STATE OF CONNECTICUT
State Innovation Model
Steering Committee – Ad Hoc Committee

Summary
November 16, 2015

Members Present: Vicki Veltri, Mark Schaefer, Mary Bradley, Kate McEvoy, Sue Laguarde, Christine, Alta Lash, Jane McNichol, Pat Charmel

Other Participants: Faina Dookh

Meeting Summary

The Subcommittee discussed **the charge** as described on the agenda (see below). There was discussion about additional areas to look at such as how SIM initiatives relate to other healthcare reform activities in Connecticut (e.g. provisions of Public Act No. 15-146 [Senate Bill 811]). There was also discussion that this Subcommittee could serve as a vehicle for considering cross-workgroup issues (drawing in additional representatives as needed) or as the core of a rapid response team. However, it was noted that the Subcommittee should not supplant the existing workgroups.

There was discussion of the need for a means of better synthesizing and illustrating the relationship among the various SIM initiatives. Two such instruments have been drafted by the SIM PMO: a logic model that will be shared with the HIT Council for comment on 11/20, followed by sharing/commenting and further editing with other councils and the steer co, and a new driver diagram, which is required by CMMI (see definition below). These will be shared with the Subcommittee in advance of the next meeting. Additionally, Kate McEvoy distributed to the subcommittee a document produced by DSS, which illustrates through info-graphics and chart format relationships among, distinguishing features and target populations/providers of the various Medicaid and SIM care coordination and practice transformation initiatives. Kate offered this document as one of several means of better synthesizing and connecting the work of the MAPOC Care Management Committee and the SIM Practice Transformation Workgroup.

There was a request to know, statewide, how many **members are in commercial, Medicaid, and Medicare;** what the dollar spend is for those beneficiaries; and how many members in those coverage plans are currently in value-based payment arrangements. The PMO offered to provide the Subcommittee with its financial analysis and estimates of VBP penetration in advance of the next meeting. (Kate has also offered to provide current information regarding Medicaid PMPM trend.) It was noted that this requires a definition of VBP (or SSP) and it was recommended we consider adopting the definition used by Catalyst for Payment Reform. A member noted that payers are signaling the intent to move to full risk and requested that we solicit information about payers' projected timeframe for this transition.

The conversation then moved on to the **design of the MQISSP program** with particular attention to the issue of required qualifications for participating providers. Recognizing the benefit of

including practices that have already self-initiated practice transformation, DSS intends to require that any FQHC that DSS selects to participate in MQISSP and any primary care practice that is affiliated with an Advanced Network that DSS selects to participate in MQISSP: 1) be recognized as a PCMH, holding either Patient-Centered Medical Home certification/recognition from NCQA (for any FQHC or primary care practice) or Primary Care Medical Home certification from The Joint Commission (for FQHCs only); and 2) be enrolled in the DSS Medicaid PCMH initiative. In addition, all potential MQISSP Participating Entities must already have at least 2,500 PCMH-attributed beneficiaries who are eligible to participate in MQISSP. Alternative approaches were discussed such as assessing the capabilities of the advanced network rather than individual practices. DSS noted it has no way to assess this and that its working model is based on building on the capabilities of similarly situated practices (i.e., all medical home recognized). Anthem acknowledged that they assess the readiness of the organization as a whole and it may be able to share additional information about their approach. URAC uses a similar approach for assessing clinically integrated networks and ACOs.

Kate presented the **current landscape with respect to Medicaid attribution** in CT and # of members attributed to PCMH vs. non-PCMH practices. There are more than 720,000 Medicaid beneficiaries in Connecticut, about 70% of whom are attributed to a primary care provider. 40% of these individuals are attributed to a PCMH practice. CHN prepares detailed break-outs of provider participation in the Connecticut Medicaid PMCH initiative. Kate offered to share this information. Members asked about whether there is more information about attribution to practices that are part of Advanced Networks, or medical homes within Advanced Networks. DSS does not have any source for this information. The PMO offered to work with DSS to determine whether information about Advanced Networks and affiliated practices/clinicians could be obtained from the OSC. The PMO has clinician level MH recognition which could be used to tag clinicians in the OSC dataset.

Next steps:

- Distribute SIM PMO logic model and driver diagrams for review
- Disseminate information about enrollment in Medicare, Medicaid, commercial, VBP penetration estimates and PMPM and projections from the grant, along with actual Medicaid PMPM trend data based on more recent data
- Compile and disseminate information re: MQISSP advanced network landscape, # of Medicaid beneficiaries attributed to AN affiliated practices, broken down by PCMH/non-PCMH
- Solicit/obtain feedback from Anthem and URAC re: readiness assessment

Ad Hoc Design and Implementation Sub-Committee - Charge

Over the course of the year, SIM key partners (e.g., DSS) and work groups have begun to produce detailed program designs to support AMH, CCIP, MQISSP and Quality Measure Alignment. As the PMO and its partners prepare to finalize these program designs, there is a need to ensure that each initiative is aligned with the reform strategy set forth in the Model Test Grant, and to ensure that, wherever possible, the strategies are mutually reinforcing and coordinated to achieve the intended results.

The Steering Committee is charged with providing oversight and guidance on the full array of SIM initiatives and they way they work together to achieve the vision and associated goals. The full

Steering Committee meetings are not conducive to a close examination of design and implementation issues. Accordingly, the Steering Committee has proposed to establish an ad hoc subcommittee charged with reviewing design and implementation issues, directly engaging and advising the various payers and other partners, and making recommendations to the HISC.

Driver Diagram

A model that depicts the theory of change for an initiative. It depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers