STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
May 9, 2017

Location: Conference Call

Members Present: Susan Adams; Lesley Bennett; Mary Boudreau; Grace Damio; Leigh Dubnicka; Garrett Fecteau; Heather Gates; Shirley Girouard; Alta Lash; Kate McEvoy; Michael Michaud; Rowena Rosenblum-Bergmans; Elsa Stone; Randy Trowbridge

Members Absent: M. Alex Geertsma; Beth Greig; Edmund Kim; Anne Klee; Rebecca Mizrachi; Douglas Olson; H. Andrew Selinger; Eileen Smith; Anita Soutier; Jesse White-Frese

Other Participants: Anne Elwell; Michele Kelvey-Albert; Ken Lalime; Russell Munson; Mark Schaefer; Vicki Veltri

1. Call to Order
The meeting was called to order at 6:07 p.m. Elsa Stone and Lesley Bennett co-chaired the meeting. Members and other participants introduced themselves.

2. Public Comment
Dr. Schaefer apologized for the meeting delay due to technical difficulties.

3. Review and Approval of Meeting Summary
Motion: to accept the minutes of the April 25, 2017 Practice Transformation Taskforce (PTTF) meeting – Alta Lash; seconded by Grace Damio.
Discussion: There was no discussion.
Vote: All in favor.

4. Purpose of Today's Meeting
Dr. Schaefer provided the objectives for today's meeting (see meeting presentation here). He said they will review and discuss the PCPM recommendations for inclusion in the draft report. He said the plan is to utilize the June meeting to discuss the report and recommend it for approval by the Healthcare Innovation Steering Committee (HISC).

5. Review and Discuss PCPM Recommendations
Dr. Schaefer presented the PCPM recommendations. He said not many comments were received but he could reference the comments that were made as they review the sections of recommendations. The Taskforce reviewed and discussed the recommendations.

Dr. Schaefer said the Taskforce agreed to recognize that a recommendation was made for Comprehensive Primary Care Plus (CPC+) to include commercial payers only in light of the administration's determination that Medicaid was unable to participate. He said a paragraph had been prepared for inclusion in the recommendation section, rather than as a recommendation

separately, because it was date sensitive and the date for application to CPC+ has passed. Dr. Schaefer said there was also a suggestion to acknowledge the Health Care Payment Learning and Action Network (HCPLAN) report, which is substantially more detailed in terms of its recommendations, as an additional point of reference. The report was first disseminated in January and when it was finalized. There were no edits proposed to the language that endorses the recommendations of the HCPLAN.

Recommendation 1 – It was noted that recommendation 1 speaks to what the Task Force has been talking about for a long time and that CT payers should implement primary care payment reform as a means to incentivize services and staff that that are not billable in primary care offices.

Recommendation 2 – There was no comment on recommendation 2.

Recommendation 3 – There was a suggestion for it to be clear that payments will still be there in the traditional sense but that there will be some dollars available for care management services. It was noted that primary care bundles do replace some FFS payments. Ms. Boudreau asked regarding the bundle payments that will support health for people, how to ensure that they don't just take the money and run. Ms. Rosenblum-Bergmans said they would be at risk for those dollars if they do not meet a financial benchmark.

Ms. Adams said not all of the bundle payment products are the 90, 60, or 30 day products. Ms. Rosenblum-Bergmans said there is a reconciliation period and if they are below the financial benchmark in the traditional CMMI program money would be reimbursed in terms of shared savings. If they are over the cost than money would need to be paid back to the federal government. She said it depends on the type and way that the bundle is structured.

Dr. Schaefer suggested that perhaps the previous comments relate to shared savings arrangements, in which providers are accountable for total cost of care. That is not the focus of the PCPM reforms. Accordingly, he noted the language of the recommendation may be problematic because the nature of the payment reform may not be clear to the reader. He said the intent is the bundling of primary care cost and the bundles do not mean there is risk born by the provider for non-primary care costs. Dr. Schaefer said it is possible for a provider to use funds that do not result in a return of investment. Such funds could add to the total cost of care if there were no savings to offset it. Dr. Schaefer asked whether there should be a different term used rather than perspective bundled payments. There was a suggestion for the language to be revised to be delineated more clearly.

Ms. Adams suggested it would help with the explanation to include all of the cost that would be expected to be paid along with the bundle of money. Dr. Schaefer said they can edit for clarity after the fact. The point is about care management fees and bundled payment option. Dr. Schaefer proposed rephrasing the recommendation with the addition of language and if necessary include footnotes for clarity on what the intent is. The Taskforce agreed. Dr. Girouard suggested saying that they recognize that transforming a piece of the system is not the answer.

Recommendation 4 – Dr. Schaefer said Dr. Selinger suggested consideration of whether to add a specific percentage that primary care should represent under the total cost of care. Dr. Girouard asked whether there was evidence to support the fact that the cost of providing advanced primary care is substantially greater than a typical practice earns through fee for service. She said they could say it "may be greater". She said she doesn't think there is evidence to support it. Dr. Schaefer said they found in the interviews of folks doing comprehensive primary care that it requires more revenue than is generated through FFS. Ms. Bennett asked whether Dr. Selinger had any evidence.

