February 20, 2019

Cover Memo

TO: OHS SIM Payment Reform Council

FROM: Arlene Murphy and Kevin Galvin, Co-Chairs, OHS Consumer Advisory Board

SUBJ: FOR PUBLIC COMMENT - Consumer Questions Regarding Primary Care Modernization (PCM)

Questions raised by PCM Consumer Representatives must be answered and addressed to ensure that the Primary Care Modernization Initiative improves health care to Connecticut individuals and families.

At the January 8th Consumer Advisory Board meeting there was discussion of whether Consumer Representative questions are being adequately addressed in the PCM Advisory Process. Some of the ongoing questions and concerns that were discussed include:

1) Consumers have expressed concerns that the proposed bundled payment would be at downside risk for all or most costs of care (in other words capitation). This means that providers could lose reimbursement if they do not generate enough savings in all medical expenses

2) It is unclear how the payment model would improve care for patients and families. For example, some of the most important elements of primary care reform (care coordination, community integration) would be funded through the Supplemental Bundle. The Basic Bundle appears to only include payment for physicians, physician assistants, advanced practice nurses and telehealth.

3) It has not been demonstrated how the proposed payment model would address Connecticut's significant heath disparities. For example, providers may be required to evaluate social determinants of health. However, funding may be insufficient to address identified needs. How will the payment model support the services needed to respond to these assessments?

4) It has not been demonstrated how the payment model supports the infrastructure needed to measure, evaluate and address access, quality of care and patient experience.

For your information, this document lists Consumer Representative questions and comments on pages 2-9. Public Comments are attached on pages 10 – 24. A list of Pediatric Design Group Consumer feedback is attached on pages 25-26 because it was not part of the original Design Group materials.

Questions continue to be raised about how the Pediatric PCM payment model will support services needed by children and families to address Health Disparities and Social Determinants of Health. Questions also continue about how accountability for improved outcomes will be built into the payment model.

To ensure accuracy, this summary of Consumer questions, comments and concerns was distributed to Design Group Consumer Representatives for review and comment before completing. Please contact Consumer Advisory Board with any questions or issues for additional discussion. Thank you for your consideration.

Primary Care Modernization – Consumer Questions Comments and Concerns

The following is a summary of Primary Care Modernization (PCM) questions, comments and concerns that have been raised by the Consumer Advisory Board and Consumer Representatives who have participated in the PCM Design Groups. This information was taken directly from meeting materials and there is a source list at the end of this document noting where these comments were presented. We have also attached Public Comments that were submitted to Practice Transformation Task Force and Payment Reform Council.

Questions Raised at CAB Meeting, April 5th 2018

1. 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.

2. Jan Van Tassel said PTTF Recommendations mentioned that providers need to be sure that they can 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?

3. 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.

4. 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 to Medicare request?

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

Genomics Design Group
Consumer Input, Questions and Concerns for Implementation

•Importance of population health data showing screenings reduce death
•Importance of education for primary care physicians to understand these are screening tests
•Need to understand lessons learned from Geisinger pilot program and how they would apply to CT
•Need to ensure primary care practice capacity to provide sufficient infrastructure for patient education, counseling and support (and
their genetic relatives who may also need to be
screened), including appropriate, timely assistance interpreting results
•Concern about the cost of testing
•Need for secure data management and privacy protections
•Need for additional medical surveillance and counseling/support for those who are "screened in"

Telehealth
Consumer Needs, Concerns and Questions

•Expanding access to providers and providing patients with the convenience of accessing care from anywhere
•Expediting the timing of medical visits
•Reducing lost work time and travel costs
•Allowing for remote second opinions
•Lowering the patient cost of a physician appointment when compared to traditional office visits

Oral Health Integration
Consumer Needs, Concerns and Questions

•Many children and adults go without simple preventives services that have been proven effective in preventing oral diseases and reducing poor oral health
(Centers for Disease Control and prevention, 2011).
•Education for caretakers and young children to establish strong tooth brushing habits
•Prevention strategies to minimize ED visits and tooth loss
Oral health has important Health Equity Lens

Functional Medicine
Consumer Needs

•Medication and supplies to manage disease are too costly and can have significant side effects
•Hard to find resources for lifestyle changes
•Need for improved communication and listening between patients and care teams
•Need for support services from a care team beyond traditional medical care

Adult Behavioral Health Integration Design Group

Consumer Needs, Question and Concerns

•Difficulty accessing primary care and specialty care (especially psychiatry)
•Need for expanded care teams
•Clinician awareness of the challenges of maintaining self-care for a person with chronic conditions (including behavioral health)
•Finding in-network clinicians who are taking new patients and accept insurance, or finding affordable self-pay options
•Access to counseling for lifestyle issues associated with behavioral health (e.g., nutritional counseling for obesity)
•Clinicians' support and understanding that behavioral health recovery is not linear

