MAPOC Care Management Committee

DSS Primary Care Program Design Update

March 13th, 2024

Agenda

- Update on Primary Care Program Design Stakeholder Engagement

Reminder: Primary Care Stakeholder Engagement Plan

Primary care program design will be conducted in close partnership with stakeholders, leveraging newly established and existing stakeholder engagement forums.

	Description	Participation	Meeting Cadence
Primary Care Program Advisory Committee (PCPAC)	Newly established committee that will serve as the primary program design advisory body	A diverse array of representatives, including providers, advocates, and state agency partners	Monthly
Primary Care Program Advisory FQHC Subcommittee	Newly established subcommittee that will advise on FQHC-specific program design topics	Representatives from each FQHC	Monthly, following PCPAC meetings
MAPOC Care Management Committee	Ongoing updates to and engagement with MAPOC Care Management Committee	Existing forum	Established cadence, every other month
Non-FQHC Primary Care Provider Subcommittee	As needed forum for primary care provider engagement	Broad-based forum for Medicaid primary care providers	TBD, as needed
CHNCT Member Advisory Workgroup	As needed engagement with HUSKY members through existing member advisory workgroup	Existing forum	TBD, as needed

Update: Primary Care Stakeholder Meetings Held Since Last Update

Today, we'll provide an update on primary care stakeholder engagement since our January update to this committee.

Month	CHNCT Member Advisory Workgroup	Primary Care Program Advisory Committee	FQHC Subcommittee	MAPOC Care Management Committee
January		***January 18th*** Primary Care Base Payment Model (Part 1)		***January 10th*** – Last Update to MAPOC Care Management Committee
February	***February 15th*** Primary Care Opportunities	***February 8th*** Primary Care Performance-Based Payment (Part 2)	***February 27th*** Primary Care Program Design Update	
March		***March 7th*** Primary Care Crosscutting Equity Strategy		***March 13th*** – Today's Update to MAPOC Care Management Committee
Update	***DSS joined the February MAW meeting to collect member feedback on Primary Care Program Opportunities***	***The Advisory Committee is wrapping up Phase 2 of program design, with recent discussions on payment model and equity strategy***	***The FQHC Subcommittee met in February to provide FQHC-specific input on program design***	***The MAPOC Care Management Committee has continued to receive regular updates on primary care stakeholder engagement***

Member Advisory Workgroup Feedback: Opportunities

The MAW group shared valuable feedback on the DSS primary care opportunities for improvement:

- Ensure members have easy and timely **Access to Care**
  - Member comments highlighted frustrations with limited availability of primary care providers, poor responsiveness and communication from doctors' offices, and lack of continuity and transparency around provider changes.
  - There is a desire for more accessible in-person primary care and stronger doctor-patient coordination.

- Better identify and **Address Health Related Social Needs**
  - Most members felt it was important that their PCP remain focused on providing high-quality medical care; a couple members expressed openness to referrals related to transport and food for needs affecting medical care, and one member recounted an experience highlighting the benefits of being referred to housing resources through a clinic.

- Enhance **Team-Based Care**
  - One member suggested including home care agencies/direct care workers as part of primary care teams, or at minimum having PCPs establish a robust referral network to connect patients directly to other programs or types of care.

- Improve **Chronic Condition Management**
  - Members cited opportunities to integrate more between-visit care coordination whether via patient portal communications or direct physician outreach as a means to enhance patient support.
  - Personal connection and follow-up after appointments were particularly valued.

Primary Care Program Design Status

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, BH & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care	*Reviewed with MAPOC CM in November and January Meetings*
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** that will be used to drive progress towards success.	
Payment Model	*How is primary care paid and incentivized for doing things that improve member health and well being?* **Jan 18th Meeting** **Feb 8th Meeting**	The primary care payment model includes **base and performance-based payments** that advance care delivery and performance measurement priorities.	**Today**

Crosscutting Equity Strategy: *How do we address inequities and racial disparities?* **Mar 7th Meeting** **Today**

Payment Model

To ground ourselves in a common understanding of payment model options, we reviewed a range of payment models and collected committee feedback on which were most well aligned with program goals.

(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*

Additional information available in the Appendix.

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

Jan 18th Meeting

Feb 8th Meeting

Committee Feedback: Payment Model

The PCPAC shared valuable feedback on payment model design at the January and February meetings.

