STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
April 25, 2017

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

Members Present: Susan Adams via conference line; Lesley Bennett via conference line; Grace Damio; Leigh Dubnicka via conference line; Shirley Girouard via conference line; Beth Greig; Anne Klee; Alta Lash; Kate McEvoy via conference line; Michael Michaud; Rebecca Mizrachi via conference line; Douglas Olson; Elsa Stone; Randy Trowbridge via conference line; Jesse White-Frese via conference line

Members Absent: Mary Boudreau; Garrett Fecteau; Heather Gates; M. Alex Geertsma; Edmund Kim; Rowena Rosenblum-Bergmans; H. Andrew Selinger; Eileen Smith; Anita Soutier

Other Participants: Supriyo Chatterjee; William Doemland; Anne Elwell; Russell Munson; Mark Schaefer; Lauren Williams via conference line; Steven Wolfson

1. Call to Order
The meeting was called to order at 6:15 p.m. Elsa Stone chaired the meeting. Members and other participants introduced themselves.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Motion: to accept the minutes of the March 21, 2017 Practice Transformation Taskforce (PTTF) meeting – Alta Lash; seconded by Anne Klee.
Discussion: Dr. Girouard said there is an amendment to page four, the motion should be "any reform" instead of "the reform". There were no other edits.
Revised motion: to accept the minutes of the March 21, 2017 Practice Transformation Taskforce (PTTF) meeting with the modification– Alta Lash; seconded by Anne Klee.
Vote: All in favor.

4. Brief Review of Key PCPM Concepts/Findings
Dr. Schaefer provided the objectives for today's meeting and a review of the Primary Care Pay Model (PCPM) concepts and findings (see meeting presentation here). He said Kaiser recently published some information about the use of telehealth. Kaiser is under a global budget arrangement and receives total cost of care payments upfront in the form of a premium. With this flexibility, Kaiser has embraced non-face-to-face modes of patient engagement with 52% of Kaiser's patient contact visits other than face-to-face. Ms. Damio asked whether Kaiser stratified the demographics of patients and looked at whether there were certain demographics that clustered more into non-face to face visits than others that either needed or preferred face to face visits. Dr.

Schaefer said he does not know how in depth the Kaiser study was conducted but can look at how it plays out in terms of patients' demographics. Ms. Damio said she thinks lower income and vulnerable populations would feel more comfortable and be successful with more face-to-face visits.

Dr. Olson said in looking at smaller practices, the change from the individual provider to the employee provider, and the emerging literature around it, Kaiser may be ahead of the curb in this regard because they have a large employee physician workforce. He said there are some large health systems in this state and regionally that are acquiring smaller practices and more closely approaching the Kaiser Model. Dr. Olson said he thinks there are some take away points and lessons to be learned in looking at Kaiser.

5. Review Outcome of HISC Meeting – March 23

Dr. Schaefer reviewed the outcome of the March 23rd Healthcare Innovation Steering Committee (HISC) meeting. He said the CHW Advisory Committee and PTTF's recommendations will be in the final report. He suggested meeting to edit the recommendations at our next meeting rather than doing so now. Dr. Schaefer asked whether it makes sense to retain the CPC+ recommendation because the report is going to be coming out two months after the CPC+ deadline. Ms. Lash said she thinks it should be included because it took up a great deal of time and it's important to show where all the players stand on this issue. Dr. Girouard suggested rewording the language to state that Connecticut payers should take advantage of opportunities to participate. Dr. Schaefer suggested they feature it in the recommendations section of the report.

Dr. Schaefer asked whether the Taskforce supports incorporating the Community Health Worker Advisory Committee and PTTF's recommendations. The Taskforce discussed the recommendations and the appropriateness of the umbrella term for Community Health Workers (CHWs). Dr. Girouard said she agrees with the concept of CHWs but by having a recognized title it precludes people from using others who may do some similar functions. She said proper titles might be a little inhibiting. It was noted that there are many different functions that CHWs play. Dr. Stone expressed concern in having the word "requirement" and CHW in the same line on one of the recommendations. She said it could narrow the definition down further. Dr. Stone suggested saying something to incorporate personnel to perform the services that CHWs are broadly understood to do. She said those services would need to be provided within the care team and right now there is an umbrella term.

Ms. Damio said CHW services in the many titles have existed for a long time and in a very sporadic way with sporadic grant funding that comes and goes. She said it doesn't allow for inclusion in the health care system that reflects the goals of the Community and Clinical Integration Program (CCIP). Ms. Damio said the approach of the Taskforce is to build it in so that it would be recognized as part of the overall structure. Ms. Lash said in looking at the CHW Advisory Committee recommendations, they are coming from a different committee. She said she thinks it is important to respect the deliberations of each of the committees. She suggested letting the CHW Advisory Committee recommendations stand as is. It was noted that CHWs are included in CCIP and the intention is for them to be paid for.

Ms. Klee asked if a requirement would it preclude people who don't have the mechanism for payment. Dr. Schaefer said it would not, given that such services are not typically reimbursed by payers. The Taskforce decided to take a vote on the CHW Advisory recommendations.

Motion: to accept the CHW Advisory Committee recommendations – Grace Damio; seconded by Doug Olson.