Pain Management Design Group
Consumer Input, Needs and Concerns

•Important to ensure alternative and preventative therapies are accessible
•Multipronged approach that includes education is needed
•Need to look at overcoming cost and transportation barriers
•Need reimbursements for providers for longer appointments
•CDC guidelines are inefficient and have resulted in unintended consequences and unnecessary prescribing. Should take caution if following these guidelines. Recommend looking at FDA guidelines that will be released soon.
•Need to ensure all services for pain management are in -network and covered by insurance
•Need for more resources for providers to prescribe affordable medications for chronic pain
•Patients and providers need education in pain assessment and management
•Patient education about pain management should be provided at all levels of care, not just as part of preventive care

Community Integration Design Group
Consumer Input, Questions, and Concerns for Implementation:

•Need to define how Community Based Organizations (CBOs) will be identified and what their roles will be
•There will be gaps in what community services are available depending on geography and need for capacity building in those areas
•If primary care practices are doing needs assessments largely based on those accessing care, We might exacerbate disparities for those who don't seek care. Attribution methodology needs to address this
.•SDOH screening needs to be culturally appropriate and provided by the appropriate care team member
•Networks should respond, via partnering with CBOs, to community needs, not just their specific patient needs as this can exacerbate disparities
•Need to be inclusive of a variety of community organizations to connect their members/clients to healthcare, such as churches, barbershops, community centers, etc.

Community Integration Design Group continued

•Need to evaluate disparities in care to provide access to appropriate community placed services
•Need to establish a baseline of community health to understand whether services are meeting needs of patients
•Non-medical meeting places should not be burdened as healthcare hubs, but rather be sources for information connecting to healthcare services (electronic feedback)

Community Integration can address the following consumer needs:

- Transportation barriers
- Access to community-based services
- Improvement of health outcomes particularly in low-income communities
- Help for patients in navigating available/affordable resources
- Religion/language barriers and other cultural differences
- Addressing a variety of support services beyond traditional medical care (i.e. mental health services, nutritional services, etc.)

Diverse Care Teams Design Group
Consumer Input Needs and Concerns

-Ongoing consumer voice is critical to PCM
-Important to monitor impact of PCM: protecting against underservice, care experience, variations in networks' abilities to transform
-Consumer need support learning to advocate for themselves in a medical setting
-Care teams need to go beyond being aware and respectful of cultural needs and norms.
-Communication with patients, should consider patients' socioeconomic, and sociocultural needs and norms
-There should be a feedback loop in the system for the consumer voice beyond the planning phase.

Older Adults with Complex Needs Design Group
Consumer Input, Questions, and Concerns for Implementation

- Primary caregivers (e.g. family members) need more support managing care needs.
- Expanded range of support services that go beyond traditional in office care, such as text, email, phone, telemedicine.
- Barriers to care include transportation and getting to medical appointments especially if frail or disabled
- Hearing and cognition issues may impair understanding of self-management instructions as well as non-native language comprehension.
- Behavioral health services (particularly for depression and alcoholism) are less integrated than for younger patients

Older Adult with Complex Needs Design Group continued

• Desire to keep existing physicians and better communication between physicians across systems and care settings
• Single point of contact in practice to connect with and coordinate care
• Need pharmacists, patient navigators, more community health workers to get connected to community programs and interpreters
• Challenges with suppliers fulfilling DME orders and insurers covering supplies and delivery, primary care team should be aware of challenges and support patients with this
• Caregiving support for patients after leaving hospital or nursing home to follow up with them.
• Home visits and care coordination are very important for people with complex needs.
• Insurance is a challenge in terms of understanding billing and finding providers accepting Medicaid patients

Pediatric Behavioral Health Design Group
Consumer Comments and Questions

PCP team training, standard periodic screenings and awareness

- Need for standard screening tools, including developmental, assess the "family health"
- Need for training for pediatric team to expand capability to provide first line care
- Break down silos across disciplines
- Pediatricians are too quick to call in department of children services – which parents felt made them less likely to share information with the pediatrician's office about behavioral health issues

Expand Care Team

- Some parents felt community health workers could help navigate systems and tackle cultural differences; others expressed concern home visits because of the perceived risk of reporting to child protective services
- "My school severely lacked in helping me with my mental health issues. School was one of the biggest stressors"
- "Cannot expect putting one person in a PCP office will solve the problem of access to specially trained behavioral health professionals"
- Avoid duplication of care coordination services
- Address overmedication in pediatrics and need for periodic re-evaluation
- Refer to ACCESS mental health model to avoid developing a parallel system

Improve access to care

- Address insurance limitations on access and coverage, including long wait times and clinicians who do not accept any insurance plan
- Must measure accountability and performance
- Ensure that payment methodology promotes robust access to treatment and recognizes time needed for implementation

Pediatrics Design Group
A list of Consumer Feedback was provided by Freedman Healthcare and is attached on page 25 of this document.

