Consumer Advisory Board Questions Regarding Primary Care Modernization

Thank you for your thoughtful questions. We've tried to answer them below and look forward to more discussion during the December 11th Consumer Advisory Board Meeting.

Please note all of the proposals and recommendations made to date are *provisional (not final)*. Design groups, the Payment Reform Council and the Practice Transformation Task Force expect to complete their work in January. We will develop a report and supporting materials to share with the Healthcare Innovation Steering Committee and release for public comment in the Spring.

1) **CAB Question: Community Integration:** What should be primary care's role in supporting patients in accessing community-placed resources? How will relationships between advanced networks (ANs) and federally-qualified health centers (FQHCs) and these organizations evolve? How will providers know where the non-traditional resources sit? Will these services be included in the bundled rate? How will the Coordinated Access Networks (CANs), which is the statewide housing network, link to the healthcare network(s)? How will PCM address regulations that hinder community integration?

   Response: The PTTF has provisionally recommended Community Integration as an optional capability.

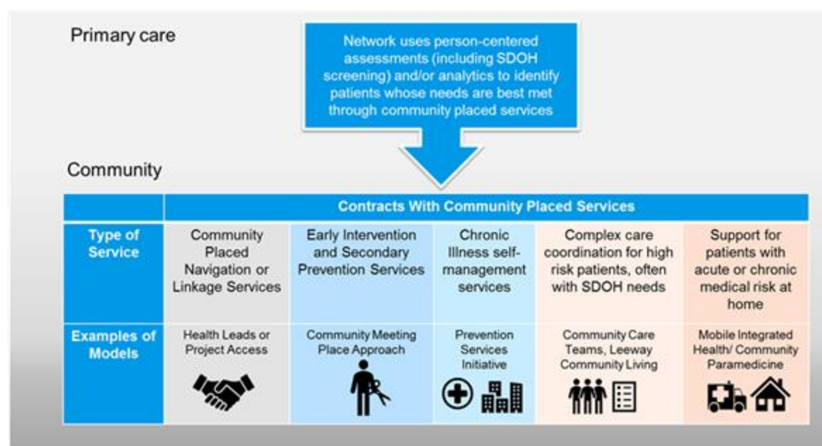
   - **Capability Definition:** Advanced Networks or Federally Qualified Health Centers (FQHCs) can purchase community-placed services that enhance patient care, better meet the needs of patient populations, address social determinants of health needs, and/or fill gaps in services.
   - **Capability Goal:** Promote the use of community-placed services when it is better for the patient and more efficient for these services to be provided by community programs.
   - **Capability Payment:** ANs and FQHCs would be able to choose whether they want to pursue the Community Integration capability. For organizations that choose to pursue this capability, the supplemental bundle will include dollars for those investments.

How would Community Integration work?

Step 1: Practices identify service gaps and needs for community-placed services	Strategies could include assessing how patients with complex medical needs are supported with chronic care management and care transitions. Social determinants of health screening could support a better understanding of needs and establish a baseline for evaluation.
Step 2: Practices partner with appropriate community-placed health services	Support evidence-based and pilot services such as early intervention and secondary prevention, chronic illness self-management services and complex care coordination for high risk patients.
Step 3: Practices track referrals and outcomes	Assess individual and community impact of services such as, ED utilization, readmissions, costs, and reduction in social determinants of health risks.

Draft Concept Map for Community Integration

We look forward to better understanding which regulations might hinder community integration or other capabilities. This topic is on the January 14th PRC agenda.



2) **CAB Question: Engaging Consumers in Primary Care Modernization:** How will we transform consumer focus and get better quality outcomes, when we are not in a managed care environment? How will this be administered?

Response:

Current Vision – The PRC will continue this discussion on January 14th

- Strong engagement of consumers will be critical to the success of Primary Care Modernization.
- Consumers will have access to unprecedented support to achieve their best health but if they do not know these opportunities exist or how to access them, the model won't work
- Primary care providers and payers will have an important role in communicating with consumers, but they cannot do this alone.
- **State Oversight:** The state, possibly through the Office of Health Strategy, will oversee these communications in part by developing accessible materials in plain language. These materials could be used by the providers and payers to communicate key messages including:
  - The importance of developing a strong relationship with a primary care team.
  - Simple explanations of the capabilities, how new services can be accessed and why they will be valuable in improving and maintaining health.
  - Ways to report providers who may be withholding or not recommending needed services or offering better access to patients they think will be more profitable.
- **Bi-directional Communications.** The current proposal includes the opportunity for consumers to share feedback through a Consumer Feedback Loop, which could function like an ombudsman.
- **Benefit Design:** The Payment Reform Council also has discussed whether it should recommend payers accompany this payment model with a benefit design that significantly reduces or eliminates consumer cost-sharing at the point of care (copays, coinsurance, deductibles) for primary care.
  - The Connecticut Comptroller's office is a national leader in this strategy – called value-based insurance design.

