

Primary Care Modernization Persons with Disabilities Design Group Meeting 1

10/05/18

Building the Primary Care System We Need

-What problems do you see in primary care today?

- Lack of coordination convenience
- Too little support between visits
- Depression, anxiety, substance use often can't be treated within the same office
- Not always good at connecting patients to community resources
- Too little money spent on primary care and providers are only paid for office visits

-What if we had...

- Care teams, instead of just doctors, with more skills and functions to keep people healthy, catch problems early and manage conditions
- Technology to connect providers with each other and their patients
- More money for primary care and payments not tied to office visits
- More convenience like options for email, phone, text

Practice Transformation Task Force Report Key Takeaways:

-Add new staff to primary care teams-pharmacists, care coordinators, community health workers

-Allow access outside of a traditional office visit-phone, text, email, home visit, telemedicine

-Double investment in primary care over five years through more flexible payment options

Discussion:

- Dr. Schaefer: The Lieutenant Governor has a steering committee, one of the workgroups is the PTF and focused on medical home capabilities, and addressed SDOH and behavioral health issues, the task force is made up of consumers, providers, and includes health plans like anthem, and state agency representatives

Care Delivery Goal: Increase the Ability of Primary Care to Meet Patients' Needs

- Participant asked what genomic screenings are being considered as part of the model. Dr. Schaefer is working with Yale on 3 conditions (BRCA, lynch syndrome, and hyperlipidemia)
 - In primary care, there aren't genomic screenings for any conditions, so we are starting with those 3 conditions to implement the infrastructure.
- Talking about having a dedicated behavioral health specialist and care coordinator, and looking at different areas of specialization
- Dr. Schaefer: Alyssa used the term networks→85% of care providers out there are a part of a network (unlike 20 years ago). So, most primary care is part of an organized network to be able to provide decision support or care coordination services (we should talk about practices being supported by those larger organizations)

Payment Model Goal: Increase spending on primary care, reduce total cost of care, prevent underservice

- Attendee: You used the word bundle twice, what does that mean?
 - Dr. Schaefer: The bundle is one of the more important features of payment reform it's also the most controversial
 - Dr. Schaefer: Fee-for-service means primary care providers get paid for everything they do and focuses their attention on seeing people in the office and time with patients (whether they need to or not) (what's billable is the revenue stream that supports the practice)
 - Dr. Schaefer: Primary care is something that should be continuous. The bundle provides a level of support and purchases primary care support that might not be a doctor visit, but a care coordinator or nurse practitioner. So, by bundling a payment upfront (i.e. 4 payments of a ¼ of a million over a year) means doctors don't have to worry about how much money is coming in to support the practice. All interactions with patients are recorded, but it's still a lot less documentation for physicians.
 - Dr. Schaefer: So, primary care practices would be going from being paid for each patient to this lump sum payment.
 - Dr. Schaefer: The downside of the bundle is: what if doctors lose the incentive to see patients? So, you must have a way to measure that you're getting better outcomes and supporting and bettering patient experiences.
 - How do you measure that?
 - Dr. Schaefer: Electronic health records can capture interactions with the care team, and anyone participating in this model is reported.
- So, you have people with significant disabilities that must see doctors much more. How do you account for those who need more services?
 - Dr. Schaefer: The actual payment amount varies based on the patient's needs. So, people with high SDOH would get the practice a larger payment (risk adjustment: payment amount varies on the risk of the patient)
 - So, when Medicare does this they also have disability status.
 - Dr. Schaefer: So, this means practices are as interested in seeing complex patients as they are in seeing noncomplex patients.
- So, how do providers reevaluate when a patient's needs have changed?
 - Dr. Schaefer - we have a Payment Reform Council working through those parts of the model and if this group is interested, we are happy to come back and explain.
- Patty Richardson: United Health Care has inflated the risk level of individuals to increase the reimbursement
 - In the Medicare world, there is a lot of problems related to inflation of reimbursements
 - Having an independent entity assessing might be the only way to stop this.
 - Dr. Schaefer: So, what you're describing is a type of fraud.
 - Or conflict free, so the people providing the services are not the ones billing the patient.
 - Dr. Schaefer: Then you have payments based on a level of risk, but people can try and inflate the risk.
 - Dr. Schaefer: In fee-for-service, you have a different problem (i.e. unnecessary medical procedures).
 - Dr. Schaefer: The risk of providers gaming the system is the same for every system.
 - So, you have an audit to ensure the patient's needs match what was billed.

