STATE OF CONNECTICUT
State Innovation Model
Payment Reform Council

Meeting Summary
November 15, 2018

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

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

Other Participants: Mark Schaefer**,** Gail Sillman, Alyssa Harrington, Laurie Doran, Jenna Lupi, Mary Jo Condon, John Freedman, Curt Degenfelder, Eve Berry, Pano Yeracaris, Tyler Anderson, Dan Lawrence, Heather Gates

Not in attendance: Fiona Mohring, Kate McEvoy, Peter Holowesko

1. Call to Order

2. Public Comment
Ms. Lisa Honigfeld shared the public comment. There was no discussion. It was asked to include the public comment discussion in the next agenda to see if there are further perspectives about approving pediatrics.

3. Approval of the Minutes
The 11/01/18 meeting minutes were approved.

4. Purpose of Today's Meeting
The purpose of the meeting was to review the revised funds flow language, discuss the basic and supplemental bundles, methods of accountability, and risk adjustment under the supplemental bundle.

5. The Basic and Supplemental Bundles
Dr. Robert Carr said he did not think the group had concluded that the supplemental bundle was best paid to the Advanced Network, as opposed to individual providers. FHC explained that it was their understanding there was a consensus over the supplemental bundle being made available to the Advanced Network, but the group can certainly delve into this more if needed. Dr. Nomizu thought the PRC did agree to this, explaining that the group more so discussed how to ensure funds would be used for specific purposes going to primary care. Dr. Carr clarified that the conversation they had was related to the size of the network, the ability of funds to trickle down, and if it makes more sense for funds to flow to the system. Members agreed they would discuss more before making a recommendation.

The PRC reviewed the results of other models that increase investment in primary care, keeping in mind that no model offers the same as the capabilities currently under consideration. The takeaways were that most programs generate 1-2% savings each year.

The PRC then reviewed permitted uses of the supplemental bundle. Should there be any prohibited uses or restricted uses? Dr. Carr explained that every single one of the items discussed should be focused within primary care. Some seem general, he continued, and could dilute intention. Ms. Terry Nowakoski asked for a more detailed explanation of community integration (one of the capabilities defined by the PTTF). It was explained this capability entails purchases of community-placed services by a primary care network to better enable certain primary care healthcare outcomes. An example of this capability can be seen in the contract between primary care providers and the Department of Public Health in addressing asthma. Another example can be seen in primary care providers and community health workers monitoring diabetes self-management in the home.

Dr. Nomizu asked about transportation, housing, and delivering food. CMS is signaling the need to give flexibility in this area, Dr. Schaefer said. Since this is emerging late, the Council could suggest that those expenses be considered a legitimate expense of the supplemental payment. Dr. Schaefer explained that if the PRC believed it would be useful and flexible, then it can be included in this effort's request to the federal government.

Dr. Carr discussed incentivizing patients for certain behaviors, and Dr. Schaefer added that the Department of Social Services has rewards to quit incentive programs. This effort could ask Medicare for permission to allow this kind of flexibility. Dr. Pano Yeracaris stated that he was fine within the limited scope but is worried that as non-personnel and support functions are added, we'll find they are expensive and it's important to ensure core items are funded.

The group noted that some capabilities may need to be staged and that it will be helpful to have a more detailed understanding of the capabilities' definitions. Dr. Schaefer agreed and said the model also intends to give providers sufficient flexibility. The group also agreed that there should be options that allow groups to scale up over time – in terms of the amount of the supplemental bundle, the capabilities pursued and the level of risk assumed.

Dr. Nomizu asked provider organizations should need to "prove" proficiency at a certain level before moving to the next. There was agreement that this is a point to consider more fully.

Eric Galvin asked if payers should be able to recoup payments not used for approved purposes. Advanced Networks could pay back funds, or use them in the following year, subject to payer approval. Restriction on funds not used within the past two years for approved purposes would be recouped. Mr. Galvin pointed out that some ACOs in the market today have some of these elements. Dr. Joseph Quaranta stated he had no problem with this approach.

Mr. Eric Galvin asked if anyone had questions on the sliding window of two years, recognizing there are activities late in the cycle. He explained there's a sliding window of time when allotment of funds are to be used as approved. Would individuals rather keep this as one year or two year? PRC members had questions about the timing of the payments and the need to define whether certain activities would be approved functions and how unused supplemental bundle payments would be included in total medical expense. The group agreed some decisions could be made later and the question would be revisited at the next meeting.

Mr. Galvin then moved the conversation to a discussion of whether the supplemental bundle should or shouldn't be included in medical costs? Dr. Quaranta said these are extra services and usually do not break-even. He said it costs providers more to put them in place and we are not getting enough funding through payments to fund year-by-year investments. Dr. Schaefer pointed out one

challenge is that there is no upfront investment under MSSP, so providers essentially have to generate $100K in savings to get a 50% share in an MSSP to offset investments. Today, providers can only invest in 2:1 ROI and get any return. That's barely sustainable. That's a tough proposition, Dr. Schaefer said. He noted that in an advance payment model, providers will get a share of savings and will be better off than a current MSSP.

Dr. Quaranta explained the problem is that exposure to downside risk doesn't make it worth the investment. If you must pay back multiples of what you got paid upfront, then there's not a very strong one. In a new scenario, Dr. Schaefer described, total medical expense could be shared equally between a provider and a payer. Mr. Galvin stated that there isn't an underlying assumption that the supplemental bundle sufficiently funds. Activities should be fully funded by the supplemental bundle, and if they're not, there's some inefficiency that must be subtracted.

Dr. Quaranta stated that if the group could agree that the supplemental bundle covers the cost, he would need to see the funding amount and what services would be required. The problem is when this risk goes beyond that, Dr. Quaranta explained. Dr. Schaefer responded that the advanced payment folded into the total medical expense is a better deal than you have today, but if the downside is not limited (especially in the early years by a reasonable cap on loss) it's unworkable. With the reasonable cap on loss, it may be a reasonable path forward on what is a stalemate today.

Mr. Jess Kupec added that part of the problem is the way these models are contemplated. It takes multiple years to realize savings. The way the model is set up, it needs some downside protections early on. Investing in years one and two may not see a return until year three. Mr. Kupec explained that in his experience in MSSP, millions of invested dollars did not generate many shared savings beyond our corridor. This is not a short-term play, but a long-term play. Sometimes we think it will happen in one year, and then it doesn't happen in that timeframe, Mr. Kupec stated. Dr. Schaefer asked about a mix between scenario four and two (shown on the slides) where in the first year, there's an attachment point to the supplemental payment amount so you're protected against any risk in the first year. In the second year, you're protected. Mr. Kupec responded that a hybrid model could work, but there needs to be some protection in there. No one wanted to move out of track one and assume downside risk because of this discomfort, Mr. Kupec explained.

Mr. Galvin noted that putting a payer at risk for an entire supplemental bundle is a challenge. It depends on the environment, for there will be pressures on how much, and these aren't percentage margin businesses. Dr. Schaefer asked that if he gave an ACO $10 PMPM, was it reasonable (if it were invested wisely) to expect improvement? He asked if it was realistic to expect an initial investment to return the same investment in that year. Mr. Galvin responded that it doesn't matter if it's the payer or provider, it's almost impossible to return a 1:1 in the same year.

6. Next Steps

FHC will go back and develop model options that offer providers additional protections and a gradual glidepath to move from shared savings to downside risk models.

7. Adjourn

The meeting adjourned at 8pm.