STATE OF CONNECTICUT
State Innovation Model
Healthcare Innovation Steering Committee

Meeting Summary
January 12, 2017

Meeting Location: State Capitol, 210 Capitol Avenue, Room 310, Hartford

Members Present: LG Nancy Wyman; Tamim Ahmed; Patricia Baker; Jeffrey G. Beadle; Mary Bradley; Patrick Charmel; Mario Garcia (for Raul Pino); Colleen Harrington (for Miriam Delphin-Rittmon); Suzanne Lagarde; Sharon Langer; Alta Lash via conference line; Robert McLean; Frances Padilla; Ronald Preston (for Bruce Liang); Joseph Quaranta; Robin Lamott Sparks; Jan VanTassel; Victoria Veltri; Deremius Williams via conference line; Michael Williams; Thomas Woodruff via conference line

Members Absent: Catherine F. Abercrombie; Roderick Bremby; Anne Foley; Terry Gerratana; Katharine Wade

Other Participants: Faina Dookh; Ken Lalime; Jenna Lupi; Russ Munson; Mark Schaefer; Lauren Williams

1. Call to Order and Introductions
Lieutenant Governor Nancy Wyman called the meeting to order at 3:01 p.m. (see meeting presentation here). It was determined a quorum was present.

2. Public Comment
There was no public comment.

3. Minutes
Motion: to approve the summary of the November 10, 2016 Steering Committee meeting- Sharon Langer; seconded by Patricia Baker.
Discussion: There was no discussion.
Vote: All in favor.

4. CAB Member Appointments
Jeffrey Beadle reported on the Consumer Advisory Board (CAB) recommendations for consumer and advocate vacancies on the Consumer Advisory Board.

Motion: to accept the recommendations of the Consumer Advisory Board for consumer and advocate representatives on CAB –Jan VanTassel; seconded by Patricia Baker.
Discussion: There was no discussion.
Vote: All in favor.

5. Population Health Council FQHC Representative Appointment
Patricia Baker reported on the Personnel Subcommittee recommendation for a federally qualified health center (FQHC) representative vacancy on the Population Health Council.

Motion: to accept the recommendation of the Personnel Subcommittee for FQHC representative membership on the Population Health Council – Jan VanTassel; seconded by Mary Bradley.
Discussion: There was no discussion.

Vote: All in favor.

6. VBID Fully Insured Employer Manual
Ms. Lupi reviewed the Value Based Insurance Design (VBID) Fully Insured Employer Manual.

Motion: to approve the VBID Fully Insured Employer Manual– Patricia Baker; seconded by Jan VanTassel.
Discussion: There was no discussion.
Vote: All in favor.

7. PCMH+, CCIP, and AMH Updates
Ms. Lupi presented on the Person Centered Medical Home Plus (PCMH+), Community and Clinical Integration Program (CCIP), and Advanced Medical Home (AMH) initiative updates.

PCMH+ – Ms. Lupi said PCMH+ launched on January 1, 2017 with nine selected entities. She applauded the Department of Social Services (DSS) for staying on timeline and for the low opt-out rate. Dr. Quaranta asked for clarification on the total number of patients attributed to each of the practices. He asked how many primary care providers are connected to the networks and what attribution was used for PCMH+. Ms. Lupi said there are 160,000 (correction: 127,000) Medicaid beneficiaries represented across the nine entities. Dr. Schaefer said DSS would have the technical specifications but his understanding is they are attributed the same way as the medical home assignment.

Pat Charmel suggested that many practices received PCMH recognition after the deadline and that including them could increase the program's beneficiary participation rates. Dr. Schaefer said that this issue was discussed with DSS and that he believes that adding practices is not an option for Wave 1. However, the PMO has discussed with DSS the possibility of setting the cut-off much later in the calendar year for Wave 2, which would increase the likelihood that new AMH program recruits could participate. Ms. Veltri said they will try to figure out a good time for Ms. McEvoy to come and provide a detailed update on PCMH+.

