Primary Care Program Advisory Committee

Meeting 1

Appendix: Learnings from the Primary Care Program Assessment

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Work to Date: Primary Care Program Assessment

Throughout 2022, DSS and FCG conducted a Primary Care Program Assessment that aimed to assess CT DSS primary care program opportunities and provide recommendations to inform the future direction of CT DSS primary care programs.

	Objective	2022
Phase 1 *Initial Evaluation*	• Review existing program documentation • Interview state team for background/ context • Complete preliminary program assessment	**Mar** **Apr** **May**
Phase 2 *Primary Data Collection*	• Interview members, providers, and other key stakeholders to understand stakeholder priorities	**Jun** **Jul** **Aug**
Phase 3 *Recommendations*	• Develop options and recommendations for the future of CT DSS primary care programs	**Sep** **Oct**
Phase 4 *Support Implementation*	• Outline implementation considerations and key activities to support implementation of recommendations	**Nov** **Dec**

Preliminary Program Assessment

Focus Group Learnings

Primary Care Program Recommendations

This Appendix summarizes learnings from Phase 1 and 2

This work culminated in a set of recommendations for primary care program design and a plan for conducting primary care program design with substantial stakeholder engagement in 2023.

Preliminary Program Assessment: Key Learnings

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Background and Context: CT DSS Primary Care Programs

DSS currently has two primary care programs with distinct requirements and payment models: the Person-Centered Medical Home (PCMH) program, and the Person-Centered Medical Home Plus (PCMH+) program.

	Person-Centered Medical Home (PCMH)	Person-Centered Medical Home Plus (PCMH+)
Overview	• Based on widely-adopted **national PCMH model** • Enhanced reimbursement rates are **credited with improving member access** • The program is **generally popular** – with community advocates, and participating providers (who see parts of the program as administratively burdensome, but value the enhanced reimbursement)	• Established in 2017; **builds on PCMH with a more advanced payment model** and more intensive care coordination requirements • Has shown **success in decreasing spending** and acute care utilization and controlling cost trend in aggregate • **Program perceptions are mixed** amongst community advocates and providers
Key Program Features	• **NCQA or TJC PCMH Recognition** is required • **FQHCs do not receive enhanced** reimbursement rates • Glide path program for practices seeking to become PCMHs, and practice technical assistance available	• **NCQA or TJC PCMH Recognition** is required • **FQHCs receive additional** care coordination payments • 2,500 members minimum to participate
Provider Participation	• **56% of HUSKY participating PCPs** (with 55% of members)	• **18% of HUSKY participating PCPs** (with 17% of members) • **FQHC dominated program:** 10 of 12 participating providers in Wave 3 (Year 1) are FQHCs
Payment Model	**(1) FFS Medicaid, with Enhanced Reimbursement Rate:** +24% on primary care services supplemental to the current Medicaid fee schedule **(2) Per Member Per Month (PMPM) Performance-Based Payments:** PMPM payments earned based on performance and improvement on quality measures	**(1) FFS Medicaid** **(2) Care Coordination Add-on Payments** (FQHCs only): Prospective monthly payments for FQHCs **(3) 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

Preliminary Program Assessment

The Preliminary Program Assessment synthesized existing program documentation and key informant input into a directional assessment across program elements that serves as a starting point for the identification of opportunities and options.

	CMAP Overall	PCMH	PCMH+	Equity	Key Finding
Member Access and Provider Participation	+	+	-	–	• CMAP performs comparatively well on measures of primary care access and preventive care, however there are disparities in performance by race/ethnicity. The majority of CMAP PCPs participate in PCMH, but participation in PCMH+ is more limited, and especially limited amongst non-FQHC providers.
Quality	+	+	+	–	• CMAP generally performs well on quality measures, and the PCMH and PCMH+ programs have shown targeted, measurable improvements on incentivized quality measures. However, disparities in quality performance by race/ethnicity were identified across programs.
Cost	+	-	+	–	• PCMH+ has demonstrated success in controlling cost trend, while PCMH practices have had a less substantial impact on cost trend in recent years. Reducing hospital utilization remains an opportunity to impact total cost of care.