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Individuals with Disabilities Design Group
Consumer Questions Comments and Concerns*

Consumer Needs:

- Phone, text, email and telemedicine visits could be very helpful to patients unable to drive and in need of transportation.
- Exam rooms must have sufficient equipment to allow for a full exam including scales and lifts to support the patient onto the exam table. If not financially feasible to have all offices set up with this equipment, have some.
- Providers need sensitivity and compassion. One way to show that sensitivity is by documenting the patient's disabilities, so they are not asked to stand when they cannot or do other activities they cannot do.
- Providers need to recognize that a patient's disability might not be their sole concern, and that a patient with disabilities may have many other health concerns.
- Many patients with disabilities need medication management (perhaps from a pharmacist). Other important capabilities include pain management expertise and coordination with providers of various services and community resources.
- All care team members need to understand behavioral health issues, social issues, and how they intersect with medical issues. Just adding a behavioral health team member is insufficient.

Concerns raised in Public Comment regarding Individuals with Disabilities Design Group is attached on page 19.

SOURCES

PTTF Report on Primary Care Payment Reform
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCPMReportRecommendationsFinal20180614.pdf?la=en

Link to April 5th CAB Comments and Questions
https://portal.ct.gov/-/media/OHS/SIM/Consumer-Advisory-Board/2018/Meeting-05-08/CAB_Questions-and-Comments_20180405_Draft6.pdf

Link to Consumer Feedback Table from CAB Consumer Engagement Events
Consumer Feedback Table VS AH MJC file dated July 28, 2018

Link to Responses to Public Comment
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/PCPM-Reports-and-Publications/PCM_Response_to_Comments_Final_20180614.pdf?la=en

Telehealth Capability Link to PTTF September 4, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-04/Telehealth-visits-capability_PTTF_082818.pdf

Draft Oral Health Capability – Links to PTTF September 4, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-04/Oral-Health-Intergration-capability_PTTF_082818.pdf

Draft Oral Health Capability – Links to PTTF November 13,2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-11-13/Capability_PTTF_Oral-Health-Intergration_20180828.pdf

Draft Functional Medicine Capabilities Skeleton– Link to PTTF September 4, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-04/Functional-Medicine-capability_PTTF_082818.pdf

Draft Adult Behavioral Health Integration Capability – Link to PTTF September ,25 2018 and January 8, 2019
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-09-25/Adult-BHI-Capability-Summary_Recommendations-for-Task-Force_092418.pdf

https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2019/Meeting-01-08-2019/AdultBHI_Summary-0102019.pdf

Draft Pain Mgt Capability Presentation – Link to PTTF October 9, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-09/Practice-Transformation-Task-Force-Oct-9-Meeting_Final.pdf,
See slides 10-18

Community Integration Draft Capability – Link to PTTF October 30, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Community-Integration-DG-skeleton-Revised-for-PTTF_102518.pdf

Diverse Care Teams Presentation to PTTF October 30, 2018 and January 8, 2019
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-30/Diverse-Care-Teams-Capability_PTTF-Review_102518.pdf

https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2019/Meeting-01-08-2019/DiverseCare_Summary-010319.pdf

Older Adults with Complex Needs Presented to PTTF Nov 13, 2018
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-11-13/Capability-Summary_Care-for-Complex-Older-Adults_20181108.pdf

Pediatric Behavioral Health Design Group
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2019/Meeting-01-08-2019/Pediatric-Behavioral-Health-Capability-Summary_102518-v3.pdf

Practice Transformation Task Force Meeting Pediatrics Capability Presentation
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-12-18/Presentation_PTTF_20181218_Final.pdf

Public Comment Attachments

Arlene Murphy, Consumer Advisory Board, Public Comment to Practice Transformation Task Force
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-10-09/Public-Comment-to-PTTF-by-Arlene-Murphy-10-3-18.pdf

Child Health Development Institute Public Comment to Payment Reform Council, November 6, 2018
Information not posted with Payment Reform Council Materials – PDF File attached

People with Disabilities and Advocates for People with Disabilities Public Comment to Practice Transformation Task Force
https://portal.ct.gov/-/media/OHS/SIM/PracticeTransformationTaskForce/2018/Meeting-12-18/CapitationLetterfrom-DisabilityAdvocatestoSIMFinal111618.pdf

ATTACHMENT

Consumer Advisory Board Public Comment to Practice Transformation Task Force Meeting October 9, 2018

I am writing to express my concern that Consumer Advisory Board was described at the last Practice Transformation Task Force Meeting as being satisfied with the consumer engagement process in the Primary Care Modernization (PCM) Design Groups.