Discussion: Ms. Greig asked what it would mean to accept the Committee's recommendations. Dr. Schaefer said CHW Advisory Committee will have a report, the Taskforce will have a report and in this particular area both reports would align.
Vote: All in favor.

6. Discuss Questions 5 through 8 from March 21st Presentation
Dr. Schaefer presented questions 5 through 8 from the March 21st presentation. The Taskforce discussed the questions.

Question five - How do we ensure that reforms don't result in higher costs for consumers, employers and taxpayers? Dr. Schaefer said in our work on VBID we have learned that employers are passing the cost to consumers with unprecedented deductibles and out of pocket expenses. Ms. McEvoy suggested it would be useful to take a look at the Rhode Island affordability standards. She said they were issued by the Rhode Island Department of Health Insurance. She said it's an interesting reference point. Dr. Schaefer said he could seek out and share the Rhode Island experience.

Dr. Trowbridge said primary care investment has to be made but it matters how it's made. He said there has to be an educational process within this approach that goes to the practitioners of healthcare, the communities of people receiving care, and employers. He said the kind of prevention that we do now actually increases the cost of care. Dr. Trowbridge suggested getting to the point where patients understand responsibility for their health and practitioners in the offices along with the healthcare team and provide educational information that will be coming through to the patient.

There was a discussion regarding the care management fee upfront options and where the money comes from to start the process. The Taskforce agreed to the PMO taking back the conversation and propose something about PCPM being a compliment to shared savings arrangements and the idea that payer strategy should be to increase the investment overtime. Dr. Schaefer said we could say that we will encourage upfront investments but not upfront investments that can't result in a return in being effective for consumers. Dr. Schaefer said the PMO could work on the language.

Dr. Trowbridge said he could make a couple of suggestions in areas of primary care that would guarantee savings and reducing cost on a long term basis. He said they could do a claims analysis and find out who the top 5% percent of the payers expenditures are coming from. Target those people with programs and functional medicine. Select out the populations and plan. Dr. Trowbridge suggested incorporating a few areas where they could save a lot of dollars. He said everything does not have to be done at once but are things that make a huge impact.

Question six - How do we ensure that consumers don't have higher out of pocket costs?

The Taskforce agreed that there be a recommendation that payers not attach new cost share requirements for non-visit based services that are being introduced. There was an agreement to make explicit that the diversification of primary care is not an invitation to burden consumers with more cost. Dr. Stone asked if anyone on the committee disagreed with this position. No one disagreed.

Question seven - How do we make sure sicker patients are protected?

Dr. Olson said among FQHCs in the state that have CHN involvement, practices have a list of what the risk is now, what the cost is now, and what the expected risk and cost will be. They don't necessarily account for social determinants. He said they don't have events that trigger re-calculation in real time per cost. He said practices have looked at this with an eye on health equity so that sick patients don't get sicker. Dr. Olson said people are doing this and things are better than it was three years ago. He said conversations are focused on how we take these risk stratifications,

cost projections, increase risk and get them into EMRs and translate them into the work of call centers and care coordinators. Dr. Girouard suggested adopting an approach that would not lead to people turning sick people away.

Dr. Schaefer acknowledged the comments that were made. Recognizing that today's risk adjustment models are imperfect, he suggested that, to the extent practicable, such models should incorporate social determinants to send a clear message to payers about the direction in which we should be headed.

Dr. Schaefer said two of the HCPLAN PCPM recommendations seem relevant to sick patients. Ms. Lash added the need for more frequent rather than less frequent risk adjustment. Dr. Munson noted that if you see the same patient every week for a year, the risk of this is low. He said the overall budget should make sure that the primary care practice is not held accountable for the management of things they cannot manage.

Question eight - How do we make sure our investments are well spent?

Dr. Munson noted two things. One - patient's satisfaction. He said either it's there or needs to be in its own box. He said the patients experience is the key and should be captured. He said the second item is for those practices that have to deal with MACRA and look at the onerous reporting. It could be an opportunity to throw them a lifeline. Dr. Munson mentioned physicians participating can get a pass on MIPS thru the alternative payment model approach. Dr. Olson said if you measure patient satisfaction without provider satisfaction it means very little because you can't have a burnt out provider doing all of this stuff.

7. Consider HCPLAN PCPM Recommendations

Dr. Schaefer asked whether any of these resonate and should we try to incorporate any of these concepts into the recommendations? Dr. Stone noted that these recommendations are excellent, particularly pointing out recommendation number 12. Dr. Schaefer noted recommendation 13 ties into what we are trying to promote with CCIP, which is community linkages. Dr. Stone further noted that all of these fit with what the members have been talking about and that with respect to recommendation #18, primary care practices should receive external coaching support and technical assistance. These are things physicians do not learn in medical school.
A caller agreed noting that the recommendations look good, particularly recommendation 12. It explains behavioral health integration well. The group will consider whether to endorse the HCPLAN report and recommendations more broadly in the next meeting. The PMO will propose language.

8. Next Steps and Adjournment

The next PTTF meeting is scheduled to be held by webinar on May 9th.

Motion: to adjourn the meeting – Grace Damio.
Discussion: There was no discussion.
Vote: All in favor.

The meeting adjourned at 8:04 p.m.