Access and Participation: Key Findings

CMAP performs comparatively well on measures of primary care access and preventive care, however there are disparities in performance by race/ethnicity. The majority of CMAP PCPs participate in PCMH, but participation in PCMH+ is more limited, and especially limited amongst non-FQHC providers.

	CMAP Overall	PCMH	PCMH+	Equity Lens
Member Access and Provider Participation	• There are **currently no major gaps in CMAP member PCP access**, as measured [6] • CMAP overall shows **strong comparative performance on measures of *Primary Care Access and Preventive Care,*** compared to other state Medicaid programs [14]	• Participation in PCMH **grew considerably in the initial years** of the program, driving gains in member access, and has since leveled off [17] • **55% of HUSKY members** are attributed to a PCMH; 80% of those attributed to a PCP (Dec 2020) -- **56% of CMAP participating PCPs** are participating in PCMH (MY 2020) [7]	• Provider participation in PCMH+ appears to be **notably shaped by the financial incentives available – the majority of PCMH+ participants are FQHCs**, very few non-FQHC practices have elected to participate [2] • **17% of HUSKY members** are attributed to a PCMH+; 25% of those attributed to a PCP (Dec 2020) -- **18% of CMAP participating PCPs** are participating in PCMH+ (MY 2020) [7]	• The **PCMH+** attributed population is **disproportionately Black and Hispanic**, as compared to the overall population, while **PCMH** attributed members are **more likely to be white than Black or Hispanic** [11] • **Disparities in performance by race/ethnicity identified** for the majority of CMAP measures of ***Prevention and Screening*** **and** ***Access/ Availability of Care*** [8]

Quality of Care: Key Findings

CMAP generally performs well on quality measures, and the PCMH and PCMH+ programs have shown targeted, measurable improvements on incentivized quality measures. However, disparities in quality performance by race/ethnicity were identified across programs.

	CMAP Overall	PCMH	PCMH+	Equity Lens

Quality of Care	• CMAP **generally performs well on quality measures**: CMAP scored above the national average on 80% of Medicaid/CHIP Scorecard measure components, and was in the top quartile for more than half (52%) of measures [14]	• There have been **targeted, measurable improvements on the specific PCMH/PCMH+ measures that have financial incentives attached** [1]
		• Broader **quality performance strengths appear well aligned with the goals and structure of PCMH/PCMH+** [1]
		  • The emphasis on prevention and screening can be seen in substantial improvements on these measures across PCMHs and FQHCs
		  • FQHCs perform better on Overuse/ Appropriateness and Behavioral Health measures vs. PCMH and non-PCMH practices (potentially encouraged by the structure of the PCMH+ program, among other factors)
				Disparities in quality measure performance by race/ethnicity identified [8]
				• Overall, there were observable disparities in quality performance by race/ethnicity for 83% of CMAP measures
				• Disparities in quality performance were most prevalent in the Black CMAP population - quality performance rates were worse than the overall rate for 70% of measures

Cost of Care: Key Findings

PCMH+ has demonstrated success in controlling cost trend, while PCMH practices have had a less substantial impact on cost trend in recent years. Reducing hospital utilization remains an opportunity to impact total cost of care.

	CMAP Overall	PCMH	PCMH+	Equity Lens
Cost of Care	• CMAP appears to be **relatively low cost overall**, although there may be an **opportunity to shift spending and invest more significantly in primary care,** as a share of total Medicaid spend. [15, 16]	• PCMH practices have had a **less substantial impact on cost trend** in recent years, as compared to FQHCs. [1] • PCMH practices perform roughly comparably to non-PCMH practices on measures of hospital utilization and have improved less on these measures in recent years (vs. non-PCMHs), suggesting there may be **some opportunity for improvement on hospital avoidance.** [8]	• PCMH+ has **demonstrated success in generating statistically significant decreases in spending and acute care utilization** and controlling cost trend in aggregate. However, shared savings performance has varied by provider. [3, 2] • **No evidence of under-service utilization has been found** in the early years of the program. [5] • FQHCs have improved on measures of hospital utilization but **may still have some opportunity for improvement** relative to PCMH and non-PCMH practices (though higher rates of utilization may also be attributed to a higher risk population, among other factors). [8]	**Disparities in hospital utilization by race/ ethnicity identified** • The Black CMAP population had a higher-than-average rate of hospital/ED utilization on 4 out of 4 measures; the Hispanic CMAP population had a higher-than-average rate on 3 out of 4 measures. [8]

