STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
April 16, 2019
6:00 – 8:00 p.m.

Meeting Location: CTBHP, Litchfield Room, Suite 3D, Rocky Hill

Members Present: Supriyo Chatterjee; H. Andrew Selinger; Elsa Stone; Douglas Olson; Mark Vanacore; Anita Soutier; Susan Adams; Daniel Lawrence; Lesley Bennett; Randy Trowbridge; Beth Cheney; Anne Klee; Jesse White-Frese; Leigh Dubnicka; Anne Klee; Heather Gates

Members Absent: Kate McEvoy; Rowena Rosenblum-Bergmans; Shirley Girouard; Alta Lash; Juan David Ospina; Donna Perlee

Other Participants: Mark Schaefer; Stephanie Burnham; Linda Green; Vinayak Sinha; Mary Jo Condon; Laurie Doran; Erika Vuernick; Ken Lalime; Brian Ly; Steven Angelo; Karen Siegel; Marie Smith

1. Call to Order
The meeting was called to order by Dr. Elsa Stone at 6:00 p.m.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Dr. Elsa Stone asked for a motion to approve the March 5th meeting summary of the Practice Transformation Task Force meeting. A motion was made, seconded, and approved.

4. House Rules Refresh

5. Purpose of Today's Meeting
Dr. Mark Schaefer reviewed the purpose of the meeting which was to review the information being presented to stakeholders on the PCM model. He went on to discuss the importance of the Task Force's input on the payment reform piece since this was the first time the group was seeing it. Dr. Schaefer added that consumer materials were being tailored for the group and that these meetings were being scheduled.

6. Review Stakeholder Engagement and Provisional PRC Work
Dr. Schaefer reviewed Connecticut's current rankings in certain areas of underperformance, such as health disparities, avoidable emergency department (ED) and hospitalization costs. Ms. Mary Jo Condon reviewed the framework for the PCM project, highlighting goals, inputs, enablers, and impacts considered in the model. Ms. Condon reviewed how health equity barriers were considered during the PCM model design. Mr. Supriyo Chaterjee mentioned that certain quality metrics from the Quality Council captured health equity barriers. Ms. Condon agreed and mentioned the alignment was going to be useful in understanding the impact on underserved populations.

Ms. Condon reviewed how the capabilities are presented during stakeholder engagement and described the process for how these capabilities were chosen. Ms. Condon explained how these capabilities will need to be supported by infrastructure and analytics and that supplemental bundle money can be used by Advanced Networks and Federally Qualified health Centers to further their successful implementation. Ms. Condon also reviewed the design process and how this effort is currently developing recommendations and engaging stakeholders on the preliminary model. Ms. Condon went on to explain how patient stories help contextualize the capabilities and display how a practice may change under PCM.

Ms. Condon explained to the Task Force that PCM envisions a gradual implementation of capabilities over the five-year demonstration with supplemental funds for technical assistance, a learning collaborative to share best practices and lessons learned, and support from the state. She explained how the capabilities would be scaled up over time and that, as a foundational capability, diverse care teams would need to be slowly introduced and augmented over time. Dr. Stone mentioned that it will be important to educate PCPs around the goals and care team work prior to implementation of capabilities. Dr. Schaefer explained that there is a tension around whether to have high level objectives or more prescriptive requirements. Dr. Douglas Olson added that accounting for supplemental funds will be important and it may be good to have OHS track geographic location to ensure a diverse care team is correctly instituted. A Task Force member then asked why behavioral health isn't a greater focus in year one and how the model seems to underestimate the amount of work taken for primary care practices to understand and make use of community services, adding that these services are not adequately funded and will need additional funds. Ms. Condon replied that the phased-in implementation plan is just an example and that there would need to be flexibility based on the individual needs of a practice's patients. Ms. Condon agreed that coordination with community services can be resource intensive and that the payment model accounts for this as a permissible use of supplemental bundle funds. Dr. Schaefer then added that there would be a need for ANs/FQHCs to provide an implementation strategy in order to be accountable for the funds used for PCM. Dr. Andrew Selinger mentioned that PCM should also require some detail around how care teams will be hired, what they will spend their time on, how their duties are defined, and so on as part of the blueprint for transformation. Ms. Condon mentioned that a number of these details are outlined in the diverse care teams two-page summary the detailed document linked within the summary.

Ms. Laurie Doran reviewed why an upfront investment is needed to implement transformative care in shared savings arrangements through the example outlined in the provided meeting materials. Mr. Chaterjee mentioned that the University of Pennsylvania Health System's community health worker (CHW) implementation strategy yielded lower readmissions and improved outcomes. He added that CHWs as an intrinsic part of the team and that with consistent training can have a great impact. Dr. Schaefer agreed and discussed other areas where CHWs would have an impact if they were part of a care team and went on to say that measurement of CHW's impact will be important to consider, but that it wouldn't be necessary to continually assess CHW inclusion on teams, but rather better to understand their impact on outcomes.

Ms. Doran mentioned that PCM would be paid by two advanced payments, the basic bundle and the supplemental bundle, and that services not included in the bundles would still be paid fee-for-service. She reviewed attribution, what services the bundles included, the basis of their calculation, how they're adjusted, and who they're paid to. Ms. Lesley Bennet asked for a clearer idea of what is included in the basic bundle. Ms. Doran replied that it included services provided by the PCP for adult and pediatric sick office visits, as well as preventive or well visits, including alternative ways to

engage patients, such as video visits. Dr. Selinger then asked whether the providers would be responsible for recording patient care for billing similar to current practice since they won't need to record detailed CPT codes for reimbursement. Dr. Schaefer replied that the PRC wanted to continue billing similar to current practices to ensure information is captured correctly. Dr. Schaefer went on to highlight how PCM is proposing the supplemental bundle include infrastructure, HIT, patient care incentives, and patient-specific expenses to address social needs. Mr. Chaterjee added that there is a system called SMMS for medication management that should be considered. Dr. Olson asked how this would change costs of care. Ms. Doran replied that the supplemental bundle would allow for the flexible delivery of care and create efficiencies, while also allowing for convenience for the patient. She went on to explain how implementation of the capabilities will help patients receive care earlier when issues are less expensive to address.

Dr. Schaefer pointed out that the access tracking reports are meant to ensure patients are not being underserved due to bundled payments. Ms. Doran explained that the purpose of the tracking reports is to understand how the bundled payments are being spent and to capture the correct categories of patient encounters with the appropriate care team members. Ms. Doran described how different types of visits with each team member would be tracked and that different types of drill downs would allow for a better understanding of patient encounters with their primary care practices. Mr. Chaterjee agreed that these are the right pieces of information to collect regarding underservice and patient selection and that it would be important to match these encounters with the spending documentation. Dr. Selinger added that it is unfortunate that consumers are worried PCPs will cherry pick and underserve them. Dr. Randy Trowbridge then asked how tracking would reflect that since a patient might be seen at the practice less. Dr. Schaefer replied that there would be simultaneous measurement of quality outcomes to ensure better care for the patients. Ms. Bennet commented that the hypothetical data shown in the access reports should better reflect the average number of visits per-patient per-year to provide better context.

Ms. Doran then reviewed the trade-offs of having a basic bundle or using additional codes and fees for PCP service delivery with the Task Force. Dr. Stone mentioned she is worried if the basic bundle is a requirement, then there will be lower participation in PCM, making large-scale transformation difficult. Dr. Olson added that PCM could do what Medicare has done with MSSP and incentivize early adopters, which could give them more benefits and flexibility through self-selection based off readiness to implement the basic bundle.

7. Adjournment
The meeting adjourned at 8:08pm.