# STATE OF CONNECTICUT
# State Innovation Model
# *Payment Reform Council*

**Meeting Summary**
**December 17, 2018**

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

**Members Participating:** Terry Nowakowski, Joseph Quaranta, Naomi Nomizu, Eric Galvin, Ken Lalime, Kate McEvoy, Robert Carr, Robert Block, Tiffany Donelson, Jenn Searls (on behalf of Jess Kupec), Thomas Woodruff

**Other Participants:** Mark Schaefer, Laurie Doran, Mary Jo Condon, John Freedman, Curt Degenfelder, Jenna Lupi, Linda Green, Pano Yerocaris, Gail Sillman, Janice Perkins, Richard Guerriere, Athena Dellas

**Not in attendance:** Peter Bowers, Jess Kupec, Peter Holowesko

**1. Call to Order**
The meeting was called to order at 6:00 p.m.

**2. Public Comment**
None

**3. Approval of the Minutes**
The PRC reviewed and approved meeting minutes from 12/6. ***Ken Lalime motioned to approve the minutes. Robert Carr seconded. All in favor.***

**4. Revised Supplemental Bundle Targets**
Ms. Doran began walking through an example of why in a Medicare shared savings program its more difficult for a provider to feel confident it will generate sufficient ROI. Essentially, providers need a 2:1 return in order to upfront the investment, wait for the return and share savings. The advance payment in PCM helps overcome this barrier.

Ms. Doran then discussed the importance of Medicare participation in PCM. Not only is Medicare an important payer but if other payers contribute and Medicare does not, it requires the dollars to be spread very thin. Ms. McEvoy noted that it was not previously clear to her that Medicaid was a required provider. She also wanted to note that PCM is not the exclusive pathway for a solution to provide additional primary care support to dual eligible beneficiaries.

We've heard the supplemental bundle should have a glidepath and not all dollars should be immediately subject to total cost of care calculations. We've also heard there should be opportunities to stay at certain levels within the program or exit the program if it is not needed.

Ms. Doran then discussed the current MSSP program and how it might applied to PCM. She also discussed how the supplemental bundle glidepath would work, allowing participants to enter at

year 1 or year 2. She noted the goal with the glidepath was to allow ANs/FQHCs to enter in a place where they felt comfortable and gradually achieve the capabilities over time. A hypothetical approach was discussed and is shared below.

**Year 1**: AN/FQHC completes successful application which includes plan for achieving capabilities.

**Year 2**: AN/FQHC completes progress report showing positive progress on plan execution.

**Year 3**: Financial results show savings in excess of Year 1 supplemental payment. If this level of savings is not achieved, ANs/FQHCs will not advance to Year 3 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

**Year 4**: Financial results expected to show savings in excess of Year 2 supplemental payment. If savings are not in excess of Year 1 supplemental payment, AN/FQHC may be terminated from the program. If savings are not in excess of Year 2 supplemental payment, AN/FQHC will not advance to Year 4 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

**Year 5:** Financial results expected to show savings in excess of Year 3 supplemental payment. If savings are not in excess of Year 2 supplemental payment, AN/FQHC may be terminated from the program. If savings are not in excess of Year 3 supplemental payment, AN/FQHC will not advance to Year 5 and will not receive additional increment in supplemental funding and may be subject to a corrective action plan.

Bob Carr noted that while some providers might be reluctant to take on risk, it may be better to have some opportunity for shared savings early on in the program. He noted that if you achieve savings early on, then you may be at a disadvantage down the road.

Ms. Doran then asked the group how they would feel about changing the approach to allow ANs/FQHCs to choose if they wanted to move to MSSP requirements immediately.

Mr. Galvin discussed how payers want all to win and they want there to be a sustainable solution to getting patients the care they need at the best possible cost and quality. But, there needs to be an economical model that forces us all to come to the middle.

Ms. Doran said the team would take these recommendations back and model additional scenarios. Ms. Doran also noted there is more work to be done to better understand how the recommendations for Medicare would apply to Medicare Advantage, Commercial payers, and Medicaid should they decide to move forward.

**5. Risk Lite**

Mr. Schaeffer noted that the slides were developed before a recent discussion with Medicare. During that discussion, Medicare made clear there needs to be sufficient focus on accountability and cost savings. He asked Mr. Lalime whether some FQHCs could participate in a risk arrangement if there was a risk lite approach to begin with that would allow the FQHCs to build the infrastructure necessary to participate.

**6. Accountability and Performance Measurement**

Ms. Doran began with a discussion of principles around accountability.

1. Individual payer shared savings arrangements and corresponding scorecards and other reporting requirements will remain in place, be applied to PCM and be the foundation for performance measurement in PCM.

2. Within the commercial space, the state would request that payers harmonize on the quality measures used for shared savings programs in Connecticut for PCM participating entities.

3. PCM must include additional methods of accountability that demonstrate achievement of PCM transformation process, quality, care experience and savings goals and the absence of underservice and patient selection.

4. The state should enable public performance reporting, which will include reporting by race, ethnic language and disability status.

She then discussed a graphic showing how the state could serve as a central hub of shared accountability data across payers, providers and patients. Ms. Nowakowski noted that data reported publicly should be clearly understood by consumers. Dr. Nomizu asked whether the state has the capacity to develop this infrastructure for reporting. Mr. Schaefer said that with regard to the oversight of the demonstration, the state could build an infrastructure and may ask the federal government for additional funds to meet this goal. Further, OHS is already building a data analytics infrastructure that could meet those needs.

The group then discussed that it may make most sense for the data to initially come from claims, either from the payers or from the all-payer claims database if it is prepared to provide this data. Mr. Schaefer noted that the goal would be to increasingly harmonize around a measure set that would rely on eCQM measures rather than traditional claims measures. He said the goal would not be to simply add measures but rather evolve the measure set to reflect PCM's goals.

Ms. Doran then discussed more detailed possible approaches to accountability and how underservice would be monitored.

Mr. Lalime asked how and when the group would discuss how the model will address uncompensated care.

Ms. McEvoy noted that the group should look at the current 211 system and noted concerns about capacity issues at CBOs currently and how those capacity issues could intensify under PCM.

**7. Risk Lite (Cont'd)**

Ms. Doran then reviewed the risk lite model. She noted that it closely resembles the current CPC plus methodology. She said the elimination of total cost of care accountability can address concerns around underserve. She said risk lite may not be for everyone, but it could offer some combinations of providers and payers a viable approach.

Ms. McEvoy said she appreciates that there is consideration of these matters. She noted the concerns of consumer advocates who have expressed concerns regarding providers' taking on total cost of care risk and regarding the bundling of primary care services.

**8. Adjourn**

The meeting adjourned at 8pm.