STATE OF CONNECTICUT
State Innovation Model
Payment Reform Council

Meeting Summary
December 6, 2018

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

Members Participating: Terry Nowakowski, Joseph Quaranta, Naomi Nomizu, Eric Galvin, Ken Lalime, Kate McEvoy, Peter Holowesko, Robert Carr, Jennifer Searls (alternate for Jess Kupec), Dan Lawrence (alternate for Peter Bowers)

Other Participants: Mark Schaefer, Gail Sillman, Alyssa Harrington, Laurie Doran, Jenna Lupi, Mary Jo Condon, John Freedman, Curt Degenfelder, Nadine Repinecz, Maria Dwyer, Karen Seigel, Lisa Honigfeld, Heather Gates, Pano Yeracaris, Athena Dallas, Robert Kosior

Not in attendance: Robert Block, Tiffany Donelson, Peter Bowers, Jess Kupec, Thomas Woodruff

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

2. Public Comment
A letter from disabilities advocates was entered into the record. The letter expressed concerns over the bundled payment model options. The letter will be posted and disseminated to the Council.

3. Approval of the Minutes
The PRC reviewed and approved meeting minutes from 11/15. Dr. Joseph Quaranta motioned to approve the minutes. Mr. Ken Lalime seconded. All in favor.

4. Revisiting Pediatrics Well Visits in the Basic Bundle
Ms. Laurie Doran explained that the Payment Reform Council provisional recommendations currently exclude preventative and wellness visits from the basic bundle, and these visits will continue to be paid fee-for-service. Some pediatrics advocates are concerned over excluding these services for children, how that will make the basic bundle less robust for pediatric practices, and in turn, not provide the same opportunity to transform care delivery. The rationale is that advocates note that flexible funding through bundling preventive services is necessary to support the clinical, developmental, social and behavioral needs of children and their families in a way that promotes long-term health and well-being into adulthood and reduces disparities.

The group discussed what percentage of visits in pediatrics were child well visits. Dr. Quaranta asked about the data source the team had used to estimate the percentage. Ms. Mary Jo Condon confirmed it was payer data that came from the Centers for Medicare and Medicaid Services (CMS).

Dr. Quaranta explained how his own data showed even more well visits in pediatrics. Dr. Naomi Nomizu asked whether the data included adults, and Dr. Quaranta confirmed it was pediatrics only. Dr. Mark Schaefer clarified that the reason for including pediatric well visits in the basic bundle is not just because it makes the bundle smaller, but because there are clinical advantages for health

promotion. Dr. Lisa Honigfeld added that preventive care is the bread and butter of pediatrics, and it represents a substantial portion of what pediatric providers do. With more flexibility, we could make large contributions to health over the course of the lifetime. Safeguards are in place in pediatrics to ensure there are no incentives to provide underservice under a bundled payment model. For example, developmental screenings are easy to track, and vaccinations are required for entry into schools, camps, and other child setting. Ms. Laurie Doran recommended the Council include preventive and wellness visits for pediatric populations in the basic bundle.

Dr. Quaranta asked how the basic bundle would factor in all screenings done traditionally on FFS. Ms. Doran replied that they would include initial preventive visits, preventive medicine for established patients, and immunizations. Dr. Honigfeld stated developmental and behavioral health screenings are add-ons, and that if they move to a bundle, they can be incorporated. Dr. Honigfeld provided codes to the Council (99160 and 96127). Ms. Doran suggested to the Council adding developmental, behavioral health, hearing, and vision screenings. Dr. Pano Yeracaris suggested maternal depression screening and post-partum screening could be added. Ms. Condon noted that she heard from a stakeholder during the design work that this should still be FFS. Mr. Peter Holowesko asked if the bills for these services would be coded as preventive services, to which Ms. Doran confirmed they would be. There are specific codes for preventive services that can be added to those covered in the basic bundle.

