drive towards the goals that have been established

Part 1: Review of Progress to Date

Goal: Take stock of where we are - orient towards goals and decisions to date on care delivery and performance measurement

Reminder

The Essential Questions of Program Design

Care Delivery

What are the key things that primary care should be doing differently or better to improve member health and well being?

Performance Measurement

What is the definition of success? How should this be measured?

Payment Model

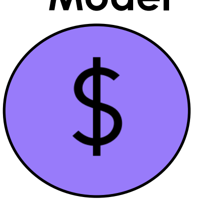
TODAY

How is primary care paid and incentivized for doing things that improve member health and well being?

Cross Cutting Equity Strategy: How do we reduce inequities and racial disparities?

Primary Care Program Design Status

We've established a starting point for care delivery and performance measurement in our recent discussions – today, we will discuss payment model options to support these priorities.

Care Delivery	*What are the key things that primary care should be doing differently or better to improve member health and well being?* **Oct 26th Meeting**	Chronic Condition & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care
Performance Measurement	*What is the definition of success? How should this be measured?* **Nov 14th Meeting** **Dec 7th Meeting**	Each domain is associated with a definition of success – and select measures and requirements that will be used to drive progress towards success. *(see appendix slides for additional details)*
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?* **TODAY**	***Next Step:*** *Review and discuss payment model options*

Cross Cutting Equity Strategy: *How do we reduce inequities and racial disparities?*

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Nov 14th Meeting

Dec 7th Meeting

Care Delivery Priorities

As we review and discuss payment model options, we will be thinking about how **primary care is paid and incentivized to accomplish these care delivery priorities.**

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in **management of chronic conditions.** Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.	**Care is easily accessible and prompt**, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is **accessible to persons with disabilities** and is **culturally and linguistically competent**.	The practice team **screens patients** for social risk factors, is knowledgeable about community resources, and **facilitates a referral to address the member's need.**	The practice team **utilizes patient information** in conjunction **with data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform **targeted quality and equity improvement activity**, including design and implementation of quality improvement plans.	Care delivery **is team-based**, with the practice team consisting of a **range of clinicians and non-clinicians**, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.

Note: Definitions of success align directly with OHS' Core Function Expectations of Primary Care Practice Teams; except for the definition associated with HRSN Screening & Community Supports, which has been updated based on committee feedback

Part 2: Payment Model Overview and Examples

Goal: Provide an overview of payment model types to ground the discussion – review models and examples from state and federal programs that are aligned with the goals and policy priorities this group has discussed

Payment Model Types

To ground ourselves in a common understanding of payment model options, we're going to start with a broad overview of different types of payment models.

(1) Base Payments	*in which the majority of revenues derive from payment*	**Fee for Service (FFS)**
		Hybrid FFS/PBP
		Population Based Payment (PBP)
(2) Incremental Payments	*in which a small base payment is combined with rewards, penalties, **or*** additional payments for specific purposes*	**Nonvisit Functions**
		Pay for Performance (P4P)*
		Shared Savings/Risk*

**This payment method typology includes both base payment add-ons ("Nonvisit Functions") and performance-based payments ("Pay for Performance" and "Shared Savings/Risk") in the incremental payments category – today's discussion will be focused on performance-based incremental payments*

Source: A Typology of Payment Methods, Urban Institute, April 2016, https://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf

Payment Model Types: Definitions

Category	Model	Definition
(1) Base Payments	**Fee for Service (FFS)**	A payment approach in which **a specific amount is paid when a particular service is delivered;** generally, the payment amount differs depending on which discrete service is delivered. Payments are made only for services that are codified and determined by the payer to be approved for payment.
	Hybrid FFS/PBP	A form of population based payment in which **some services, but not all, are to be delivered in return for a population based payment,** while other services are paid through FFS.
	Population Based Payment (PBP)	Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period. **A specific dollar amount per member per month** (or per year) is paid to providers, and in return they provide whatever quantity of services is needed to meet defined patient population's health needs.
(2) Incremental Payments	**Nonvisit Functions**	In its simplest form, this model is a per member per month payment, layered on top of another form of payment like fee-for-service. Providers typically receive this payment to help them **manage their patients' care and to support their coordination with other providers** in the patient-centered medical home.
	Pay for Performance	A payment model that includes financial incentives based on the ability or inability of the provider or provider organization to **meet certain performance standards.** A P4P system can provide rewards (upside), penalties (downside), or both upside and downside.
	Shared Savings/Risk	A form of payment in which a provider or a provider organization **shares generated savings with the payer when actual spending for a defined population is less than a target amount.** Under shared savings—also referred to as one-sided or upside-only—the recipient is not at risk for overspending. Two-sided or upside/downside models—referred to as shared savings and shared risk or just shared risk—require providers to share in payers' financial risk by accepting some accountability for costs that exceed their targets.

