CT Primary Care Modernization
Design Group: Care for Older Adults with Complex Needs

PCM Older Adults with Complex Needs Design Group Meeting 3

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- Consumer: How do we ensure no duplication of coordination efforts?
    - How will this work simultaneously with other adults who also receive coordination services?
    - FHC: You have a care coordinator in the practice. Or, the practice would contract out.
- Consumer: Shared a concern over duplication of effort and duplication of funding
    - State: This effort will set up rules to ensure the care coordination we are funding in the practice doesn't duplicate what is already being funded
        - The supplemental payment is fluid, so it supports many services
        - The bundle is flexible and fluid
- One of the areas of greatest risk- care coordination based on a host of waiver services.
    - Would it be useful to have a clinical scenario- a patient story -that allows folks to understand how the care coordination might work?
    - It's a clinical scenario, though.
- State: I used to do assessments and care coordination. Its more of a clinical nature. There is confusion on the part of the beneficiary-it's not clear. People are coming in the home and they are not able to relay whose been there and why. A waiver service is going to be coordinating and there must be some support from the primary care coordination.
    - State: You're suggesting- in any -case the primary care provider should pay for those services?
    - State: It's confusing to the individual. All this effect the plan of care. Must make sure that care manager assigned to that individual is intricately involved
    - Provider: We don't have care coordinators per say, we have a social worker. We do have a nurse as part of our chronic care management. Its difficult to operationalize that. Somebody needs to understand they're the central person for coordinating care for this individual. Its mostly patients and patient family members who come to us. How can we incentivize this?
    - FHC: Doing population health analytics, outreach to the member, we have a capability on chronic pain management.
        - Either from the patient or provider recognizing the need- PCPs must talk to the family, and if needed, make a transfer over to the specialist in the area.

- Provider: You must be aware there may be some sensitivities, providers don't have the resources to give these patients this or some might not know what they're doing
- Consumer: When I did case management services, the response from the physician was very negative, for some it didn't matter whatever the circumstances
- Consumer: From a patient standpoint, it's hard to find a physician group to coordinate when you're dealing with complex chronic illness, it's hard to find someone that can coordinate well
- FHC: Primary care providers should be driving that?
- Consumer: It's who the patient feels most comfortable with. It should be whoever is the best provider to be able to be giving the best guidance. Not all doctors are equal in a group setting, and that would limit their ability
- FHC: Patient choice is in this effort. Patients can see whichever provider they want. Requirements of AN would have to have some kind of Center of Excellence on Aging. The network is responsible for making it known that that resource is available
    - Consumer: I am not in favor of a network, period.

- State: for Medicare beneficiaries for fee for service, the PCM initiative is focused on individuals who are attributed to ACOs that are basically physician networks. Focused on improving capabilities of networks. The ACOs would say we have a few practices that specialize in the challenges of older adults with complex care needs, and you may find this is an option in other practice where they're in tune with the kinds of challenges you're encountering. Patients have total freedom of choice. The point is do we think its important for the network to have this capability?
    - Consumer: If there's high cost, how are you going to prevent an incentive to encourage people to go elsewhere for services if they're finding that bundled payment is too expensive for that practice?
    - State: So, we are not talking about health plans.

Revised Concept Map for Primary Care for Older Adults with Complex Needs

- FHC: Reviewed provided diagram.
    - Is this a capability all networks should provide?
- Role of subspecialists-other opinions on why there needs to be a primary care provider for that patient
    - Provider: It's not just acute episodic care.

- Another provider: Yes. It is system-specific, it is related to the patient's issues. Most primary care physicians would agree this is based in primary care. I think it makes a lot of sense to have a true primary care physician to help coordinate care for them.
- Consumer: Cardiologist is a good example. There are times when other systems come into play (spinal cord injury, MS, brain injury, central issue) that are being addressed and it doesn't always mean the specialist is centrally located. Most of the time, that specialist ends up being the main coordinator of care. This is important because other health issues must be factored in when introducing new medication, and, for example, that cardiologist (i.e. specialist) would not necessarily be coordinating all their care.
- FHC: We want to make sure patients have the choice to choose their care through a subspecialist to get paid fee for service. And if the patient didn't have a PCP at all because they only see their subspecialist, they wouldn't have to change providers and that specialist would get paid as a PCP
- Provider: You're going to want PCP providers to continue to provide preventive care, immunizations, cancer screenings
- State: It's important we find a way to describe this, not limiting freedom of choice. Not to limit freedom of choice but to understand the focus of PCM is because of the unique and critical roles they can potentially play into the care of all patients. In the disabilities group meeting, this came up as well.
- Provider: In PC, it's not like it's a default specialty, primary care is its own type of practice.
- FHC: There needs to be a PCP to address those other needs.
- FHC: Primary care is absolutely its own specialty.