Ms. Doran noted that this change would not impact member experience, except for having broader access to other modalities and a more flexible range of services. Ms. Doran noted the services correspond to age rather than provider specialty. The Council discussed how including these services in the basic bundle would allow for more flexibility in care. Dr. Robert Carr asked if this effort assumed that since there is not enough wellness and preventive services right now, putting them into the bundle would incentivize more use of these services. Dr. Honigfeld replied that families come for well visits because they're required to do everything else. This effort would provide more flexibility to spend funds in ways to get more out of in-person visits that FFS. For example, Yale New Haven is using group well child visits and found they can do a better job with nutrition counseling through this format. This would typically not be reimbursed FFS. The bundled payment provides the opportunities to bring in the care team and provide services beyond what a physician can do in 15 minutes (e.g. lactation consultants, dieticians, Reach Out and ReadDr. Schaefer explained that freed up PCP time could expand the panel or could be used to hire someone in the waiting room to provide reading consultation. Opportunities around the shared visits approach are much greater in pediatrics than adults. Dr. Yeracaris noted that including preventive visits would also help with the needed 60-65% in revenue to really transform a practice.

Mr. Eric Galvin pointed out that the discussion of pediatrics is outside the scope of Medicare and pushes into Medicaid and commercial plans. Ms. Doran replied that the hope is that recommendations will be for all payers. Dr. Schaefer noted that the next step would be conducting actuarial modeling and analysis through the Office of the State Comptroller to bring back to the Council. Mr. Galvin said this effort needs to be very prescriptive about the range of activities that fall into the basic bundle for pediatrics. Ms. Condon explained that the design group is still working on making these recommendations. Dr. Schaefer added that with Advanced Networks and ACOs, there is a balance between prescriptiveness and allowing flexibility to optimize performance and test out innovation.

Mr. Galvin noted that if this expands into the commercial space, clients will demand to know what they're getting from those funds. Dr. Nomizu asked if the Council could still agree that if there's a basic bundle for people under 18, it would include preventative services as discussed, and defer

details on screening codes to a more expert group on pediatrics. Mr. Galvin noted that adult preventive services are not included in the basic bundle, and the group must understand why it should be different from pediatrics. Dr. Schaefer summarized that there is provisional support for the recommendations, but that the Council will revisit the recommendation on adult prevention. Mr. Galvin stated that having the two harmonized is important.

5. Supplemental Bundle: Quick Review, Calculations, and Risk Adjusting

Ms. Doran discussed how the cost estimates for the supplemental bundle were developed using literature. Dr. Quaranta asked if the $0 cost for phone text, email, and telemedicine is because it's rolled into the care team estimates. Ms. Doran confirmed. Dr. Carr asked if Medicare or Medicaid cover eConsults. Ms. Kate McEvoy explained that in Medicaid, they are covering eConsults, are rolling this out on a broader basis, and are proposing telemedicine options. Dr. Carr expressed that he was a proponent of eConsults but would not encourage bundling the subspecialist costs. Dr. Schaefer noted that it might not be necessary to put this into the bundle if Medicare and Medicaid are already paying it FFS. Ms. Gail Sillman confirmed that Medicare will start reimbursing for eConsults in 2021. Dr. Quaranta explained that it would be much easier operationally to traditionally pay for it FFS. Dr. Carr noted that eConsults create additional work for the PCP that's not being compensated and explained that the funding built in is more to support subspecialists than primary care providers. Ms. Doran stated that this is based on assumptions of new costs that would be incurred by the practices. Dr. Carr noted that a provider can bill more in FFS but cannot do so in the bundle.

Dr. Schaefer clarified that it's about how to use the provider's time, and that includes having other functions handled by another care team member. Dr. Carr added that if a primary care practice has to do all that work, they either need to have smaller panels or see fewer patients. Ms. Doran explained that this effort needs to note programmatic changes and will need to look at how these impact the historical basis of the basic bundle. This will put more pressure on primary care, but other things will take more pressure off. Mr. Lalime asked if the bundle included costs for establishing new workflows. Ms. Sillman explained that the bundle includes a platform in terms of tracking but not workflow changes. Ms. Condon noted that this effort thought about how the basic bundle will need to be adjusted over time and recognizes there will be changes in services that the PCP is delivering. Physician time that would go towards primary care doing eConsults would be paid out of the basic bundle and the specialist and platform would be paid for through the supplemental bundle. Dr. Schaefer noted that the FFS arrangement typically doesn't result in compensation for the primary care practice, and it will be important to collect data and get information that ensures compensation is enough to support the provider's time.

