MAPOC Care Management Committee

DSS Primary Care Program Design Update

May 15th, 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)	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	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 March update to this committee.

Month	Primary Care Program Advisory Committee	FQHC Subcommittee	MAPOC Care Management Committee
March	***March 7th*** Primary Care Crosscutting Equity Strategy		***March 13th*** – Last update to MAPOC Care Management Committee
April	***April 4th*** Primary Care Phase 2 Review, DSS Supports & Payment Model Structure	***April 16th*** Primary Care Program Design Update	
May	***May 2nd*** Refined Payment Model Structure & Transition to Phase 3		***May 15th*** – Today's update to MAPOC Care Management Committee
Update	***The Advisory Committee wrapped up Phase 2 of program design earlier this month, with recent discussions on payment model structure***	***The FQHC Subcommittee met in April to provide FQHC-specific input on payment model structure***	***The MAPOC Care Management Committee has continued to receive regular updates on primary care stakeholder engagement***

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?*	Chronic Condition, BH & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care **Oct 26th Meeting**	*Reviewed with MAPOC CM in November and January Meetings*
Performance Measurement	*What is the definition of success? How should this be measured?*	Each domain is associated with a definition of success – and select **measures** that will be used to drive progress towards success. **Nov 14th Meeting** **Dec 7th Meeting**	
Payment Model	*How is primary care paid and incentivized for doing things that improve member health and well being?*	The primary care payment model includes **base and performance-based payments** that advance care delivery and performance measurement priorities. **Jan 18th Meeting** **Feb 8th Meeting** **Apr 4th Meeting** **May 2nd Meeting**	*To review* ***TODAY***
DSS Supports	*How can DSS provide support to practices to achieve primary care program goals?*	Tools and strategies that **DSS could develop and implement to support practices** in achieving primary care program goals **Apr 4th Meeting**	
Crosscutting Equity Strategy: *How do we address inequities and racial disparities?*		**Mar 7th Meeting**	*Reviewed in March*

Phase 2 Review: DSS Supports

Throughout Phase 2, committee members have highlighted tools and strategies that DSS could develop and implement to support practices in achieving primary care program goals.

DSS Support

How can DSS provide <u>support</u> to practices to achieve primary care program goals?

- Pursue strategies to **get more members attributed to a primary care doctor**, recognizing the importance of a regular source of care to quality and prevention
- Increase availability of **timely, actionable data**
- Provide **technical assistance to providers**, acknowledging different provider starting points, and providing the supports and flexibilities to help practices develop priority primary care capabilities
- Develop **trainings, materials and technical assistance related to health equity** data collection and interventions
- Explore how to **streamline access to services within the DSS portfolio** in parallel with this work

Payment Model Review and Feedback Process

The PCPAC has spent the past few months discussing payment model options, establishing design principles, and refining a high-level payment model structure that will guide Phase 3 technical design.

Jan	Feb	Mar	Apr	May
Reviewed and discussed **base payment model options** and collected feedback	Reviewed and discussed **performance based payment models** and collected feedback		Introduced **payment model principles and first draft payment model structure** and collected **feedback**	Introduced **refined payment model structure** and collected **feedback**

Reviewed with MAPOC CM at the last meeting

Focus of today's meeting:

- *Payment Model Design Principles*
- *High Level Payment Model Structure*
- *April-May PCPAC Feedback*

Design Principles

Based on Phase 2 PCPAC discussions, we established a set of design principles to guide the detailed design process in Phase 3.

1. **Build in flexibility for broad based participation, using tiers/tracks or a glide path** that recognizes different starting points and gives providers options and the flexibility to choose which path is the right fit
2. **Align with other payer models** to the greatest extent possible, while recognizing the distinct characteristics and needs of the Medicaid population
3. **Limit model complexity and administrative burden** to ensure provider participation and patient choice
4. **Recognize the respective strengths of FFS and PBP/PMPM** and assess which payment model is the best fit for addressing opportunities on a service specific basis
5. **Provide predictability and flexibility to enable** practices to advance care transformation goals
6. **Incorporate risk adjustment** and explore methods that recognize needs that are more prevalent in the Medicaid population
7. Establish a quality measurement program that will **drive performance and enable ongoing monitoring of quality, equity, and access**, recognizing both performance and improvement at the practice level

