STATE OF CONNECTICUT
State Innovation Model
Practice Transformation Task Force

Meeting Summary
May 21, 2019
6:00 – 8:00 p.m.

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

Members Present: H. Andrew Selinger; Elsa Stone; Douglas Olson; Susan Adams; Daniel Lawrence; Lesley Bennett; Randy Trowbridge; Beth Cheney; Leigh Dubnicka; Alta Lash; Juan David Ospina; Lori Pennito; Supriyo Chatterjee

Members Absent: Mark Vanacore; Anne Klee; Jesse White-Frese; M. Alex Geertsma; Heather Gates; Rowena Rosenblum-Bergmans; Shirley Girouard; Kate McEvoy; Grace Damio; Anne Klee

Other Participants: Mark Schaefer; Stephanie Burnham; Ellie Bloom; Mary Jo Condon; Laurie Doran; Ken Lalime; Karen Siegel; Laura Morris

1. Call to Order
The meeting was called to order by Ms. Lesley Bennett at 6:00 p.m.

2. Public Comment
There was no public comment.

3. Review and Approval of Meeting Summary
Ms. Lesley Bennett asked for a motion to approve the April 16th 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
Ms. Laurie Doran reviewed the purpose of the meeting which was to discuss the response to the CAB Public Comment, review project model savings, performance measurement and accountability, discuss stakeholder feedback on the PCM model, and give an update on Medicare primary care programs.

6. Review of the Consumer Advisory Board Public Comment Response
Dr. Mark Schaefer went over various terminologies with the Task Force, such as "bundled payment" to refer to payment methods that bundle the costs associated with specific services, procedures or conditions, and "capitation" to refer to models in which a provider organization or managed care organization is paid a monthly premium for all or nearly all of the costs of care. He explained that in order to avoid any confusion, this effort uses the term "bundled payment" rather than "capitation" to refer to the bundling of primary care services, whether rendered by a PCP (Basic Bundle) or by members of the primary care team (Supplemental Bundle). Dr. Schaefer noted that the Payment Reform Council has not recommended capitation in the form of a monthly payment for all of the costs

of care and that, regardless of terminology, this effort recognizes the concerns of some advocates that bundled payment may result in less care for a population, such as people with disabilities.

Dr. Schaefer noted Task Force members were provided the draft responses to the public comments two weeks ago, and explained that because the response had different origins, they broke it up into different sections (**A** through **F** in the provided materials). Dr. Schaefer then reviewed the comment sections with the Task Force. He noted how Freedman HealthCare has kept an exhaustive inventory of all consumer comments. Dr. Schaefer went on to say that Ms. Arlene Murphy and Mr. Kevin Galvin have resigned from the Consumer Advisory Board (CAB), that the CAB has lost several other members, and that a total of twelve members remain to resume the work of the CAB under interim leadership that is to be determined.

Section A

Dr. Schaefer then reviewed the comments and questions submitted by the Consumer Advisory Board (Section A in the provided materials). Dr. Schaefer shared how consumers expressed concerns that the proposed bundled payment would be at downside risk for all or most of care, meaning that providers could lose reimbursement if they do not generate enough savings in all medical expenses. Dr. Schaefer then explained that PCM will provide higher risk-adjusted payments for patients with complex medical and social needs, monitor the volume of patient encounters and "touches" to flag under-service, disseminate consumer surveys to determine whether primary care services are more accessible and convenient, and deploy quality measures to hold providers accountable for good health outcomes. He added that encounter reports will help hold providers accountable for how they are using their time and the supplemental payments will be adjusted to recognize those with greater social needs. A Task Force member noted that some of the information in Dr. Schaefer's oral presentation should be clearer in the provided materials. In addition, it was noted that at least with Medicare, there is an appeals process if people feel as though they are being underserved. Dr. Schaefer agreed, and acknowledged that the Office of the Healthcare Advocate (OHA) does a similar process today.

For the CAB comment about how the Payment Reform Council (PRC) has not specifically recommended or required downside risk, Dr. Schaefer discussed how Medicare is moving to downside risk over time, and how the Payment Reform Council has recommended each PCM sit within the payer's existing total cost of care accountability program.