- Where risk scoring is important → it makes sense to have an audit process to ensure the diagnosis were real
 - There must be some method of ensuring, but some methods are pricier than others.
- Dr. Schaefer: This initiative is just about primary care
 - In a Medicare fee-for-service, the model is also based off risk adjustment.
 - They focus on physician productivity measures by volume and the other is risk scoring
 - The risk scoring is a bigger issue. We just need methods of ensuring accountability
- Tom Fiorentino: Is there bundling in Medicare like what you're proposing for Medicaid?
 - Dr. Schaefer: At some point in the middle 80s, they went to bundle groups and it solved an access problem. Hospitals were very eager to get patients admitted and weren't concerned about readmissions. So, the bundle payment fixed that.
 - Dr. Schaefer: You see them now for things like cardiac procedures (Commonwealth Care Alliance started taking bundled payments as well)
 - Dr. Schaefer: Getting away from fee-for-service is key
- Patty Richardson: Bundling payments allotted for home care, but now it's the same amount of money for less care received. We must look carefully at the total picture or else you can miss the adverse effects to beneficiaries.
 - The problem with Medicare is that there have been so many initiatives in reimbursement models.
 - Reductionists services for most people under the Medicare benefit.
- There is a disconnect from the beneficiary/patient and we need to get that consumer perspective back in.
- People are concerned this is going to be a capitation system.
- Dr. Schaefer: We are also working on consumer experience measurement.
 - Unsure whether the group agrees that primary care is underfunded, but it's the thing that everyone relies on for basic care needs.
- Dr. Schaefer: This relentless focus on volume, billing and having report cards on encounters is what is burning physicians out.
- Dr. Schaefer: I totally get downside risk of bundling, but the question is, are there enough protections?
- Everywhere across the state, patients have SDOH needs. Patients with PTSD and depression are more likely to have chronic diseases. Patients with language barriers have providers who can't understand them and their needs (or vice versa). Pharmacies might be better equipped to do this. The people who cannot speak English, don't know how to access proper primary care. The community health worker must have access to the community that really needs them (communities with high SDOH patients). These people are isolated. Other patients come from violence and trauma from other countries, and we must be aware of that issue as well.
- Judy Levy: Part of the goal is to have care teams who can speak their language. So, people that go into the homes, meet them where they are with feet on the street. With the disabled population, we must try to move away from the medical model. Maybe they need a social worker to better obtain access to services in the community? With the bundled payment, there are many more options and its more flexible. This should be the goal: for it to happen for everyone.