Source: A Typology of Payment Methods, Urban Institute, April 2016, https://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf

Application of Payment Model Types

Recognizing the distinct strengths and limitations of each payment model type, most programs combine multiple types of base and incremental payments to achieve their goals.

		State Medicaid Models				CMMI Multi-Payer Primary Care Payment Reform Demonstrations		
		CT PCMH	CT PCMH+	MA PCACO	CO APM 2	CPC+	PCF	MCP
Base	FFS	✓	✓			✓	✓	✓
Base	Hybrid FFS/PBP (%)				✓	✓		✓
Base	PBP			✓			✓	✓
Incremental	Nonvisit Functions		✓	✓		✓		✓
Incremental	P4P	✓		✓		✓	✓	✓
Incremental	Shared Savings/Risk		✓ (Savings)	✓ (Risk)	✓ (Savings)			

Indicates program has distinct tiers/tracks, each with different payment arrangements; we will discuss this in more detail in Part 3

CT DSS Starting Point: PCMH and PCMH+

CT DSS' current primary care programs use a combination of base and incremental payments.

		CT DSS PCMH	CT DSS PCMH+
Base	FFS	**FFS Medicaid, with Enhanced Reimbursement Rate** +24% on primary care services supplemental to the current Medicaid fee schedule	**FFS Medicaid**
	Hybrid FFS/PBP (%)		
	PBP		
Incremental	Nonvisit Functions		**Care Coordination Add-on Payments** (FQHCs only) Prospective monthly payments for FQHCs
	P4P	**Performance-Based Payments** Per Member Per Month (PMPM) payments earned based on performance and improvement on quality measures	
	Shared Savings/Risk		**Total Cost of Care Model Shared Savings Payments** Practices that generate savings and meet quality standards can share in up to 50% of the savings achieved; unearned savings can be earned based on quality performance

Part 3: Weighing Options and Collecting Directional Feedback

Goal: Collect directional feedback - discuss strengths and limitations of each model type and collect feedback from the committee on which options are well suited to drive towards the goals that have been established

At the end of this discussion, we hope to have…

Directional feedback on these **key payment model design questions**:

Topic 1: Base Payment	1. 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?
Topic 2: Performance Based Payment	2. How should DSS use financial incentives or incremental payments to drive performance and ensure measures and requirements are met?

Purpose of Today's Discussion

Today's discussion is a starting point – we are looking for directional feedback, **NOT** a **final answer** or **"a one size fits all"** payment model.

This group has already had considerable discussion about the need to **acknowledge variation amongst providers** in terms of starting point and characteristics like size and geography.

Today, we will begin discussing how to **design and implement a payment model that enables broad-based participation;** we anticipate having further discussion on these considerations.

Strategies might include:

- Establishing tracks or tiers for different provider types or levels of readiness
- Developing a glide path with incremental advances in expectations
- Providing technical assistance to providers
- Investing in data infrastructure and data sharing, or other centralized investments

Topic 1: Base Payment

Design Question 1: 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?