Consumer Advisory Board has expressed appreciation for consumer representation in the PCM Design Groups but there have been serious concerns raised about time frames, materials not getting to participants with enough time to prepare and the need to know what happens with consumer questions, comments and issues raised in the Design Group discussions.

I know the time frames on this project are very difficult and that this is a work in progress. Freedman Healthcare has been very supportive of consumer participation in PCM Design Group discussions. But it is important that the concerns that have been described are addressed through the following.

1) Consumer Representatives must receive materials with enough time to review and consider them.

2) Questions and issues raised by Consumer Representatives must be documented, answered and addressed.

3) Consumer Representatives must receive updates, decisions and amended materials related to their Design Group work.

Many thanks to the Practice Transformation Task Force for your commitment to improving the health of Connecticut individuals, families and communities.

Respectfully Submitted by
Arlene Murphy
Consumer Advisory Board

ATTACHMENT

Public Comment to Payment Reform Council

November 6, 2018

Child He **te of Connecticut, Inc.**

November 6, 2018

To: Payment Reform Council

From: Patricia Baker, Connecticut Health Foundation

Lisa Honigfeld, Child Health and Developmental Institute Children's Fund of Connecticut

Re: Bundling Payment for Pediatric Primary Care

The Connecticut Health Foundation and Child Health and Development Institute and Children's Fund of Connecticut are supporting the work of a pediatric primary care payment reform study group, with membership from providers, payers, state agencies, and health policy experts. Our two organizations embarked on this work with the recognition that alternative payment for pediatric primary care could support improved long term population health, improve health equity, and better embed health services within community systems dedicated to children's health and well being. Over the past year the study group formulated goals for pediatric primary care, identified the gaps in primary care capacity and capabilities, and crafted recommendations (included below) to guide the development of alternative payment to encourage a larger contribution from primary care.

We urge the Council to prioritize bundling preventive service payments for children's health and to consider payment for health outcomes achieved as a second step in reforming payment for pediatric primary care.

It is well documented that health promotion in the very earliest years can alter the life trajectory of vulnerable children.1 Health promotion happens in families and communities, but pediatric primary care providers can make a strong contribution also. More than 90% of children use primary care services annually,2 providing a venue to support families in promoting health, deliver health messages, identify health concerns, and connect patients to services that can address health risks early before they lead to larger problems, which are costly to manage and become lifelong chronic conditions. The American Academy of Pediatrics (AAP) and federal Ea rly, Periodic, Screening, Diagnosis and Treatment (EPSDT) schedules outline an array of primary care services that, when fully implemented, contribute to long term health outcomes.[3]

1 https:/ / developingchild.harvard.edu/resources/inbrief-the-foundations-of-lifelong- healt h/

2 https:/ / ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/201S_SHS _Table_C-8.pdf

3 https:/ /www.aap.org/ en-us / documents/ periodic ity_schedule.pdf

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Noteworthy in these recommendations is the abundance of preventive visits in the early years of life. The AAP and EPSDT schedules call for 12 preventive care visits before the second birthd ay. 4 Preventive care topics for these visits include: physical growth monitoring, immunizations, sensory screening, developmental screening, lead screening, and anticipatory guidance to promote parenting skills, home and car safety and socio-emotional development. Not only are these visits universally reimbursed by public and private payers, but data show high adherence to the schedule.5 Research has clearly shown the importance of the early years in determining lifelong outcomes, from development of resiliency to mitigate the effects of toxic stress to moving families out of poverty, 6 suggesting that pediatric primary care can make an enormous contribution to population health and health equity.

An effective pediatric primary care payment model, then, that recognizes the numerous opportunities for parent and child contact in the early years can maximize the contribution of pediatric primary care services to population health and other societal goals. Payment that allows health providers to collaborate with community supports, to spend time with families, use evidence-based innovations such as group well child visits and literacy promotion, and generally support caretakers in parenting, can go a long way in supporting the health of future generations. Current fee-for-service payment forces pediatric providers to limit visit length so that they can conduct enough visits in a day to sustain their practices. They are also constrained in using social service and other providers, whose services are not reimbursed under traditional health insurance plans.