Dr. Schaefer then reviewed the CAB comment over how it is unclear how the payment model would improve care for patients and families. The CAB gave the example of how some of the most important elements of primary care reform (care coordination, community integration) would be funded through the supplemental bundle and that the basic bundle appears to only include payment for physicians, physician assistants, advanced practice nurses, and telehealth. Dr. Schaefer went over the provided response to the CAB that reiterated the basic and supplemental bundle definitions and purpose. He also pointed the Task Force to the compendium of two-page summaries of the capabilities that the bundled payments are intended to enable. These two-page summaries outline the benefits to patients, families and providers and also to the goal of improving health equity, Dr. Schaefer added. He explained how any video services provided would be a part of the basic bundle before moving on to discuss how it will be up to the ACOs to demonstrate that they are actually investing the extra payment in line with the capabilities. Dr. Schaefer noted that the two pagers were intended to answer the question: Why is this good for consumers?

Another comment from the CAB talked about how it has not been demonstrated how the proposed payment model would address Connecticut's significant health disparities. Dr. Schaefer explained how each capability does this in a different way, and that for each capability.

A comment from the CAB discussed how 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. Dr. Schaefer explained how the PRC recommends that providers be permitted to use the Supplemental Bundle funds to pay for infrastructure costs needed to measure and address access, quality of care and patient experience as they relate to the proposed PCM capabilities. Dr. Schaefer noted that the more that is put into the infrastructure, the less they have for care teams.

Section B
Dr. Schaefer stated that many of the questions submitted in Section B asked about specific capabilities, therefore, this effort referred the questioner to the corresponding two-page summary. He added that questions were also raised about patient risks/protections and whether PCM has developed a package of quality and under-service measures. He referred to a package of Access Tracking Reports that have been developed to show one of the ways access would be tracked. He also discussed proposed new targeted surveys of individuals with disabilities to assess and reward improvements in their ease of access to primary care.

The CAB also raised questions about workforce capacity. Dr. Schaefer read the provided OHS response (see materials) and noted that its PCM's intent is to work with the Department of Labor's Office of Workforce Competitiveness (OWC) once it's clear this project is moving forward. Together, a pipeline will be created to help support an expansion in the available workforce to effectively support diverse care teams (including CHWs). Ms. Bennett asked if there was legislation around this, to which Dr. Schaefer confirmed that this effort will discuss the status of the legalization in its response.

Section C
The CAB questions in this section raised concerns over time frames and how materials were not getting to participants with enough time to prepare. Dr. Schaefer explained that although PCM consultants have made adjustments to the process to address these concerns, concerns about the consumer voice in the design group process have continued. Dr. Schaefer confirmed that all meeting materials were accessible to the public. Ms. Morris said there should be a better communication loop between members of the CAB and the design groups. She added that the CAB felt things were simply moving along too fast and that they were not being kept up to speed about what was happening.

Section D
The Task Force then reviewed the comment brought forth by Ms. Patricia Baker and Dr. Lisa Honigfeld that recommended the inclusion of preventive services in the basic bundle and a greater focus on health promotion and population health. The second part of their comment referred to the inclusion of non-health outcomes such as school readiness in the PCM payment model. Dr. Schaefer explained how the PRC added preventive visits to the basic bundle for pediatrics and that the supplemental bundle helps put a greater focus on health promotion and population health. Dr. Schaefer also agreed that things like school readiness are extremely important to a child's wellbeing, however, this effort will not be recommending this (and other non-healthcare related subjects) to be apart of the payment reform process at this time. Dr. Schaefer reassured that this effort does have plans to help measure it, but just not attach it.

Section E
Dr. Schaefer then reviewed the CAB comment focused on the potential risks associated with the basic bundle regarding under-service, in addition to the introduction of downside risk as part of the associated total cost of care payment model. Dr. Schaefer explained how PCM has included the

Access Tracking Report and other transparency/accountability measures to ensure that patients are getting better access. He added that it has not yet been decided whether PCM will include the basic bundle and that PCM has been asking stakeholders whether they feel the benefits of the basic bundle outweigh the risks. Dr. Schaefer said that discussions with individuals with disabilities, we repeatedly heard stories about how difficult it is to find a primary care provider if you have significant disabilities. He discussed how this is one of the weaknesses of today's fee-for-service reimbursement model, which provides no incentive to serve individuals with disabilities. Providers report that serving such patients can make exceptional demands on the time and resources of their primary care practices. Patients with disabilities can be more challenging to treat and sometimes have complex medical histories that require extensive review. Yet the FFS reimbursement for such individuals is no more than it is for other patients. The PCM payment model provides this additional reimbursement. Dr. Schaefer explained how PCM will adjust the amount of the bundled payments upwards to consider disability status and other complex medical and social needs. This will, in turn, create incentives to accept people with disabilities into all participating primary care practices. In addition, Dr. Schaefer explained how PCM plans to test out these access assumptions through targeted surveys for individuals with disabilities to assess and reward improvement in ease of access. In contrast, Dr. Schaefer added, FFS provides no incentive to serve individuals with disabilities. Patients have reported that it is very difficult to get access to primary care for individuals with disabilities. Providers report that serving such patients can make exceptional demands on primary care practice time and resources, for which they are simply not compensated through FFS. Patients with disabilities can be more challenging to treat and sometimes have complex medical histories that, with new patients, take a long time to review.

