STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
February 27, 2018

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

Members Present: Lesley Bennett; Grace Damio; Leigh Dubnicka via conference line; Garrett Fecteau via conference line; Shirley Girouard; Rebecca Kaplan via conference line; Alta Lash; Kate McEvoy via conference line; Douglas Olson; Rowena Rosenblum-Bergmans via conference line; Anita Soutier via conference line; Elsa Stone; Randy Trowbridge via conference line; Mark Vanacore

Members Absent: Susan Adams; Mary Boudreau; Heather Gates; M. Alex Geertsma; Edmund Kim; Anne Klee; Andrew Selinger; Eileen Smith; Jesse White-Frese

Other Participants: Evan Dantos via conference line; Michele Kelvey-Albert via conference line; Ken Lalime via conference line; Jenna Lupi; Mark Schaefer

1. Call to Order
The meeting was called to order at 6:08 p.m. Lesley Bennett chaired the meeting. Members and other participants introduced themselves.
Mark Vanacore is serving as Michael Michaud's replacement following Michael's retirement in January of this year. Mr. Vanacore is a clinical manager at the Department of Mental Health and Addiction Services (DHMAS) in the Office of the Commissioner.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Motion: to accept the January 2, 2018 Practice Transformation Taskforce meeting summary – Douglas Olson; seconded by Grace Damio.
Discussion: There was no discussion.
Vote: All in favor.

4. Purpose of Today's Meeting
Dr. Schaefer reviewed the purpose of today's meeting (see presentation here). He explained why there will not be a report out of the Healthcare Cabinet's Education Workgroup. He said PCMH+ is in the process of a second wave procurement. Ms. McEvoy provided an update on the PCMH+ procurement. She said she is limited on what she can convey. There are two important messages. The first is DSS maintains a centralized webpage as a repository about information on PCMH+. On the first page is a link to the PCMH+ procurement. There is a section that displays all of the entities monthly reports and they provide information on care coordination, engagement of staff, and various focus points for PCMH+ wave one.

Ms. McEvoy said she wanted to make sure everyone is aware of their webpage because a group has created an alternative webpage with the intention of notifying beneficiaries of their rights under PCMH+. Members discussed the alternative webpage. It was mentioned that there is misinformation on the alternative website. The opt out number is incorrect and could be confusing. Ms. McEvoy said the department does not consider the alternative webpage to be representative. She advised looking at references. Dr. Girouard said someone should say something if they know something is wrong. Ms. Damio said it is not helpful for misrepresentation. It almost seems like an alternative website to DSS but it is not. It was reported that Kate McEvoy and Dr. Zavoski have responded right away and have dealt with families and patients within hours if there is an issue.

5. HCC Prescription Drug Cost Work Group Recommendations

Dr. Schaefer said the Education Workgroup of the HCC decided that they would prefer to shepherd their work on their own rather than coordinate with the Task Force at this time. The SIM PTTF work on primary care payment reform will be a many months process and lend itself to incorporating new information that might arise in the future if the Education Workgroup elects to circle back at a later date.

Dr. Stone suggested for the education component of the HCC to also work with physicians. Dr. Schaefer said cost is a barrier to compliance and is something that needs to be navigated. The HCC is trying to make recommendations and dealing with transparency. Dr. Olson said it could be helpful to have a single website for people to see the various formularies. He said it would require some stewardship behind the scenes to ensure that it was updated on a regular basis. Dr. Girouard said it is a piece of information that informed consumers should have. Consumers need to know about drug cost and other cost such as an office visit. Dr. Schaefer said part of the function for a navigator might be to help navigate all of the issue that arise when using the health care system including costs. Primary care payment reform is a way to get to navigators and health coaches.

Dr. Schaefer said we have the recommendations and they are out to public comment until March 22nd. The report went to HISC. At the HISC meeting, Dr. Stone, Lesley Bennett, and Dr. Selinger did a wonderful job. The stories really resonated with the HISC. They strongly endorsed the recommendations without any modifications or changes. They had a concern around the 2020 date and strongly encouraged a more aggressive timeline.

6. Planning for Post-SIM Reform Initiatives

Dr. Schaefer presented on the planning for post-SIM reform initiatives. The Taskforce discussed the need to invest upfront resources that are non-reimbursable today. It was mentioned that various stakeholders will have to come together to define population health and what they want the community to achieve. The other piece is how primary care is defined. It was noted that the community should come together with the providers. Faith-based plays a big role. There is a need to have housing and others at the table. Ms. Rosenblum-Bergmans said there are many ways to deal with the community other than a clinical setting. She recommended partnering in ways that we have not historically. Dr. Schaefer noted that there is a New England collaborating group, the New England Systems Consortium Organization, that is looking at how to define primary care. This group may consider community services provided outside of the clinical office.

Ms. McEvoy said DSS is making advanced payments to FQHCs. They do not make them to the advanced networks. She acknowledged comments about upfront cost. They will be regarding it as proof for use case for advanced payments to be analyzed for return of investment and cost trend. It will be important across payers. Dr. Schaefer said starting with an all-inclusive PMPM may not be

realistic for commercial payers. He said they previously talked about the idea of phasing in higher PMPM payments as an alternative to all at once PMPM. This is a design question.