Dr. Quaranta noted that under the current FFS system, there are no incentives for PCP to use eConsults, and it's easier for PCPs to pass the patient to the specialist. Mr. Robert Kosior asked if the global savings model would enough incentive eConsults. Dr. Quaranta said it was enough if there is an incentive going directly to PCP. Mr. Kosior explained that this is exactly why many payers aren't getting lots of uptake on eConsults, and said he encourages this but believes there should be appropriate incentives to make it easier for the PCP to do things right. Dr. Nomizu pointed out that this would improve access to specialists and reduce the cost of care (if we assume specialists always increase costs).

Ms. Doran reviewed a tiered approach for Medicare target ranges for the supplemental bundle. The three tiers aimed to provide a glidepath to move towards larger investments. Dr. Quaranta asked about the benefit of being in the lower tier, and that if this was assuming downside risk. Ms. Doran replied it could also assume an upside risk. Ms. Condon explained the lower end of the range for

expanded care teams reflected CPC+ and the higher end was what the diverse care teams design group recommended.

Ms. Doran asked the Council to recommend whether if funds were not used appropriately, the payer should recoup them. Dr. Quaranta said that it's important to have spending completed by the end of the first year. If services are implemented in an efficient way and save money, the organization is put in a position to spend money simply to avoid losing them (rather than for efficiency). Ms. Doran clarified that if funding is not used as intended, then carriers have the opportunity to recoup it. Funding needs to be used within a reasonable timeframe and for primary care, or, needs some opportunity to go back to payer. Mr. Kosior asked how this would work, and Dr. Quaranta asked if it would be calculated per payer. Dr. Schaefer confirmed it would not.

Dr. Quaranta asked if analytics and IT infrastructure were included in the estimates. Ms. Sillman said that they weren't and assumed that most practices were already doing analytics. Dr. Quaranta said organizations are going to need to ramp up their IT and infrastructure. Ms. Condon reassured that this would be covered but is not spelled out in calculations. Ms. Terry Nowakoski asked if payers would be feeding organizations information about how they're doing, and Ms. Condon explained that its important to have up-to-date data to be able to see how they're doing. Dr. Carr explained that he did not think there were too many organizations that had the ability to calculate their own savings. Ms. Doran explained that the team would share a savings model next week.

Ms. Doran explained the approach to risk adjusting the supplemental bundle. Ms. Doran explained the Council will advise on which criteria should be considered as risk adjustment tiers are developed, and what process or method should be used to apply the secondary adjustment. The Council will also weigh in on which populations should receive a secondary adjustment: people with social determinants of health risk, people with behavioral health and substance use issues, and individuals with dementia. Ms. Doran noted this effort would not recommend something it couldn't track and stated that this Council needs to be mindful as to whether these are appropriate for all payers. Ms. Doran explained that this effort's intention is to evaluate what is already available for social determinants of health risk adjustment. Ms. McEvoy explained that the team should look into the opportunity of CMMI accountability communities of health that are doing this, and that there are two large ACOs already participating and building this into routine practice. Dr. Quaranta noted that the Council should also be aware of upcoding in risk scores and not using methods that incentivize this.

6. Next Steps

The Council will discuss options for different levels of risk and accountability at the next meeting and asked the group to look at the remaining slides discussing risk. Dr. Schaefer explained that this effort is focused primarily on Medicare and directional alignment for other payers, and that this effort wanted to surface different models where the risk is on a performance incentive (to combat underservice).

7. Adjourn

The meeting adjourned at 8pm.