A further argument for bringing flexibility to the delivery of pediatric primary care through bundled payment is that there are so many opportunities in states and communities to promote health and development and to address child and family risks once they are identified. Federally mandated and funded early intervention services under the Individuals with Disabilities Education Act,7 the Children and Youth with Special Health Care Needs program,8 Head Start and Early Head Start,9 and other block grant programs provide support for families with a variety of needs. Connecticut also has a *Help Me Grow* system, which ensures that children who do not qualify for publically funded programs are linked to community services that promote development and address social determinants of health and development. Primary care can ensure that families are connected to these services if supported by a payment model that recognizes expanded services in primary care within a system of services that includes community partners.

In summary, bundling payment for well visits for children can bring flexibility to practices to allow them to make a bigger contribution to health promotion and health equity with outcomes over the lifetime and in many sectors. Further, we believe that flexibility in payment can encourage practices to use community services better to address child and family health as well as increase their unique contribution to health. The innovations are out there to do this, and the measurements to ensure

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4 ibid

5 https:/ /www.aap.org/ en-us/Documents /practicet_Profile_Pediatric_Visits.pdf

6 http://developingchild.harvard.edu

7 https://www.gpo.gov/fdsys/pkg/PLAW-108publ446/html/PLAW-108publ446.htm

8 https://mchb.hrsa.gov/maternaI-child-heaIth-topics/chiIdren-and-youth-specia1-heaIth-needs

9 https://www.acf.hhs.gov/ohs

quality and guard against under-provision of services are also available. Once primary care payment is reformed to provide flexibility in service delivery, we will see outcomes in a variety of sectors, such as improved kindergarten readiness, 3rd grade reading scores, and social competence. Large-scale studies have documented that young children's challenges in school are more the result of health and behavioral health challenges than cognitive ones,[10] suggesting that we can use educational system data to add payment for outcomes to the State's alternative payment methodology.

Please contact either one of us to discuss these issues further

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10 Wertheimer R, Croan T, Moore KA, Hair EC. Attending kindergarten and already behind: a statistical portrait of vulnerable young children. Washington, DC: Child Trends;2003.

Recommendations for Reforming Payment in Pediatric Primary Care

The Pediatric Primary Care Payment Reform Study Group recognizes that physical, emotional and social factors affect children's lifelong health and well-being. Building on existing structures of primary care, changes to pediatric practice can advance long-term goals of improving population health, promoting health equity and reducing health disparities among children and adults in Connecticut, and better connecting health with other sectors to support life outcomes. These improvements, in turn, will have positive societal effects: an economy made stronger by a better educated, healthier workforce, and a populace with better prospects for social mobility.

The path to lifelong well-being - characterized by a variety of health and other developmental assets (e.g. supportive social relationships, healthy weight, reduced risk of chronic illness, and economic productivity) - begins in childhood. While health care is not the only sphere that can influence a child's life course, the regular, frequent, and near- universal engagement of children and families with pediatric primary care is an opportunity to better work within a comprehensive childhood to adolescent system to increase pediatrics' contributions and value.

Not all families have the same resources available to provide for their children early in life.[11] Acknowledging these disparities early on, through development of Family Protective Factors [12] and other pediatric-lead early intervention and health promotion mechanisms, can mitigate long-term impacts of childhood poverty and other social determinants of healt h.[13]

The transformation of pediatric practice - the services children, adolescents and their families receive, how care is delivered, and how effectiveness is measured - is critical to achieving goals of lifelong well-being for individuals and improved overall population health. The success of practice transformation will require reform in how primary care is paid for, to ensure providers have the flexibility to deliver new kinds of services that are integrated within the larger social context in which children and their families live and grow. With this perspective in mind, the Study Group offers the following recommendations for payment reform.

1. **Payment reforms in pediatrics should reward effective health promotion and prevention among all children, receiving care in all practice settings, and covered by all payers.** Primary care should enhance families' capacity to achieve such priorities as:

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11 *Eat'/v Childhood is Critical to I-lea/th Egui v* Report, Robert Wood Johnson Foundation, UCSF (May 2018)

12 Strengthening Families, Center for the Study of Social Policy Protective Factors Framework Overview

13 The Inte rde pend e nce of families. Communities. and Children's He a lt h: Public Investments That Strengthen Families and Communities, and Promote Children"s Healthy Development and Societal Prosperity."[...] *therefore a crucial factor in optimizing health in this developmental period is building the capacities of families and communities, which includes access to community-based early childhood enrichment services (for example, early care and education, home visiting, and parent support programs."*

a. Promoting healthy weight (e.g. through lactation consultation, nutritional counseling, connecting families to community nutrition support such as WIC).

b. Promoting socio-emotional well-being among all children, and particularly children with social or medical complexity. This can be achieved through parent support and education interventions such as the Positive Parenting Program, strategies for enhancing family and child resiliency as used in the family protective factors framework, and greater integration of behavioral health services with primary care throughout childhood and adolescence.

c. Promoting developmental outcomes to ensure school readiness and success for all children, and particularly children who may have lower rates of success in school due to language, cultural and other barriers.

2. **Payment methods for pediatric primary care should motivate the restructuring of practices that can improve population health, health equity, health care quality, and address costs.** Payments should:

    a. Allow flexibility to support service innovations that would ordinarily not be covered within traditional fee-for-service payment, including two- generation approaches that involve parents/caregivers in care. New capabilities in a restructured practice might include:

        i. care coordination for children and families with medical or social complexity, or who are at risk of falling behind on health and related goals;

        ii. flexible office hours that include some weekend and evening hours;

        iii. alternative visit capabilities (such as e-consults, group visits and telehealth video-appointments);

        iv. embedded or easy access to behavioral health screening, follow up, and consultations;

        v. embedded or easy access to additional practitioners such as nutritional counselors and pharmacists;

        vi. transportation assistance;

    b. Reduce physician burden, optimize efficiency, and expand practice capabilities by accommodating innovative staffing using non-physician professionals and paraprofessionals;

    c. Ensure dollars are used to directly support changes at the individual practice site level;

d. Provide up-front funds, separate from payments for care and services, to support practices in developing infrastructure needed for practice innovations;

e. Support practices to report back to payers on the new capabilities, activities and outcomes new payment structures have enabled;

f. Ensure families directly experience and realize the benefits of practice innovation for their children's health and future well-being;

g. Support existing innovative primary care models and bring evidence- informed innovations to scale.

3. **Stakeholders in Connecticut should support efforts to improve measurement and supply data that connects effective pediatric primary care to adult health and well-being.** Focusing on both process and outcome measures (proximate and distal) will fortify the evidence base for primary care innovations. Over time, this will supply the Return on Investment {ROI} evidence that is needed to promote adoption of payment reform by different payer constituents (e.g., State Medicaid Agency, Health Insurers, Self-Funded Employer Sponsors, etc.).

4. **The participation of all payers in payment reform solutions for pediatric primary care is essential to success.**
    - Practice transformation to achieve significant contributions to population health and health equity requires pervasive change in the delivery of primary care services. Such change is only feasible if implemented across the entire practice population, not just for those insured by one plan only.
    - Participation by all payers mitigates the disincentive any single payer has to finance innovations that may yield its benefits (savings) to other payers later.

5. Payment methods need to recognize the variety of service sectors' overlapping encounters with and responsibilities for children. Cross-sector collaborations (e.g. medical, social service, education), financed through braided and/or blended funding, will allow for efficiency in service delivery, shared financing, accountability and, ultimately, support improved health and other benefits.

6. The benefits of improved pediatric primary care are considered a public good; they accrue across the lifespan, to many spheres of social policy, and to the state's economy in general. As with public education, which analogously spends on children to reap benefits across the population and over time, a public-sector role, in some form, is warranted.

ATTACHMENT
Capitation Letter from People with Disabilities and Advocates for People with Disabilities Public Comment to PTTF

To: Vicki Veltri, Office of Healthcare Strategy
Mark Schaefer, Office of Health Care Innovation

From: People with Disabilities and Advocates for People with Disabilities
Date: November 16, 2018

Re: Opposition to Proposal to Capitate Primary Care Providers (SIM "Modernization" Plan)

A number of us have been contacted by your consultants, Freedman Healthcare, to seek our support for the plan to pay primary care providers a fixed payment per member per month ("pmpm"). We are writing today to express our continued opposition to this capitation proposal and to the efforts to enlist people with disabilities, including those on the Long-Term Care Rebalancing Committee and the CT Cross Disability Lifespan Alliance, to support it. Our opposition is based on our experience of your office's failure to listen to the voices of dozens of consumer advocates, including advocates for people with disabilities, who have related their concerns that this payment model could be harmful to patients, particularly those with complex medical conditions.

This latest outreach effort followed a meeting of the SIM Steering Committee on September 13, 2018, at which several members complained about the August 23, 2018 written comments of 31 independent advocates (including some of us) in opposition to the capitation plan (comments attached). *See* http://www.ctn.state.ct.us/ctnplayer.asp?odID=15603 (starting at 1:42:45). It was stated there that the SIM group had somehow failed to properly "educate" the community about what the plan was, and that there was "confusion" about the plan, rather than any acknowledgement of, or having a substantive discussion about, these advocates' valid concerns. The group concluded that there was a need to go back to the community with the goal of getting them on board to support the plan which had already been largely developed (and completely developed, in the case of the core capitated payment model).