Ms. Lupi said a lot of the work that this group has done around CCIP has laid the beginning ground work. A lot of what we want to do, we can't do because of limitations on funding. Ms. McEvoy said the pieces around examining the barrier point and what could influence better outcomes is an extraordinary important point. It is some of the things we have been doing under Medicare. PCMH+ is focusing on barriers, particularly around behavior health integration. Ms. McEvoy said part of the challenge is how to increase our flexibility. How do we wrap around for that flexibility and advance payments. She said they already know there are efforts to expand care teams to use CHWs.

Ms. McEvoy said she wanted to clarify the advancements with advanced payments. They are making payments to FQHCs but didn't have the budget to do it for advanced networks. SIM is investing in the advanced networks from the standpoint of transformation award grant dollars.

7. Primary Care Payment Model Planning

Dr. Schaefer presented on the primary care payment model planning. He ask should they be looking at over the next five years what practices ought to be doing in terms of patient generated data. Ms. Lash said it's the insurance company having access to it that bothers me more. Dr. Girouard said some of the more successful models that she has seen uses the patient/ person to do the analysis of the data to monitor. Some organizations do it as a research project but not ongoing day to day. Goals need to come from the end users, the providers, and patients. Dr. Olson asked are you envisioning looking at the primary care modernization menu and saying to a practice to pick one or three of these. Dr. Schaefer said he thinks some things should be "core" or required, perhaps everybody should have the ability to do e-visits. Kaiser is doing more than 50% of their work through e-visits. He said we should define what we think are the minimum essential core capabilities. He suggested engaging practice advisors and consumer advisors in the process and have a compendium of what the proposed change on the curriculum would be.

Mr. Lalime said the concept of e-consults lead specialist back to primary care. It provides the educational platform to make the visit better by using the specialist information that comes from an e-consult visit. Dr. Schaefer said he does not see anywhere in primary care across the nation where genomic medicine fits into the transformation strategy. We are charting out a process for 5 years. There may be a need to talk to folks to see if there needs to be a pathway to take advantage of that.

Dr. Schaefer asked whether there are things that are not on this list. Dr. Girouard said the concept of population health is an organizing principle for all of our modernization. Dr. Schaefer he sees it as more of an over-arching concept. There are capabilities around population health and how to deal with subpopulations that have barriers to neighborhoods at higher risk. He said it is a great point and he would like to flag it as something that we explore. Dr. Girouard said if you define it as sense of community, it is very different. You can define the population by age, gender, by disease, by geographic, etc. She said it's important to have an organizing principle around it. The population health model helps to fit the pieces. Dr. Schaefer said they will take it under advisement on how to fit it into the model.

Dr. Olson said to keep in mind the size and capability of a practice. Things seem good but for a 3-5 provider practice this is a huge lift for them. Dr. Schaefer said 85% of a practice is affiliated with or employed by an ACO. They are getting some level of support with an infrastructure. Many that are not may be retiring or maybe they value their independence. This initiative is geared to support the

primary care network that supports ACO accountability. Dr. Stone said it is a big shift for physicians that have been trained in the care of the patient to go to a larger scale.

Dr. Schaefer asked if any thoughts on the advisory panel approach. Members discussed panel approach. Dr. Girouard suggested having consumers on each panel. Ms. Bennett said they should include patients. Dr. Schaefer said they thought to have a mixture and have diversified panels to get a reaction to what we are doing. He mentioned they have a Consumer Advisory Board to get input from consumers. Dr. Girouard said there should be end users involved in the design and in the thought process. Ms. Damio said if PTTF has consumers, where else do they need to be. Dr. Girouard said they should be on all of the panels. It's all about engagement. It will strengthen and play well with the funders that are calling for this kind of engagement.

Dr. Girouard said if the payers are not at the table, we won't get to where we need. Dr. Schaefer said the payers are at the table and noted that three payer representatives endorsed the report. We are fortunate to have the payers as much as we have involved in the work. He said he believes you have to have individual conversations with payers. He said he group meetings have not worked. It is not a reasonable expectation for them to disclose their commercial plans in a group setting. Dr. Stone said we are trying to figure out a way of surviving. She said she is okay with having individual conversations with the payers.

It was mentioned there is a concern about the PCM board, with how they would modify the recommendations of the group. Dr. Stone thanked Dr. Schaefer for bringing it to the group for them to have input. Dr. Girouard asked whether they are being asked for input or to endorse it. Dr. Schaefer said input. Members continued to discuss the PCM board. Ms. Damio said she is unclear about the function and what would they do. Dr. Schaefer explained the function of the board. Dr. Olson said there is a lot of information to take in. He said everything explained makes sense. Ms. Lash suggested a different name other than board. She said it implies that it is a final say group. Dr. Schaefer said the group would include high level people. Ms. Lash said high level is offensive. Ms. Damio said she is still unclear about the in between group. Ms. Lupi suggested they come back to this and do a narrative on this. Dr. Olson asked whether there was pushback from HISC on this group. Ms. Lash said there was no pushback. It was discussed during the last 15 minutes of the meeting. She said a member of HISC suggested that we need a committee with higher level people. It is an issue because how this is structured affects the outcomes.

Dr. Schaefer thanked members for the depth and debate. He said you have given us a lot to think about.

8. Next Steps and Adjournment

The meeting adjourned at 8:32 p.m.