# Connecticut Primary Care Modernization Initiative

**DRAFT 5/9/2018**

## RESPONSE TO PUBLIC COMMENTS

### Introduction

The Office of Health Strategy (OHS) received more than twenty public comments on the report and recommendations of the Practice Transformation Task Force (Task Force) entitled *Primary Care Payment Reform: Unlocking the Potential of Primary Care*. In this report, the Task Force recommended that Connecticut's payers and providers implement reforms to enable primary care providers to expand and diversify their care teams and provide more flexible, non-visit based methods for patient care, support and engagement. The Task Force urged the state to engage Medicare and the State's public and private payers to examine how to make such reforms a reality in Connecticut. Since the report was published OHS has named this reform the Primary Care Modernization (PCM) initiative. All of the public comments received can be accessed in their entirety below.

American Academy of Pediatrics Chapter Taskforce
Community Health Center Association of Connecticut
Connecticut Academy of Family Physicians
Connecticut American College of Physicians
Connecticut Hospital Association
Connecticut Voices for Children
David Parrella
Family Medicine Interest Group and Primary Care Progress
Family Medicine UConn Health
H. Andrew Selinger, MD
Independent Advocates
Jacob Quinton
Joseph L. Quaranta, MD
Khmer Advocates
Priya Tandon, MD
Rebecca Andrews, MD
Starling Physicians
UConn School of Pharmacy
Value Care Alliance
Yale Primary Care Progress
Consumer Advisory Board
Velandy Manohar, MD

OHS has prepared the following response to comments and questions, highlighting some of the more prominent themes reflected in the written comment and also in the conversations that our Office has had with various stakeholders since the draft report was published in January 2018.

1. The SIM Primary Care Payment Reform statement rightly concludes that to be effective, the plan must cover the majority of the patient population, for which reason there must be general agreement among payers with respect to bundling, management fees, and practice quality metrics. This will involve discussions and negotiations within the commercial insurance community, as well as between that community and other key primary care stakeholders. Such discussions should be mediated by a disinterested third party. The obvious challenge will be to avoid even the appearance of price-fixing involving the insurance companies, but clearly the problem of inconsistent reimbursement must be addressed if medical practice in Connecticut is to move away from the fee-for-service (FFS) model.

   Response: Thank you for these comments. We welcome the support of CHCACT and the input of its members as we begin phase 2 planning. We recognize that FQHC funding, services and populations differ in important ways from the broader practice community. We intend to establish an FQHC Advisory Panel as part of the advisory structure for the PCM initiative. Our aim would be to create an inclusive panel with representation from all CHCACT members that are considering participation in the PCM initiative.

2. The Community Health Center Association of Connecticut (CHCACT) is pleased to offer this letter of support for the Primary Care Modernization demonstration project sponsored by the State Innovation Model and managed by the Office of Health Strategy (OHS).

Our sixteen member organizations are looking forward to working in collaboration with OHS on this important initiative. This demonstration project will prove the value of consumer engagement through additional non-office based interventions and patient centered team-based care. The added flexibility this project provides in-patient support and engagement, the development of coordination activities, health promotion, and care delivery methods will ensure that the best solutions have the exposure needed to realize change. OHS continues to champion the need for enhanced Primary Care funding needed to support infrastructure development and ultimately to help control the total cost of care while enhancing quality of care and satisfaction for our patients and quality of life for the care teams that serve them.

CHCACT particularly appreciates the opportunity to participate in the planning process for this initiative, to ensure that issues unique to health centers and their patients are recognized and addressed up front The number of Connecticut residents utilizing community health centers is over 375,000 and continues to grow each year. We look forward to the ongoing collaboration among CHCACT, the Federally Qualified Health Centers in Connecticut, and the Office of Health Strategy. This demonstration project is yet another example of the commitment we all have to achieve quality health care for Connecticut's residents, improve health outcomes, and to address and eliminate health disparities.

The potential for additional revenue and flexibility as well as overall savings and better health outcomes that this initiative provides should enable a level of transformation that simply is not possible in the current fee-for-service environment. We look forward to participating in the planning process intended to create a partnership with the Centers for Medicare and Medicaid Services (for Medicare beneficiaries) as well as Connecticut's public and private payers.

Response: Thank you for these comments. We welcome the support of CHCACT and the input of its members as we begin phase 2 planning. We recognize that FQHC funding, services and populations differ in important ways from the broader practice community. We intend to establish an FQHC Advisory Panel as part of the advisory structure for the PCM initiative. Our aim would be to create an inclusive panel that provides for representation from all CHCACT members that are considering participation in the PCM initiative.

3. We encourage early and intimate involvement with Connecticut's medical school and residency programs due to our desire for a robust reform that sustains our efforts. Recruitment of residents to family medicine starts in medical school and residency retention for our state is a prime concern of our board.

   Response: We share your concern about residency retention. This is a foremost consideration in our efforts to place Connecticut on the forefront of primary care practice in the US. By enabling the most advanced primary care and a rewarding practice experience, our residency programs will be among the more attractive options for training. Connecticut will also be a promising place to spend one's career in practice. We will reach out to Connecticut's medical school and residency programs as we begin our planning.

4. Despite our innate and trained abilities to practice medicine according to the team based, whole-patient, cost-efficient model now being proposed nationally, we are struggling from lack of not only financial resources, but resources of time and persons. It is well known that our administrative burdens have outrageously increased which takes time away from patient contact. In addition, in our effort to give quality, cost-effective care to our patients, we require other professionals such as pharmacists, social workers, care coordinators, and patient educators to perform those roles for us. Similarly, once these resources are allocated, we believe a system needs to be in place to monitor and assess how they are being utilized by PCPs.

   Response: We are in agreement that our investment in primary care must free-up physician time for patient care and team leadership activities while reducing administrative burden. Monitoring and assessment will be an important element of implementation to provide needed insights and ensure confidence that the additional resources are being effectively deployed. One challenge will be ensuring that such monitoring occurs without adding to the administrative burden.

5. We do not agree with the re-definition of specialists as primary care providers. Specialist physicians have chosen an area of expertise that does not include, nor should it for good medical care, the training or practice of primary care medicine. We do not see how this helps improve payment reform or patient care.

   Response: The re-definition of specialists as primary care providers is among the questions that will be considered by our Practice Transformation Task Force and advisory panels. It is included in our planning materials as a design consideration rather than an endorsement.

6. This draft presents the possibility to rejuvenate and remake primary care in the state of CT. WE are a small state with multiple medical schools and training residencies- our care should top the charts, but without time to devote to prevention, improving diseases, and coordination of care for the patients- this has not happened. When you think about it, the primary care provider drives the cost of the system down if they have the time needed- we keep patients out of the hospital, same day visits keep patients out of urgent care, and we know our patients so prevent medication interactions or use of medications that a patient has had an adverse effect with. Multiple studies have discussed the burnout rate currently for doctors in primary care- we are completing 2 hours of paperwork for each hour of patient care; this needs to be revolutionized. Lastly, as the state with the highest percentage of docs in the retirement age cohort- we need to attract new doctors. This is my opinion as a doctor in primary care and the education of medical students and residents.

   Response: OHS believes that the aspirations outlined in this comment are eminently achievable in this small State with the wealth of talent and expertise that resides in our diverse physician, consumer, and payer stakeholder communities. We believe that the level of burnout and administrative burden are without precedent and jeopardize the future of primary care in Connecticut. Moreover, these issues are unlikely to be addressed by incremental fixes, but instead require a wholesale redesign of primary care reimbursement with the preservation of relationship-based medicine as a core principle.

7. Hospitals believe it is important to ensure that primary care is adequately resourced so providers can effectively manage the complex system of care delivery. CHA would like to emphasize, however, the importance of funding these efforts through channels other than a reduction to current hospital funding. Connecticut's Medicaid reimbursement rates to hospitals remain among the lowest in the nation. There should be no additional reduction to hospital funding and it should be a priority of the state to bring Connecticut's Medicaid rates in line with the national average.

   Response: OHS acknowledges CHA's concern that the funding for primary care advancement should not be achieved through a reduction in hospital reimbursement. Our understanding from other similar initiatives is that a staged increase in primary care funding could be achieved in large part through a reduction in avoidable inpatient, emergency department and specialty care. We appreciate that hospitals have made a range of efforts that reflect a shared commitment to reducing this avoidable use, for example, through participation in alternative payment models and CHA's asthma initiative.

8. We would like to raise a concern regarding recommendation 5, which states *"the design of primary care payment models should not increase out of pocket costs. As much as possible, the cost of new services should be included in the determination of the prospective primary care bundled payments and care management fees, rather than paid FFS as this will ensure that the costs of such services are not subject to the deductible. In addition, providers should not be permitted to charge co-payments for services and support that are included in bundled payments and care management fees such as phone and video communication or health coaching provided by community health workers."* As written, this recommendation implies that a provider would have the ability to charge or not charge a co-payment for services, but this is not a decision made by the provider. Co-payments are insurance design features; to eliminate them as per the recommendation, the insurance product would have to change. CHA is unclear how this recommendation would be implemented and coordinated with payers.

Response: We recognize the commenter's point that decisions with respect to deductibles and co-payments are not at the discretion of the provider. We believe that it is possible to introduce bundled payments without adding new co-payments for services that are not otherwise billable as covered services or subject to co-payments. During the planning process, we will examine how these issues have been handled in other states. The implementation timetable may need to allow for the phasing in of features that require insurance product re-design and approval by the Connecticut Insurance Department.

9. Invest in pediatric primary care practice transformation. Whether within one of the proposed models or as a separate effort, the state should recognize meaningful transformation of pediatric primary care practices. Suggestions for how to measure "meaningful progress" are included in our second recommendation, below. Practices must invest in care coordination, linkages to community services, and integration of behavioral and oral health services in order to accomplish a transformation of care; payment systems should recognize these efforts.

   Response: The intent of this initiative is to substantially increase the investment in primary care including pediatric primary care. We recognize that the investment in pediatric primary care will not result in a dollar for dollar return on investment within the healthcare sector in the short term. However, there is evidence from other models that the return on investment for more complex populations may be high enough to enable us to raise the standard of primary care in lower risk populations, with a focus on health promotion and prevention. This in turn may result in savings over a substantially longer time horizon.

10. Require ongoing evaluation of any new payment system to ensure quality, monitor progress, adjust for changes in best-practices, and inform future improvements. Quality measures should be robust, meaningful, and outcome-based. In particular, Connecticut's existing innovations do not measure the encouraged integration of community-based services with health services. Progress towards health equity necessitates connecting families with the housing, environmental, nutritional, and community-based supports that affect social determinants of health. National projects have developed specific outcomes and process indicators; these projects can guide the development of evaluation tools that are feasible and reliable. Further, evaluation tools should participate in and utilize state efforts to integrate data. Meaningful practice transformation requires communication across social services, community-based services, and non primary-care providers. The triple aim of improving health care experiences, improving the health of populations, and reducing costs should guide practice transformation efforts.

    Response: Thank you for these comments. We agree with the importance of maintaining our focus on the integration of community-based services with health services and appreciate the reference provided regarding outcomes and process indicators. We will take these recommendations into consideration in planning.

11. Safeguard the HUSKY programs' administrative efficiency. Recent reports from the Department of Social Services show a stable state share of Medicaid spending and low per member per month costs. While some of this fiscal efficiency may be related to lower expenditures in some areas, it would be counterproductive to bundle payments in a manner that increases administrative costs without expanding access to services or resulting in other correlated benefits to patients.

    Response: We concur that administrative efficiency must remain an important consideration in the design of the PCM program and associated payment models. Although payers may incur additional costs to design and implement bundled payment models, they may not be more burdensome to administer over the long term than their FFS counterpart.

    In addition, bundled payment offers the promise of reducing the administrative burden on providers. Providers are currently required to spend considerable time documenting in the EHR solely for the purpose of billing. We have been advised by our provider stakeholders that physicians recognize the importance of documentation that supports patient care and communication among members of the care team; however,

documentation that is solely for the purpose of billing and extraneous reporting contributes to the perception of wasted time that detracts from patient care and contributes to burnout.

12. Recognize and promote the role of community health workers in improving access to community-based services. The state has begun a process to consider certifying community health workers. Integration of social services, coordination of care, and connecting patients to community-based services often depend on the knowledge and skills of community health workers. Any model that aims to bolster services to address social determinants of health should include funding for and recognition of this work.

    Response: The Task Force and the SIM CHW Advisory Committee concur with your recommendation. We anticipate that the final design will incorporate community health workers as an essential member of the modernized primary care team, for both adult and pediatric practices, fulfilling a range of roles such as supporting person-centered assessments, health coaching, patient navigation, care coordination and linkage to community services.