Dr. Lagarde said the Centers for Medicare and Medicaid Services (CMS) requested 200,000 to 215,000 attributed lives in phase one. She asked whether the difference in number is problematic. Dr. Schaefer said in a variety of our initiatives we set goals and targets for participation and acknowledges that this is several thousand less than targeted. He said this should not jeopardize our State Innovation Model (SIM) test grant funding. Dr. Schaefer said there is a nearly twenty percent participation rate among Medicaid beneficiaries in the first wave. He said it is a notable achievement and strong start.

AMH – Dr. Schaefer spoke regarding participants that gave perspective in the recent AMH event. Ms. Veltri said the AMH event was supported by people around the room, payers, the foundation, and CT stakeholders. She said the attendance was really great and the SIM team did a tremendous job organizing the event. Dr. Schaefer recognized and expressed thanks for the five sponsors that helped to support the program. LG Wyman congratulated on the successful event. Ms. Padilla asked regarding the outcome of recruitment from the AMH event. Ms. Lupi said the last recruitment count was between 10 to 20 practices. Dr. Schaefer said the target is 150 practices. He said a number of emails have been sent directly to physicians to help raise awareness. Dr. Schaefer mentioned some of the issues that raised a lot of uncertainties about where to invest for the future such as the Affordable Care Act (ACA). He said the AMH solicitation will be open for another 30 to 60 days.

CCIP – There was a discussion regarding how the various initiatives work together. It was noted that entities participating in Practice Transformation Network (PTN) cannot participate in CCIP.

Dr. Schaefer explained the separation of funding for CCIP and PTN. Ms. Baker asked for clarification regarding the nine entities participating in CCIP, in which seven FQHCs are not required to do the CCIP piece and are exempt. She asked whether there are only two networks participating in CCIP. Dr. Schaefer said there are three networks participating in CCIP and it is a smaller number than anticipated. He said the grant targeted another nine joining in wave two of non-FQHC/PTN providers.

Ms. Lupi said Qualidigm was selected as the technical assistance vendor for CCIP through a competitive procurement process. She said Qualidigm has a fully Connecticut based team of experts to support the participating entities. Dr. Schaefer said he wanted to acknowledge Anne Elwell and Michele Kelvey-Albert of Qualidigm in the audience. He said they have an extraordinary history of working with providers, hospitals, practices, and health systems. Dr. Schaefer said they were going to have Ms. Elwell and Ms. Kelvey-Albert talk about how the Qualidigm team is preparing for the transformation process but decided to defer this in the interest of time. He mentioned Qualidigm as great partners having expertise and flexibility.

Ms. Langer asked whether there is something available that explains the difference between the PTN requirements and the CCIP requirements. She asked whether there is a way to enable the FQHCs to work on some of the CCIP standards that are not included in PTN. Dr. Schaefer said they have not yet circled back with Dr. Bruce Gould, who is heading up the transformation process with Community Health Center Association of Connecticut (CHCACT) and is the director of the Community Health Worker (CHW) initiative. He said now that they are twelve months into the transformation process and a lot of the mystery of the transformation curriculum for PTN is resolved, it is a better time to look at the elements of CCIP that might be able to be extracted and applied to PTN participants. Dr. Schaefer said with regards to materials, they did a crosswalk with the Practice Transformation Taskforce (PTTF) on PTN participants and a deep dive on their requirements. He said requiring elements of CCIP for PTN participants maybe something that could be revisited with the support of DSS for Wave 2.

Dr. Lagarde said for clarification, CHCACT is well within six months of the second year of the transformation process. She said there are gaps beyond the CHW issue, such as e-consultations. She said e-consultations are within CCIP but is being touched upon lightly in the CHCACT program. Dr. Lagarde encouraged having a discussion on this because there could be a benefit. Dr. Schaefer said they will take it as a follow up. Ms. Veltri said it is not just CHCACT that received the PTN but UConn also. She asked would it also apply for both entities. Dr. Schaefer said yes. He said there have been similar conversations on this and he could meet with the respective teams to look at how it could be helpful.

LG Wyman announced that the state has hired a Health Information Technology Officer (HITO). She said his name is Allan Hackney and he will be starting on next week.