Approach

- **Review** starting point considerations, including:
  - Strengths and limitations of different base payment models
  - Examples from existing programs
  - Starting point assessment of alignment between models and care delivery priorities
- **Discuss** and collect committee feedback

Base Payment: Strengths and Limitations

Base Payment for Primary Care Services

	Fee for Service (FFS) *a specific amount is paid when a particular service is delivered*	**Hybrid FFS/PBP** *some services are delivered in return for a PBP, and others are paid FFS*	**Population Based Payment (PBP)** *a specific amount is paid per member per month or per year for a defined population*
Strengths (+)	• Provides a strong **incentive to increase the volume of services** delivered • Does not need to be risk adjusted – providers are paid based on the number of services provided	• Can be designed to **maximize the respective strengths** of FFS and PBP	• Provides **more flexibility in care delivery** • Reduces the imperative to generate office visits and **enables delivery of non-visit care** (e.g., care coordination) • Enables the **use of different care modalities** (e.g., email, phone, patient portal) • Provides more **revenue predictability** • Incentivizes **patient empanelment**/attribution
Limitations (-)	• Can create an **incentive for overservice** • Provides **little flexibility** to deliver non-visit care or integrate non-clinical staff • Encourages high volume, which can lead to **shorter appointments and limited scheduling flexibility** for urgent needs	• **Retains the respective limitations** of FFS and PBP	• Can create an **incentive for underservice** • **Must be implemented with guardrails,** including adequate risk adjustment to protect against “lemon dropping” and a quality program to protect against “stinting”

Base Payment: Program Examples

Different state and federal primary care programs have taken different approaches in implementing alternatives to FFS base payments.

		Starting Point (CT)		State Medicaid Models		CMMI Multi-Payer Primary Care Payment Reform Demonstrations			
		PCMH	**PCMH+**	**MA PCACO**	**CO APM 2**	**CPC+**	**PCF**	**MCP**	**Some programs…**
Base	**FFS**	✓	✓			Track 1: **FFS** payments	**Flat visit fee** for in-person treatment	Track 1: **FFS** payments	*…retain a FFS track and/or FFS payments for select services*
	Hybrid FFS/PBP (%)				**Practice-selected % blend** of prospective PBP/FFS	Track 2: **Practice-selected % blend** of prospective PBP/FFS		Track 2: **50/50 blend** of prospective PBP/FFS	*…have implemented hybrid FFS/PBP models by reducing FFS payments by a practice selected or program defined %*
	PBP			**Prospective PBP** tied to a 3-tiered practice classification based on practice capacity			**Prospective PBP**	Track 3: **Prospective PBP**	*…have implemented full PBP for select primary care services*

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Base Payment: Alignment with Priorities

Which payment model is most aligned with the care delivery priorities we have established?

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in **management of chronic conditions.** Care delivery follows evidence-based guidelines…	**Care is easily accessible and prompt,** using multiple care modalities… and including time outside of traditional work hours. Care is **accessible to persons with disabilities** and is **culturally and linguistically competent.**	The practice team **screens patients** for social risk factors, is knowledgeable about community resources, and **facilitates a referral to address the member's need.**	The practice team **utilizes patient information** in conjunction **with data…** to identify patient care needs, monitor change over time, and inform **targeted quality and equity improvement activity…**	Care delivery **is team-based,** with the practice team consisting of a **range of clinicians and non-clinicians…**
FFS	✓	✓	✓		✓
PBP	✓	✓	✓		✓
Considerations	*PBP can support non-visit care management activities more flexibly*	*PBP can support accessibility through different care modalities (e.g., patient portal, phone, email)*	*PBP can support traditionally non-billable activities; a FFS rate for screening was recently introduced*	*Data driven improvement can be incentivized using performance-based payments with FFS or PBP*	*FFS pays for defined clinician types; PBP can support integration of non-clinicians more flexibly*

✓ Checkmark indicates policy goals of the payment model are aligned with care delivery priorities

Base Payment: Discussion

Design Question 1: 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?

For Discussion:

- Which payment model is most aligned with the care delivery priorities we have established? Do you agree with this starting point assessment - what would you change or add?
- Are there other strengths and limitations that need to be considered? Including considerations to address the needs of different types of practices (e.g., rural, urban, small independent practices)?
- Are there mitigation strategies that need to be considered to address potential unintended consequences of a new payment model?

Topic 2: Performance Based Payment

Design Question 2: How should DSS use financial incentives or incremental payments to drive performance and ensure measures and requirements are met?