We in the disability community are not confused about the plan. We understand what the payment mechanism is, and what it is designed to accomplish. That is why we are so concerned and continue to object to it. A plan that capitates payment to primary care providers is likely to result in less care for a population (people with disabilities) that needs it most: restricted access to essential care, failure to inform patients about more expensive care options, and denials of critical tests, because every dollar of health care provided by the primary care provider comes out of their pocket. We know exactly what the model is and we oppose it.

In previous presentations to disability groups, a series of claims has been made in the attempt to enlist support for this payment model, as discussed below.

Your consultants refer to the proposed change in payment as “modernization” when capitation has, in fact, been tried before in the Medicaid program. It failed, which is why it was replaced in January 2012 with a managed fee for service program (now run by DSS and contracted “administrative services organizations” paid on a non-risk basis), which is not only more efficient but has also both saved the state hundreds of millions of tax dollars **and** improved access to care. The number of participating primary care providers has significantly increased. This latest proposal represents a change in that it would capitate payments to providers rather than insurers- but this is precisely the reason why we are concerned about its impact on patients with disabilities and other chronic conditions who need complex care. The proposal may result in placing providers, who will be principals in or employed by the capitated entity, in a direct financial conflict with their patients’ best interests. Capitation of primary care providers specifically was already tested by commercial HMOs in the 1980s, and failed. It does not make sense for Connecticut to move forward with a plan design that has already been tried, with poor results, in the past.

We support the concept of “flexibility” for primary care providers to hire community health workers, provide telemedicine and other innovations. However, we do not believe that the payment mechanism that is an essential part of this plan design would accomplish that goal. Under capitation, there is no assurance that **any** of these services, all of which must be paid out of the provider’s pocket, would actually be provided. There seems to be a failure to acknowledge that most of these services could be covered via Medicaid fee for service under a simple state plan amendment. Providers already have the “flexibility” to pay for non-covered services out of their own pockets, if they choose to do so. However, a per member per month payment system would create disincentives even for the provision of standard office visits, since providers would receive little or no payment for these. People with disabilities do not have this worry under the current Medicaid fee for service model.

In fact, at SIM Payment Reform Council meetings it has been offered to providers that, by **reducing** visits, they will generate more revenue by taking on more patients (with each patient bringing in a pmpm payment regardless of any services provided) without needing to expand capacity. The Medicaid system should be operating for the benefit of the patients receiving care, not the profit margins or administrative convenience of the providers of medical care.

Promises have also been made about a “doubling” of funds for primary care, with no explanation of where that money would come from. People with disabilities have had promises made to them in the past; rarely have those promises actually been kept. Even if more funds were somehow to be made available for primary care, this does not eliminate the incentive, under a capitated payment model, for a provider to limit access to care, because the cost of that care still would come out of the primary care provider’s pocket.

Risk adjustment through making higher pmpm payments for people with complex conditions will not necessarily stop providers from discriminating against people with disabilities with greater health care needs. In fact, it may provide a perverse incentive for a provider who receives the higher differential payment for accepting people with disabilities as patients to **then** deny them care, because that would result in additional profit to the provider. Unlike a fee for service model, a capitated payment model does not condition payment on the provision of services. The provider gets the same amount of money regardless of the services provided. The plan includes no meaningful or realistic proposals to monitor either for the dumping of expensive patients or for underservice. People with disabilities and other chronic conditions requiring complex care are particularly threatened under this payment scheme, with or without risk-adjusting.

We are particularly troubled by the fact that previous written comments from large groups of independent advocates (dated April 9, 2018 and August 23, 2018) urging you to reconsider this payment model seem to have been ignored, and no changes to the payment model have occurred in response to these comments. It appears to us that you are not looking for any meaningful input, but instead only seeking to obtain post-hoc endorsements of your proposal. Because we continue to have serious concerns about the threat to the health of people with disabilities, we cannot support this plan.

Finally, we wish to note that we are not ignoring some access issues under the current Medicaid system. For example, people seeking mental health services report being steered toward group therapy instead of individual therapy and being given very short appointments, presumably to save the state money. Similarly, we are aware that significant health disparities remain, with people of color often given less treatment or less expensive treatment than white patients due to implicit bias – even when the provider does not have a financial stake in reducing the cost of care. While we would like to address these deficiencies and have some ideas for doing so, capitating primary care providers will only make these problems **worse** by affirmatively incentivizing providers to deny appropriate services.

We do not need to be "educated" about what this plan proposes. We understand what the SIM proposal would do, and we are concerned about the potential for adverse consequences which seem to have been completely discounted by those advocating for it. However, if SIM is willing to restart the process and genuinely hear suggestions with no pre-determined payment model in mind, we remain happy to work with you toward **real** primary care reform that supports both people with disabilities and providers.

Thank you for your attention to these comments.