Overall, the design of the payment model should consider how to:

- **Build in flexibility for broad based participation, using tiers/tracks or a glide path**, but do not require practices to graduate from one tier to the next; give providers options and the flexibility to choose which path is the right fit
- **Ensure FQHCs are able to participate**
- **Align with other payer models** (i.e., Medicare Advantage, State Employee Health Plan)
- Limit model complexity and administrative burden **to ensure provider participation and patient choice**
- Support providers with **data, tools, and technical assistance**

Preferences for a base payment model were mixed; some advocated that DSS use **a FFS model**, some spoke to the value of a **PBP/PMPM model**, many highlighted the benefits of **a hybrid model with FFS payment and PBP/PMPM.**

- **FFS** is well aligned with some of the care delivery priorities, and there are opportunities to expand the FFS payment structure by adding new codes.
- A **PBP/PMPM** is easier to bill, guarantees hiring, and enables partnerships with community providers
- **FFS payment with a PBP/PMPM** for additional capabilities is the best route to harmonizing with other payers
  - *For behavioral health services:* a FFS model is the best way to advance BH access and integration; any integration functions that are not FFS reimbursable should be included in an add-on PBP/PMPM.

Jan 18th Meeting

Feb 8th Meeting

Committee Feedback: Payment Model

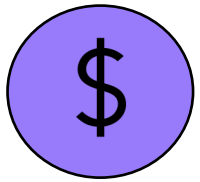
The PCPAC shared valuable feedback on payment model design at the January and February meetings.

Performance-based payment model design should:

- Recognize that some **larger providers have ample experience** with VBP and are ready for risk arrangements, while **smaller providers often have less experience,** especially with risk, and will need more flexibility and support
- **Drive improvements in quality of care,** creating incentives for all providers to improve
- **Drive improvements in access**, recognizing a regular source of care to be foundational to quality and prevention
- **Incentivize a focus on prevention**, considering how to offset disincentives to investing in prevention that result from downward adjustments in cost benchmarks
- **Incorporate risk adjustment** and explore methods that recognize needs that are more prevalent in the Medicaid population
- **Set the stage for a financing and accountability model** that enables upstream prevention and invests in community capacity – for example, a regional model under which primary care practices and community partners share in any savings generated

Equity Strategy Review

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

		Equity Strategy Components
Care Delivery 	*What are the key things that primary care should be doing differently or better to improve member health and well being?*	• Integration of community health workers (CHWs) • HRSN screening and referral • Use of HRSN/SDOH data to implement interventions and prioritize needed community resources • Requirements for competencies in care of individuals with disabilities and/or ADA training for care team members • Adherence to National Standards for Culturally and Linguistically Appropriate Services (CLAS)
Performance Measurement 	*What is the definition of success? How should this be measured?*	• Collection of race, ethnicity, language and disability (RELD) data and performance measure segmentation to identify and track reduction of disparities in quality of care and member outcomes, at the program and provider level • Use of patient reported experience measures • Use of process measures related to screening for and addressing health-related social needs
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	• Performance-based payment tied to collection of RELD data and/or performance on population-segmented measures • Base payment that provides care delivery flexibility and funding to support care delivery and performance measurement priorities • Medical and social risk adjustment that accounts for patient needs • Multi-track program that enables broad-based provider participation

Committee Feedback: Equity Strategy

The PCPAC shared valuable feedback regarding the crosscutting equity strategy at the March meeting:

- Members generally agreed that the health equity strategy **components represent a good starting point**, while highlighting areas that could be **enhanced or built upon.**
- Members noted that **practices should be held accountable to existing standards** (e.g., language access and disability accommodation standards) before adding new requirements.
- Members advised DSS to **leverage evidence-based practices and build on existing programs** to the greatest extent possible.
- Members emphasized the need to **appropriately support and fund community health workers,** both those embedded in medical settings and community organizations. Members highlighted the important role CHWs can play in advancing health literacy goals, educating members, connecting with hard-to-reach populations, and assisting with navigation and connection to services.
- Members noted the importance of **patient choice in HSRN providers**, and the participation of smaller agencies with representatives that share culture, language, neighborhood, race/ethnicity, etc.
- Several members stressed the importance of **educating providers and patients on why REL data is collected** and how it will be used to further health equity – and noted that DSS could play a role in developing trainings and common messaging and materials.

For Discussion

Any additional feedback you would add on either of these program design topics?

- Payment model
- Crosscutting equity strategy

Next Steps: Phase 3

DSS will be transitioning to Phase 3: Technical Design and Implementation in May.

During Phase 3, stakeholder engagement will shift from more open-ended co-design to a more detailed design phase focused on articulating the technical details of the program.

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – Apr 2024***	***May – Dec 2024+***
✓ Establish advisory committee and FQHC subcommittee ✓ Review prior work with committees ✓ Respond to requests for additional starting point data and information ✓ Host listening sessions to understand priorities	✓ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including: ✓ Care Delivery Requirements ✓ Performance Measurement ✓ Payment Model ✓ Equity Strategy	❑ Review key decision points in the development of program technical specifications and incorporate feedback ❑ Discuss key budget, authority, and program implementation model decisions