Approach

- **Review** starting point considerations, including:
    - Strengths and limitations of different performance based payment models
    - Examples from existing programs
    - Starting point assessment of alignment between models and care delivery priorities
- **Discuss** and collect committee feedback

Performance Based Payment: Strengths and Limitations

Broader Accountability Narrower Accountability

	Shared Savings/Risk (Cost and Quality) *provider shares generated savings with the payer when spending is less than target amount and/or provider shares in payers' financial risk for costs that exceed targets*	**Pay for Performance** (Cost and/or Quality) *financial incentives to meet certain performance standards*
Strengths (+)	• **Encourages a more wholistic view of member health** and incentivizes investments in preventive care and reductions in avoidable ED visits and hospitalizations (key drivers of cost) • **Creates an incentive to deliver high-value care** by enabling providers to share in a portion of any savings generated from delivering care more efficiently • **Drives investment in a population health approach** including investments in data infrastructure, integration of new staff, and greater coordination between providers	• **Creates a direct incentive** to improve on defined cost and/or quality metrics • **Can be implemented with small providers;** practice size threshold is low
Limitations (-)	• **Must be implemented with guardrails,** including adequate risk adjustment to protect against "lemon dropping" and a quality program to protect against "stinting" • **Can not be implemented with small providers**; requires a large enough population to ensure measurement is credible • **Shared risk is not appropriate for all provider –** requires organizational capacity and adequate capitalization to effectively manage; additionally, there are substantial regulatory limitations for FQHCs	• **Incentives must be sufficiently meaningful;** amounts should be large enough to compensate providers for the level of effort required to obtain them • **Does not incentivize broad based accountability** for a member's outcomes; impact is likely to be more narrow

Performance Based Payment: Program Examples

Different state and federal primary care programs have taken different approaches to implementing incremental rewards or penalties.

		Starting Point (CT)		State Medicaid Models		CMMI Multi-Payer Primary Care Payment Reform Demonstrations		
		PCMH	PCMH+	MA PCACO	CO APM 2	CPC+	PCF	MCP
Incremental	P4P	✓		**P4R/P4P:** Incentive funds tied to ACO quality and health equity reporting and performance (upside only)		**P4P**: PMPM incentive tied to patient experience, clinical quality, and hospital/ED utilization (upside only)	**P4P:** up to 50% upside; 10% downside incentive tied to hospital utilization or per capita cost (up/downside)	**P4P:** bonus payment based on quality, utilization and cost (upside only)
Incremental	Shared Savings/ Risk		✓	**Total Cost of Care Shared Savings/Risk** for ACOs with 3 risk track options (up/downside)	**Shared savings for chronic condition episodes** of care with benchmark prices; 50% savings (upside only)			

Some programs…

…have implemented reporting and/or performance bonus and/or penalty payments tied to quality, utilization and/or cost

…allow providers to share in savings generated against a cost target and/or recoup losses

Payment amounts or parameters differ by tier/track

Performance Based Payment: Program Examples

Many of the programs we've reviewed have implemented strategies to acknowledge provider characteristics in the design of the performance-based payment structure.

This most commonly takes the form of different tiers/tracks for providers with different characteristics, sometimes with an option to ramp up over time.

Characteristic	Program Examples
Capabilities/ Readiness	• **Making Care Primary:** has three tracks that recognize varied experience in value based care, with performance bonus payments that increase incrementally (from 3% upside in Track 1 to 60% upside in Track 3) • **MassHealth Primary Care ACO:** has a three-tiered base payment structure based on practice capabilities (e.g., fulfillment of staffing and care delivery requirements); and three ACO risk tracks, with higher savings/loss rates available for ACOs that select into higher risk bearing arrangements (60-100% savings/loss)
Size	• **PCMH/PCMH+:** to participate in the PCMH+ shared savings/risk model, providers must have a minimum of 2,500 attributed members; there is no minimum volume threshold to participate in the PCMH P4P model
Population Acuity	• **Primary Care First:** includes four practice risk groups, which have different P4P measures (risk group 1 and 2 are responsible for Acute Hospital Utilization; risk group 3 and 4 are responsible for Total per Capita Cost)
FQHC Status	• **Rhode Island Accountable Entities:** has a shared savings/risk model with required downside risk; however, FQHCs are able to participate with upside only risk

Performance Based Payment: Alignment with Priorities

Which payment model is most aligned with the care delivery priorities we have established?