13. Ensure compliance with American Medical Association's guidance regarding patient consent to non-visit-based care. We are supportive of encouraging telehealth and other innovations; however, the system needs to honor patients' preferences for visit-based care resulting from potential impediments, such as language or communication challenges, limited access to technology, or prior experience with health systems.

    Response: Thank you for this comment. OHS concurs with the recommendation to ensure compliance with the American Medical Association's guidance regarding patient consent to non-visit-based care. OHS intend to include this as an element of the program model.

14. The concept of expanding bundled payments to encourage additional resources for primary care is a notable advance over traditional fee for service shared savings models and Dr. Schaefer and his team, are to be applauded for the initiative. My reservations are born from more than 30 years of experience working with low income populations here and in South America. Fundamentally, most of the significant improvements in the health of these populations come from social and public health factors, such as clean water, reduced exposure to environmental toxins, reduced exposure to violence, better nutrition, better housing, and a sense of a supportive community. All of those sound as though they are well beyond what primary care improvements can deliver. Traditional western medical care may only be able to move the needle so far in communities that are economically, educationally, and socially challenged. Improved funding for basic needs may be a better answer. Still, I think that are ways to integrate those factors that go beyond health promoters. Community health workers are a start, but I would encourage you to think about ways that those workers could be deployed that go beyond reminding patients about their upcoming medical appointments. Medicaid has granted waivers in the past for states to fund housing stabilization. Just learning how to have a permanent home can go along way to reducing illness and ED visits. I would love to see a project where all of our bureaucratic funding to support families was placed into a bucket with maximum flexibility to improve the lives of needy families. That could include SNAP, WIC, Section 8, TANF, Medicaid, etc.

15. Response: Thank you for these comments. OHS is in full agreement with your recommendation that the State must think broadly about the role of Community Health Workers as members of the primary care team. Without question this role includes the identification of social determinant risks that interfere with the achievement of better health and healthcare outcomes and working with patients and community partners to address those risks. We also recognize the importance of addressing root cause solutions to poor health and poor healthcare outcomes such as such as clean water, reduced exposure to environmental toxins, reduced exposure to violence, better nutrition, better housing, and a sense of a supportive community. These solutions will require cross-sector community action, including healthcare providers, and will also require new financial or payment models to create a market for cross-sector community investments. The State has recently launched the Health Enhancement Community initiative in an effort to address these issues. Those interested can review our overview of the planning strategy and follow the work of the Population Health Council at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=336904.

16. As students from the Frank H. Netter MD School of Medicine at Quinnipiac University representing the Family Medicine Interest Group and Primary Care Progress, and as future healthcare providers, we support the recommendations set forth by OHS and SIM PMO's primary care payment reform proposal. We believe primary care is important because health represents well-being, not just the absence of disease. Primary care should encompass preventative care with continuity, food security, housing, and access to social services that keep our patients happy and healthy. We support a model that diversifies the healthcare team to include social workers, community healthcare workers, nutritionists, and others to promote comprehensive care for all, including our most vulnerable patients. This payment reform proposal is an important step in the right direction, not only to increase the satisfaction and well-being of our patients but to give providers greater capacity to adapt and innovate in their practices.

    Response: Thank you for these comments.

17. We are responding to this payment reform proposal as a collective group of Family Medicine faculty at the University of Connecticut School of Medicine. We care for a diverse group of patients of all ages, races and social and economic backgrounds across a variety of settings (an inner city office in Hartford, an office location on the UConn Campus in Farmington, an office in East Hartford, and the UConn Health Storrs office). We are responsible for teaching the next generation of students and residents, for providing continuing education options for the currently deployed physicians within the state, as well as assisting in the development of next generation methods of patient care through research and piloting innovative ideas and sharing these experiences through scholarly activities such as national presentations and publications. We also have a long history of assisting the state's family physicians both in and out of organized medicine in delivering the best of primary care. For example, 3 of the most recent CT Academy of Family Physicians (CAFP) presidents have been from this Department.

    It is with these various roles in mind that we respond to the payment reform proposal for Primary Care. First and foremost, we find the proposal to be extremely encouraging and directionally correct for how our future resources should be spent on patient care. We endorse a doubling of the percentage of the healthcare spend being purposely focused on Primary Care. We believe that payment for primary care that is at least partially bundled, focused on outcomes and pre-paid can facilitate a dramatic shift in the process and outcomes of care. The primary care setting and the relationships that derive from it can be substantially enhanced as the place of first and continuous contact for patients and their families.

    The faculty at UConn have been a leading voice in our state and even nationally, in promoting the ideas of what the future of primary care can look like with regards to patient-centric, interdisciplinary, team-based care that utilizes technology to augment the process in a thoughtful and evidence-based manner.

    Yet we struggle to cover the costs to deliver this care in an educational environment. We feel that adoption of some additional technology tools (care coordination software, additional clinical decision support aides, eConsults, Telemedicine, additional remote monitoring for example) as well as hiring additional faculty, Nurses, Medical Assistants, mid-level providers, care managers and Care Navigators is necessary to complete the transition to this proposed model of care and developing an optimal training environment for our learners. Based on our experience, it is imperative the reimbursement for this model be sufficient to cover the costs of transition and that front-loading of payments occur for some anticipated costs including software upgrades, additional software tools and key personnel.

    Our Recommendations:

    a. Engage the primary care training programs (residencies and medical schools) early on in the further development of the proposal and any early pilot projects because we:
        - are on the leading edge of some components of team-based care delivery, lagging in others but strongly desire to train the next generation of clinical primary care leaders.
        - can help elucidate how to carry these activities out at scale (what type of education, training, how to integrate interdisciplinary teams etc....)

- graduate the next generation of clinicians to transform our healthcare environment.
- place student learners throughout the state in a variety of primary care settings and train them to be both ambassadors of the proposed changes and also to help assist in the transition to the new model of care.

b. Give priority to the unique transformation of the Residency Training programs by providing substantial early fiscal and transformation support to these settings because:
   - These sites are focal points of learning for future primary care providers and students who are considering career choices and they should understand what the future of primary care will look and feel like while they are making their choices.
   - Faculty and Residents face a special form of burnout in that they often care for the most underserved populations while also facing challenges with being excellent teachers.
   - They often care for the most vulnerable populations and therefore transformation may lead to larger cost savings and provide timely feedback.
   - This will require negotiations with their sponsoring organizations and might include a real opportunity for them to "lead the way" for larger healthcare organizations.

Response: Thank you for these comments. OHS appreciates the importance of engaging the primary care training programs (residencies and medical schools) early in the development of the proposal and in any pilot projects for the reasons set forth. We will modify our planning to process to include an advisory panel or other advisory structure comprised of representatives from Connecticut's residencies and medical schools. We will also modify our planning deliverables to specifically elucidate the role of primary care training as part of the overall program design. We will add a 12th recommendation to the Task Force report consistent with this recommendation.

From early on, we have envisioned that primary care practices participating in the PCM initiative can be focal points of learning for future primary care providers and students who are considering career choices and will provide insight into what the future of primary care will look and feel like as they make their choices. We support the examination of options for obtaining early fiscal and transformation support.

18. I would like to offer my comment on the Primary Care Payment Reform white paper. In a word, the changes suggested and recommendations offered are essential to move our state and our nation out of the dismal performance on quality metrics globally that we currently occupy.

    Speaking specifically about primary care which occurs in the ambulatory setting we can no longer practice "business as usual". When I came to practice in Connecticut 31 years ago I was able to practice nearly full scope medicine which included ambulatory office care, hospital medicine, patient management in the Intensive Care Unit, Skilled Nursing Facility care, night call for my patients and home visit services. I elected not to practice obstetrics.

    I am now part of a large Primary Care Group - ProHealth Physicians Inc.- recently an Optumcare practice which is a subsidiary of United Healthcare Group. For The last 5 Years nearly all physicians in our group no longer practice Hospital medicine, many no longer visit patients in the nursing home, few of any continue to make house calls and even night call has been centralized removing it from the relationship based service it often provided.

    This narrow focus of ambulatory medicine and the electronic documentation requirements contribute to physician and Allied Health professional burnout.

    I believe that the only way to restore joy in practice is to build Healthcare teams and redesign ambulatory Primary Care in such a way that restores our sense of contribution and professional and patient relationships. By necessity this will include working with co-located nutritionists, Behavioral Medicine specialists, and Allied health professionals to build an actively functioning patient-centered medical home. This also must include creating telemedicine services and Outreach members of the healthcare team

including specifically community health workers. Finally, creative activities that involve patient education, supporting patient housing and transportation and nutritional needs will be absolutely essential.

If my day is not measured by the volume of patients I see and for whom I try to maximize billing but rather by the number of patients I can "touch" through my outreach colleagues, my telemedicine interactions, my on-site group disease-specific medical visits and other Innovative interventions that specifically address high risk patient need and preventative health services I will be reinvigorated. Payment reform will accomplish this by removing the limitations of visit based only reimbursement. Primary care payment form will allow us to be creative and proactive leveraging the population health access to data and accelerate the transition from volume to value-based Primary Care delivery. We must not ignore and lose this opportunity.

Response: Thank you for these comments. The capabilities that you emphasize and the goals with respect to provider experience and patient care will be addressed in the phase 2 planning, which will begin in May 2018.

19. In making the assertion that FFS payment is inherently broken and "unsustainable" because it "stimulates the provision of more services, instead of helping to fund and support new care delivery capabilities that ultimately benefit and engage patients" (page 5), and it "does not give providers flexibility to implement new processes that would help their patients," (page 14), the report fails to take into account successful payment reform models already operating in CT which are based on fee for service payment plus rewards for significant quality improvements. Specifically, the rigorous patient-centered medical homes (PCMH, no "+") program administered by DSS and its ASO contractor, Community Health Network, Inc., since 2012, involves payment of NCQA-accredited PCMHs in three ways: fee for service payment for primary care visits, enhanced fee for service payment to PCMHs which have achieved NCQA accreditation (or are on the glide path to this) to cover care coordination costs for all patients accredited to them, and extra payments to reward such practices which do well on important quality measures, such as ER usage reduction. These reward payments are based on two kinds of quality measures: how practices do relative to their peers and relative to their own past performance. Combining these three forms of payments incentivizes quality of care, not the volume of care perceived to be incentivized by all FFS payment systems.

    And, according to DSS, this FFS-based approach has had remarkable success in cost control. As DSS explained in a detailed presentation to the Medical Assistance Program Oversight Council in February, 2018, our Medicaid program far outshines programs throughout the country in both cost control and in how much of our Medicaid dollars (94.3%) go to actual health care (instead of administrative expenses). https://www.cga.ct.gov/med/council/2018/0209/20180209ATTACH_HUSKY%20Financial%20Trends%20Presentation.pdf This has all been done specifically by emphasizing primary care and the use of patient-centered medical homes to coordinate all healthcare.

    Yet, not only does the report omit this successful program from its analysis (though it discusses the "PCMH+" shared savings Medicaid program, albeit as a failure), but it creates a set of categories of primary care payment under the "HCP-LAN Framework," none of which include DSS's successful non-risk PCMH program. For example, while PCMH (no +) is closest to "Category 2: FFS – Link to Quality and Value," page 15, the report rejects this model because, "while slightly better the FFS model, pay for performance models are still limited in their ability to support the addition of diverse team members," again omitting the fact that PCMH also includes enhanced payments specifically to provide for innovative care coordination through accredited practices.

    Response: OHS recognizes that Connecticut experienced the most favorable Medicaid trend in the nation between 2010 and 2014. Connecticut's per member cost trend during this period was -5.7%. In fact, most Medicaid expansion states experienced favorable (i.e., negative) per member cost trend, which is likely at least in part attributable to the influx of healthier Medicaid beneficiaries. Connecticut was the first state in the nation to expand Medicaid under the Affordable Care Act (ACA), and accordingly, Connecticut was likely among the first State's to benefit from this early enrollment of healthier members.

Connecticut Medicaid's trend during this period is nearly identical to Massachusetts's trend (-5.6%). Massachusetts also expanded early but did so prior to the ACA. Massachusetts did not rest with this favorable trend; instead, they proceeded to implement Medicaid ACOs with up and downside risk in order to ensure a drive to greater value in the future.

In addition to an influx of healthier beneficiaries, there are other factors that may have contributed to Connecticut's favorable trend including the following:

- The great majority of other State's in the nation have Medicaid managed care, which means that provider rates and fees are subject to negotiation and tend to increase over time. Connecticut Medicaid's rates and fees are set by the State and as such the program is insulated from the upward pressure of rate negotiation on cost.
- DSS has other programs including rebalancing initiatives such as Money Follows the Person and the medical ASO management model, which may also have contributed to the favorable trend.

Whether and to what extent PCMH might have contributed to this favorable trend has not been evaluated, so it cannot be said with certainty the degree to which PCMH has contributed to DSS' reduction in costs, if at all. This was one reason PCMH was not specifically referenced. Another reason is that this program design does not enable many of the primary care advancements that were the focus of the report including the improvement in physician experience that follows from reducing the demands of FFS billing.

Finally, while there is always room for discussion about how to evaluate and respond to this complex topic, there is widespread consensus that fee-for-service has contributed to the extraordinary rate of growth in healthcare costs in the United States…now approaching 18% of the GDP. This unrestrained growth is directly affecting consumers as evidenced by the high deductible plans. With these plans, consumers face higher costs and greater barriers to accessing essential, high value care. The rationale for Alternative Payment Models is best summarized in the HCP LAN Framework white paper.

20. Without mentioning the successful FFS-based non-risk PCMH program operating right now in CT, the report states that only putting financial risk on primary care providers through bundled payments can cure the alleged drawbacks of FFS. The SIM consultants were advised of this model by independent consumer advocates interviewed for this report. It is unfortunate and concerning that this report does not include mention of it, as it would show that this FFS-based payment system is already meeting the goals claimed by SIM, including, according to DSS, significant cost control.

    Response: The Task Force report does not mention the DSS PCMH model as an option for the reasons noted in the response to question #19. To our knowledge, no other state in the nation relies on PCMH as the primary means to drive improvement and affordability. In fact, North Carolina's highly regarded PCMH program, which was a point of reference in advocating for the DSS PCMH program, is in the process of being supplanted by Medicaid managed care. Nationally, much has been learned about healthcare purchasing in the past two decades and the conversation has moved well beyond PCMH and pay for performance as evidenced by the HCP LAN Framework and innovative primary care initiatives such as CPC+ and Next Generation ACO. We have not identified a single health care purchaser in the nation that endorses a simple PCMH pay for performance program as sufficient means to achieve the triple aim of better care, better health and lower cost.

21. The report does correctly identify community health workers as a potentially valuable innovation in care coordination. But it declares that an enhanced FFS payment model like PCMH makes it "difficult to support the hiring of alternative/diverse team members such as CHWs." In making this claim, it ignores the enhanced payments to PCMHs under DSS's PCMH program which compensate primary care practices for such innovations. But beyond this, if there was a desire to incentivize the hiring of CHWs directly, this is readily available through DSS choosing a state plan option which would allow direct reimbursement from the federal government for expenditures made by DSS to PCMHs to incentivize their hiring. This also allows

state oversight to ensure that CHWs are being paid to improve effective care, and not to lower costs or cherry-pick patents to improve practices' finances. Since CHWs are reimbursable on a FFS basis, there is no reason DSS cannot do this now, under the existing successful

PCMH program which is founded on a FFS payment system. In the absence of the imposition of a provider risk model, the state would then enjoy all of the savings from CHWs hired directly via Medicaid, providing even more relief to the state budget.

Response: Published evidence supports the value of CHWs in improving healthcare outcomes and reducing avoidable costs. Rigorous evaluations typically test care innovations like CHWs in a manner that ensures that they are carefully targeted to support patients in clinical situations that will result in value. Adding fee-for-service coverage of CHWs has a variety of drawbacks. When services are paid fee-for-service, the services may not be directed to the patients who will benefit. Instead, the use of services paid fee-for-service tends to grow without sufficient regard to whether they generate value for patients. This pattern of overuse and cost inflation is well established (x) and it is one of the reasons that payers are cautious about adding new fee-for-service coverage options. It is also part of the reason that states have been slow to adopt fee-for-service reimbursement for CHWs under Medicaid. Note that overuse of services and procedures as a result of fee-for-service is the basis for Choosing Wisely, an initiative of the *ABIM Foundation* and *Consumer Reports* to help recognize when a provider recommends low value, potentially unnecessary care.

Fee-for-service has other problems including that it adds to administrative cost and inefficiency, which is a direct burden on practices and the CHWs that work in those practices. Under fee-for-service, CHWS would be subject to the same onerous billing documentation requirements, time coding, etc. and their services would be subject to the billing compliance audits that are a central feature of Medicaid and Medicare.

22. Throughout the report, it takes on faith that imposing a risk-based payment model on primary care providers will "allow providers to develop care delivery capabilities that benefit patients" and "[t]he flexibility afforded by these payment arrangements can lead to improved access" because providers "can use the additional revenue to invest in innovative patient engagement and support services….," like telemedicine. But it ignores the fact that practices must, under these models, pay out of pocket for any services provided, whether telemedicine or an office visit. "Flexibility" to pay for something out of your own pocket is always present— indeed, practices have the "flexibility" now to pay for telemedicine out of their pockets. The assumption that practices will do this is just that.

    Practices can instead take the difference between their capitated payments and how much they spend on patient care to simply increase their incomes or fill budget holes. While certainly we would hope that most practices would spend at least some of this new money on such innovation, none of the report's three risk models actually require this. As was the case with the capitated Medicaid managed care organizations with which DSS contracted for years, which always professed "flexibility" to pay for services not covered under fee for service so as to better coordinate care, under such a risk model, flexibility can also mean flexibility to make more money by denying needed care, in this case in the form of needed office visits or other services, or through cherry picking patients.

    Response: Practices generate sufficient revenue through fee-for-service to be able to cover only the costs of a practice and modest salaries for office staff and primary care providers. The current payment model does not provide practices with revenue to support telemedicine or other care innovations, which is why they generally are not doing these things today.

    We can provide practices with true flexibility—meaning the ability to change the way they care for patients (e.g., telemedicine) without sacrificing their monthly income—by providing them with upfront payments to cover the time the care team spends doing office visits, shared visits, home visits, telemedicine visits, and phone, e-mail or text support. The Task Force recognizes the importance of verifying that practices are making demonstrated changes in the way they practice and providing better quality care, which is the focus of Recommendation 10, which reads:

**Recommendation 10:** *Payers that utilize primary care payment models should ensure that quality of care is measured and rewarded and that practices demonstrate that they are investing in and have implemented transformational change.*

With respect to patient selection or "cherry-picking," this risk is substantially mitigated or eliminated by recommendation 6, which reads:

**Recommendation 6:** Primary care payment models should use risk adjustment to adjust payments to account for underlying clinical and social-determinant differences in the patient populations served by different primary care practices.

This recommended approach would ensure that providers receive up-front payments commensurate with the level of patient need. Thus, practices would receive more revenue for patients with more complex needs. In addition, practices will have an incentive to bring more patients into their practices and to keep them engaged in care.

Note that Connecticut did not utilize risk-adjustment for its capitation payments to Medicaid Managed Care program from the inception of this program in 1995 until its cessation in 2011. As a result, patient selection was a prominent concern that required close monitoring and the threat of penalties. Many other states have used capitated Medicaid managed care with a positive effect on patient care and the use of funds for flexible purchasing beyond the covered services. For example, this is true of Oregon's highly regarded place-based capitated Medicaid managed care approach with Coordinated Care Organizations.

In light of the above concerns about appropriate service and patient selection, recommendation 10 has been edited to include language regarding appropriate levels of service and equitable access.

23. As problematic as imposing financial risk on providers is, it is particularly troubling that the report, citing the CMS Healthcare Payment Learning & Action Network (LAN), encourages that these kinds of direct financial incentives "should reach providers across the care team that directly delivers care." (page 10). In other words, in addition to recommending that a primary care practice have a direct financial incentive to cut costs, it also recommends that individual providers be so incentivized.

    This is a dangerous approach rejected even by a SIM Committee. The final report of the SIM Equity and Access Council recommended that any shared savings payments to ACOs include this protection against incentivized under-service:

    "Recommendation #3.7: Payment Distribution Methods. To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel."

    http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf

    (page 35)

    As the Equity and Access Council's Report noted, "[b]y keeping the incentive to become more cost efficient at the level of the ACO or the provider group, rather than extending it to the individual provider, it is more likely that cost efficiencies will come from providers working together to manage utilization effectively, and not from inappropriate under-service." This protection was thus included in the design of the Medicaid shared savings model, PCMH+. This protection would be completely undermined if individual providers had a direct financial stake in saving money on their own patients' health care because of the fixed payments under bundles or capitation, as proposed in the SIM consultants' report.

    Response: We agree with the recommendation of the Equity and Access Council cited above. The quoted statement, "to the greatest extent possible, value based incentives should reach providers across the care

team that directly delivers care…" *does not suggest* that individual providers should be rewarded based on the portion of savings they individually generate. In fact, the Task Force is recommending that individual providers and care teams have the opportunity to share in the savings that their organization generates proportional to their own quality performance and the number of attributed lives on their panel. The report has been edited to address this concern.

24. The report fails to adequately address the major concern with shifting risk onto providers under all three of its options that under-service could result, declaring that "the literature review found no evidence to support that it occurs." Page 19. The statement is striking given the extensive evidence of under-service resulting from capitated managed care organizations in which, as with the proposed options, the entity is fully responsible for every dollar of health care (here, primary care) provided. While the risk models being advocated by SIM are new and untested, the basic financial incentive system is not, and time and again it has been shown to result in under-service. Indeed, this was a major reason why risk-based MCOs were pushed out of the CT Medicaid program. In addition, there is evidence in other states that provider risk models do result in adverse selection (Hsu, et al 2017), and SIM is proposing no protection in policy, monitoring or enforcement so that it will not happen in Connecticut.

    Many, in addition to independent consumer advocates, have noted the risk of under-service and adverse selection from pushing risk onto providers. In the Project Management Office's Narrative for its application for grant funding for the SIM initiative, it noted:

    > "CT acknowledges that providers in [shared savings] arrangements may seek savings through under-service, which might include reducing necessary access, inappropriate patient selection, cost shifting, withholding appropriate care or inappropriate referral practices. CT has established an Equity and Access Council comprised of physicians, consumer advocates, payers, and researchers from the state's public academic health center to develop methods that will help guard against such risks."
    >
    > Connecticut SIM Model Test Proposal - Project Narrative, at page 11 (emphasis added).

    SIM's Equity and Access Council met over many months and produced a 72 page report specifically to try to address at least some of those risks of under-service/adverse selection, including after a review of the literature at the time. The SIM consultants' report does not reference the Equity and Access Council's report, which is quite concerning considering the hundreds of hours spent by that Council's members, including consumer advocates, and the pertinence of this report to the analysis.

    Even SIM's own report in support of imposing risk on primary care providers notes, in discussing another less-aggressive risk model, "CPC+", that this model includes "some FFS reimbursement for certain services to reduce the risk of under-service." (pages 25-26) (emphasis added).

    Finally, while the SIM Narrative sent to CMS recognized the risk of under-service/adverse selection from the imposition of shared savings, that risk is even more extreme under the proposed primary care payment models in this report, for at least three reasons: (1) shared savings involves "upside only" risk, not downside risk as under bundles and capitation, where significant amounts of money might be lost; studies have documented the more powerful incentive to avoid losing something one already has than to have the chance of gaining something additional, (2) putting financial risk on primary care providers directly means that patients might not be brought in for office visits when they should be, such that early diagnosis will be missed, which is less of a concern under a global shared savings model, and (3) as noted above, the options all assume that individual providers will be financially incentivized to save money on their own patients' health care, involving the kind of excessive and dangerous incentives which the SIM Equity and Access Council, and DSS, have warned about and guarded against. It is alarming that no acknowledgement, weight or deference was given to these previous concerns, given that they were made specifically in consideration of Connecticut's program.

Response: Thank you for noting the work of the Equity and Access Council. We are grateful for the work of this Council and its 72-page report that sought to address some of the risks of under-service and patient selection in shared savings program arrangements.

The literature review cited in the report focused on bundled payment or risk-arrangements with *providers* rather than capitated managed care. Insurance companies are not provider organizations. As such, there is reason to believe that capitation may have a different effect on insurers than providers. It is also important to consider that Connecticut's experience with capitated Medicaid managed care was problematic in part because it did not employ risk-adjustment which is a critical element of the design of capitated programs nationwide. Risk adjustment helps insure that managed care organizations serve and work to improve the care of complex patients. The newer risk adjusted models can be beneficial to patients, as evidenced by a number of papers on the topic by the Center for Health Strategies.

We disagree that "the risk models being advocated by SIM are new and untested." The shared savings program model promoted by SIM has been adopted by more than 900 provider organizations nationally. The Medicare version of this model has been studied extensively. None of the studies has found conclusive evidence for under-service or patient selection. The primary care payment model that was recommended by the Task Force has been around, in various forms, since the 1990s and more extensive provider capitation models have been in existence since the 1970s (e.g., Kaiser Permanente). Our northern neighbor, Massachusetts, offers examples of successful provider capitation or global budget models focused on patients with the highest level of need and vulnerability. For example, Commonwealth Care Alliance has been successfully serving high risk Medicare/Medicaid eligible beneficiaries under a capitation model since the late 1990s[1] [2]. More recently, Cambridge Health Alliance changed from fee for service to global payments and reported improved quality health outcomes for a safety net population to above the national 90th percentile, while reducing total cost of care by 10%[3].

Note that one of the earliest examples of bundled payment methods was initiated in the early 1980s for inpatient hospital services paid for by Medicare. While the DRG method of payment has drawbacks, it has been refined over the years and remains among the most effective methods in history for containing the cost of a category of health services without negatively impacting quality. This method of payment is used for patients who are by far the sickest and most vulnerable patients— including patients who may be unable to advocate for themselves. Even though a hospital incurs a cost under this bundled payment approach when undertaking expensive diagnostic tests and procedures, there appear to be benefits with respect to access, no evidence of stinting on care and very little evidence for patient selection.[4] The DRG payment method is widely accepted today by providers, payers and the public.

The commenter cites a study by Hsu and colleagues (2017) as "evidence in other states that provider risk models do result in adverse selection." This case study examined only *one* ACO of more than 400 ACOs nationwide that participate with a Medicare accountable care program. The focus on one case study limits the generalizability of the findings. Moreover, although the authors speculate on the possibility that an ACO might, in the future, game the financial model by dropping physicians, per the abstract below, they did not conclude that there was adverse selection:

> *Abstract: Alternative payment models, such as accountable care organizations (ACOs), attempt to stimulate improvements in care delivery by better alignment of payer and provider incentives. However, limited attention has been paid to the physicians who actually deliver the care. In a large Medicare Pioneer ACO, we found that the number of beneficiaries per physician was low (median of seventy beneficiaries per physician, or less than 5 percent of a typical panel). We also found substantial physician*

[1] The First Social ACO: Lessons from the Commonwealth Care Alliance
[2] Commonwealth Care Alliance
[3] Accountable Care in the Safety Net: A Case Study of the Cambridge Health Alliance
[4] https://www.urban.org/sites/default/files/04_diagnosis_related_groups-based_payment_to_hospitals_for_inpatient_stays.pdf

*turnover: More than half of physicians either joined (41 percent) or left (18 percent) the ACO during the 2012–14 contract period studied. When physicians left the ACO, most of their attributed beneficiaries also left the ACO. Conversely, about half of the growth in the beneficiary population was because of new physicians affiliating with the ACO; the remainder joined after switching physicians. These findings may help explain the muted financial impact ACOs have had overall, and they raise the possibility of future gaming on the part of ACOs to artificially control spending. Policy refinements include coordinated and standardized risk-sharing parameters across payers to prevent any dilution of the payment incentives or confusion from a cacophony of incentives across payers.*

The commenter references the report of the Equity and Access Council, which contains a number of recommendations intended to lessen the risk of under-service and patient selection. The Council's report is focused on the shared savings program model, which rewards reductions in total cost of care. The Council's report is not referenced by the Task Force, *because the recommended primary care payment reforms do not focus on* the design of *shared savings* or other *total cost of care accountable* models. The Task Force report focuses on primary care payment models that provide practices with a) more revenue, b) more flexibility, and c) reduced administrative burden.

Because these recommendations focus on the smaller, more predictable primary care revenue stream, the risk of converting to upfront bundles is relatively small. Any risk is further mitigated by the use of risk adjustment to adjust upfront payments on a quarterly basis. While some patients may need a few more visits than expected (and others less), the burden of a small number of extra visits is much less than the burden of the "free" work that primary care providers are currently expected to provide such as phone, e-mail, and text support for their patients as well as hours of documentation each day. The burden is also far less in comparison to the services that physicians would have to pay out of their own pockets to provide such as home visits, shared visits, e-consult (for most Medicare and commercial patients), and e-visits.

With regard to the final concerns:

*(1) shared savings involves "upside only" risk, not downside risk as under bundles and capitation, where significant amounts of money might be lost; studies have documented the more powerful incentive to avoid losing something one already has than to have the chance of gaining something additional,*

*(2) putting financial risk on primary care providers directly means that patients might not be brought in for office visits when they should be, such that early diagnosis will be missed, which is less of a concern under a global shared savings model, and*

*(3) as noted above, the options all assume that individual providers will be financially incentivized to save money on their own patients' health care, involving the kind of excessive and dangerous incentives which the SIM Equity and Access Council, and DSS, have warned about and guarded against.*

Studies have not suggested that the fears about stinting on care will be borne out—in fact, the opposite may be true. As noted in the Task Force's report, four primary care sites in the United States cited as "medical home runs" by Milstein and Gilbertson (2009) had in common a capitated or bundled model of payment. Moreover, while patients may not come in for as many office visits, they will have the option of other kinds of visits that are more convenient. With fewer barriers to engaging the doctor or care team, one could speculate that early diagnosis might be more rather than less common. Multiple ways of accessing your care team may also make it more likely that one will seek care from the care team that knows you, rather than an anonymous option such as a national telemedicine doctor or retail convenience clinic. Finally, it means less time away from work or the burden of arranging for child care and transportation. These are exactly the types of outcomes we are seeking and any future initiatives will incorporate rigorous monitoring and evaluation to determine if these positive outcomes are achieved.

The Task Force believes that the vast majority of providers will use the flexibility that primary care payment reforms to figure out ways to better serve their patients. Nonetheless, they acknowledge the importance of

monitoring the impact of these changes, such as by monitoring the number of patient "touches" before after the reforms have been implement, to ensure that the changes results in an appropriate level of service and equitable access for all. Recommendation #10 has been edited to reflect this concern.

In summary, OHS and the Task Force continue to hear from consumers and consumer advocates with respect to Medicaid and other payers that the current healthcare system does not effectively serve them (see e.g., comment #40). While the Task Force acknowledges the concerns about under-service and patient selection, it is the consensus of the Task Force that CT needs to focus on the development of bundled payment and risk-arrangements that will support effective and efficient person-centered care that truly works for and benefits Connecticut's 3.6 million consumers.

25. The report assumes that whatever risk of under-service/cherry-picking there might be from imposing financial risk would apply only for the most extreme proposals for full capitation (Options 2 and 3), and is not an issue under "Option 1" partial bundled payments. This assumption suggests that the report's authors do not appreciate the basic problem with imposing any kind of downside risk on providers. It certainly is true that imposing a partial or "'full bundle' of primary care services including 'sick' and preventive primary care services," i.e., capitation, as under Options #2 and 3, will "pose a risk of under service," in the form of discouraging visits, page 29. But that also is true for Option #1. Paying capitated payments for 65% of the practice's annual income from "sick" visits, just as paying 100% of that income as under Option 2, absolutely incentivizes under-service because, under either of these models, there is either dramatically reduced payment (Option 1) or no payment (Option 2) for bringing a Medicaid enrollee identifying a medical issue into the office. On the margins, this powerful financial incentive will induce some providers, mostly unconsciously, to err on the side of not bringing the patient in. Yet, the only risk from imposing this kind of financial risk identified in the report for its Option 1 is "some risk that conversion to non-visit based care could jeopardize patient income." (emphasis in original).

Response: Thank you for these comments. See response to question #24.

26. Ironically, the SIM Project Management Office, which forcefully pushed for imposing the shared savings/ACO model on Medicaid enrollees over the objections of agency staff and advocates, is now dismissing that model, which first went into operation in January of 2017, as a failure. Specifically, it declares that there are "limitations in the model that prevent providers from undertaking transformative change," so we must "move beyond shared savings program models." (Pages 1 and 6). But in so arguing, the proponents ignore that the first qualitative data on the implementation of the Medicaid shared savings program, and its effectiveness, will not be available until July or August of 2018. In addition, the problem with PCMH+ is not that it does not go far enough, but rather that it is already imposing a risky experiment on vulnerable Medicaid enrollees with upside only risk. The answer is not to double down and INCREASE the risk on providers by imposing downside risk, which, as is well established in the literature, brings an even higher risk of harm through under-service.

Response: Thank you for these comments. The phrase "move beyond shared savings program models" does not accurately reflect the recommendations of the Task Force and has been removed.

The Task Force did not dismiss the shared savings program model, but instead identified limitations in the model that needed to be addressed in order to spur investment in the advancement of primary care. This is evident in the full text of this excerpt from the Task Force report as follows:

> *"Despite the potential benefits of shared savings programs, there may be limitations in the model that prevent providers from undertaking transformative change, especially in primary care. For this reason, the SIM Program Management Office (PMO) invited the Practice Transformation Task Force (Task Force) to examine the limitations of Connecticut's shared savings reforms and make recommendations to address these limitations with a focus on transforming primary care."*

In the report, the Task Force identifies shared savings program arrangements and other payment models that hold providers accountable for total cost of care as an essential companion to the proposed primary care payment reforms. This is evident in Recommendation #3 on page 39 of the report as follows:

> ***Recommendation 3:*** *Prospective reimbursement for care management and other non-billable services, in combination with bundled payments for visit-based primary care services, provide practices with the resources and flexibility to achieve the goals of reform. However, these reimbursement methods should be introduced in a way that ultimately reduces the total cost of care, because increases in the total cost of care are ultimately borne by employers, consumers or taxpayers.* ***Accordingly, primary care payment models should be coupled with an alternative payment model, such as a SSP, that rewards practices for controlling the total cost of care****.* [emphasis added]

Finally, the commenter notes that PCMH+ is "already imposing a risky experiment on vulnerable Medicaid enrollees." The shared savings program model promoted by SIM has been adopted by more than 900 provider organizations nationally. The Medicare version of this model *has been studied extensively*. We disagree that SIM's central payment reform is "a risky experiment."

27. In service of defending its push for imposing full risk on primary care providers, the SIM consultants' report falsely paints a picture that there is consensus on the need to move beyond FFS and put financial risk on providers. See pages 3, 33, 36, 37, 38. In fact, this is extremely misleading. Even providers do not all agree. But particularly troubling is the report's attempt to suggest that consumer advocates agree with this position. E.g. "consumer advocates agree that the current FFS direction will not support the advancements in primary care needed to improve outcomes, reduce costs, and improve patient and care team satisfaction" and they "appreciate the significant benefits that PCPMs could have for consumers." (page 36, 38). In fact, consumer advocates, at least those representing Medicaid enrollees, overwhelmingly support maintaining the fee for service system tied to the use of compensated PCMHs, with rewards for improved quality, as has already been successfully demonstrated under the CT Medicaid PCMH (no "+") program. And the one consumer advocate on the SIM Practice Transformation Task Force who is a health policy expert, Shirley Girouard, Ph.D., voted against adopting any of the options in the report.
    The report's authors attempt to conflate obtaining widespread consumer support with the fact that the SIM "Consumer Advisory Board" (CAB) at least vaguely supports its proposed models, declaring the CAB to "represent culturally and geographically diverse backgrounds" (page 36). While that may be true, it is hardly diverse on the question of whether imposing financial risk on providers is a good thing or a bad thing. The members of the CAB were appointed by the administration, directly or indirectly, and a primary concern was that such members be supportive of the SIM approach to payment reform, which is focused on imposing such financial risk. While certainly not all of the CAB members have committed to that position, most have. Thus, looking just to the CAB clearly does not accomplish the goal of getting broad "consumer representative" input.
    Independent consumer advocates are overwhelmingly opposed to all three of the risk-based options in the report, and have expressed their concerns with the SIM push to impose financial risk on Medicaid providers in numerous letters addressed to SIM and officials overseeing it. A partial list includes: July 22, 2013 Letter to Health Care Cabinet, August 22, 2013 Letter to Lt. Governor Wyman, July 10, 2014 Letter to Lt. Governor Wyman and Dr. Mark Schaefer, September 12, 2014 Letter to CMS CMMI, April 10, 2015 Letter to Lt. Governor Wyman, September 28, 2015 Letter to Lt. Governor Wyman, March 8, 2016 Letter to Lt. Governor Wyman, Feb. 17, 2017 Letter to Lt. Governor Wyman.

    Response: We have edited the report to avoid making conclusive statements about the level of agreement among consumer advocates.

    We would note, however, that the SIM advisory structure contains nearly 50 independent consumer advocates. They are *independent* consumer advocates in as much as they are free to take any position on a health care payment proposal without jeopardizing their participation. Nearly all of the consumers on the CHW Advisory Committee, the Practice Transformation Task Force, and the Healthcare Innovation Steering

Committee support the Task Force recommendations as do some individual members of the Consumer Advisory Board. We will continue to pursue this public and rigorous process that allows differing opinions to be voiced and discussed.

28. The report also wrongly assumes that SIM (and its committees), which is committed to the SIM PMO philosophy of imposing financial risk on providers through shared savings and similar "value-based payment reforms," is the right entity for deciding on payment reforms for the Medicaid program. The report declares that "There also needs to be a pathway to the participation of Medicare and Medicaid to make any new approach to Connecticut a 'directionally aligned' multi-payer one" (Page 38) (emphasis in original).

    It is not correct structurally for SIM to be redesigning any aspect of the Medicaid program administered by DSS, since federal Medicaid law establishes DSS as the single state Medicaid agency. SIM does not redesign or dictate to other payers, including those with populations less vulnerable to the risks of these payment models and those with more opportunity to generate savings. It is likely that, to date, SIM has only been rolled out in Medicaid because of its vulnerability as a government program, not because it is the right course to take for either Medicaid members or state taxpayers. It also would be very unwise policy: Unlike the MAPOC, the SIM steering committee is not comprised solely of individuals well acquainted with Medicaid policy. The right entity for proposing or implementing Medicaid reforms is the Department of Social Services, with input and oversight from MAPOC, and its committees, which is populated by individuals with a strong knowledge base of, and commitment to, the Medicaid program and its participants. In fact, SIM's attempt to push the reforms in this report onto the Medicaid program has already raised concern with the co-chairs of the MAPOC. In a letter dated January 10, 2018 (attached), from the co-chairs to Dr. Mark Schaefer, they raised major concerns with the risk payment models in the report, if applied to Medicaid:

    "Since the Affordable Care Act was passed, hundreds of additional physicians now serve individuals in Connecticut's HUSKY Health Program. While we are always looking to make improvements to the healthcare system, new initiatives, like bundled payments for services, could have adverse effects. This new payment methodology could lead to a reduction in providers willing to serve persons on Medicaid and create a gap in access to care and quality services.

    "Bundled payments are a new concept and relatively untested. It is not known how the new system would work in a State like Connecticut and how it would coincide with incentivized programs like PCMH and PCMH+. With all of the hard work Connecticut has put into building our Medicaid program, we cannot risk the wellbeing of our citizens." (emphasis added).

    In any event, the MAPOC co-chairs concluded:

    "Finally, we would like to ensure that any SIM initiatives that could have an impact on Medicaid are brought before the Care Management Committee of MAPOC before being voted on. While we ourselves are members of the Steering Committee, a diversified group with expertise in Medical Assistance, like MAPOC and its Care Management subcommittee, can appropriately provide stakeholder input and oversight to anything that relates to Medicaid; as is statutorily directed."

    Response: TBD

29. Thanks for this report! It's a common sense transition that includes many recommendations consistent with my understanding of extant primary care payment models and I believe if implemented with fidelity could be transformative to our state. That being said, I had a few questions regarding Recommendation 6 (quoted below):

    > "Recommendation 6: Primary care payment models should use risk adjustment to adjust payments to account for underlying differences in the patient populations served by different primary care practices. To the extent feasible, risk-adjustment methods should take into consideration both clinical and social-determinant risks. The risk adjustment and corresponding bundled payments should be updated

frequently enough to ensure that practices have the revenue necessary to support patients whose needs and complexity are increasing."

What social determinant data would you recommend collecting for this? It's not clear which SDH the report is referring to, and what would be the underlying risk adjustments? These seem like very reasonable ideas however how these weights are determined and which data are included will determine their effectiveness.

Response: Thank you for these comments. The State is just beginning its second phase of planning in which it will further define how each of the recommendations will be addressed. With respect to social determinant risk adjustment, we will examine models used by other states such as Massachusetts and Minnesota to see whether those models could be adapted to serve the purpose of this initiative. We will also consider whether the collection of social determinant risk data needs to be standardized to enable the capture of this information in a uniform manner across all providers. Such data would need to be made accessible to participating payers through new technologies that the State is in the process of rolling out, including a Health Information Exchange and clinical data repository referred to as the Core Data Analytic Solution. It is likely that these methods will have to be built and tested and thus may not be available in the initial phase of implementing the Primary Care Modernization initiative.

30. I am writing this letter in support of the SIM Primary Care Modernization initiative. The proposal would bring important changes to primary care, allowing our providers to continue the transition to value based care and improve the quality and efficiency of care delivery. I encourage adoption of these recommendations and efforts to implement them across the delivery system.

    Response: Thank you for these comments.

31. I am the Executive Director of Khmer Health Advocates (KHA), a not-for-profit organization in West Hartford that promotes the health of Cambodian refugees in Connecticut. KHA is also part of the Connecticut Southeast Asian American Health Coalition, along with the Vietnamese Association of Connecticut, and the Lao Association of Connecticut (the Coalition). I am submitting comments on the Practice Transformation Task Force's report on Primary Care Payment Reform, dated February 1, 2108, on behalf of the Connecticut Southeast Asian American Health Coalition.

    First, the Coalition would like to commend the Task Force for its ambitious report on the limitations of the state's shared savings reforms and for its recommendations for transforming primary care. The Coalition agrees that the Fee-For-Services (FFS) model does not promote the overall health of primary care patients. The FFS model only rewards providers who schedule more patient visits, order more tests, and negotiate higher fees with payers. It also limits the time providers spend with patients and does not allow for the engagement of other care team members, such as community health workers, whose services are not payable on the fee schedule. The Coalition also supports most of the Task Force's recommendations for primary care payment reform. The Coalition does have a few comments to make about gaps in the report, however. These comments are not intended in any way to detract from our overall support of its recommendations. Our Southeast Asian American community members are concerned about two issues that did not seem to surface in the Task Force's report.

    First, the need to mandate that providers collect, report and analyze demographic data on patient populations. The Community and Clinical Integration Program (CCIP) states as a goal "introducing new care processes to reduce health equity gaps" (p. 5). Category 4 payment models are called "population-based" payments (with no definition of what constitutes a "population"), implying that primary health care would be concerned with improving the overall health of certain groups of patients (p. 20). The LAN PCPM report recommends that primary care practices be held accountable "for demonstrating success on metrics of patient access, quality of care, comprehensive provisions of services," and the like (p. 13). Payers want providers to demonstrate accountability for their upfront payments. Accountability requires evidence-based monitoring and reporting. Health equity, population studies, accountability for success---all of these essential components of primary care payment reform assume the need for data.

The Coalition recommends that the Task Force include a mandate for providers to collect extensive demographic data, such as age, gender, primary language, race, and ethnicity, including smaller ethnic subgroups currently subsumed by the OMB's pan-ethnic categories. Without that data, it will be impossible to identify or improve health inequities. Without that data, there can be no metrics of success. Without that data, providers cannot demonstrate to providers their successes in improving the health of various populations. The various recommendations imply the need for demographic data, but the Task Force recommendations do not expressly require the collection of that data.

Response: Thank you for this comment. The Task Force will include requirements in the PCM program design for the collection *and use* of demographic data, such as age, gender, primary language, race, and ethnicity, including smaller ethnic subgroups currently subsumed by the OMB's pan-ethnic categories, along the lines of what is currently required under the Community and Clinical Integration Program, Health Equity Improvement Standard, Part 1. In addition, as a broader consideration, Recommendation #9 has been edited to make reference to the use of more flexible payment models to promote health equity.

32. Second, the failure to consider the hidden costs of providing language services to Limited English Proficiency (LEP) patients, and to acknowledge the role that community health workers play in providing access to health care for many of the Limited English Proficiency (LEP) patients in the state. The Task Force report does not acknowledge that LEP is a significant barrier to health care for the over 730,000 people in Connecticut who do not speak English as their primary language. Neither does the report focus on the role that community health workers play in ensuring access to health care for LEP patients. Community health workers provide language interpretation and translation. Because providers are not reimbursed for taking the time for language interpretation, or for providing language services, LEP patients are often denied access to primary health care.

    The issue of how to reimburse providers for providing federally mandated language services did not seem to be part of the Task Force's considerations. While community health care workers were often mentioned in the report, there was no recognition of their role in providing language services. This failure to reimburse providers for the use of community health workers as language interpreters results in unserved, or underserved, LEP health care patients. It should be noted that many of the alternatives to office visits referred to in the report, such as e-consults and text message support, require literacy and English proficiency. The Coalition is also concerned that many of these alternatives assume that patients have computers and know how to use them—an assumption that cannot be made of most Southeast Asian refugees. LEP patients, as well as many elderly patients, are often on the wrong side of the digital divide. Reliance on e-Health, without translation support for LEP patients or assistance for those without computers, may result in more health inequities.

    The Coalition is grateful for this opportunity to make public comment on the Primary Care Payment Reform report. Our comments reflect two issues that are of great concern to the Southeast Asian American communities that we serve: the silence about the need for data, and the failure to consider the hidden costs of providing LEP language services. Thank you very much for your consideration.

    Response: Thank you for these comments. The report has been edited to make several references to language interpretation and assistance services (see e.g., page 30). In addition, the Task Force will include requirements in the PCM program design regarding the provision of language services for Limited English Proficiency (LEP) patients.

33. I am interested in this initiative- my concern is Even if there is bundle and upfront payments there are documentation that is always required when such payments are made with threats of recoupment if measures are not met. I would like to partake in residency training to train the next generation of physicians to retain them and ourselves in CT.

    Response: Thank you for these comments. As part of the planning process, we will consider the documentation that is typical of bundled or capitated payment models with the aim of determining the

minimum necessary requirements to support both clinical care and the payment model. The Task Force believes that this initiative must achieve a net reduction in the documentation requirements relative to today's fee-for-service primary care environment.

34. This draft presents the possibility to rejuvenate and remake primary care in the state of CT. WE are a small state with multiple medical schools and training residencies- our care should top the charts, but without time to devote to prevention, improving diseases, and coordination of care for the patients- this has not happened. When you think about it, the primary care provider drives the cost of the system down if they have the time needed- we keep patients out of the hospital, same day visits keep patients out of urgent care, and we know our patients so prevent medication interactions or use of medications that a patient has had an adverse effect with. Multiple studies have discussed the burnout rate currently for doctors in primary care- we are completing 2 hours of paperwork for each hour of patient care; this needs to be revolutionized. Lastly, as the state with the highest percentage of docs in the retirement age cohort- we need to attract new doctors. This is my opinion as a doctor in primary care and the education of medical students and residents.

    As the governor of the CT chapter for the American College of Physicians, the largest subspecialty organization representing 150,000 internal medicine doctors worldwide- I agree that this draft report is aligned with current ACP policy – putting patients before paperwork, team based care, high value care, reducing readmissions, and the PCMH model, which has evolved a bit since the joint principles from about 10 years ago now, but it still in place. The ACP is also a founding member of the Patient-Centered Primary Care Collaborative (PCPCC, www.pcpcc.org).

    Response: Thank you for these comments. The Task Force concurs that we must use this opportunity to substantially reduce the paperwork burden on practice physicians and nurse practitioners in order to make more time available for patient care, reduce burnout, and attract the next generation of primary care physicians in Connecticut.

35. We commend the SIM program on the comprehensive draft report titled "Primary Care Payment Reform - Unlocking the Potential of Primary Care." The transformational recommendations for multi-payer primary care payment models will: (1) diversify and expand the primary care team, (2) allow flexibility for payment of both patient encounters and non-visit care, and (3) provide prospective payment for new services. The report's recommendations and proposed payment models reinforce the feasibility of pharmacist integration into expanded primary care teams.

    Although the Connecticut SIM program has a practice standard for comprehensive medication management (CMM), its implementation has been diminished by the lack of a payment mechanism for primary care providers (PCPs) to engage pharmacist services or integrate pharmacists into primary care teams. We offer the following comments and examples of integrated primary care pharmacist services and payment models as you finalize the report and consider a multi-payer demonstration project.

    *Pharmacists on Expanded Primary Care Teams*
    Expanded primary care teams with clinical pharmacists allow for the diversification of the team's skills and expertise. Pharmacists' specialized training is complementary to the skills of PCPs, and includes chronic disease medication management, preventative care, and wellness services.

    Primary care pharmacists provide a variety of medication optimization and management services that are delivered by face-to-face encounters and non-visit services. The initial visit between a primary care pharmacist and patient should be in-person to establish a trusted working relationship. Follow-up visits may be conducted either in-person or through non-visit based methods based on the patient's needs and preferences.

    Non-visit medication-related services can improve the flexibility and access to care for primary care services. Telephonic services provided by a pharmacist for improved medication use and safety can positively impact various outcomes, including: (1) reduction in preventable hospital readmissions/emergency department

(ED) utilization, (2) improvement in patient-specific therapeutic treatment goals, and (3) improvement in medication management during care transitions for high-risk populations (e.g., post-Ml, COPD, CHF).

*Pharmacists Impact on the PCP "Joy of Practice"*

Primary care pharmacists can help PCPs achieve the Quadruple Aim through the use of collaborative practice agreements (CPAs) with physicians as specified in the State of Connecticut Pharmacy Practice Act. 13 14 This approach can allow for: (1) efficient practice workflows for medication optimization and safety; (2) relief of PCPs' medication-related "administrative tasks," such as medication refills and resolution of telephonic/faxed medication-related inquiries; (3) increased PCP capacity to focus on acute or more complex patient needs; and (4) closure of the physician shortage by utilizing the pharmacist to manage the medication regimens of high-risk chronic care patients.

Pharmacist e-consultations (e-consults) are a practical solution for PCPs to improve "on-demand" access to clinical pharmacist expertise as pharmacotherapy specialists to: (1) assess complex patients' medical histories and medication regimens, and (2) make timely, actionable recommendations that optimize patient outcomes and minimize medication-related problems. For some patients, e-consults between PCPs and pharmacists may avoid the need for more expensive referrals to medical specialists for medication-related assessments or management. Of note, a clinical pharmacist e-consult service with PCPs is currently being planned through the Community e-Consult Network (CeCN) in Middletown, CT.

*Payment Models for Primary Care Pharmacists*

We support the proposed primary care payment models (PCPM) recommended in the draft report. We believe that a combination of bundled and population-based payments is necessary to provide practice-level flexibility in team-based care delivery transformation.

Below are examples of innovative, value-based payment models that have been implemented in demonstration projects to improve medication use, safety, and cost-effectiveness. These examples of capitated, bundled, and pay-for-performance payments for pharmacist services could be considered for future multi-payer payment models.

Per Member Per Month (PMPM) Payments

a. Cincinnati-based Patient Centered Medical Home (PCMH) Practice and Kroger Pharmacy: a demonstration project was completed between Kroger Pharmacy and one PCMH practice in the Cincinnati area. Kroger pharmacists offered various medication management services to high-risk patients within the practice (e.g., inability to reach therapeutic goals for diabetes, hypertension, and hypercholesterolemia). This model used a capitated payment fee of $15-$20 per member per month (PMPM) for patients seen/managed by the pharmacist. The payment model was structured after the Comprehensive Primary Care (CPC) initiative to determine if this approach was practical for community pharmacist payment for medication management services within a PCMH. The study demonstrated that pharmacists produced significant reductions in hemoglobin A1C and systolic blood pressure from baseline after 1year compared to a control PCMH practice within the area. Although total cholesterol levels improved, they were not significant.

b. Community Pharmacy Enhanced Services Network of North Carolina (CPESN): CPESN is a network of community pharmacies that is engaged in medication management activities with primary care practices attributed to the Community Care of North Carolina (CCNC). CPESN pharmacies are involved in services aimed at improving medication adherence, care transition medication safety, as well as preventative care and chronic disease state management. Pharmacists help to develop e- Care plans with clinical nurse coordinators and primary care physicians using a common electronic health record platform and communication tool. In this model, pharmacists are members of the community-based health team. CPESN pharmacies are paid $5-$40 PMPM based on patient risk scores and the pharmacy performance to provide medication management services for attributed high-risk patients. The current 7 pharmacy performance measures include: risk-adjusted total cost of care, hospitalizations, and emergency

department visits; Medicare STAR measures of adherence to anti-hypertensive medications, statins, and diabetes medications; and adherence to multiple chronic medications. The 3 risk-adjusted cost and utilization measures are weighted higher than the adherence measures. Pharmacy PMPM payments are only paid if the pharmacy submits to CCNC either a new or updated pharmacy care plan for the patient. The CCNC payment model was part of a CMMI award and is currently being analyzed for its impact on clinical outcomes and total health care costs.

*Bundled Payment*

a. Connecticut Medicaid Medication Management Demonstration Project: in 2009-10, we implemented a CMS Medicaid demonstration project in 4 federally qualified health centers (FQHCs) for beneficiaries with multiple chronic diseases and chronic medication regimens. Nine embedded, part-time clinical pharmacists met with 88 patients (401 encounters total} over 6 months to identify and resolve drug therapy problems (DTPs). Pharmacists identified an average of 2.3 DTPs per patient and resolved approximately 80% of DTPs after 4 pharmacist-patient encounters. Approximately 78% of the DTPs were resolved without requiring the patient to make a separate appointment with the PCP (e.g., changing the timing of medication administration to eliminate adverse drug events/drug interactions; preventing abrupt discontinuation of chronic medications; timing of medication administration relative to home monitoring). At the end of the study, patients had a 28% improvement in the rate of achieving treatment goals (i.e., control of blood pressure or hemoglobin Ale) consistent with evidence-based guidelines. This study used a bundled fee-for-service (FFS} approach to pharmacist payment, where CT Medicaid paid a fixed bundled fee for an initial visit and up to 5 follow-up patient encounters (i.e., averaged $2-3 per minute of pharmacist time). There was an estimated annual saving of $1,123 per patient on medication claims and $472 per patient on medical, hospital, and emergency department expenses, resulting in an approximate return on investment (ROI) of 2.5:1.

*Impact on Pay-for-Performance Payments*

a. Commercial Insurer with South Dakota and Iowa Primary Care Clinics: a pay-for-performance pilot project was implemented by a commercial insurer with primary care clinics in South Dakota and Iowa. The project assessed the impact of clinical pharmacist medication services on medication- related performance measures (Healthcare Data and Information Set, HEDIS). Three pharmacists performed medication therapy management (MTM) and disease state management in 3 primary care practices. The goal was to improve therapeutic and clinical outcomes for diabetes, hypertension, hypercholesterolemia, and asthma. The study demonstrated that HEDIS performance scores for the study practices that embedded a pharmacist were higher than the national average.

b. Minnesota Blue Cross Blue Shield Demonstration: a study was conducted in 6 ambulatory care clinics across Minnesota to determine the impact of pharmacist-provided MTM services on clinical and financial outcomes for commercial insurance beneficiaries with chronic diseases. HEDIS measures for hypertension and hypocholesteremia in the pharmacist intervention group were compared to BCBS patients who did not receive pharmacist services. The results demonstrated that primary care pharmacists can improve clinical goal achievement for chronic diseases states (e.g., hypertension, hypercholesterolemia). Additionally, HEDIS measures improved in the intervention group compared with the comparison group for hypertension (71% versus 59%) and cholesterol management (52% versus 30%). Total health expenditures decreased from $11,965 to $8,197 per person, producing a positive ROI of 12:1.

c. Health Partners Multi-payer Comprehensive Medication Management (CMM) Program:

   HealthPartners, is an integrated health care organization providing health care services for more than 1.2 million patients in Minnesota and western Wisconsin that have multiple payers -- HealthPartners insurance, Medicare, Medicaid, and commercial insurers. Pharmacists provide CMM services and take responsibility for the medication-related patient outcomes using HEDIS measures, focusing on the whole patient, and optimizing their entire medication regimen.

A randomized controlled clinical trial studied the program's effect on hypertension - uncontrolled hypertension study patients who received their usual care from a physician were compared with a similar patient group who received pharmacist-provided CMM with a tele-monitoring component.

The pharmacists used a broad collaborative practice agreement to adjust blood pressure medications based on home blood pressure values. Pharmacists worked actively with patients for 12 months and then followed by 6 months with no intervention.

By the 6-month mark, 71.8% of CMM patients had their blood pressure under control, compared with 45.2% of the usual care group; at the 12-month mark, it was 71.2% versus 52%. At the 18- month mark-6 months after the CMM group stopped receiving pharmacists' services-the CMM group's lead was steady at 71.8% versus 57.1%.

Although not reported in these studies, our pharmacy colleagues have commented that the primary care organizations' pay-for-performance/care quality incentive payments were a major source for the pharmacists' compensation as a member of the primary care team.

We strongly encourage the CT SIM PMO to pursue a CMS 1115a waiver for a Connecticut multi-payer primary care demonstration project to align payers towards a value-based payment system. Such a waiver would provide practices with the ability to develop and test new payment models for primary care pharmacist integration. Additionally, this demonstration could help the SIM Community and Clinical Integration Program (CCIP) advanced networks and FQHCs to add pharmacists on care teams to implement core and elective practice standards, (i.e., complex care management, comprehensive medication management, and e-consults).

*Connecticut SIM 1115a Waiver*

As SIM moves towards the establishment of health enhancement communities (HECs), we advocate that community pharmacists are included as a community-based health professional resource for patients with complex health and medication-related needs. Community pharmacists are highly-accessible health care professionals and are actively involved in health promotion/disease prevention programs. In addition, many community pharmacists work with other health care professional and social agencies to resolve community-specific health care gaps.

*Going Forward*

The UConn School of Pharmacy is well positioned to work with the Connecticut SIM Program on a multi-payer demonstration project to advance primary care delivery through new payment arrangements. We can offer our expertise in integrated primary care pharmacist services to: (1) develop and facilitate provider/payer educational modules on value-based pharmacist payment models; (2) plan, implement, and evaluate pharmacist services in the demonstration project; and (3) advise the SIM program management office and related workgroup members.

Response: Thank you for these comments. Your comments provide compelling evidence regarding the value that pharmacists can provide to improving patient outcomes and reducing avoidable utilization as part of a primary care team. The Task Force has previously recognized the value of pharmacists and Comprehensive Medication Management (CMM) by including elective CMM standards in the Community and Clinical Integration Program (CCIP). As part of the planning process, we will consider the recommended roles and functions of pharmacist consultants as well as the level of pharmacist support that might be needed depending on the level of risk that characterizes a practice's patient population.

On behalf of Starling Physicians, Connecticut's largest independent multispecialty group practice, I am writing to express support for the Primary Care Payment Reform proposal developed by the Practice Transformation Task force. The current fee-for-service payment system often has a negative impact on the patient-provider relationship. Concern for what services will be reimbursed can interfere with providers' ability to address Whole Patient care. The proposed upfront/bundled payments will allow providers to begin

to address the diverse (and often non-medical) needs of patients through direct services and enhanced ability for self-management in the community.

Response: Thank you for these comments.

Yale Primary Care Progress Statement: This proposal is a step in the right direction towards primary care payment and practice reform. We need more flexibility in how primary care is paid for so that we can take further strides towards innovative, patient-centered, and inter-professional care. This is especially needed for patients with significant psychosocial health issues that fee-for-service medicine repeatedly fails. Right now it financially makes more sense to hire another clinician to address biomedical diseases through 15 to 20 minute visits than to hire a community health worker when what many patients need is someone to visit them at home, help them figure out how to schedule physical therapy, arrange transportation, and most importantly listen to them and make them feel heard. We need payment to align practitioners more closely with patient health and wellbeing, which is what full risk sharing will lead to.

Response: Thank you for these comments, which aptly describe our central intent with these reforms—flexibility in the service of more patient centered care.

Comments and Questions Received from Members of the SIM Consumer Advisory Board in Response to a Presentation about the Report

36. Ann Smith asked when Dr. Schaefer was commenting on the slide about Primary Care Modernization capabilities, was it an oversight, intentional, or not an important element of the model to include Behavioral Health Integration.

    Response: The omission was an oversight. The slide correctly reflects the importance of Behavioral Health Integration, which will need to be included in the Primary Care Modernization design, consistent with Recommendation 8 of the report.

37. Jan Van Tassel said PTTF Recommendations mentioned that providers need to be sure that they are able to measure quality and under-service. She said that this needs to be part of the package. She asked are we going to have an effective way to measure quality and measure under-service?

    Response: Recommendation 10 acknowledges the importance of measuring quality. It is not known at this time whether additional quality measures will be recommended above and beyond those primary care quality measures that are already part of each payer's shared savings program arrangement. We continue to encourage all payers to adopt the Core Measures recommended by the SIM Quality Council.

    Recommendation 10 also speaks to ensuring that providers demonstration transformational change. This recommendation has been further modified to reference the importance of monitoring level of service and equitable access. We envision that the EHRs of participating practices may be required to report the number of patient "touches" in addition to direct patient encounters.

    - **Recommendation 10:** Payers that utilize primary care payment models should a) ensure that quality of care is measured and rewarded, b) should employ minimally burdensome methods that are aligned across payers for comparable populations (e.g., Medicaid, Medicare, commercial) to enable practices to demonstrate that they are investing in and have implemented transformational change (e.g., care team composition, engagement in non-visit-based activities), and c) should monitor to ensure that the changes result in appropriate level of service and equitable access.

38. Robin Lamott Sparks described a meeting about Integrated Mobile Health held because 60% of 911 calls in their community are not emergencies. If people call 911 for healthcare, care coordinators do not get to see them. Robin Lamott Sparks said we have not talked about integrating the existing system and transition. She noted the need to address what is going on in the cities.

Response: OHS recognizes that misuse of 911 is a problem that undermines our efforts to ensure that patients get the right care, in the right setting at the right time. We will need to examine areas where work with related systems, agencies and policies may be needed to better support primary care patient engagement and the use of enhanced primary care teams and capabilities.

In addition, bundled or capitated payments can provide the opportunity for practices to create new creative partnerships that support a better, more person-centered care experience, while also reducing avoidable costs. For example, Commonwealth Care Alliance used the flexibility afforded by capitated payment to payment for community paramedicine as an extension or enabler of advanced primary care. OHS is currently participating in a Mobile Integrated Health Workgroup convened by the Department of Public Health. Depending on the outcome of this work group process, the PCM initiative may afford an opportunity for Advanced Networks and FQHCs to design and test local community paramedicine partnerships.

