Alternative Payment Methodology & Measurement-Based Care
October 27, 2021
2:00 pm – 3:00 pm
Co-Chairs: Eric Schwartz, Tim Marshall, Jeff Vanderploeg

1. **Welcome & Introductions (:03)**
   Jeff opened the workgroup meeting and introduced co-chairs and presenters.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline (:02)**
   Tim Marshall overviewed the above workgroup goals.

3. **Presentation from OHS on the Prospective Primary Care Payment Model (:10)**
   Victoria Veltri, JD, LLM is the Executive Director of the Office of Health Strategy. Veltri provided a brief update about the executive order #5. It's been in place since January 2020. It directs OHS to set cost benchmarks, and to set primary care spending targets as a percentage of all medical expenditures to create quality benchmarks.

   The primary care shortage in the state of CT is deepening, including challenges with internal medicine and pediatric care. The state intends to double the spending expenditures on primary care by 2025. Medicaid is already at 9-10% and so is ahead of the state as a whole. There are multiple recommendations underway in the state to address both patient needs as well as the challenges that primary care physicians have identified. The state wants to make sure physicians are equipped with the supports they need. They also address many needs that go beyond the clinician.

   In a traditional fee-for-service model, practitioners don't have enough time to spend with people. The practitioner is there to address a specific health problem and does not always have time to get to additional problems. As an example of integration of BH in primary care, looking at having clinicians being a part of the practice that can provide brief treatment, assessment and referral for substance use. Smaller providers will need much more assistance. OHS is considering support through practice coaching and a learning collaborative - this would need to be funded, and there is more to come with additional budget information.

   OHS is listening to the many organizations that have told us they are not ready to do a prospective payment model or want to. There is consideration of how to roll out, including a voluntary prospective model for those that want it and/or a potential fee-for-service path where providers with agreement to achieve key functions to get the enhanced payments. The intent is to incentivize primary care to improve the primary care space and work towards high-quality patient-driven care and reward those who do it well.

   OHS is anticipating putting out a draft road map in November 2021 for public comment before finalizing, and then begin discussions on an implementation plan for 2022. OHS is really committed to community health models that incentivize upstream investment and encourage other linkages with primary care.

   Eric Schwartz read the following questions from the chat box: ***How does the number of behavioral health clinicians align with the requirement to have one in each practice that wants to participate?*** Most primary care practices would love to have a BH clinician in their practice but cannot find or

afford the staff under the current reimbursement rates. ***Another question in the chat asked if the prospective payment model would include any specialty care.*** Veltri answered that it depends on the route the practitioner takes, under the perspective payment model, team-based practice is based on a budget. It's based on the number of patients the practice has and is multiplied by how many services they are to have (with risk adjustment) the payment is expected to pay for the team. On the fee-for-service side it would need to be included in reimbursement rates – this would need to be addressed with commercial carriers. This is still TBD because there isn't an implementation plan yet; we are still focused on the high level road map.

4. **Presentation on APM Modeling for Pediatric Populations (BE-InCK NY) (:35)**
   Henry Chung, MD Professor of Psychiatry, Albert Einstein College of Medicine Consultant, Montefiore Care Management Organization

   Dr. Chung presented on the APM model for pediatric populations for the InCK program in New York. From a population health perceptive the place to start is primary care. When you start going down the road with pediatrics there are a lot of challenges. A lot of work done with families and children is preventive, so it is challenging to achieve savings. That is why most APM models are focused on adults.

   Partnership is key to be successful in an APM. For the InCK model, pay for performance, bundle payment approach, shared savings with no downside, full risk capitation model all can potentially be successful.

   There are unique considerations for pediatric APM. Children and youth services not only result in less cost savings across the board but they are also served in so many more non-clinical settings that impact their health outcomes than adults are. For example, early intervention systems, schools, child welfare, etc. A lots of these related services are not reimbursable.

   There is a lot to think about in regard to the model: how will you build an accountability model, considering longer term savings down the road, data infrastructure is critical, and the stakeholders who are interested in quality measures. Quality measures in pediatrics focus on prevention but have a key role to play in terms of the premium dollar in New York Medicaid and Commercial payers. In New York high scoring health plans get large premium adjustments that are meaningful and therefore pediatrics can play a role in that space.

   With the New York InCK its being thought that from a population standpoint there can be two buckets: (***1) healthy children who don't appear to be high cost in the moment or have significant risk factors for chronic illness*** (this is called the service integration level 1 and about 75%-80% of the Medicaid participants are going to fall into the category); ***(2) children whose high utilization is preventable (e.g. asthma, depression, attention deficit, etc.).*** We should be developing two types of APMs within the larger APM model. If you segment the population to service integration level 1, generally healthy Medicaid kids, there's a much more likely chance of being successful with quality measures (e.g., child welfare visits, wellness checks at appropriate levels, immunizations, etc.). You're going to get more for reward dollars but less cost savings. With the children that use the ED a lot, asthma, sickle cell, behavioral health, there are cost savings to be achieved. The weighting of the incentive would be evenly split between the cost saving measures. This component has not yet been implemented.

One of the things that is being tested is starting with smaller APM models to build to up and forward. The Healthy Steps model, starts with 0-3, could go to 0-5. It's hard to make Healthy Steps reimbursable without a clinical diagnosis. One of the things being worked on is a monthly bundled supplement with providers who are willing to do the Healthy Steps program. Even though it's largely a primary care model, it's often times beyond what primary care providers can do.

A questions was asked if there was any data that demonstrates results in cost savings for services to kids? Dr. Chung answered Yes –the evidence base is starting to grow. There are subsets where's it's meaningful (e.g., kids with asthma, sickle cell – this is one of the highest cost diagnoses for children). There is a little data emerging, but it's not clear yet because the savings typically accrue outside of the health care system. If you prevent one kid from going into a residential setting that is a big cost savings.

Another questions was asked about early thoughts on structure to behavioral health providers, mechanics of getting the cost savings. A question in the chat noted that most primary care practices would love to have a BH clinician in their practice but cannot find or afford the staff under the current reimbursement rates. ***How will this be addressed?*** The best analogy would be the collaborative care model on the adult's side. When behavioral health providers are in primary care, consider who pays the specialist. In the advanced primary care model, the behavioral health agency is willing to provide licensed mental health providers to the primary care office. Question is who bills for that in the pediatric office.

5. **Wrap-Up, Next Steps and Adjournment (:10)**
   Eric Schwartz thanked the presenters and the meeting was adjourned.

6. **Chat box**
   Note that comments from the chat box were included in the minutes above.

Next Meeting Date:
November 17, 2:00-3:00 p.m.