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in **management of chronic conditions.** Care delivery follows evidence-based guidelines…	**Care is easily accessible and prompt,** using multiple care modalities… and including time outside of traditional work hours. Care is **accessible to persons with disabilities** and is **culturally and linguistically competent.**	The practice team **screens patients** for social risk factors, is knowledgeable about community resources, and **facilitates a referral to address the member's need.**	The practice team **utilizes patient information** in conjunction **with data…** to identify patient care needs, monitor change over time, and inform **targeted quality and equity improvement activity…**	Care delivery **is team-based,** with the practice team consisting of a **range of clinicians and non-clinicians…**
P4P	✓	✓	✓	✓	✓
Shared Savings	✓	✓	✓	✓	✓
Considerations	*Shared savings encourages focus on management; relevant measures can also be P4P*	*Shared savings encourages access to reduce avoidable ED/hospitalization; relevant hospital or access measures can also be P4P*	*P4P screening/referral measures exist; shared savings may provide more incentive to ensure needs are met*	*Both performance-based incentive models encourage use of data to improve performance*	*Shared savings encourages broader care delivery model changes, e.g., increased coordination*

✓ Checkmark indicates policy goals of the payment model are aligned with care delivery priorities

Performance Based Payment: Discussion

Design Question 2: How should DSS use financial incentives or incremental payments to drive performance and ensure measures and requirements are met?

For Discussion:

- Which payment model is most aligned with the care delivery priorities we have established? Do you agree with this starting point assessment - what would you change or add?
- Are there other strengths and limitations that need to be considered? Including considerations to address the needs of different types of practices (e.g., rural, urban, small independent practices)?
- Are there mitigation strategies that need to be considered to address potential unintended consequences of a new payment model?

Further Feedback

What haven’t we addressed yet? Are there other topics or considerations that we need to discuss in follow-up?

Closing Remarks and Next Steps

		Primary Care Program Advisory Committee Meeting Topics
Phase 1	April 6	Background & Introductions
	May 4	Primary Care Goals and Strategies
	June 1	Scope of Primary Care Design and Prior Work
	July 13	Listening Session: Strategies for Addressing Community Needs
	August 3	Review of Primary Care Program Examples and Discussion of Supplementary Data
	August 24	Supplementary Data Review Meeting
Phase 2	October 5	Process Check In and Review of Program Examples
	October 26	In Person Meeting: Care Delivery Redesign
	November 14	Primary Care Capabilities and Measurement
	December 7	Primary Care Capabilities and Measurement
	January 18	In Person Meeting: Payment Model
	February 8	Payment Model Follow Up
	March 7	Equity Strategy Review *(cross-cutting elements to be discussed within each topic area)*

Note: Topic areas are subject to change; this schedule will be adapted as needed

Appendix

Program Acronyms and Links to Resources

CT PCMH: Connecticut Person-Centered Medical Home

CT PCMH+: Connecticut Person-Centered Medical Home Plus

MA PCACO: MassHealth Primary Care ACO

CO APM 2: Colorado Alternative Payment Methodology 2

CPC+: Comprehensive Primary Care Plus

PCF: Primary Care First

MCP: Making Care Primary

Outcome Measures

Our discussions to date have also given us a starting point array of cross-cutting outcome measures that will allow us to **measure if we are accomplishing our care delivery priorities.**

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Outcome Measures					
Plan All-cause Readmission	++	++	+		++
Avoidable ED	++	++	+		++
Avoidable Hospitalization	++	++	+		++
PCMH CAHPS Survey		++			++
PCPCM Survey	++	++			++
Comprehensive Diabetes Care	++	+			+
Controlling High Blood Pressure	++	+			+
Chronic Condition Cost of Care	++	+			+

++: substantial impact; +: moderate impact

Process Measures

We have also discussed a starting point array of more domain-specific process measures that can be used to drive progress on care delivery priorities, when outcomes measures are insufficient.

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Process Measures					
Child and Adolescent Well-care Visits		++			+
Asthma Medication Ratio	++	+			+
Eye Exam for Patients with Diabetes	++	+			+
Kidney Health Evaluation for Patients with Diabetes	++	+			+
Behavioral Health Screening and Management	++	+			+
Cancer Screenings		++			+
Participation in an Alerting Exchange System				++	
Social Determinants of Health Screening			++		

++: substantial impact; +: moderate impact