39. Arlene Murphy asked for clarification of exactly what is being proposed and the time frame. The PTTF recommendations talk about needed improvements in primary care. What exactly is being proposed and how will risks be addressed? What would be the proposed concept paper Medicare request?

Response: In October 2017, the Center for Medicare and Medicaid Innovation (CMMI) invited State Innovation Model (SIM) states to propose state specific multi-payer demonstrations as a means to sustain and build upon the payment reforms that they have undertaken through SIM. A multi-payer demonstration enables Medicare participation in State-directed reforms. It also provides the opportunity to tap Medicare resources to help finance reforms. SIM states have a time-limited opportunity to use their SIM grants to fund the considerable cost of planning for a demonstration. In order to be considered for a demonstration, CMS requires the participation of Medicaid and the state's largest private payers, and the support of stakeholders. In order for Medicare to participate in a SIM model under this pathway, the model must meet the set of principles outlined below, and be an Innovation Center test of a novel model under section 1115A authority. In other words, the demonstration would require a **Medicare** waiver. A waiver would not necessarily be required for Medicaid, if the Department of Social Services elects to participate.

OHS has begun examining how a multi-payer demonstration could provide a means to implement Primary Care Modernization as well as a second initiative focused on rewarding provider and community partners for enhancing community health. This second initiative is called the Health Enhancement Community (HEC) initiative. The slide presentation from the April meeting of the Population Health Council is the best way to become familiar with what this initiative is about.

CMMI has set forth principles that it would consider in reviewing a state's proposal for Medicare participation in a multi-payer model that could require specific new waiver authority to align Medicare with the model. These include the following:

1) patient-centered,
2) accountable for total cost of care,
3) transformative,
4) broad-based,
5) feasible to implement and
6) feasible to evaluate.

The process of seeking a demonstration begins with a State's expression of interest to its SIM project officer. After this expression of interest, there are three steps to negotiating a demonstration as follows:

- **State submits proposal to CMS on state-specific model**: To initiate the co-development process, states should be prepared to describe in a proposal the overarching payment structure they are proposing, rationale for selecting that structure, and rationale for why this cannot be accomplished through an existing CMS model or program. States should also articulate their vision for payment delivery reform, how Medicare participation advances that goal, and what else it will take to achieve that vision. A proposal can be submitted to CMS at any time and can 4 be submitted at the same

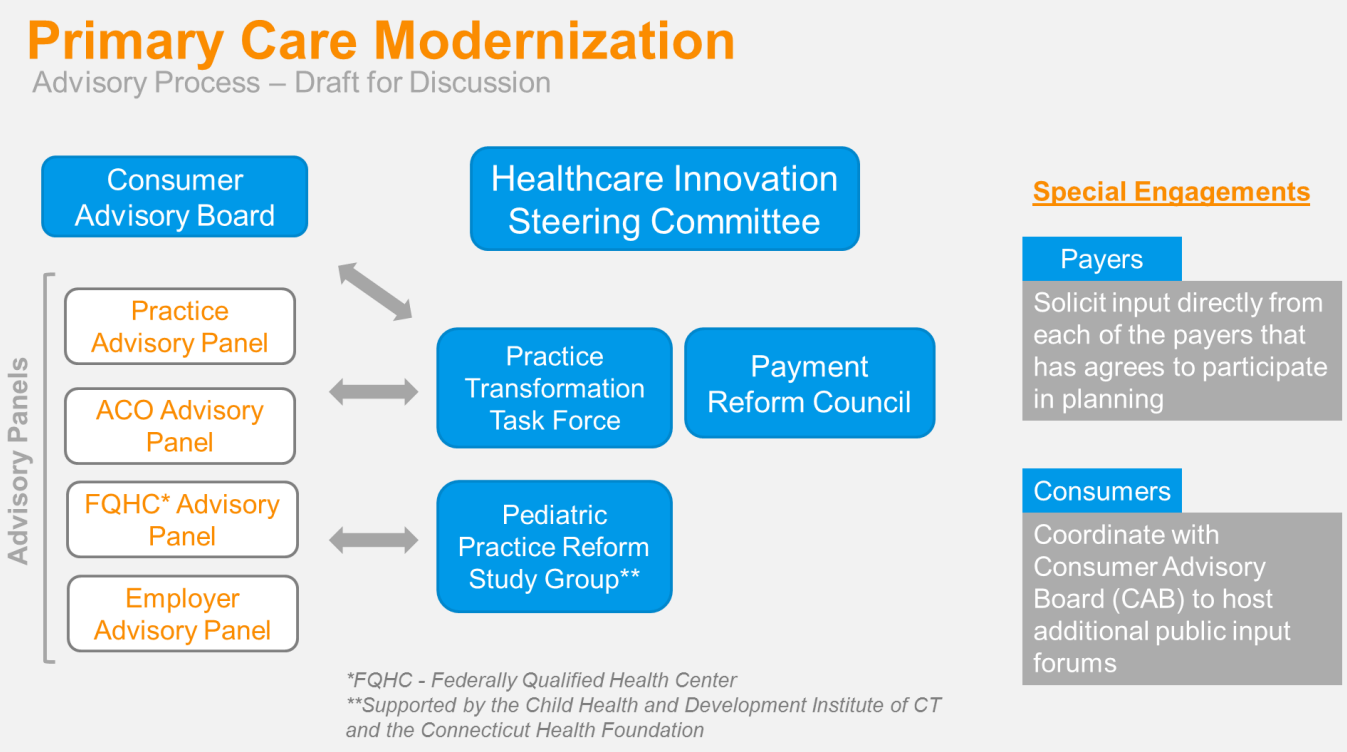
time as when a state and the Innovation Center begin to engage in a series of discussions on a potential state-specific multi-payer model.

- **CMS and state co-develop high-level parameters of state-specific model**: Through a series of discussions, the Innovation Center and the state will work to come to agreement on a viable model design that meets the criteria outlined below including the high-level parameters of the model (e.g. overview of payment structure, framework for financial targets achieved under the model, population health and quality goals under the model and goals for healthcare provider and multi-payer participation and lives covered by the model).
- **CMS and state enter into in-depth negotiations to co-develop model**: Negotiations will include identifying the financial, quality and scale targets that the state will commit to, and identifying the Medicare program/policy waivers and operational considerations that CMS would need to provide to give the state the flexibility to operate the multi-payer model and that is necessary to test the model. The goal of the negotiations is to develop an agreement between CMS and the state on the terms of the state-specific model with Medicare participation. Such an agreement would be signed by the Innovation Center and the Governor of the state.

OHS anticipates submitting an initial proposal after the conclusion of the next phase of PCM and HEC planning, which we are projecting will be in the fall of 2018. More information about this process can be obtained from https://innovation.cms.gov/Files/x/sim-medicare-mpmodelsguidance.pdf.

40. Ann Smith noted the importance of consumer input at the beginning of the process. She said that we have been hearing from consumers on how the Connecticut system does not serve them. She said that there is not an understanding how the proposed Primary Care Modernization model will do this.

Response: OHS has proposed to modify the *draft* Advisory Process to include the Consumer Advisory Board as a key advisor early in the planning process and throughout the process. In fact, we would propose to have the Consumer Advisory Board be the first advisory panel that we engage in early June as we begin the planning process with our new PCM consultant. We would then circle back to the Consumer Advisory Board on one or more occasions to get feedback on the provisional model design. The revised *draft* Advisory Process is illustrated below:



Most of the design work would be done by the work groups in the center of the model. The Practice Transformation Task Force would be responsible for defining the practice capabilities that would be a focus of the initiative. The Payment Reform Council would recommend more specific payment methods that would enable these capabilities. The Advisory Panels have a relatively limited role. They would be consulted early in the process to provide input into their reform priorities and then later in the model to provide feedback on the provisional program design. The same two step approach is envisioned for the payer meetings.

41. Ann Smith stated that there must be a focus on CHW's in workforce development as they are in communities and can develop rapport with residents. If we do not have this, then bundling primary care payment is not going to get us to where we want to be in terms of improvement and healthcare outcomes for those with substandard healthcare.

    Response: CHWs will feature significantly in the program design likely serving various roles such as health coach, navigator, care coordinator, linkage to community services and language support. The question regarding planning for an adequate workforce will be referred to the CHW Advisory Committee for consideration, once they have completed their certification study.

42. Terri Nowakowski stated that until you have trusted members of every community who can sit alongside the clinician, you are never going to get what is going on in that person's life. She noted that Community Health Workers are often paid very little in primary care settings but are tasked with trying to manage so much that it is impossible. It is all about someone being able to go into homes and the community to what is going on and we don't have that today.

    Response: See response to question #42.

43. Jesse White-Frese stated there is a need to have a deeper understanding of the multiple needs that so many families have and how difficult things are for them to manage in primary care.

    Response: Quite a bit of information is available from listening forums of the Consumer Advisory Board and other sources, both Connecticut specific, and more broadly, about the barriers that interfere with the effective use of primary care. We are open to considering additional listening forums or focus groups with the Consumer Advisory Board if more information or a deeper understanding is needed. However, we also suggest that patient and family advisory councils might be the best long term strategy for ensuring that providers are self-evaluating their services and making changes over time in response to consumer input. This is especially important if the new payment models provide them with the flexibility to make changes in real time, without having to deal with the limitations of fee-for-service.

44. Bob Krzys said that whatever services are in the bundle whether they include CHWs, behavioral health, transportation, telemedicine, there may be some parts that are so profound that they would have to be essential health benefits. One thing that must be addressed is workforce.

    Response: The Task Force supports this recommendation. We envision that the bundle(s) will be accompanied by certain "essential benefits" or capabilities, while also leaving room for flexibility and innovation. Part of the design work over the coming months will be distinguishing *essential* from *elective*. For example, it might be the case that every practice is required to have a collaborative agreement with a consulting pharmacist and to offer patients the option of video appointments (when clinically appropriate), while only a few might elect to contract with a community paramedicine partner or a community based provider of diabetes self-management services.

    Once the model is defined, we will need to project the workforce needs that are likely to emerge as a result of the initiative. Part of the rationale of staging the initiative, with respect to capabilities and funding, is to provide time for workforce supply to meet demand.

45. Kevin Galvin said one thing he finds exciting about this is the care coordination. He said one of the challenges with it is the fact that as we all went through the ACA people might argue that we didn't do a

very good job of bringing the people into the primary care arena. He asked whether there will be a methodology to bring people into the primary care arena from the different segments of our communities to make it as robust a population as possible.

Response: By offering practices a bundle or capitation, there is more of an incentive to do outreach to get patients assigned to their practice and to keep them engaged in care. In addition, by risk adjusting the payment (clinically and based on social risks), practices will be more receptive to higher risk patients. Of course, practices will need to have capacity on their panels in order to outreach and engage new patients. We anticipate that the expansion of the care team and the use of more efficient methods of patient care and support will enable practices to increase their panel size beyond what they have today under fee-for-service.

46. Kevin Galvin asked whether workforce development should be more at the front end of the discussion in the development of this. He said they should consider developing the workforce population.

    Response: Once the model is defined, we will need to project the workforce needs that are likely to emerge as a result of the initiative. One of the reasons for waiting until the model is further defined is because we are not certain which members of the workforce will be required under the model and at what volume. Part of the rationale for staging the initiative, with respect to capabilities and funding, is to provide time for workforce supply to meet demand.

47. Jesse White-Frese asked whether capitated payments are made by the insurance companies to the providers. She asked whether the rates paid to the providers different for every payer for the same requirements.

    Response: Under the proposed model, commercial and public payers would pay for services through upfront bundles or capitation, while some primary care services would remain fee-for-service. Currently, there do not appear to be many primary care capitation arrangements in Connecticut.

48. Alan Coker asked whether anyone was familiar with the WISE program. He said it is run through the Department of Mental Health and Addiction Services (DMHAS). It provides a case manager and recovery assistant to check on patients several times a week. He said the program is good and he thinks we could borrow from what they do and what is being recommended for primary care. He said the program is active and is state run. He suggested looking at what they do and "piggy back off" of this program.

    Response: During the review process that informs the next phase of planning, we will examine the WISE program and other programs that might inform the design of our PCM model.

49. Ann Smith noted if we don't have the needed infrastructure to support this initiative, we won't be able to realize the potential it proposes for us. She asked how we are going to develop a robust pool of CHWs that will be inclusive and representative of the communities being served. This should not be a one size fit all strategy. How are cultural sensitivities going to be addressed? Ms. Smith raised the concern that initiatives are often not presented in understandable language. By the time consumers become involved, the initiative is set in stone and it is too late to make changes. The timeline for this initiative is too aggressive.

