

State of Connecticut
GENERAL ASSEMBLY



Medical Assistance Program Oversight Council
Care Management (PCCM/PCMH) Committee

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www.cga.ct.gov/med/

Co-Chairs: Rep. Abercrombie, Rep. Michelle Cook & Rep. Hilda Santiago

MEETING MINUTES

Wednesday, March 16, 2016

10:00 AM in ROOM 2A OF THE LOB

Attendance is on Record with the Council.

- I.** The meeting was started at 10:08 PM by the Clerk, Richard Eighme. He explained that the chairs would not be present due to their session day obligations. Members were welcomed and thanked for being present.

Introductions were made by those in attendance.

- II.** Mark Schaefer provided context and an overview of the two provided documents (See Attachments).
https://www.cga.ct.gov/med/committees/med1/2016/0316/20160316ATTACH_CCIP_Response-to-Concerns_3_15_16_Final.pdf
https://www.cga.ct.gov/med/committees/med1/2016/0316/20160316ATTACH_CCIP_Response-to-Concerns_Final.pdf

Ellen thanked DSS and SIM for their work.

Sheldon talked about what the main message of the advocates was and how he was happy to see some changes. He brought up the question from yesterday's workgroup regarding the inclusion of ICM and also not wanting to interfere with PCMH.

A question was made on the inclusion of technical assistant even on track one and why this would be necessary if they not agreeing or working towards the standards. Dr.

Schaefer discussed the openness of the initiative and working to improve quality even if a network is not agreeing to meet the standards.

Kate discussed the participation in the workgroup and the approach/ procedure. Networks are not being asked to be bound by the standards but are being asked to commit to working on the standards. Kate explained what the technical assistance would consist of, including helping networks realize where progress could be made and providing suggestions for work on the standards even though they will not be mandated.

Sheldon further asked about ICM. Kate talked about the point that was raised about ICM not being included. It was agreed that there should be some reference to ICM in the CCIP standards.

III. Kate stated that she is so grateful for the work that is being done in the work group sessions and the committee meetings. She explained that there is an issue amongst members working on a position for the requirements of practices in an advanced network. In the interest of coming to closure on model design DSS feels confident that it is balancing its position on the requirements knowing committee members will most likely not achieve a consensus.

Charles began by stating the not address all of the papers that were distributed would be addressed and the documents on PCMH and CCIP would be focused on. He began with the PCMH Issue Paper (See Attachment).

https://www.cga.ct.gov/med/committees/med1/2016/0316/20160316ATTACH_PCMH%20Issue%20Paper%202016%2003%2016.pdf

Charles started by discussing what came up at yesterday's workgroup. One issue that has been raised is that networks could potentially move persons to different practices outside of MQISSP. He talked about the safeguards that have been put into place to try and prevent this including that non-PCMH practices must become accredited within the first 18 months. It was discussed what is in place to try to get practices to achieve PCMH accreditation.

Charles went over what he felt was understood from yesterday's meeting, including that all practices in the advanced networks need to be certified in the PCMH glide path. He discussed the requirements and the understanding that the entirety of the program in the first month is sufficient and binding. Charles talked about the recommendations of the EAC on underservice and going back to his team to see if panel manipulation can be included to bar from shared savings and participation. Panel manipulation is currently undefined but may be as it becomes noticeable and measurable. Charles talked about the corrective action plan and hoped to define this further what would happen if practices did not meet MQISSP requirements.

Sheldon stated that the Department did not do the things that were suggested so it was necessary to review what could be done to minimize the harm. An applicant has 30 days to file and then another 30 days for a more detailed application for the guide path. Sheldon feels this big issue is not required/ enforced and asked what happens when the PCP does not do this. This would then be a breach of contract and Sheldon questioned what consequences can be built into the RFP that specifies what happens when there is this particular breach of the contract. He appreciates that the corrective action plan will at

least include dismissal or no shared savings. Sheldon added that he doesn't believe that panel manipulation is not defined and that is within the charter of EAC, which he would send to Charles. The problem is how underservice detected. Sheldon finds that detailed monitoring doesn't have to be included in the RFP but a commitment to develop the best monitoring possible for underservice and panel manipulation should be.

Kate responded that in the concept paper she feels DSS has committed to develop monitoring and discussed the pains it takes to describe the protective features of model design. DSS struggles to see where the pieces around attribution and timing of specific issues would be prevalent towards underservice. She discussed trying to get everyone to PCMH status and how, while aspects of SIM have acknowledged the need to prevent and deter underservice, they don't say specifically how to monitor this. Dr. Schaefer underscored Kate's observation that this is not a big area of focus in other states and there are not a lot of tools or ideas on how to do this. CT is in a position to lead the nation on how to develop underservice monitoring. Dr. Zavoski discussed some research in underservice as far as who is getting different services and who is not.

Mike expressed his appreciation for what the advocates are saying but feels the emphasis that is being put on clients/ patients on monitoring underservice might prevent the idea behind the whole project by discouraging people from participating. He asked for clarification on how long it would take for all providers within a network to become PCMH. Charles clarified that it is 18 months from program launch.

It was questioned whether shared savings was the whole benefit or if there were others. Kate discussed the MQISSP financial aspect and also financial incentives that come with PCMH recognition.

Ellen talked about the workgroup and how they originally started with building on PCMH. There are people who don't feel that PCMH is right and MQISSP is a tool to further PCMH. She expressed how she was unhappy that the committee couldn't come to a complete consensus and expressed that she would continue to advocate.

Dr. Carbanari asked for clarification on providers vs networks and what Ellen meant. Mike expressed that he also has a hard time understanding in some of the language. Sheldon stated that it's not about the practices and what you would do, the concern is the networks. He expressed that because we don't know every impact this initiative will have, it is necessary to build in these protections. Kate added that DSS and the committee will relentlessly monitor the progress of this program. She stated that this was a purpose of this committee and DSS commits to means of devising monitoring. Dr. Zavoski added that DSS is not talking about not monitoring; they are making sure there is not bad behavior.

Sharon Langer commended on CCIP and the compromises that were made. She discussed from her prospective, seeing an opportunity to really improve the health of the Medicaid population and wanting to be involved with monitoring.

Marilyn added how she is at a disadvantage having not been as involved with MQISSP and discussed what she was hearing and what makes her comfortable. She feels that DSS picked the solution that would be the least guaranteed to prevent underservice and that corrective plans never work.

Kate stated that she hopes that there is not discomfort and that there is a responsibility for the Department on model design.

Sheldon asked about one more thing being included in the RFP which Charles confirmed was in the concept paper and would be in the RFP.

Gail DiGioia from CHN talked about unassigned members (See attachment).

https://www.cga.ct.gov/med/committees/med1/2016/0316/20160316ATTACH_Unassigned%20Members%20Document.pdf

Charles talked about the Member Assignments (See attachment).

https://www.cga.ct.gov/med/committees/med1/2016/0316/20160316ATTACH_MQISSP%20Assignment%20Scenarios%20.pdf

Jesse asked if there would be instances where someone went to a PCP and then spent a significant amount of time at a School Based Health.

Ellen asked about attribution and quality scores. Dr. Zavoski talked about some of the reasons why people do not get attributed.

Sharon Langer asked about where attribution percentage is looked at. Child attribution is a lot higher than adults.

IV. The meeting was adjourned at 11:49 PM.

Richard Eighme
Council Clerk