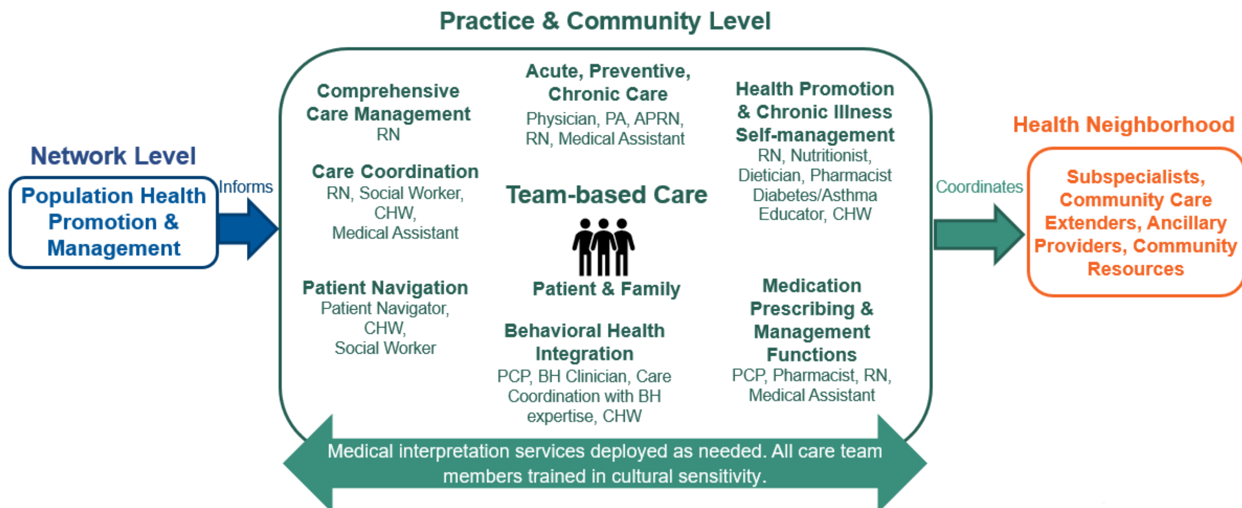
    - Making this kind of change in benefit design would likely need to occur gradually since benefit designs are negotiated by employers, unions and employees and in some cases, cannot be easily changed.
    - The recommendation potentially could be implemented sooner with Medicare beneficiaries with CMS approval.
- **Provider Accountability:** In addition to communications, providers will be held accountable for how well they are engaging patients as demonstrated by their investments in the capabilities, how often they engage with patients and the quality of those interactions.
    - Reporting to demonstrate bundle dollars were used on approved methods to support achieving the capabilities.
    - Reporting of numbers of patient encounters through phone, text, email and telemedicine as well as office visits.
    - Reporting of quality metrics and patient satisfaction metrics through existing programs.
    - Accountability for the total cost of care.

3) **CAB Question: Diverse Care Teams:** How will the structure for the care teams be built out? How will the care teams be funded and how will the funding be sustained?

Response:

- **Capability Requirements:** The PTTF has provisionally recommended this be a required capability.
    - Care team members may be on-site at the practice, in the community and patient homes, and/or at a central hub in the network or FQHC.
    - Advance Networks/FQHCs may partner with other organizations to provide appropriate staff.
    - Advance Networks/FQHC determine care team compositions, location of team members, and staffing ratios based on practice size and structure, patient population acuity and needs, availability of workforce, staffing costs, and team member role.
- **Capability Payment:**
    - The supplemental bundle would support all practices in diversifying care teams to support primary care team core functions.
    - Payments support training care teams on efficient communications, care team member roles and functions, and workflows to support team-based care.
    - Models from across the nation show increased investments in primary care can produce reductions in total cost of care. Over time, these savings would fund the supplemental bundle payments and allow for sustainability of the additional investment in primary care.
- **Principles of Team-Based Care:**
    - The patient and family are at the center of the care team and are responsible for being actively engaged as part of the care team.
    - Care teams are ideally representative of the communities they serve and take into account patients' socioeconomic, and sociocultural needs and norms when working with patients. Care team members are trained in cultural sensitivity and awareness.