Preliminary Program Assessment: Sources

	Sources
PCMH/ PCMH+ Program Performance Data	1. CHN PCMH Longitudinal Review 2. Mercer PCMH+ Annual Shared Savings Reports 3. PCMH+ Formal Evaluation: RTI, *Evaluation of the State Innovation Models (SIM) Initiative Round 2: Model Test Final Report*, June 28, 2021
PCMH/ PCMH+ Program Requirements	4. PCMH and PCMH+ Program Guidance and RFPs 5. Mercer PCMH+ Under-Service Utilization Monitoring Strategy, July 2020
CMAP Overall Primary Care Data	6. CHN Gap and Network Adequacy Analysis 7. CHN MY 2020 Annual Provider Profiling Report 8. CHN 2021 HUSKY Health Program Health Equities Report (MY 2019 Performance) 9. CT OHS Cost Growth Benchmark Program 10. CMAP CAHPS Survey Data - SPH Analytics, *2020 Medicaid Adult and Child At - A - Glance Reports* 11. CHN Member Attribution data request; attribution as of 1/1/2022 12. Supplementary enrollment, utilization, and expenditures data as requested
Multi-State Benchmarking	13. Kaiser Family Foundation Primary Care Access Indicators 14. Medicaid/ CHIP Scorecard Quality Measures – *FY 2020 Child and Adult Core Set Performance* *15. Primary Care Expenditures: Investing in Primary Care, A State-Level Analysis*; July 2019, Patient-Centered Primary Care Collaborative and the Robert Graham Center 16. Medicaid.gov Medicaid Per Capita Expenditure Estimates for States and Data Quality Assessment (2019)
CT DSS Input Sessions	17. Input Sessions with CT DSS, CHN, and Mercer teams *18. Report from Advisory Board for Transparency on Medicaid Cost and Quality*, July 2021

Primary Care Focus Groups: Key Learnings

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Primary Care Focus Groups: Approach

Qualitative feedback was collected through focus groups with members, providers, and other key stakeholders.

	Identify Focus Groups	Outreach to Participants	Focus Group Facilitation
Member Focus Groups	(1) English - Adult (2) English - Pediatric (3) Spanish - Adult (4) Spanish - Pediatric	**Email Invitation with Follow-up Phone Calls to Member Sample** • CHN member engagement sent email invitations to 15,604 members • Member selection criteria used ADI to target underserved geographic areas (ADI: 5-10) • Member engagement team followed up with phone calls to increase response rate (especially for Spanish speaking groups) • Members received a $25 gift card for participating	1-hour sessions Spanish language sessions conducted with an interpreter
Provider Focus Groups	(5) PCMH Practices (Non-FQHC) (6) PCMH+ Practices (Non-FQHC) (7) PCMH+ Practices (FQHC) (8) Non-Participating Practices (FQHC + Non-FQHC)	**Email Invitation to Nearly All HUSKY Health Practices** • CHN provider contacts sent email invitations to their assigned PCMH/+ participating and non-participating practices	1.5-hour sessions
Non-Member/ Provider Stakeholders	(9) MAPOC Care Management Committee Members (10) Provider Advocates (11) Community Advocates	**Email Invitation to Stakeholder List** • All MAPOC Care Management Committee members invited • Provider advocacy organizations identified and invited via DSS/CHN contacts • Community advocacy organizations identified through DSS and CHN, list enhanced with suggestions from MAPOC CM Committee	1-hour sessions

Primary Care Focus Groups: Approach

Participants were asked to share their perspectives on Medicaid primary care broadly, and the PCMH and PCMH+ programs specifically.