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Gretchen Knauff
Disability Rights CT

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Lt. Governor Nancy Wyman

Senator Terry Gerratana
Rep. Catherine Abercrombie
Rep. Michelle Cook
Rep. Hilda Santiago
Rep. Susan Johnson
DSS Commissioner Roderick Bremby
Medicaid Director Kate McEvoy, Esq.
Ted Doolittle, State Healthcare Advocate
Rep. Toni Walker (Governor-Elect Ned Lamont Transition Team)
Attorney General George Jepsen (Governor-Elect Ned Lamont Transition Team)

Freedman HEALTHCARE

PCM Pediatrics Design Group Consumer Feedback

Diverse Care Teams:

- **Expanded care team functions and roles support the goals of the pediatric medical home, and, at the same time, expanded care teams need to be clearly defined.**
- **All the diverse care team roles and functions should be core, including referrals and follow ups.**
- **Parent navigators could be a parent with children who went through a similar experience; would love to see this type of role embedded in the practice to help patients.**
- **Community Health Workers are critical and support care coordination**
- **The Subgroup defined community integration as a core, practice-based service that is facilitated by the network, which makes arrangements with certain community-placed services on behalf of practices to help them meet patient and families' needs. In response to this definition, a consumer noted that this definition is okay but wanted more specificity around a standardized process for how CBOs will be selected and compensated. "This needs to be a transparent and fair process so that smaller capable CBO's are not forgotten."**
- **Need to ensure that referral and follow up are parts of this model. This is where patients fall off the cliff. Help Me Grow is an essential part of that follow up piece.**
- **Networks should be required to have a population health specialist so that the care teams make this a priority.**
- **Consumers agreed that aligning the definition of care coordination with the AAP definition is good.**
- **Care coordinators should be making formal referrals and, like United Way 211, help families make connections to a medical home.**
- **Care coordinators can help fill gaps in services.**
- **The programs I've seen that have been successful in the state are through care coordinators. They aren't necessarily coming directly from a provider in the home. Collaborating with organizations that already have that cultural competence in the community is key (in fact, would pull equity and cultural competence out to be its own goal). Wouldn't discount the ability of the CHWs that can be monitored to ensure quality and be carefully linked to the medical home. If it is a network-level capability, that makes sense.**

Community-Placed Services

- **SDOH screening is vital but can go wrong if its not done with some care.**
- **The capability should include community-placed services for youth, including those that support youth transitioning to adulthood.**
- **Regarding connections to school-based care, community-based services can provide more help and resources to the school nurse. A consumer said: "Our communities are our schools for our children and this needs to be a part of the conversation. More coordination between schools and practices."**
- **Practices need flexibility in connecting families with community-placed services; this coordination should not be required unless these services are necessary**
- **Would love to see contracts with community-based organizations as a requirement. CBOs lack funding. If contracts are required, those CBO's develop a standard process. Funding will help CBO's develop coordination and infrastructure mechanisms and help with measurement of outcomes of the interventions.**
- **Must appropriately compensate community-based organizations and find a way for CHWs to be able to bill this work in coordination with the practices.**
- **Need to develop accountability measures and how we are determining these functions are met.**

Oral Health Integration

- **More dentists need to be aware that children with disabilities may have sensory issues.**
- **Oral Health integration complements school medical homes**
- **Oral Health integration is a great capability, quick and simple.**
- **Oral health in pediatric practices complements the CT legislation that provided for dental screenings in schools.**

Universal home visits for new parents

- **Home visitor should be seen as fully connected to the primary care practice.**
- **In addition to the nurse-family partnership, home visits by CHWs have a positive effect.**
- **Home visit team should include a community health worker who is a parent and understands the family's situation CBO's can help support the Home Visiting Team with support services that go beyond health care services such as advocacy in school issues and a variety of training that will help the caregivers become skilled advocates. They can also help with follow up which usually results in many hours beyond the medical or home visit.**

- **Bright Futures does practice under some medical homes and agrees this definition is more comprehensive.**

Telemedicine, Phone, Text, Email Encounters:

- **Has been a "godsend" for help with a sinus infection or UTI.**
- **A consumer said: "I support this concept but would go beyond this to include a way not only for Providers to provide services through video consult but also as a way for the practice to connect to a CBO for consult, care coordination, learning and providing triage support as well as a mechanism for training for Care Coordinators, CHW and caregivers (ECHO Model)."**
- **Phone, Text, Email Encounters are the future of medicine as part of larger telemedicine initiative. Youth/young adult will appreciate this option.**
- **A consumer said: "There is a telemedicine movement that we need to consider."**
- **Telemedicine could be utilized to avoid duplication of services and to extend services beyond what is available now and utilizing tools such as Project echo**