Next Steps:

- Develop some of the language around care coordination (i.e. a patient could choose to see a specialist in geriatrics while seeing a PCP)
- Provider: Is there any element of shared savings model like the Independence at Home project. Taking them out of the most expensive parts of the primary care system
  - State: Was that for individuals who were dually eligible?
  - Provider: You had to have two or more medical conditions. You had to have been discharged from a hospital setting, so you had enrollment criteria. Medicare knew what the overall costs would be for this type of patient population. any element of that in the program?
  - State: I would have to look carefully in how that program is structured. Today, any Medicare beneficiary is attributed for those and any patients able to achieve a reduction. I'd like to respond to the group with an answer in writing once I've taken a look at that program.

  - Provider: Fee-for-service has never served primary care particularly well. It must be tied to a reimbursement model. We've been trying to operationalize those. It's good care. Its good practice. But dedicating time and resources to it is too hard and burdensome to set it up. A system like this makes so much sense; you've got to really give a lot of thought in how to incentivize providers and how it makes sense for their practices
  - State: That's helpful. I think that the basic arrangement of giving practices the money up front to invest in things like care teams in the home. One of the problems generally is many physicians are part of larger systems not as deeply invested as they're in avoidable use. You're saying the incentive needs to be there
    - State: What's missing with regard to the incentive for the practices to participate in this model?
    - Provider: There may not be anything missing. I don't fully understand the reimbursement mechanisms behind this, but I do believe where and when you can allow PCP to share in the savings in the care coordination, they do. Where and when you can allow them to share in those savings, the model will be more sustainable
    - State: Independence at Home is a reference we should just make sure there aren't capabilities that are a focus of Independence at Home which is designed for patients with chronic illness and a multitude of care management needs. We'll circle back and will make sure we cover that base.

- State: Circle back with proposed design that will go to the task force. In that process we may call out a feature from Independence at Home. And design group members can approve or disagree and then it will go on to the Task Force. In the circle back with adjustments, I can talk about how the payment model and Independence at Home is similar to what we're doing here
- Consumer: For the individuals that are selecting this PCM (who they're selecting as a PCP), the choice is not with the beneficiary or with the patient themselves, by virtue of selecting a provider, it's the provider participating in this that would decide whether the patient would be receiving this?
- State: The Medicare shared savings program-if you're choosing an MSSP provider, you're attributed under the model, you do have an option to opt out of data sharing, with regard to this primary care modernization, those same practices participating in MSSP, the network would opt to participate in the PCM complimentary program if you will. Their payment model would change based on patients attributed to them. We haven't discussed any issues around whether patients would be attributed to MSSP, but elect not to participate in PCM
- Consumer: People do not understand what's driving this is the payment structure
- State: It's too early to design member communications, it's important to flag this as one of the materials that would need to be developed to ensure Medicare beneficiaries are informed
- Consumer: Systematically underserving patients is a concern.

- State: We'll make sure providers develop approaches vs person-centered needs rather than payer preferences. The downside is also true if someone is systematically underserving patients as a strategy
- Provider: Patients who might not otherwise be on their way to a nursing home, skilled nursing care, long-term care -the Pace program-anything similar built into this?
- State: Pace extends beyond dual eligible.
- Provider: We don't have a pace provider in CT. Medicare is not on the hook for long-term nursing home costs.
- Consumer: Medicare network of providers convey a geographic region almost like a special needs plan but not designed to meet skilled nursing level care I think, it's just a model of providing care under Medicare
- State: The avoidable use when you better serve patients with complex care needs in the community, a group that's Medicare only, and then there's the group dual eligible today. the idea that we can surface to Medicaid is this question of creating an opportunity for the duals who are attributed, for there to be a shared savings payment. When you avoid both Medicare and Medicaid costs, is there a way for the beneficiary to benefit from some of these savings. Its complicated to do that and there are duals initiatives around the country to do that. Its cost advantageous to keep someone in the community usually. We can flag that as something that can be considered as a policy objective with DSS.
- FHC: For Pace, you don't have to be a dual. You need to meet nursing-level facility for that level of care.