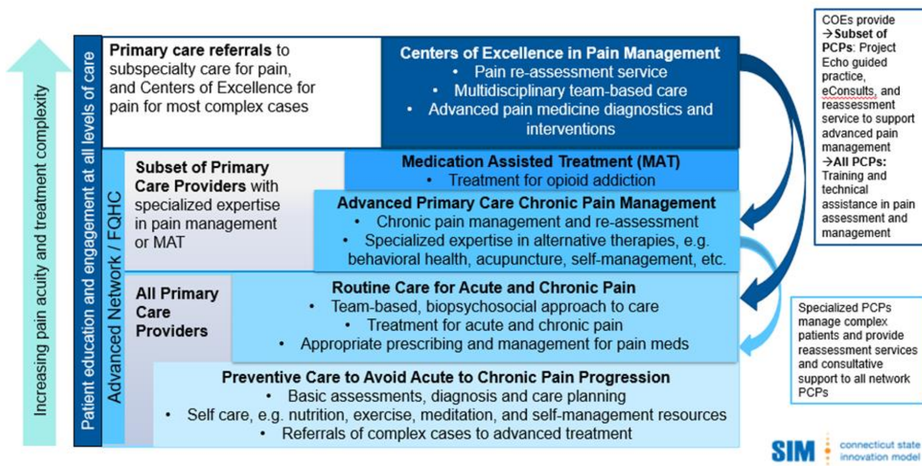
- Care teams enable all professionals to perform at the top of their training and better meet patient needs through expanded roles and workforce
- Advanced Networks/FQHCs work with practices to compose care teams depending on their patient population
- Care team members may be embedded within the practice site or centralized at the network level to serve multiple practices based on individual practice needs
- Care teams have a collaborative structure that values and encourages each team member's contribution. Care team members are trained on the roles and functions of other team members.



4) **CAB Question: Opioid Crisis -** I am still hoping that we can develop a statewide, crisis response effort for this population. We need to know who is in need, where services sit and what interventions are working. CT has a siloed approach. When providers are managing this level of risk, they need this type of support. Other states have more coordinates, single point of entry, statewide response efforts and have brought their number of fatalities down.

Response:

- PCM does not currently propose this type of statewide network. PCM proposes increasing primary care providers expertise in pain management and medication assisted treatment. A draft concept map is below.



5) **CAB Question:** Pediatric care for children with special needs is critical. I hope that they consider having a single point of access for parents who are struggling with a child's health issue, need to find the "right" care and can report back if things go wrong. Managing child health is unique and timing is essential. I think a secondary gain to a statewide responsive system is that it would reduce ED visits dramatically.

Response: The pediatric design group is continuing to meet. They are currently considering a definition of a pediatric primary care medical home with the attributes described below. Can you share any additional information on how you might envision implementation of a statewide network?

- Standard screenings for developmental, socio-emotional, behavioral health
- Integrated pediatric behavioral health. The pediatric behavioral health integration capability will have behavioral health clinicians in the practice as well as care coordination with community supports and schools.
- Care coordination with other clinical providers and coordination with schools, including school nurses, school-based health clinics and child care health care workers. They are also considering whether care coordinators within the pediatric practice should be required to be linked to a care coordination resource, like DPH Children and Youth with Special Health Care Needs (CYSHCN) care coordination centers.
- Expanded care teams and more communication options such as phone/text/email will create more opportunities for in-office visits, instead of the emergency department.
- The Task Force will discuss pediatric specific capabilities at its January 8 Task Force meeting.

6) **CAB Question:** Where will the data be stored and who will manage the data? I am told that the Office of Healthcare Access will be managing the data. I am hoping that I will grow to understand this better as this process unfolds.

Response: Throughout the PCM design process, stakeholders have noted that sharing information throughout the primary care team (including behavioral health, care coordinators, community health workers and other care team members) is essential for delivering truly integrated care. This is reflected the development of the capabilities. The Office of Health Strategy currently oversees the development of the health information exchange and under current thinking would oversee the clinical data management.