State and Federal Constraints

As we move forward with technical design, we will also be working within the context of state and federal constraints and will need to:

1. **Recognize state budget constraints** in the design of the model, acknowledging the dependency of certain design elements on state appropriations and developing options that could be pursued with or without additional funding
2. **Recognize federal authority constraints** in the design of the model, and work with our federal partners at CMS to design a model that is consistent with federal requirements

Refined Payment Model Structure

Provisional, pending technical design review

	Track 1	Track 2	Track 3
Base Payment	**Fee For Service (FFS) Base Payment**	**Fee For Service (FFS) Base Payment**	**Primary Care Hybrid Population Based Payment** (PBP/PMPM) **and FFS**
Incremental Payments	**Flexible Funds Payment** (PBP/PMPM)	**Flexible Funds Payment** (PBP/PMPM)	**Flexible Funds Payment** (PBP/PMPM)
	Quality Performance P4P	**Quality Gated Shared Savings/Risk**	**Quality Gated Shared Savings/Risk**

Key Features

- **Three capability-based tracks** with an option for all providers to select the track they participate in
- Different base payment models across tracks that **give providers the option to remain in FFS or transition to a hybrid PBP/FFS model**
- **A flexible funds PMPM add-on payment that** provides upfront funding for otherwise unfunded activities – payment increases by track, aligned with increasing care transformation expectations and accountability
- **A performance-based payment model that holds providers accountable for quality of care,** member outcomes and/or a defined array of member costs beyond primary care, with parameters tailored by provider track

Program Alignment

Tracks 1-3 build on DSS' existing primary care programs and align with other payer models to limit complexity and administrative burden.

	Goal	Track 1	Track 2	Track 3
CT DSS Program Alignment	*Build off DSS' existing primary care programs, making refinements to the current models to advance program goals.*	**PCMH similar** *+ Flexible Funds Payment*	**PCMH+ similar** *+ Flexible Funds Payment* *+ Phased Approach to Shared Risk*	**PCMH+ similar** *+ Hybrid PBP/FFS Base Payment* *+ Flexible Funds Payment* *+ Phased Approach to Shared Risk*
CT Multi-Payer Alignment	*Align with other payer models to the greatest extent possible, limiting complexity and administrative burden.*	**SEHP aligned,** on Flexible Funds Payment and Quality Performance P4P components	**SEHP** and **MSSP aligned**	**SEHP** and **MSSP aligned,** with additional base payment transformation

SEHP: State Employee Health Plan
MSSP: Medicare Shared Savings Program

Committee Feedback: Refined Payment Model Structure

At the May meeting, the committee shared valuable input on key design elements related to the refined payment model structure to be considered during technical design in Phase 3:

- Members acknowledged the success of the **refined payment model structure is dependent on detailed elements** that are yet to be defined.
- Concerns were raised regarding payment model risk arrangements and the following **protections were recommended**:
  - A quality gate/performance requirement to participate in tracks with risk sharing
  - Delayed implementation of shared risk
  - Full and complete disclosure to patients whose providers are in risk arrangements
- A proposal was made to use shared savings as a budget neutral community reinvestment tool, recommendations included **reinvesting 100% of shared savings** with the majority going to community partners and hospitals, contingent on achieving certain Medicaid impact goals.
  - Several members supported this proposal agreeing this approach acknowledges the value community partners provide for Medicaid members, and highlighting the importance of investing in community resources using fair and transparent methods
- Members expressed interest in **further discussion of provider eligibility requirements** (e.g., PCMH recognition and variation by track)

For Discussion

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

- DSS supports
- Payment model structure

Next Steps: Phase 3

During Phase 3, stakeholder engagement will shift from more open-ended co-design to a more detailed design phase.

Members of the Primary Care Program Advisory Committee (PCPAC) will meet monthly as part of a Technical Design Subcommittee to advance this work – updates will be provided to the overall PCPAC on a quarterly basis, and to MAPOC Care Management on an every-other-month basis.

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – May 2024***	***Jun – 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