- Michelle Jordan: Where does the money come from to create this? (Coming from someone who has worked in the community)
 - Dr. Schaefer: One of the reasons we have health plans, employers, Medicaid is that they must be persuaded to pay more initially to get a system that is less costly long-term.
 - The avoidable use will be the offset. We are already one of the most expensive states for Medicare and Medicaid. Reallocating how we spend the dollar overtime combined with a staged expansion of primary care.
- Patty Richardson: Stressors on physicians → the networks that have developed are driving that pressure. I have a feeling that the stressors will still be there if you just change the system and do not address the network.
- A lot of folks who have Medicaid **only** don't necessarily have that access. The folks who have Medicare are getting the access to those groups, the folks with Medicaid aren't (they're only 5% because they're **not** going to the doctor)
- What groups are we talking about?
 - Dr. Schaefer: The universe.
 - Dr. Schaefer: If you're a practice, you can't completely reinvent primary care for just that population.
- Dr. Schaefer: What should primary care look like tomorrow and what should it look like in five years?
- Quality care means caring about who the patient is.
- Dr. Schaefer: How does primary care fall short for yourself or the consumers you represent?
 - Attendee: My practice is not part of network (we serve a geriatric population and oversee people with disabilities). People have frustrations with office-based visits and want to jump into telemedicine. We have increasing requests for home-bound patients, and patients are worried about not being cared for in the community (so they chose nursing homes/ care facilities)
- Attendee: When we are talking about a care team, the individuals we work with often have frequent stays. Supporting patients throughout their need for care is so important. A lot of patients travel far (costs issues). Telehealth and care teams can better connect patients to care.
 - Dr. Schaefer: I hear two principles: **relationship-based medicine** and **continuity in care**
 - Dr. Schaefer: We can keep these principles at the center of it.
 - Attendee: That and value of care.
- Dr. Schaefer: We can come back and talk about what's emerging from the Payment Reform Council
- Attendee: Cost of care is an issue. Transportation: when you've missed too many visits, and practices can no longer hold a spot for you. Practices are turning down patients in the community and a lot of these folks are Medicaid patients. So, the issue is not just that practices are not taking new patients.
 - Dr. Schaefer: The new patient problem is going to get worse since workforce in primary care is going down.
 - Having other members of the care team doing things the physician doesn't want to do will help alleviate this problem.
 - Cutting down in person visits would cut down costs and alleviate transportation issues.

- The-fee for-service price is not necessarily the barrier, but it's probably attached to some of the other patient's characteristics.
- Dr. Schaefer: We solve for some of the issues around missing visits (this is a practice revenue challenge). If you miss a visit under pay-for-service payment model, its big deal. If you miss a visit under a bundle, you just want to make sure that patient received the care owed to them.
- Within a primary care network, self-specialized practices became very good at this treating their chosen specialty disease (and they had an expert coaching them too).
 - Dr. Schaefer: Dr. Rebecca Andrews said we should find enough folks who really want to see a patient with chronic pain receive the training to become an expert in pain management. We are thinking of something similar with older adults (like Commonwealth Care Alliance)
 - Pain is something a lot of practitioners are not interested.
- Mary Ann Langton: I have had negative experiences with providers who did not know a thing about my disability.
 - Dr. Schaefer: You don't think it's a good idea because? Where did you experience this?
 - Hartford, Connecticut
 - Attendee: You worry they wouldn't have the expertise that they're saying they have?
 - Yes.
- Patty Richardson: I would be in support of having care right from diagnosis of a disability. It's challenging to make sure the nursing home is communicating with doctors for patients in homes.
 - There are not a lot of specialty areas who know how to work with special populations (i.e. spinal cord injuries, neurological issues). There are just not enough long-term in specialty service entities in our state.
- Patty Richardson: Transportation for Medicaid patients right now is a real problem. SDOHs are a barrier, and it's the system that is the problem. Telehealth is good only if it's not being used to replace a real physician's assessment. I would love to see specialty care teams, too.
- It would be good to have specialists in Connecticut that are able to virtually connect with primary care doctors→then you're expanding this coordination of care.

Next steps:

- We have one upcoming webinar meeting and one in-person meeting in November
- Dr. Schaefer: We are hoping to do a reform over the course of next year and are working hard to identify the definition of advanced primary care→ so we can begin the conversation with Medicare early next year.
- Attendee: Are we assuming that Medicaid would already be experimenting with this or what?
 - So, we make the proposal to Medicare, and Medicaid would have to have its own design process. When you do a multiplayer demonstration, you have to have Medicare, and secondly, we can't make decisions with Medicaid (our goal is to describe as much of the model by December, and not finalize a report until March)
- This is the first meeting of disabilities of this group, but we did another one in September of consumer engagement (this is our second conversation regarding this, but this is the main group we were hoping to enlist)
- Attendee: Is this process televised?

- FHC: We can send out information on how to attend/call in to future meetings (i.e. PRC, PTF)
- FHC will be in touch about scheduling the next session between this meeting and the November meeting