STATE OF CONNECTICUT
State Innovation Model
Payment Reform Council

Meeting Summary
November 1, 2018

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

Members Participating: Terry Nowakoski, Tiffany Donelson, Joseph Quaranta, Naomi Nomizu, Eric Galvin, Robert Block, Peter Bowers, Ken Lalime Kate McEvoy, Thomas Woodruff, Peter Holowesko, Robert Carr

Other Participants: Mark Schaefer**,** Gail Sillman, Alyssa Harrington, Laurie Doran, Jenna Lupi, Mary Jo Condon, John Freedman, Curt Degenfelder, Eve Berry, Jenn Searls (designee of Jess Kupec)

Not in attendance: Fiona Mohring, Jess Kupec,

1. Call to Order
Naomi Nomizu called to order at 6:00pm

2. Public Comment
There were no public comments.

3. Approval of the Minutes
The PRC reviewed and approved meeting minutes from 10/25. There was a request to clarify that FFS payments would be made for basic bundle services delivered to non-attributed patients. It was agreed that this clarification would be incorporated.

4. Purpose of Today's Meeting

Ms. Doran gave an update and reviewed the purpose of the meeting:

- Discuss Funds Flow: Determine how basic and supplemental payments will be distributed to providers.
- Continue Discussion of Attribution: Determine whether attribution will be reconciled retrospectively.
- Begin Discussion of Performance Measurement: Begin conversation of how performance will be measured and reported.

5. Funds Flow: How will Basic and Supplemental Bundle payments be distributed to providers.
Basic Bundle: Ms. Doran began by presenting the trade-offs of various ways to distribute the basic bundle funds.

Options	Benefits	Risks
1: Basic Bundle funds flow follows current FFS path	• Less operational complexity, "change" for CMS, ANs, Providers • Even if calculated by Provider or TIN, providers could elect dollars be deposited in AN account	• Does not provide another motivator for greater integration
2: Basic Bundle paid to AN/ACO	• May smooth out differences in historical utilization trends	• Difficult for some ANs to administer • Requires additional "ask" of CMS • Some providers might object to AN capturing dollars first

PRC members discussed the need for flexibility and to ensure practices, particularly those in multi-TIN organizations, receive the correct amount of funds, efficiently. Some feared that flowing all basic bundle dollars to the AN could make it difficult to ensure practices receive the right level of payment and be a significant amount of additional work for ANs.

PRC members agreed some of the supplemental bundle payments would need to be leveraged across practices such as for investments in new, shared care team members or new technologies. However, there was some concern that the payments may be diverted away from primary care. It was recommended that language be included to reflect the need to spend the dollars on primary care and achieving the desired capabilities.

PRC members appreciated that ANs needed the flexibility to construct compensation arrangements that fit within existing contracts, employment agreements, organizational culture and priorities. However, there was strong support for language that prohibited ANs from structuring provider compensation in a way offered an incentive for providers to not recommend care that would be helpful or select certain patients over others (i.e. cherry picking). Some providers said while they do not want to incent underservice, it is important to compensate providers for providing high-quality, efficient care, which often has the impact of lowering total cost of care.

<u>Funds Flow Recommendations:</u>

Medicare FFS:

- Basic bundle payments follow current path for FFS payments.

- Supplemental bundle is calculated for each AN and paid to the AN.
  Funds will be used to support primary care transformation and limited to the allowable uses identified by the primary care modernization design process.
- ANs determine internal compensation structure within their organizations.

Individual provider compensation will not be directly related to a provider's contribution to total cost of care in a manner that incents underservice or patient selection (i.e. cherry picking).

Other Payers:
Same as for Medicare FFS unless existing contracts suggest another approach would be preferable.

Retrospective Reconciliation of Attribution:
The PRC then discussed whether attribution should be reconciled retrospectively. Dr. Nomizu noted the discussion highlighted the need to have an engaged patient population. She said it would be ideal if ANs could require patients to affirmatively choose a provider for primary care attribution. Other PRC members noted this would likely not be possible and Medicare has put forward its opinion that consumers maintain choice of providers.

After reviewing the trade-offs of retrospective reconciliation and no retrospective reconciliation, several members noted that they did not feel the work and effort of retrospective reconciliation would be worth it.

When specifically asked for input, most members were ambivalent regarding whether retrospective reconciliation was beneficial enough to make it recommended or required. Considering the lack of a strong opinion on its benefit and a PRC principal to minimize administrative burden where possible, the PRC determined it would not recommend retrospective reconciliation.

Performance Measurement:
Ms. Doran introduced the topic of performance measurement to setup the conversation for future discussions of the PRC. She reviewed consumer priorities for the PCM and how the model was addressing them.

Providers are well-positioned for success and outreach to patients
- Provider qualifications require experience in population health management and shared savings
- Prospective attribution

Patients choose their providers
- Patient choice of providers maintained
- Attribution prioritizes when patient affirmatively chooses provider

Reduced cost-sharing
- Value-based insurance design likely to be recommended with waiver of cost share for the PCP to whom you're attributed

Improved access
- Phone, text, email, telemedicine offer fast access for minor needs and frees up PCPs to spend more time on complex medical 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
- Pressure on total cost of care puts focus on keeping patients well and out of the hospital
- Home visits, telemedicine and remote patient monitoring support patients with transportation needs

Protections against underservice (i.e., seeing patients less than they need or in different ways than they prefer)

- *Require that providers submit periodic reports that demonstrate how new funds are being invested (e.g., CPC+)*
- *Measure volume of patient contacts by the PCP and by members of the Care Team*
    - *Include office and telemedicine visits; phone, text, email interactions;*
    - *Urgent care and ED visits; hospitalizations*
- *Measure Care Experience (specific questions/items to be considered) and link care experience performance to financial rewards*
- Ensure that patients are given the option of an in-office visit when appointments are scheduled
- Ensure that patients are given information about who they can contact if they feel they are not getting needed services

Protections against patient selection (i.e. avoiding patients that are more challenging to serve)

- Adjusting the basic and supplemental bundle based on clinical need or complexity (risk adjustment)
- Potentially adjusting the supplemental bundle to include social determinant risks
- *Mystery shopper function, which is currently used in PCMH+ to test whether practices are not attempting to avoid some patients over others*

Improved health outcomes and equity for underserved populations

- Increased primary care expertise to care for vulnerable populations (older adults with complex needs, people with disabilities, populations with SDOH needs)
- Social determinants of health screening
- Care team members coordinate with community services and ensure follow up
- Home visits for patients who are unable to get to office visits

Care teams responsive to differences in patients' needs based on culture and ethnicity

- Training in cultural sensitivity and awareness
- Increased access to community health workers, who should represent the communities they serve.
- Medical interpretation services always available.

Additional support for patients with unmet medical, behavioral and social needs

- Integrated behavioral health care team member on site or available via telehealth
- Integration with community placed services, including coordination
- Screening for social determinant of health needs and linkage to services
- Care coordination functions to connect to SDOH community supports

Dr. Nomizu adjourned the meeting at 8:00 pm.