Major Topics	Sample Prompts *(prompts were tailored to each group)*	*Substantially addressed by:*		
		Member	Provider	Advocate
Primary Care Experience and Goals	• What do you see as the biggest issues/challenges for the primary care system today? If you had to choose one thing for DSS to do to improve the primary care system – what would it be? • What do you like about your primary care clinician/primary care practice? Are there any things that you don't like about the way your primary care clinician/primary care practice provides your care?	✓	✓	✓
Health Equity	• What barriers are you aware of that would make it difficult for underserved populations to be able to access the care they should be receiving? // Have you experienced any barriers to being able to access the care you should be receiving? • Are there strategies you would recommend to better identify and address disparities in member access, experience, and quality of care?	✓	✓	✓
Member Preferences	• What are the top 1-3 things members want out of their primary care experience? Where are the biggest opportunities to improve member experience? • What suggestions do you have for ways that your primary clinician/ primary care practice could improve the way that they provide care for you and/or your family?	✓	✓	✓
PCMH and PCMH+ Program Experience	• What do you like most about the PCMH (+) program? In what ways has the program succeeded? • What do you not like about the PCMH (+) program? Where do you see room for improvement? What would you change?		✓	✓
Payment Model Preferences	• What has your experience with different provider payment models been (e.g., pay for performance incentives, shared savings or risk arrangements)? • What kinds of provider payment models are you participating in with other payers? What are the success factors or lessons learned from participation in these models?		✓	✓

Focus Group Key Learnings: Summary

Key Theme	Summary of Feedback	*Substantially addressed by:*			Excerpts
		Member	Provider	Advocate	
Identifying & Addressing SDOH Needs, Promoting Equity	Providers and advocates were almost unanimously **supportive of initiatives focused on identifying and addressing SDOH needs and promoting equity,** and generally recognized the **significant impact SDOH needs have on health outcomes.** Members, providers and advocates identified a **range of barriers that impact the equitable delivery of care and member health outcomes**, including: access to transportation, housing and food security, translation supports, technology enabled care, behavioral health access, extended care hours, disability access, cultural competency, and workforce diversity.	✓	✓	✓	*If you need insulin to manage your diabetes, and you don't have a refrigerator to keep your insulin cold, that's a huge barrier - but it's hard for me to fix that.* (Provider) *We do an SDOH screening and have a resource list to hand to patients, but we need more resources - the social work connection is really challenging.* (Provider)
Care Coordination	Providers and advocates generally cited care coordination as the area of greatest need for improvement and saw enhanced **care coordination as critical to addressing a member's full range of needs and improving health outcomes**. Providers and advocates stressed the substantial time and energy required to **help members navigate the system and connect to other services**, especially in the Medicaid population; and were broadly supportive of **expanded care teams, inclusive of community and peer-based health workers.** Members frequently mentioned office staff in describing what they liked and didn't like about their primary care experience – many **members value helpful, responsive, friendly staff who take the time to answer questions**.	✓	✓	✓	*Care coordination is a huge need, especially in this population. Members have trouble navigating the system, and that falls on office staff.* (Provider) *We need to connect community health workers to primary care doctors – they can support patients with questions, figure out what insurance covers, and help find specialists.* (Advocate)
Easy and Timely Access to Care	Members and providers most often reported **easy and timely access to appointments and more time with providers** as the things members most want out of primary care. Many providers and advocates saw **promise in technology enabled care options**; and while some members preferred office visits, many appreciated the **convenience and more timely access associated with telehealth**.	✓	✓	✓	*I really like telehealth, it's a great addition. Sometimes I don't need to go to the office, I can just do a quick, last minute telehealth call.* (Member)
Availability of Specialists	The **lack of specialists serving Medicaid members** was raised as a **critical issue** in nearly every focus group conducted – difficulty finding specialists impacts member experience and requires substantial care coordination time from providers.	✓	✓	✓	*We spend tons of time trying to locate specialists for Medicaid members – it's one of the biggest staff time consumers.* (Provider)

