STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
February 28, 2017

Meeting Location: Connecticut Behavioral Health Partnership, Litchfield Room, Suite 3D, 500 Enterprise Drive, Rocky Hill

Members Present: Susan Adams; Lesley Bennett; Mary Boudreau via conference line; Shirley Girouard via conference line; Colleen Harrington; Abigail Kelly; Anne Klee; Alta Lash; Rowena Rosenblum-Bergmans via conference line; Randy Trowbridge via conference line;

Members Absent: Grace Damio; Leigh Dubnicka; Heather Gates; M. Alex Geertsma; Beth Greig; Edmund Kim; Kate McEvoy; Rebecca Mizrachi; Douglas Olson; H. Andrew Selinger; Eileen Smith; Anita Soutier; Elsa Stone; Jesse White-Frese

Other Participants: William Doemland; Faina Dookh; Erika Edlund; Anne Elwell; Julia Grabowski; Lisa Honigfeld via conference line; Michele Kelvey-Albert; Ken Lalime; Jenna Lupi; Russell Munson; Mark Schaefer; Lauren Williams

1. Call to Order
Lesley Bennett chaired the meeting. The meeting was called to order at 6:02 p.m.
Members and participants introduced themselves. Members expressed concern that they were at a disadvantage because they did not receive the discussion materials before the meeting.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Motion: to accept the minutes of the January 10, 2017 Practice Transformation Taskforce (PTTF) meeting– Alta Lash; seconded by Susan Adams.
Discussion: There was no discussion.
Vote: All in favor.

Ms. Dookh reviewed the purpose of the meeting (see meeting presentation here). She said some of the Qualidigm members are here to talk about primary care payment reform and this will be a continuation of the conversation from the last PTTF meeting. Ms. Dookh said there will be an explanation of the different models that have been explored and an update on conversations with stakeholders since the last meeting. She said there will be an update on a Medicare initiative called Comprehensive Primary Care Plus (CPC+) and the potential opportunity. Qualidigm will provide an overview of the readiness assessment tool that they are hoping to use with participating entities in the Community and Clinical Integration Program (CCIP).

4. Primary Care Payment Reform Update and Discussion
Ken Lalime presented on the primary care payment reform update. He explained the Advanced Medical Home (AMH) initiative. He said AMH address a lot of issues related to team based care,

tracking and coordinating care. Mr. Lalime said the CCIP defines an extensive program and what attributes would be needed. The major aim is to be more effectively integrated into primary care. Ms. Dookh said the Healthcare Payment Learning and Action Network (HCP LAN) framework was provided as a little bit of context as they look at where the primary care payment model fits along the continuum. She said the HCP LAN is a national collaborative. It consist of private and public health plans, provider groups, patient groups, and employer groups. She said they all came together at the national level to look at alternative payment models. There are four categories that HCP LAN provided to be used to track and understand which types of models are being adopted. The idea is to move away from fee for service and take on as many as possible payment models to align better care delivery.

Ms. Lash said she had three questions. The first question is regarding fee for service. She said a new director of HHS is a proud proponent of fee for service medicine and does not like any of this. Second, Ms. Lash expressed concern whether the patient payment will be affected as we change the payment models, for example if a patient has a deductible. She said it affects what is paid by the health plans to the practices but does it affect patient copays or does it remain the same. Third, Ms. Lash asked how category four is different from the capitated payment system that Medicaid attempted in the 90's. Ms. Dookh said they are hearing from payer and provider groups at the federal level that there is bipartisan support towards advancing alternative payment models. She said the pace around alternative payment models is not likely to slow down.

Dr. Schaefer said Health and Human Services (HHS) Secretary Price is not a proponent of bundled payment. However, most of the medical association health plans, many consumer groups, and congress have signed on to MACRA and believe an emphasis on value is not something that is dependent on party association. Dr. Schaefer said a promising sign occurred after Secretary Price's appointment when CMMI released yet another solicitation for the CPC+ primary care payment reform. Ms. Dookh said that alternative payment models are clearly a way to try to curb healthcare costs. The hypothesis is, if you can curb cost, costs to consumers should also be more beneficial.

