STATE OF CONNECTICUT
State Innovation Model
Payment Reform Council

Meeting Summary
October 11, 2018

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

Members Participating: Terry Nowakoski, Kate McEvoy, Thomas Woodruff, Joseph Quaranta, Naomi Nomizu, Eric Galvin, Robert Block, Peter Bowers, Robert Carr, Ken Lalime, Jess Kupec, Peter Holowesko

Other Participants: Mark Schaefer**,** Gail Sillman, Alyssa Harrington, Laurie Doran, Pano Yeracaris, Janice Perkins, Jenna Lupi, Mary Jo Condon, John Freedman, Curt Degenfelder,

Not in attendance: Fiona Mohring, Tiffany Donelson

1. Call to Order
Dr. Nomizu called to order at 6:00pm

2. Public Comment
There were no public comments.

3. **Approval of the Minutes**
The PRC reviewed meeting minutes from 9/20 and 9/27. Dr. Quaranta made a motion to approve. Mr. Galvin seconded the motion.

4. Purpose of Today's Meeting

Ms. Doran gave an update and reviewed the purpose of the meeting:

1. Confirm qualified provider organizations

2. Discuss services to include in basic bundle

3. Revisit discussion of hybrid versus full basic bundle

4. Determine whether retrospective attribution should be used to settle payments

Ms. Doran reviewed insurance risk and performance risk as follow up from last meeting. Provider risk arrangements compare provider specific performance.

5. Qualified Provider Organizations

- At the suggestion of Dr. Quaranta, removed "provider governed" from the definition as most ANs are governed by boards that include provider participation.

- Ms. Doran notes PCM is strategy to support participants in upside/downside risk models, not intended to replace these programs. Meant to be complement. Also, most ACOs in CT will transition to downside risk in July 2019 unless they decide not to stay in MSSP. Current MSSP contemplates glide path to move to downside risk with appropriate corridors.
- Ms. McEvoy noted Medicaid only has upside risk and no mechanism for downside risk.
- Mr. Galvin suggests establishing a target and sharing in performance-based upside.
- Mr. Schaefer notes total timeframe will be 10 year demonstration, with a 5-year PCM commitment and then revisit in five years. He suggests proposing: Commits to downside risk as condition of participation. Timetable and extent of risk TBD.
- Ms. McEvoy notes different payers may need different timeframes. Medicaid focused on preserving robust provider network and unintended consequences on access and cherry-picking.
- Mr. Schaeffer notes CMMI said we need to be assured of substantial savings which haven't seen in MSSP if we're going to put in upfront payments over several years. Need assurance of this. Cost benchmarks and risk arrangements are one way to do this. How else would you provide assurance of this? Not to say there's not a more understanding side – CMS isn't necessarily going to take a harsh position but takes a lot to operationalize a state demonstration and this is something they're going to expect. Hear the same thing from employers – we want to turn the curve.
- Several provider members of PRC note some limitations of MSSP including lack of upfront investment.
- Mr. Holowesko notes that as an employer he can envision fully steering our employees toward primary care provider groups that have made investments and aligned financial incentives in ways that we've talked about. Willing to invest in primary care to see that value. He understands hesitations from business standpoint but we as large payer are very committed to making this happen and won't make payments on FFS.
- Mr. Woodruff agreed. He said he is already steering members to go towards incentives but we're narrowing this to groups that embrace payment reform further including downside risk.
- PRC determines eligible providers will participate in Medicare programs with risk criteria TBD.
- PRC also determines practices (as defined by TIN) not participating in MSSP will also not participate in PCM. Any practice (as defined by TIN) participating in MSSP will need to participate in PCM.

6. Services to Include in the Basic Bundle

- Ms. Doran shared the next part of the discussion will focus on which services should be included in the basic bundle.
- Ms. Doran presented three criteria:
    - Services that account for a significant portion of primary care practice revenue so that the dollars collected from the bundle are sufficient to support practice transformation;
    - Services that are an important part of care for the population served by the program
    - Services provided by the majority of eligible providers
- Mr. Schaeffer proposed a forth criteria: services are not to susceptible to underservice risk.

- Ms. Doran noted the PCM starting point might be the current code set leveraged by CPC+.
- The PRC discussed that some care currently provided in the office might move to non-office-based touches, essentially freeing up physician time and increasing convenience for patients.
- The group discussed whether it may want to include some additional payment on top of the historical experience in the basic bundle to account for services not traditionally billed but already delivered and essentially built into today's FFS payment.
- Group also discussed the potential for underutilization of preventive and wellness visits if included in the basic bundle.
- Dr. Quaranta noted there may need to be different services included depending on the payer.
- PRC agrees that BH screening should be included in the basic bundle.
- Ms. Doran proposed a strawman.

"Strawman" Services Included in the Basic Bundle:

- **Included for all Practices:** Office Visit, new or established patient, Prolonged Encounter, Encounter Payment for FQHC Visit, Behavioral Health Screening, Cognition Assessment, Phone/Email/Text, Telemedicine, Home Visits (limited use), Shared Visits (limited use)

  Not Included at this Time: Hospital, SNF rounding, Immunization Administration, Preventive Medicine Visit, Preventive Counseling, Annual Wellness Visit,

Dr. Nomizu adjourned the meeting at 8:10 pm.