Focus Group Key Learnings: Summary

Key Theme	Summary of Feedback	*Substantially addressed by:*			Excerpts
		Member	Provider	Advocate	
Timely Data & Measurement Transparency	Increased access to **timely data and greater transparency** in quality measurement and shared savings calculations was a significant priority amongst providers, especially those participating in the PCMH+ program.		✓		*We get all of the data 9 months after the year ends. With other insurers, you know how you're doing and where you stand all year long – it's much more incentivizing and you can correct more easily if you see where you're at.* (Provider, PCMH+)
Administrative Burden	Providers had some **concerns about the additional administrative burden** imposed by the PCMH and PCMH+ programs, especially the **NCQA PCMH recognition** process, and ongoing reporting requirements. Non-participating practices noted that administrative burden is **a significant deterrent to the participation of small, independent practices** in the existing value-based models.		✓		*Recognition is a giant, daunting process. We needed technical consulting help because it's an extremely arduous process. We have to submit a huge number of files every year.* (Provider, PCMH) *There is so much that PCMH wants to know. The reporting is really painful and is leading to provider burnout.* (Provider, PCMH)
Payment Model Preferences	Providers and advocates had **mixed feelings about value-based payment models**. Some saw the transition away from FFS-based models as positive or inevitable, while others had significant concerns. Some advocates were especially concerned that any model with a **savings incentive would impact quality of care or access**, especially for people with complex needs. Providers pointed out the **limitations of shared savings models** and were concerned that models that do not adequately adjust for patient complexity inappropriately penalize providers with complex, high-need patients.		✓	✓	*When there is an incentive for providers who save money, how do you ensure quality of care and access for people with disabilities or who have complex medical needs?* (Community Advocate) *Shared savings is tough because when you have a really good outcome already you can't improve and then there's no benefit.* (Provider) *This is where capitation avoids this issue entirely - the upfront, increased investment in primary care is foundational.* (Provider)

Focus Group Key Learnings: Program Specific Learnings

	PCMH Program Experience	PCMH+ Program Experience
Strengths	• PCMH practices value the **program's enhanced reimbursement rates**, which they've come to rely on. Practices would like to receive long-term assurances to continue to receive the enhanced rate for their work to improve quality of care and patient experience. • Non-traditional primary care providers found that **PCMH recognition gave its clinics more legitimacy** when they initiated primary care services.	• PCMH+ participants regard **investments in care coordination** as a major program success. Practices and FQHCs have used the funding to formalize and standardize care coordination processes. • The program established a **standardized set of quality measures** to base improvement upon. • Participants in favor of **shared savings** expressed that the bonus payments were significant and helpful. One FQHC appreciated the opportunity to test out shared savings in an upside only model.
Opportunities	• **PCMH's NCQA recognition process and reporting requirements** are difficult and time-consuming. Practices rely on the support of HUSKY Health CPTS representatives to assist in the recognition process. Many practices would readily forgo the NCQA recognition if not for the enhanced reimbursement rates. • There is a **large need for investment in care coordination**. Care coordination is very resource-intensive cost for practices, and practices and community advocates would like to receive more support and funding for this work. • Practices desire **greater program flexibility** to account for the evolving landscape of primary care, which impacts care delivery and quality metrics. • Nearly all stakeholders (members, providers, advocates) support increased **integration of SDOH assessment and resources.**	• PCMH+ health centers and practices requested improvements in the **timeliness and accessibility of data and reporting**, such as more interim reporting and data, to support proactive engagement with the program • Program participants would also like to see **greater transparency and integrity** in shared savings calculation and methodologies for quality measures and risk adjustment. There is also a desire for more communication and support from DSS. • Most **quality measures are not applicable to pediatric practices** and/or provide little room for improvement if they already perform well on the measure. • Community advocates worry that **PCMH+ primarily rewards cost savings**, which may unintentionally increase disparities and decrease quality of care. Advocates recommend that DSS realign the program with more explicit goals for quality of care and health equity. • Nearly all stakeholders (members, providers, advocates) support increased **integration of SDOH assessment and resources.**