Task Force members agreed that more of Dr. Schaefer's comments should be included in writing in the response.

Section F
This section compiled an extensive range of comments that consumers made during the design groups. Dr. Schaefer explained how that PCM provided the design groups with a link to the skeletons and two pagers to help further explain the capabilities. Ms. Morris stated that she found the two paged documents to be very helpful in keeping consumer up to date and felt that they were very easy to read. Ms. Morris suggested that this effort takes some of that plain language and add it to these materials.

Dr. Olson then stated that the comments made by the CAB are only going to strengthen the PCM project. Mr. Juan David Ospina agreed. Dr. Elsa Stone then moved to approve PCM's response to the CAB comments.

Ms. Bennett asked if all were in favor of approving the CAB comments.

All were in favor.

7. Review Savings, Performance Measurement and Accountability
Ms. Laurie Doran reviewed the slides providing evidence of the PCM capabilities saving money over time. A Task Force member added that a lot has changed since the provided studies and papers came out, and Ms. Doran agreed and explained that PCM is simply using these sources to try and determine feasibility.

Ms. Doran then reviewed the slide showing how savings increase as the capabilities improve outcomes. Dr. Doug Olson agreed with the presented numbers. Ms. Doran added that if people really

wanted to be a shared savings program, they would go further than the 2% shown (see materials). Ms. Doran then clarified that this is the delta between the savings previously discussed and the glidepath investment of the capabilities. This happens to be a Medicare exhibit, she added, but this effort is also working with commercial payers in addition to looking at what national payments look like. A Task Force member then stated they did not understand where the 4.7% deployed spending to primary care came from (see materials). Ms. Doran explained that the provided chart simply shows the total savings potential, and that the 4.7% is taken from the next slide (i.e. $45 PMPM is about 4.7% of the total medical expense right now in CT primary care). Ms. Doran stated that this effort will be taking 6.6% out of avoidable care, and that at the end of the day, you are looking at about a 2% impact. Essentially, Ms. Doran continued, PCM is looking at about $970 a month for a Medicare beneficiary, and $63 out of that $970 is avoidable. But, Ms. Doran stated, that $63 doesn't come free.

Ms. Doran went on to review the glidepath with the Task Force, and reviewed the year-to-year change, explaining that high-value care needs to be put forth to be able to generate savings. By year three, there needs to be financial evidence that the program is sustainable, Ms. Doran noted.

Ms. Doran then reviewed the slide depicting the transformation of care across the delivery system. She explained how it shows how PCM is a combination of setting goals and determining how to best meet those goals (the goal being to get people to go into primary care and stay there).

8. Review Stakeholder Feedback

Ms. Doran reviewed the stakeholder feedback overview with the Task Force (i.e. how PCM met with 6 payers, 6 advanced networks, 2 physician training groups, 6 employers, etc.). A Task Force member asked if PCM had met with stakeholders about this, to which it was explained that PCM is in the process of preparing materials and soliciting comments from the CAB. They went on to state that 99% of people would not be able to understand what was being presented. It was suggested that these materials be revised. Ms. Doran acknowledged that this was helpful.

Ms. Doran then reviewed the basic bundle feedback and other stakeholder feedback to date. Dr. Selinger asked what the point was of going from specialized practices to specialized clinics, to which Ms. Stephanie Burnham explained that specialized clinics are more of a focus that can occur within a practice. Ms. Mary Jo Condon agreed. It was mentioned how the term "clinic" sounds a bit depersonalized. Dr. Schaefer acknowledged this change.

9. Update on Medicare Primary Care Programs and Next Steps

Ms. Doran then reviewed the new Medicare primary care programs slide with the Task Force and discussed next steps, which are to conclude the remaining stakeholder engagement meetings, have the PRC review a draft report summarizing the capability and payment model, and send the report to HISC for approval to send to public comment.

10. Adjournment

Ms. Bennett motioned to adjourn the meeting. Dr. Stone accepted the motion to adjourn.

The meeting adjourned at 8:00pm.