7) **CAB Question:** We need to be able to link the various systems through sharing data. DMHAS, DOC, DSS, DCF and OEC - they should be able to track their high-risk clients and share information across systems. The new healthcare system can play a role in this. Perhaps the ASO's can become a partner and this group can be managed more effectively.
Response: We agree that an integrated data system across Connecticut social services agencies would be an important asset in developing a coordinated response. This project is focused on

building a strong primary care foundation. Once the capabilities are fully up to speed, the state may have an opportunity to consider whether to build out additional collaborations.

8) **CAB Question:** How is the Payment Reform Council developing provisional recommendations while the design groups are still meeting?

Response: While the PRC has begun meeting and is making provisional recommendations, FHC is noting any areas where design groups are offering a differing opinion and facilitating communications as needed. For example, the pediatrics design group objected to wellness and preventive visits being paid fee for service and instead wanted those visits to be included in the basic bundle, at least for kids. Representatives from the pediatrics design group submitted a public comment sharing their concerns. Additional research was completed to support the public comment. This research was shared with the commenters to gain their input and revisions. During the next PRC meeting, pediatrics design group representatives were invited to join and share their perspectives. The PRC decided to revise its previous recommendation to align with the pediatrics design group.

9) **CAB Question:** How do the Practice Transformation Task Force and Payment Reform Council share ideas, gain input and reconcile differences?

Response: The Practice Transformation Task Force recently received a report from the Payment Reform Council updating it on its work and seeking input of PTTF members. Similarly, the Payment Reform Council has been briefed on the proposed capabilities at a high level since its launch. With the work of almost all design groups complete and the PTTF having weighed in on most capabilities, the PRC recently begun learning more about the proposed capabilities requirements and estimated costs. Both groups are now spending about half of their meetings on work that overlaps with the other workgroup. At the end of January, a subgroup comprised of the co-chairs of each group and possibly some additional members will meet to discuss any outstanding differences and propose a way to resolve those differences. Following this "reconciliation meeting," both full groups will finalize their shared provisional recommendations before they are provided to the Healthcare Innovation Steering Committee.

10) **CAB Question:** What Consumer Representative input from the PCM Design Groups was shared with Payment Reform Council? How did the Payment Reform Council utilize these questions and comments in the development of their Provisional Recommendations?

Response: The Payment Reform Council received consumer input that came from design groups, the Practice Transformation Task Force and discussions with consumers and consumer advocates. Below we have bolded what we heard from consumers and below inserted how the model addresses those priorities and concerns.

Patients choose their providers

- Patient choice of providers maintained
- Attribution prioritizes when patient names primary care provider

Providers are well-positioned for success and outreach to patients

- Model options that reflect diverse providers current readiness for population health management

- Prospective attribution

Lower out of pocket costs

- Value-based insurance design could remove patient cost share for visits with attributed PCP

Improved access and support, especially for those with greater medical, behavioral health and social needs

- Phone, text, email, telemedicine offer fast access for minor needs and frees up PCPs to focus on complex needs
- Expanded care teams offer additional support between visits
- e-Consult offers quicker access to a specialist's opinion of a treatment plan and whether a visit is needed
- Home visits, telemedicine and remote patient monitoring support patients with transportation needs
- Integrated behavioral health care team member on site or available via telehealth
- Integration with community placed services, including coordination
- Dollars to address social determinants of health needs such as food scarcity, housing instability and transportation

Protect against underservice (i.e., offering patients less care than they need) and patient selection (i.e. avoiding patients that are more challenging to serve

- Periodic reports show how new funds are being invested
- Monitor and report rate of patient contacts by PCP and care team (office and telemedicine visits; phone, text, email), urgent care, ED visits, hospitalizations, care experience
- Adjust basic and supplemental bundle based on patients' needs and expected costs
- Adjust supplemental bundle to include factors not always captured by risk adjustment (social, behavioral needs)
- Mystery Shoppers (like in PCMH+) offer additional layer of accountability

Improved health outcomes and equity for underserved populations

- Increased primary care expertise and care coordination support for vulnerable populations (older adults with complex needs, people with disabilities, populations with social determinants of health needs)
- Social determinants of health screening
- Home visits for patients who are unable to get to office visits
- Care teams receive training in cultural sensitivity and awareness.
- Community health workers should reflect the communities they serve.
- Medical interpretation services always available