# STATE OF CONNECTICUT
# State Innovation Model
# *Payment Reform Council*

## Meeting Summary
## February 21, 2019

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

**Members Participating:** Joseph Quaranta, Naomi Nomizu, Eric Galvin, Ken Lalime, Kate McEvoy, Jess Kupec, Thomas Woodruff, Tiffany Donelson, Robert Carr

**Other Participants:** Mark Schaefer, Laurie Doran, Mary Jo Condon, Gail Sillman, Vinayak Sinha, Arlene Murphy, Colleen Swedberg, Heather Gates, Karen Siegel, Robert Kosior, Curt Degenfelder, Suzanne Lagarde

**Not in attendance:** Peter Bowers, Peter Holowesko, Robert Block, Terry Nowakowski, Fiona Mohring

### 1. Call to Order
The meeting was called to order at 6:00pm

### 2. Public Comment
Ms. Arlene Murphy brought forward the public comment compiled by the Consumer Advisory Board. Dr. Mark Schaefer stated that questions on new downside risk arrangement introductions into the model are no longer applicable since MSSP Pathways to Success eventually results in downside risk. Payment Reform Council deliberations proposed not to modify the new MSSP program, but rather think about how additional upfront payments may help care delivery goals. Ms. Kate McEvoy mentioned that leadership of the Center for Medicare and Medicaid Innovation signaled primary care as an emphasis area for the future direction of Medicaid. There are concerns over models that too rapidly precipitate pace towards downside risk, Ms. McEvoy continued, and this effort should consider risk in the Medicaid space more iteratively. There should be room for tailoring downside risk in the Primary Care Modernization effort for Medicaid, she added. Dr. Joseph Quaranta asked why there is discrepancy between MSSP and Medicaid guidance? Ms. McEvoy responded that Ms. Seema Verma had concerns over a potentially negative impact for Medicaid members. Concepts on value-based payments have moved in the same direction, but implementation varies. Dr. Joseph Quaranta expressed concern that there may not be enough consideration across payers to buy into downside risk. Dr. Schaefer replied that the new OHS Consumer Engagement Director will work on responses to this public comment.

### 3. Approval of the Minutes
Dr. Naomi Nomizu motioned to approve the minutes from the previous Payment Reform Council meeting. Mr. Jess Kupec seconded the motion. All were in favor.

### 4. Review Purpose of Today's Meeting

Ms. Laurie Doran mentioned that the meeting would focus on the Practice Transformation Task Force recommendations for care delivery modifications and then turn to how these capabilities can be achieved.

**5. Review of Primary Care Modernization Capabilities**

The Council moved on to discuss how there has been an increased focus on health equity improvement. Mr. Eric Galvin asked if the provided list of barriers was inclusive, or if there were others that broadened the definition of the barriers? Ms. Doran replied that implementation will require more flexibility. Dr. Schaefer added that they also focus on social determinants of health. Ms. Tiffany Donelson asked where input for the list came from? Ms. Mary Jo Condon mentioned that during the stakeholder process, 500+ people were engaged to understand systemic barriers to accessing care – largely focusing on health equity. Ms. Condon then reviewed the PCM process with the Council and highlighted how consumers have shared their views. Ms. Doran mentioned that this work is now resulting in additional stakeholder engagements to ensure that the final report reflects stakeholder recommendations.

Ms. Condon went on to review the list of capabilities included in the PCM process. Ms. Condon discussed how alignment of the capabilities to share best practices can help drive transformative primary care. The capabilities compendium includes information on the capabilities for different audiences and summarizes the recommendations, how they will improve care for patients, how they will augment the functions of the primary care team, and the means to which these functions can be achieved.

Dr. Sue Lagarde felt singling out eConsults from telemedicine was important, but admitted it is a form of telemedicine, but is distinctly different from video visits. Dr. Schaefer explained how eConsults and co-management extends care team member capabilities, but does not engage patients, therefore it falls into the team-based care category. Dr. Schaefer then pondered if telemedicine should be considered as video visits. Dr. Lagarde said that she thinks most people would think of eConsults as part of telehealth/telemedicine.

Ms. Condon then reminded the Council that core capabilities would be required and that elective capabilities would be optional. Ms. Condon then reviewed Behavioral Health Integration with the Council, and broke it down as an assessment, brief intervention, and providing connections to specialists in the community or network for further treatment.

Ms. Condon discussed how alternative ways to engage patients magnifies the way the team can support patients, such as engaging patients through phone, text, email, and telemedicine. Ms. Condon reviewed how remote patient monitoring for Congestive Heart Failure would allow the care team to better engage and care for the patient.

Ms. Condon went on to explain how Health Equity Improvement is central to the delivery of the capabilities and that every capability has a section explaining how it will impact health equity.

Ms. Doran then reviewed the elective capabilities with the Council. Dr. Schaefer mentioned that specialized practices within the network would provide enhanced care for patients as needed and that the supplemental bundle should suffice to cover these services due to risk adjustment and reflection of the needs of the patient population. Dr. Schaefer went on to highlight various types of community groups that can help augment care team work.

A Council member asked about the presented capabilities in grey. Mr. Vinayak Sinha explained that these capabilities are still under development for review by the Practice Transformation Task Force.