8. Primary Care Payment Reform

Dr. Schaefer presented on the Primary Care Payment Reform. He said aspirations have been articulated but there is additional work to be done, in terms of payment reforms, to supplement the basic structure that has been put into place with the shared savings program model. Dr. Schaefer said the program management office (PMO) did not feel they could take on the task of doing a full review of the national research in this area and do the kind of stakeholder engagement that would be necessary to inform the Healthcare Innovation Steering Committee (HISC). Dr. Schaefer introduced the members of the Qualidigm team that will be working in this area: Ken Lalime, Lauren Williams, and Russ Munson. He expressed thanks to Qualidigm for dedicating their time to the initiative for the next several months.

The group reviewed and discussed the various delivery payment models. Mr. Lalime said the Qualidigm team will work to bring different payment models from around the country to the committees under SIM and walk through the process of how they could work here. Ms. Williams provided an overview of the Iora Health Care Model. Dr. McLean said the Iora Health Care model sounds great if we want to start afresh but many have invested a lot of money in electronic health records and will not transfer to this model. Dr. McLean asked how the cash flow would work in the Iora Health Care Model.

Mr. Lalime said the Iora Health Care's basic model is a percentage of premium model. The bundled payment represents about 10 percent of premiums and the premiums run $550 per member per month (PMPM) on average for the commercial population. The primary care bundled payment therefore represents about $55 per member per month. Mr. Lalime said in this particular model, they use the input of ICD-9, ICD-10, and other codes to understand their population health issues but not necessarily to drive revenue. He said they have not generated profits yet but are pretty close to it. Dr. Quaranta said the Iora Health Care model is basically doubling what is being paid to the primary care system and increasing their responsibility.

Ms. Langer said she understands the goals of trying to keep people out of the ED and dealing with the most complex health issues. She said there is a lot going on in this state to deal with, both in Medicaid and elsewhere, but does not want us to lose sight of the importance of children and trying to prevent them from being the high need and high cost adults later on. She said children grow up to be adults. Dr. Schaefer said it is a great point and it has come up in the planning for this. He said the Child Health and Development Institute offered to be a partner in the examination of models to look at specifically at what could be adapted to the pediatric community.

Mr. Munson said the real clinical key to all of these payment models is the care plan. He said the care plan that each individual patient has will drive all of these activities. Ms. Baker asked whether there is literature or information on outcomes produced available to look at. She asked whether there is information on populations being served particularly different racial ethnicities where disparities issues are higher than others. Mr. Lalime said he thinks that this is some of the information that they will be bringing forward along with other good examples from around the country, not just the Iora Health model.

Ms. Dookh provided an overview of the Comprehensive Primary Care Plus (CPC+) initiative. Ms. Padilla asked regarding the scale of the model. Ms. Dookh said CMS just solicited practices last year and fourteen regions were selected. She said providers and practices looking to participate in this model would have to be in a region that has been selected by CMS. Ms. Dookh said unfortunately Connecticut was not in a CPC Classic region nor a CPC+ region for the first round last year. She said CMMI is targeting 5500 practices for this program. Dr. Schaefer said approximately 3000 practices came into the first cohort. He said CMMI will reopen the solicitation in February for additional payers to apply for new markets.

Ms. Padilla asked whether regions apply or just get selected. Ms. Dookh said CMS is implementing CPC+ in regions only where there is a multi-payer partnership. Dr. McLean suggested paying PMPM type payments at a good rate to make primary care an attractive specialty and get people off the "hamster wheel of volume" and deliver value. He said he is encouraging that we jump at this opportunity. Ms. Baker agreed. She asked how collective efforts over the last couple of years can bring the right folks to incentivize commercial, Medicare, and Medicaid to explore this in a real strong way. She said she is not looking for the answer now but it is "food for thought".

9. Work Stream Updates

Work Stream updates were not discussed due to a lack of time.

10. Adjourn
LG Wyman thanked the presenters for all of the information and everyone for coming.

Motion: to adjourn the meeting- Sharon Langer; seconded by Patricia Baker.
Discussion: There was no discussion.
Vote: All in favor.

The meeting adjourned at 5:00 p.m.