    Response: OHS acknowledges the importance of infrastructure for both planning and implementation. The ambitious timeline for this initiative is based in part on access to planning dollars through SIM. These dollars can also be used to cover planning and pre-implementation costs; however, they are only available until early 2020. A 2020 implementation target for a demonstration offers the possibility that the demonstration will provide new source of funds to support care delivery reform after the SIM grant ends. Finally, some of our accountable provider stakeholders feel that helping their networks is critical and time sensitive due in part to high levels of frustration and burnout.

    The Task Force will take into consideration the importance of ensuring that we do not impose a one-size fits all solution. It is likely that we will recommend certain core capabilities for all practices, while recommending other capabilities depending on the characteristics of the practice, the goals of the practice,

their patient population and the communities they serve. Urban practices serving vulnerable populations are likely to need a different care team composition than a suburban practice in an affluent community. Similarly, practices that focus on older adults with chronic conditions will need different capabilities than practices that serve a younger employed population.

As noted previously, we are planning to include Consumer Advisory Board input at the start of the process. However, our goal should perhaps be to connect provider organizations with patient and family advisory councils that can help ensure that there is a consumer informed continuous improvement process over time.

50. Robin Lamott-Sparks said that what is missing is another layer to figure out a linkage to fit with the community and what is happening at the ground level. She said there should be a solution that works for the community and not be just sitting there and nobody uses it.

    Response: This comment seems to underscore the importance of ensuring ongoing engagement by the accountable provider organizations with the communities they serve to ensure that the solutions are relevant and responsive. Moreover, this would seem to be a caution against the pursuit of overly-prescriptive and inflexible standards developed by state-level groups.

51. Velandy Manohar said there should be someone looking at all the information coming in. He noted it will take a tremendous effort otherwise there will be silos.

    Response: OHS will contract with a PCM consultant that will be responsible for gathering and synthesizing all of the information that informs the planning process and using this information to solicit design input from the work groups, the advisory panels, and the Consumer Advisory Board.

52. Arlene Murphy asked whether there is a way to have more consumer participation at the beginning of this process. She said not just practices talking here and consumers talking there but people around the same table to communicate with each other. She asked whether this is a good next step.

    Response: OHS has proposed to modify the *draft* Advisory Process to include the Consumer Advisory Board as a key advisor early in the planning process and throughout the process. In fact, we would propose to have the Consumer Advisory Board be the first advisory group that we engage in early June as we begin the planning process with our new PCM consultant.

    We agree with the importance of having people around the same table communicating with each other. The draft Advisory Process currently has three groups for multi-partner discussion including the Steering Committee, the Practice Transformation Task Force and the Pediatric Study Group. We are asking the Child Health and Development Institute to add additional consumers to the Pediatric Study Group. These groups include a mix of consumers, practices, healthcare organizations, health plans, and state agencies.

53. My research took much longer than I expected. This is very important data-dense and document- rich endeavor that we are all deeply committed to which includes this most important PC modernization Initiative. Failure is not an option. Three out four documents provide a ringing endorsement for the inclusion of Consumers only one doesn't. We can do better than 75%. We are almost at 4.0 why settle for anything less than the top score like 3.0
    1. I have previously expressed my overall support for the PCM Initiative: To reiterate I fully endorse this statement from page 1, Item II. "Improving Primary Care is the Key to better care, spending, and healthier people and communities… "It will double primary care spending, so doctors can provide more support and increase flexibility to make care better and more convenient for patients.
    2. What are proposing? This is key for me for this Initiative:" The new office of Health Strategy OHS is Partnering with Physicians, Payers and Consumers to launch a Primary care modernization initiative. [PCMI]
    3. How will this be different from other care delivery and payment models? CT Physicians, Payers and Consumers will participate in the development of the model by defining the new ways of providing care and stages of change that will take place over a five- year period. [All three Stakeholders Must to be involved in

the process through the whole process of planning, implementing and monitoring the impact of the potentially transformative Primary Care modernization initiative. VM]
4. How will it work? [PCMI] OHS will engage ACO practices, FQHCs, Employers, Payers and Consumers through committees, panels, and special engagements. [One of these vital stakeholder engagement strategies is described exquisitely in Item IV especially in the text and pages in 3-8. VM]
5. [How will it work?] "The Stakeholders [this includes Consumers] will develop a model that includes: critical components of PCMI including "Care-team Capabilities, payment Model Design, Staging, Reporting and Technical assistance." [VM]

Response: Thank you for these comments.

Questions and Comment on April 5th CAB Meeting Presentation Slides (12 pages)
1. Opportunities for PCM (page 2) I like the contents of this document, but I am irrevocably opposed to the plans that will sideline consumers and discount steeply the primacy of the consumer's role accorded in the foundational documents I have cited above at the formative stages of the PCMI. Illustration on page 2 on medication compliance is of colossal importance- and demands major changes in funding and delivery of medical services.
2. I like this clear, pithy, accurate concluding statement of the severe limitations of the current payment system. (page 4) I also like and support this; Recommend Multi-Payer demonstration organized around the following recommendations: [Parenthetically I was disappointed we didn't get a chance at the same or another meeting to review discuss and vote on each of the 11 worthy, creative, useful Recommendations.
3. I emphatically endorse Recommendation #1. (page 5) Once we restore the co-primacy of Consumers with other stakeholders namely Physicians, Hospitals, and other providers, Policy advocates, Researchers and Advocates from Page 5 of 5 of Item #I and Page 11 [List of Advisory Panels of 12 of Item # III] we will be ready in CT to lead the Nation in PC Payment Modernization. Recommendations 1, 2, and 3 are an important cluster of innovative initiatives.
4. Recommendations 5 and 6: I like these creative and just solutions and support the implementation.
5. Recommendation 7: I support full implementation ASAP. Recommendation 8: Strongly support this innovation. Recommendation 9. This must be carefully monitored and fully funded as needed. All three recommendations are very important components of any reform effort anywhere.
6. Recommendation 10: It is crucial, must be funded and the evaluations system must be cued in to start from the very first day of operations. Recommendation11: This is 100% accurate. Primary Care Payment models should be multi-payer, cover the majority of a practice's patient population, and provide practices with external coaching support and technical assistance.
7. Pages 8, 9 and 10 are very helpful. It is essential part of any document that seeks to illustrate the components of plans under consideration and the processes that can impact on stakeholders.
Importance of Consumer Involvement
The CAB Comprehensive Multi-Channel Consumer Engagement and Communication Plan is a crucial document which will explain why Consumers need to be involved: Engaged, Educated and empowered to take their rightful place in the PC Payment modernization planning process
The three proposed focus areas for future Community engagement and Communications Plan activities:
I. Influence Systems: ORGANIZE CONSUMERS to INFLUENCE THE DESIGN AND IMPLEMENTATION OF HEALTH CARE REFORM INITIATIVES AND PUBLIC POLICY. This is what I am taking about.
2. Enable Providers: Engage HC providers in WHAT THEY NEED to KNOW about CONSUMER NEEDS…
3. Empower Consumers: IDENTIFY AND SHARE INFORMATION AND SHARE INFORMATION TO FACILITATE CONSUMER INTERACTION WITH THE HC SYSTEM, PARTICULARLY FOR COMMUNITIES FACING BARRIERS TO EFFECTIVE CARE. The Illustrations on Pages 5,6, and 7 and the explanatory texts clearly describes HOW THESE ACTIVITIES CAN AMPLIFY THE INFLUENCE OF CONSUMERS ON THE DESIGN AND IMPLEMENTATION OF HC REFORM INITIATIVES AND PUBLIC POLICY.
Concluding Comments

This response focusses on my concerns [Besides 2 out of 3 pages of positive comments] about the stark dissonance between the Text and Illustrations in the following Key Office of Health Strategies Documents with respect to the importance of consumers playing a deservedly pivotal role in the potentially life changing transformational process of "…combining new ways of caring for patients with flexible up-front payment. It builds on a strong foundation of patient – centered, relationship-based medicine." I have said all that I believe needs to say to influence the choice of next steps to rectify the dissonance with respect to co-primacy of the role of Consumers in the key documents. Almost of the documents, in fact only one out of the four foundational documents, Item # III, does not carry the ringing endorsement of the Consumers in each of the key documents:

I. Office of Health Strategy: OHS-CT Pages 1-5
II. OHS-CT. Primary Care- Modernization Initiative 2-page document
III. Presentation on 04 05 2018 at Special CAB meeting- Opportunities for Primary Care Modernization [PCM] Page 1-12. My additional response is available for subsequent discussion
IV. CAB Comprehensive Multi-Channel Consumer Engagement and Communication Plan-Pages

Response: Thank you for these comments. We agree that consumers are an essential voice among a multitude of stakeholders that must be engaged early and throughout the planning process. Please see response to question #52 as to how this co-primary role for consumers might be achieved.

54. Today I was at DPH as a member of the hearing Panel of the CT. Medical Examining Board. While I was being checked in to go to the Hearing Room. I saw the Scroll like document displayed in the Reception area in the Basement. I had been going in for many years as member of the Board and the Hearing Committee and don't remember really paying attention to the two scroll like documents- one in English and one in Spanish. But in the midst of these protracted negotiations I was struck by the thematic phrases: Healthy People in Healthy Communities. It struck me that my advocacy is consistent with carrying out this mission of DPH. I had always used the Reports entitled Healthy people 2010 etc. to support my advocacy efforts.

I am attaching my photograph from the front Lobby in the Basement floor of the DPH Building where we had our hearing on the third floor. This provides an over-arching set of precepts that provide context for my statements especially in the current endeavors about Primary Care Modernization Initiative Namely Vision: These modernization proposals must illuminate our efforts to support Healthy People living, working and socializing in Healthy CT Communities. One of the key items under Values is the last entry which is not the Least by any stretch of the imagination: Service oriented: We, Respect, Listen and Respond to our Customers. This and other indispensable Values such as the importance of Equitable policies and programs that promotes fairness, social justice, equity and cultural competence and to be Accountable, Collaborative and Innovative.

I later found out the information in the Scroll like document in the Lobby is based on the material published [Page 7] in the CT. DPH Strategic Plan 2013-2018 issued by Dr. Jewell Mullin, MD.

Now, after reading this document I understand better why it is very important for us to infuse and integrate these Values into the PCMI in every way possible in every step of the way if we are to accomplish this extremely, excruciatingly long delayed and worthy and essential goals embedded in Public Act No. 08-71 based on the Principle of Health Equity In passing Public Act No. 08-171, the General Assembly finds that "equal enjoyment of the highest attainable standard of health is a human right and a priority of the state".

I fully endorse this lofty goal and urge all others working on PCMI to find inspiration and strength from this clearly, unequivocally stated aspirational and urgent high priority goal. This matter of providing equitable Health Care is about our basic Human Rights as residents of CT.

NB: http://www.portal.ct.gov/-/media/DPH/Strategic-Planning/OSP_CT-DPH-_Final.pdf?la=en
CT. DPH Strategic Plan
Vision, Mission and Values

Our vision, mission, and values guide us in setting priorities by articulating our goal for the future, what we can do to achieve that goal and how we will conduct ourselves in pursuing our goal.
Our Vision Healthy People in Healthy Connecticut Communities.
Our Mission To protect and improve the health and safety of the people of Connecticut by:
• Assuring the conditions in which people can be healthy;
• Preventing disease, injury, and disability; and
• Promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.
Our Values:
Performance-based: We learn from our past efforts and use performance measures and data to focus our future efforts.
Equitable: We foster policies and programs that promote fairness, social justice, equity, and cultural competence.
Professional: We respect and uphold the high standards, skills, competence, and integrity of our professions.
Collaborative: We work together and with others who share a similar vision for the mutual benefit of the community.
Accountable: We are responsive and transparent to the public in our actions and communications.
Innovative: We are creative and seek out new ways to solve problems.
Service-oriented: We respect, listen, and respond to our customers
Principle of Health Equity In passing Public Act No. 08-171, the General Assembly finds that "equal enjoyment of the highest attainable standard of health is a human right and a priority of the state".
It is understood that barriers exist to the equal enjoyment of good health and that efforts must be directed at developing and implementing policy solutions that eliminate disparities in health status based on race, ethnicity and linguistic ability to improve the quality of health for all state residents.
The Connecticut Department of Public Health also recognizes other priority populations in its efforts to address health disparities, which in addition to race, ethnicity, and language, may be based on age, gender, socioeconomic position, immigrant status, sexual minority status, disability, homelessness, mental illness, and geographic area of residence.
CT. Dept of Public Health Strategic plan; Page 7

Response: We heartily concur with the noted importance of health equity, which has been a central element of our SIM aims since 2013. However, our work has not specifically incorporated this Principle of Health Equity as established by the legislature when it created the Commission on Health Equity. We encourage the Consumer Advisory Board to consider whether and how this principle might inform their advocacy work as it pertains to the Primary Care Modernization initiative.