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Identifying and Addressing SDOH Needs and Promoting Equity	**Providers and advocates were almost unanimously supportive of initiatives focused on identifying and addressing SDOH needs and promoting equity. Members, providers, and advocates identified a range of barriers and strategies to promote equity.** • Providers noted challenges (and some successes) collecting information about SDOH needs and connecting members with SDOH supports – many identified the need for enhanced financial support for this work • Some community advocates stressed the importance of aligning payment models with explicit goals for reducing disparities and improving quality of care • Members, providers and advocates identified the following barriers/focus areas as key to promoting equity: access to transportation, housing and food security, translation supports, technology enabled care, behavioral health access, extended care hours, disability access, cultural competency (especially LGBTQ+, people with disabilities, non-English speakers), and workforce diversity.	*I haven't been referred to any of those* [social service] *organizations, but I feel it would be good because I wasn't aware that there were these kinds of services – other people have helped me and showed me where these places exist.* (Member) *I wouldn't care if they know about culture or anything like that; they don't need to know more about me, its just a medical appointment.* (Member) *If you need insulin to manage your diabetes, and you don't have a refrigerator to keep your insulin cold, that's a huge barrier - but it's hard for me to fix that.* (Provider) *I hope the next step is to address more SDOH concerns and have Medicaid payments for services provided in the community.* (Provider) *We do an SDOH screening and have a resource list to hand to patients, but we need more resources - the social work connection is really challenging.* (Provider) *Disparities are there – unless we address them and the things that cause them. We need to make sure any payment model addresses disparities instead of perpetuating them.* (Community Advocate)
Member Preferences	**Members and providers most often reported easy and timely access to appointments and more time with providers as the things members most want out of primary care.** • Convenient access to primary care, including extended hours and same-day care, was a major member priority, along with sufficient time with a physician, kindness and respect, and less time waiting • While some members preferred office visits, many appreciated the convenience and more timely access associated with telehealth • Many providers and advocates saw promise in technology enabled care options (e.g., phone, email, patient portal, remote monitoring), and suggested investments here could improve member experience	*The problem with appointments is when you get seen it's 5-8 minutes, but the time in the waiting room is way longer.* (Member) *My pediatrician is amazing – they are open late and on holidays and Sundays, especially for emergency visits.* (Member) *I really like telehealth, it's a great addition. Sometimes I don't need to go to the office, I can just do a quick, last minute telehealth call.* (Member) *We need to give providers more tools to make care faster and better for patients. More investment in technology and telehealth would be great for patients.* (Provider)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Care Coordination	**Providers and advocates generally cited care coordination as the area of greatest need for improvement and saw enhanced care coordination as critical to addressing a member's full range of needs and improving health outcomes. FQHCs participating in PCMH+ noted the investments in care coordination as a major success of the program. Community advocates were broadly supportive of investments in care coordination.** • Providers highlighted that there is huge unmet need for assistance in navigating the health care system within the HUSKY population and stated that additional funding is needed to support the work to find and arrange specialist referrals, navigate coverage limitations, track referrals, and provide member support • Community advocates were broadly supportive of funding for care coordination and saw the integration of community and peer-based health workers as a major priority • Members frequently mentioned office staff in describing what they liked and didn't like about their primary care experience – many members value helpful, responsive, friendly staff who take the time to answer questions.	*Care coordination is a huge need, especially in this population. Members have trouble navigating the system, and that falls on office staff.* (Provider, Non-FQHC) *It is a huge cost burden to have enough CHWs to support all of this work, and we get no payment for it.* (Provider, Non-FQHC) *Dedicated resources for care coordination has been a huge benefit.* (Provider, FQHC PCMH+) *We need more emphasis on care coordination in PCMH.* (Community Advocate) *We need to connect community health workers to primary care doctors – they can support patients with questions, figure out what insurance covers, and help find specialists.* (Community Advocate)
Availability of Specialists	**The lack of specialists serving Medicaid members was raised as a critical issue in nearly every focus group conducted.** • Members described long wait times and significant travel time to see specialists, especially dental • Providers spoke to the administrative burden and substantial care coordination effort required to find specialists who will accept their Medicaid members • Members of the advocate community pointed to low Medicaid reimbursement rates as a major driver of the specialist shortage, and some MAPOC members argued this should be the focus of any system improvement effort DSS takes on given the comparatively strong performance of the primary care system	*I've heard a lot of doctors say they don't want to take HUSKY insurance because they don't pay them. I wish it were possible to fix that and make doctors more available, so you don't have to drive long distances to be seen.* (Member) *We spend tons of time trying to locate specialists for Medicaid members – it's one of the biggest staff time consumers.* (Provider) *Access to behavioral health, dental, and specialists are the three things HUSKY needs to address.* (Community Advocate)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Timely Data and Measurement Transparency	**Increased access to timely data and greater transparency in quality measurement and shared savings calculations was a significant priority amongst providers, especially those participating in the PCMH+ program.** • PCMH+ providers cited the need for more real-time information and interim reporting to support accountability and proactive engagement with the program; year-end reports and out-of-date attribution rosters were a significant source of frustration. • PCMH+ providers also requested greater transparency and insight into measurement methodologies – proprietary risk adjustment and quality measurement methods make it difficult for providers to have confidence that performance calculations are meaningful and limit active participation in the program.	*We get all of the data 9 months after the year ends. With other insurers, you know how you're doing and where you stand all year long – it's much more incentivizing and you can correct more easily if you see where you're at.* (Provider, PCMH+) *Shared savings are calculated based on proprietary risk score calculations – we can't actively take part or be proactive about improving.* (Provider, PCMH+)
Administrative Burden	**Providers had some concerns about the additional administrative burden imposed by the PCMH and PCMH+ programs, especially the NCQA PCMH recognition process. Non-participating practices noted that administrative burden is a significant deterrent to the participation of small, independent practices in the existing value-based models.** • PCMH practices stressed that the NCQA PCMH recognition process is a very arduous annual burden; the support of the CPTS team was appreciated and considered an important support in obtaining PCMH recognition. • PCMH practices also highlighted the burden of ongoing reporting requirements and the staff time required to set up reports and track all of the measures – some measures were seen as unnecessarily burdensome and a waste of time.	*Recognition is a giant, daunting process. We needed technical consulting help because it's an extremely arduous process. We have to submit a huge number of files every year.* (Provider, PCMH) *Some of the measures help monitor, and some are a complete waste of time. We did it because we would get more money, but it's a full-time job for multiple people.* (Provider, PCMH) *There is so much that PCMH wants to know. The reporting is really painful and is leading to provider burnout.* (Provider, PCMH) *Independent practices have lots of challenges with HUSKY. Reimbursement rates are much lower and program administration is incredibly onerous, which pushes small practices to stop seeing HUSKY patients.* (Provider)