Mr. Lalime said some of the alternative care and patient care activities associated with these models do not have billing codes. He said the non-billable events seem to be what many practitioners are able to get done to care for the whole patient. This is for visits on the primary care side. Ms. Lash asked whether the community health worker would be an extra cost to the patient. Dr. Schaefer said Mr. Lalime hit on a key point and Ms. Lash raised a principle for consideration as we examine the models. He said he thinks we need to figure out what the parameters are that will be the basis for assessing a model's advantages and disadvantages. One parameter would be the impact on consumer out of pocket costs. Some of the models will potentially avoid introducing new co-payments for services such as community health workers (CHWs) and may eliminate copayments for some services that are carried out electronically. If providers are able to use email or phone calls with a patient, that would eliminate the consumer's having to pay for an in-office co-pay.

Dr. Schaefer said that category four is basically disconnecting visits and procedures from the reimbursement. The accountability is on measured performance and the value it provides to consumers. Ms. Rosenblum-Bergmans identified important distinctions between the new bundled payment models and CT's history in the 90s with capitation. She said historically capitation was not risk adjusted (same payment regardless of patient complexity). She also noted that the provider infrastructure has changed a great deal since the 90's. Providers now have tools for being more precise about illnesses, the health of the population, and the ability to manage the population.

Ms. Rosenblum-Bergmans said that with the fee for service model, many times physicians will call patients back in for a visit to be given results or follow-up when the information could have been shared over a phone call. She said if the system is set up so that the only way a provider gets paid is a face to face encounter, than these practices are going to continue. She said these reforms move us to start to look at the patient in totality and find ways to deliver care in a more effective manner that benefits the patient.

Dr. Munson reviewed what was learned from the various primary care payment models. He provided an overview of the pros and cons of fee for service, care management payments, other advance payments, and model of care/practice business model. Ms. Lash asked whether there would be a variety of payment models. She asked whether it's possible for a small practice to have a different payment model than a large accountable care organizations (ACO). Dr. Munson said it is likely and there is some variation in the models. He said one size does not fit all.

The Taskforce continued to discuss the primary care payment models. Dr. Schaefer said he was at the Health Information Technology conference last week and heard a presentation from Kaiser and the work that they are doing to ease access and to efficiently engage consumers. Dr. Schaefer said he will see if he can get some of the materials to provide more insight in terms of what they are doing. He said Kaiser is on a global budget, which allows them to be innovative in the primary care setting.

Ms. Williams provided an overview of the diverse stakeholder interviews. Ms. Lash suggested having a sheet available on the different types of primary care practices. Dr. Schaefer said there is a something like that available that he can share. An updated sheet will be developed with Qualidigm. Ms. Williams said they asked a series of questions in a structured interview and are hearing some key messages. In general, primary care providers are not satisfied with the current model of care they are able to provide, it ranges from mildly dissatisfied to very dissatisfied. Dr. Girouard said she appreciates the provider interviews. She asked whether there will be interviews for consumers and patients also. Mr. Lalime responded yes.

Ms. Williams mentioned the percent paid to primary care providers may not be sufficient to fund the innovations that everyone seems to agree are necessary. Dr. Schaefer said he spent some time with Rushika Fernandopulle of the Iora Health Model and he emphasized that you simply cannot fundamentally reinvent primary care without substantially dedicating more dollars. Ms. Lash asked whether this will translate into higher premiums. Mr. Lalime noted that more things will have to have an impact lower utilization of ER services, lower utilization of hospitalization that is not necessary, and utilization that is appropriate for whatever type of care is needed. He said an example is contracting with Uber so patients will have a ride to see their primary care provider. The Iora model suggested raising premium costs by an additional $50 monthly to increase payments to PCPs. Talk Force members reacted negatively to this, noting that CT residents already pay $550 to $600 a month for insurance premiums.

Ms. Lash said the pharmaceuticals and the technology piece aren't going to let the money come from their sector. The increase in five percent for primary care has to come from somewhere. The group discussed where the increase in dollars could come from. It was noted that it would likely come from inpatient and outpatient diagnostics. Mr. Lalime said fees are not being changed but rather how many times patients show up to have something done. He said it will take some time and could take about three to five years for transformation.