Dr. Joseph Quaranta pondered how specialized practices would meet the requirements outlined in the capabilities? Dr. Schaefer explained that this effort wants to avoid having the state dictate exactly what compliance would look like, and that the supplemental bundle can be used to work towards the capability (as a starting point). The networks can decide how they will serve these specialized populations. Dr. Quaranta mentioned how flexibility does not seem to come across in the provided two-pager, and that this nuance mentioned by Dr. Schaefer should be highlighted. Dr. Schaefer added that specialized practices in networks may self-identify to provide additional support to the rest of the network. Dr. Naomi Nomizu then asked if consumer input has been given regarding shared medical appointments? Dr. Schaefer replied that there has been input from the pediatrics community on shared medical appointments and that this process is elective. Dr. Nomizu mentioned that this capability should be optional for patients, to which Dr. Schaefer agreed and pointed to how this is mentioned in the provided capability summary document. Dr. Robert Carr stated that stakeholder engagement should ensure all capabilities are supported by consumers and address consumer needs.

Ms. Doran went through the patient stories to highlight how the capabilities come together to provide care for someone who may have a less common chronic illness to a young person who is an active member of the workforce. Dr. Schaefer went on to highlight the next patient story for the Council and mentioned that their feedback on these capabilities was very much appreciated. Ms. Doran then highlighted the two universal capabilities, Health Equity Improvement and Community Integration for Social Determinants, that allow practices to identify and address disparities and leverage community supports to tackle social determinant needs.

Ms. Doran discussed the potential phase-in of the adult capabilities with the Council, starting with the diverse care team capability (as it serves as the foundation for several of the other capabilities). Ms. Doran explained that since health equity improvement involves data collection, this capability would be implemented earlier (i.e. year 2).

**6. Medicare Cost and Savings Estimates**

Ms. Doran reviewed the process used to determine costs and savings of the capabilities and highlighted that the bibliography provides more nuanced information on the cost and savings for each capability. Ms. Doran then discussed the Medicare cost estimates for adult capabilities and highlighted how the cost of these capabilities leaves room for additional supplemental bundle money to be used for infrastructure development, beneficiary incentives, and patient-specific social determinants. Ms. Doran explained how this effort wanted to ensure the availability of resources at the practice level to address social determinants. Ms. Doran highlighted that although specialized practices cost quite a lot, there are significant savings for those individuals. Dr. Carr mentioned how PCP time is covered via existing resources, and asked how this would work? Dr. Schaefer explained that the basic bundle would take historical PCP cost, risk adjust it, and provide a payment for the PCPs work on establishing capabilities. Dr. Quaranta stated that this effort should consider the fixed cost for remote patient monitoring. Dr. Schaefer replied that certain infrastructure costs may be covered by fee-for-service, per the new Medicare rules. The supplemental bundle also allows for the flexibility to be used for infrastructure development, Dr. Schaefer continued. Mr. Ken Lalime stated that the basic bundle may not cover new capability payments if there is only review of historical revenue. Dr. Schaefer noted that these assumptions will have to be tracked and re-evaluated. Dr. Lagarde added that for eConsults, there may be inefficiencies that decrease PCP patient panel size.

Dr. Quaranta stated that eConsults can take up more time and Mr. Eric Galvin mentioned that any capability may be more resource-intensive without establishing the basis of diverse care teams and other cross-cutting capabilities.

Ms. Doran discussed technology infrastructure costs with the Council. Dr. Carr explained that when a PCP is referring to a specialist, the work for the PCP is minimal. The specialist then does what needs to be done for that patient, he continued. In this system, Dr. Carr went on, there is more work for the PCP. Dr. Schaefer mentioned that the Council's feedback regarding increased PCP time to provide eConsults was noted. Dr. Eric Galvin added that PCPs are reimbursed for eConsults by ConnectiCare to ensure a more efficient use of specialist capacity.

Dr. Carr stated that $0 telemedicine costs are unlikely due to the lack of infrastructure, and that training and TA cost is often higher than anticipated. Dr. Schaefer replied that the stepwise increase in the supplemental bundle, and the phase-in of the capabilities, allows for a step-wise development and training of the care team members to enable capabilities in an advanced network. Mr. Kupec then explained how pharmacists are being implemented at St. Francis practices and that training and deployment is scaled over time.

Ms. Doran then went on to discuss the breakdown of the cost of the Diverse Care Teams capability. Dr. Lagarde expressed concern that a Licensed Clinical Social Worker will not be covered under the $4 PMPM ($72,000). Dr. Quaranta explained that it may be worth modeling for each care team member, based on their own panel, rather than the PCP's panel. Ms. Condon then explained how this was the way cost estimates were calculated and how economies of scales that a network brings must be considered in terms of the number of care team members needed for each practice. Ratios may be helpful, Dr. Quaranta added. Mr. Kupec discussed how embedding all the diverse care team members within all practices would be too expensive, and, thus, an integrated model would work better to which Ms. Condon and Dr. Schaefer agreed.

**8. Next Steps and Adjourn**

Ms. Doran stated that the next steps will be to discuss cost assumptions with stakeholder over the coming weeks. Ms. Doran highlighted how the Council did not cover accountability and performance measurement, and that this will also be reviewed with stakeholders. Dr. Schaefer added that questions regarding the wisdom of the investment, the solidity of assumptions on the cost model, and the validity of savings will be important for stakeholders to understand in order to effectively understand their ability to deliver savings and the capabilities.

Ms. Murphy mentioned that there are concerns that should be addressed prior to additional stakeholder engagement. Dr. Schaefer replied that the rest of the content would be reviewed via a potential hour-long webinar session focused on return of investment, accountability, and performance measurement as decided by the Council co-chairs.

**9. Adjournment**

Mr. Ken Lalime motioned to adjourn the Payment Reform Council meeting. Mr. Jess Kupec seconded the motion to adjourn.

***The meeting adjourned at 8:13pm.***