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Dr. Schaefer said he only offered a comment that we should consider whether the recommendation should specify a percentage.

Dr. Schaefer said he could pass on any evidence to Qualidigm that members would like to submit to the PMO related to this recommendation. Dr. Schaefer asked whether there was concern about the recommendation to increase investment into primary care. The Taskforce agreed there should be increased investment into primary care, but not to specify a percentage.

Recommendation 5 – The Taskforce discussed out of pocket cost. Dr. Munson noted that there are some CPT codes that are currently excluded from payment even if physicians submit them by commercial payers. He said if some payers decide to pay for certain things such as phone calls and email communications there are some codes that are not currently payable. If the non-payable codes were to become payable it exposes patients to copays and deductibles. Ms. Rosenblum-Bergmans said taking away telehealth as a billable service could be problematic. Dr. Schaefer said the point of the payment bundle *is* to make it no longer billable. Ms. Rosenblum-Bergmans clarified and said if it's a global payment than it's correct, but the hybrid models would be more problematic. Dr. Schaefer said hopefully things will be clear in the recommendation, but if not they will have to tune the language so it will be less confusing.

Recommendation 6 – Ms. Gates expressed concern that recommendation #6 does not have a lot of substance. She said she questions why it is included at all. Dr. Schaefer said it was taken from HCPLAN and not formulated from the deliberations of the Taskforce and the stake holder engagement. He said it was suggested that it was entirely consistent with the care delivery reforms under SIM and made sense to call it out in the Task Force recommendations. Ms. Damio asked whether the language is exactly as in the report. Dr. Schaefer said he believes it is but can confirm. He noted that the Task Force otherwise endorses the HCPLAN report so perhaps it is not necessary. The Taskforce discussed and agreed to eliminate recommendation #6.

Recommendation 7 – Dr. Munson said the last sentence in this recommendation works both ways and supports patients "whose needs and complexity are increasing and decreasing". Dr. Girouard suggested using "whose needs and complexity are changing". Ms. Lash suggested keeping the language as is. There was a discussion on whether it would say enable practices to support patients and their families whose needs and complexities are increasing. The Taskforce discussed the language in the recommendation and decided to vote on whether to leave the language as is or revise it. Dr. Stone tallied the vote via roll call. The vote supported leaving the language as is. Dr. Girouard mentioned it is important to recognize that families are considered. However, after discussing, the group decided by vote to leave the language as is.

Recommendation 8 – There was a suggestion for the language to be changed to "fee for service payment may continue to play a role". There was another suggestion for language to be "fee for service payment should continue to play a role". The group discussed the language. Dr. Schaefer said under the rephrasing it could be fee for service may play a limited role as part of a blended primary care payment model to incentivize certain services, etc. Members agreed to the rephrase.

Recommendation 9 – Dr. Schaefer said recommendation #9 is appropriated from the HCPLAN report. He asked whether members felt it was needed in the report and whether comfortable with it. There was a discussion on second line regarding the management of mental health and substance use services. It was noted that it is not managing the services but managing the condition. Members agreed on including this recommendation.

Recommendation 10 – The Taskforce discussed broadening the language on recommendation #10. It was suggested to add language and the last part would say, "…including the use of community health workers as care team staff and direct support for community based services that support patient care and demonstrably address social determinants of health to improve patient outcomes". The Taskforce agreed.

Recommendation 11 – The group discussed the language and whether it would be saying that the payers would be the influencer. It was noted that the payers do not implement the models by themselves. Payers utilize primary care payment models as opposed to implement but the connection between the requirements and the payer responsibility is crucial. There was a suggestion to change the language from "payers that implement" to "payers that utilize". The Taskforce agreed with this suggestion.

Recommendation 12 – Ms. Lash expressed concern that recommendation #12 needs some work. She said while they have always been talking about the multi-payer approach, in terms of the recommendation it kind of comes in from left field. Ms. Lash said she would like to think about this one a little bit more. She suggested thought into how to reduce the paperwork demand and the administrative cost that goes with paperwork demand. Dr. Girouard said the recommendation is too broad. Ms. Rosenblum-Bergmans said the method should be to deliver comprehensive care for whoever walks through the door and it should not matter which payer they have. She said patients should not be penalized because they are not part of one payer verses another payer. She said she thinks CPC+ from the feds was intended to be more of a standard operating procedure. It is important to have payers agree to consistent and comprehensive care. She said it is a huge undertaking and she is not suggesting that they solve it tonight.

It was determined that the group could not do this and respect the end time of the meeting. Dr. Schaefer invited members to submit comments about this one. He volunteered to take a look at how it could be modified if someone wanted to provide the guidance. He said the information could be put into the draft report but flagged as something that would need to be discussed. The Taskforce agreed.

6. Next Steps and Adjournment

The next PTTF meeting is scheduled for June 13th. Dr. Schaefer said if anyone would like to provide additional comments to the recommendations to please do so online. He thanked everyone for their participation.

The meeting adjourned at 7:37 p.m.

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