The group discussed the primary care payment reform models. Option 1: Partial E&M Bundle, Option 2: Full E&M Bundle, and Option 3: Full Primary Care Bundle. Ms. Lash said if she is looking at Option 2: Full E&M Bundle and they get 100% of the E&M bundle. She said if she is a healthy person they get to keep more of the money than if she were a sick person and using a lot of the money. She asked what would prevent them from "cherry picking". Mr. Lalime said the numbers are risk adjusted on a regular basis, quarterly going forward. He said if they stop providing services than their rate would go down. He said adjustments have to be included in these systems to make them work.

Ms. Lash asked whether there is also a quarterly evaluation of quality measures. Mr. Lalime said there are standards for quality that they have to meet. Ms. Williams mentioned some of the measures are not applicable more often than annually or less often than annually. Dr. Schaefer mentioned some models are based on CPC+ concept and they reward for quality based on annual performance. Ms. Lash suggested for some of the questions to be written on paper when presenting this to the next committee so that if they have the question it is answered upfront and clearly.

Mr. Lalime noted things are done a little differently for pediatrics. Ms. Honigfeld said they could use the help of pediatric providers as they explore the opportunities to change payment models within pediatrics. She said some of the prime considerations are age related adjustments. She mentioned unlike adults, follow up care is needed outside the health system. Ms. Honigfeld said they are interested in putting together a work group at some point if people are interested in being involved. She said they looking to expand the payment models to accurately reflect with what happens in pediatric primary care. Dr. Girouard suggested reaching out to The Child and Adolescent Health Measurement Initiative (CAHMI). She said they could be incredibly helpful because they have a huge database and are closely aligned on the national level with Family Voices. She said they have done work in Connecticut as well.

Dr. Girouard suggested changing the wording, in the consideration for pediatrics, away from "less emphasis on chronic disease management". She said it is not less emphasis on chronic disease management but a lesser volume of chronic disease management and a smaller component. She said there are many children that have chronic conditions, they use a lot of resources, and need help and support in the healthcare system. She mentioned it is a specialization within pediatrics that need to be given consideration. Dr. Girouard suggested adding to give special consideration to the transition to adult care. Ms. Honigfeld said these are great points and will add them to the agenda.

Ms. Bennett said she is a rare disease advocate. She said today is rare disease day. There are thirty million people with rare diseases and more than half of them are children. Ms. Bennett said if rare diseases are detected early we could stop the long term health care cost. She said there is an emphasis on visits in the first two years of life. Ms. Rosenblum-Bergmans said to Dr. Girouard's point, there are services for children at the state level but after the age of eighteen there is very little. She asked does behavioral health get incorporated into this. She said there are transition issues for physical health and behavioral health as well.

5. CPC+

Ms. Dookh presented on Comprehensive Primary Care Plus initiative. Ms. Rosenblum-Bergmans said this is a nice summary. She said having this be a multi-payer including the biggest payer, which is Medicare, is hugely important in terms of being able to deliver care across the board in a consistent efficient matter to direct resources of the population. Dr. Schaefer noted having Medicare at the table is key. Dr. Schaefer said the CMMI solicitation for CPC+ Round 2 was recently released. Without CPC+, he do not have a strategy for getting Medicare to participate in primary care

payment reforms and this is a big limitation. He said there needs to be a rapid assessment of this opportunity.

6. CCIP Readiness Assessment Strategy
This was not discussed due to a lack of time.

7. Next Steps and Adjournment
Dr. Schaefer reviewed the next steps. He said we will continue working on the models, continue the stakeholder interviews, and develop straw models. The next HISC meeting is March 9, 2017. Dr. Schaefer said we would like to have a PTTF meeting on the third week in March to continue the discussion and address questions. Dr. Girouard said meetings are a good thing but expressed concern regarding the schedule changes. She suggested it would be helpful to have stability around the meeting schedule.

Dr. Girouard asked about the workforce taskforce. She said there has been a lot in the news recently about providers related to primary care in demand. She asked where the workforce taskforce is. Ms. Lupi provided a brief update on the CHW Advisory Committee. She said the committee is releasing recommendations this week regarding scope of work and certifications. She said the committee is working closely with the Qualidigm team on building the CHW's capabilities through CCIP. Dr. Girouard suggested having an update on the whole workforce issue at the next PTTF meeting. She said it would be good to know what needs to be done to meet the needs of primary care in the future.

Motion: to adjourn the meeting – Abigail Kelly; seconded by Alta Lash.
Discussion: There was no discussion.
Vote: All in favor.

The meeting adjourned at 8:04 p.m.