Focus Group Key Learnings: Details, by Theme

Key Theme	Summary of Feedback	Excerpts
Payment Model Preferences	**Providers and advocates had mixed feelings about value-based payment models. Some saw the transition away from FFS-based models as positive or inevitable, while others had significant concerns.** • Some providers and advocates voiced significant concerns that population-based payment models do not adequately adjust for patient complexity and inappropriately penalize providers with complex, high-need patients. • Advocates were especially concerned that any model with a savings incentive would impact quality of care or access, especially for people with complex needs. • Some providers also voiced concerns that the opportunity for shared savings diminishes over time and is more limited for those that already have high marks on quality and cost • On the other hand, some providers saw the move away from FFS as positive or inevitable – and appreciated the opportunity to partake in savings resulting from improving patient care • At least one provider saw the flexibility of capitation as foundational to addressing SDOH needs and enabling providers to take full accountability for members.	*When there is an incentive for providers who save money, how do you ensure quality of care and access for people with disabilities or who have complex medical needs?* (Community Advocate) *The negative about shared savings is: if you have medically fragile patients, you can get penalized for taking care of them. It could be a two-year-old with a brain tumor – these are not people misusing the ER – but you can get dinged for that.* (Provider) *Shared savings is tough because when you have a really good outcome already you can't improve and then there's no benefit.* (Provider) *The FFS model is going to go away, and shared savings is a good way to do it. It benefits the patient – we focus on them, try to help them, and then get to partake in savings which is good for all of us.* (Provider) *This is where capitation avoids this issue entirely - the upfront, increased investment in primary care is foundational. To the point on social risks being taken on in the clinical setting – it's all intermingled. Better to fund the investment in a place where the work can be structured and coordinated.* (Provider)