Addendum 1

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Person-centered Medical Home Plus Program Wave 3
Request for Proposals
(PCMH+W3 RFP) _09062019

The State of Connecticut Department of Social Services is issuing **Addendum 1** to the **Person-Centered Medical Home Plus Program Wave 3 (PCMH+W3 RFP)_09062019**.

Addendum 1 contains:

- Revision of SECTION IV. Proposal Outline. B Proposal Organization I. Administrative Requirements H. Forms. Change is to section numbering only.
- Questions submitted by interested parties and the official Responses. These Responses shall amend or clarify the requirements of the RFP.
- PCMH+ WAVE 3 Bidders Conference hold on Sept 12, 2019
- Addendum Acknowledgment Sheet to be signed and returned by Respondents as per RFP Section IV. B.I H.8

In the event of an inconsistency between information provided in the RFP and information in these Responses, the information in these Responses shall control.

- **REVISION**

  SECTION IV. Proposal Outline. B Proposal Organization I. Administrative Requirements H. Forms of the RFP has been revised to include consecutive numbering as follows:

  H.1 Certification Regarding Lobbying
  H.2 Consulting Agreement Affidavit (OPM Ethics Form 5)
  H.3 Nondiscrimination Certification
  H.4 Gift and Campaign Contributions
  H.5 Iran Form
  H.6 Notification to Bidders, Part I-V (CHRO)

H.7 Affirmation of Receipt of State Ethics Laws Summary
H.8 Addendum Acknowledgement(s)
An addendum acknowledgement form is included with each posted addendum.

- **QUESTIONS AND RESPONSES**

1. **Question: We provide Personal Emergency Response Systems with 24/7 monitoring. I have read the 63 pages for the PCMH+W3 RFP. Can you tell me if this RFP covers our services? We would really like to participate in the RFP process if our services fall under the DME/ Home & Community Based Services umbrella.**

   Response: The Department will only enter into contracts under PCMH+ with FQHCs and AN Lead Entities (on behalf of ANs) that meet minimum requirements. At a minimum, an AN must include one or more primary care practices that are current participants in DSS' PCMH program (other than Glide Path practices). In addition to primary care practices, ANs may also include one or more specialty practices (including behavioral health and dental) as well as one or more hospitals. The AN Lead Entity must be a participating provider in the AN (either a physician group or a hospital).

   In order to meet the definition of an AN, the AN must demonstrate the same standards across the entire AN to coordinate member care. ANs must perform as a complete system of care coordination, providing both clinical and social care coordination to members. ANs must be able to share and access all necessary electronic health record information needed to support the health, wellness, and care coordination of all PCMH+ members.

   DSS understands that ANs may have a variety of arrangements with emergency physicians, on-call services, and other practitioners. Many of these physicians may not be part of the PCMH+ AN but could provide services to the member without the AN violating PCMH+ requirements. However, the AN is encouraged to require all physicians who provide services to Medicaid patients to enroll as Medicaid providers for other reasons, including in order to comply with federal law at 42 U.S.C. § 1396a(kk)(7), which requires any order/referral/prescription for Medicaid goods/services to be issued by a physician or other applicable licensed practitioner who is individually enrolled in Medicaid.

2. **Question: In the Organizational Requirements of PCMH+ PEs, under letters g and h, bottom of page 32 and top of page 33 there is a discussion of PEs having to distribute shared savings to participating providers, at the PE's discretion. First, how are we to interpret "providers"? Does it include all**

clinical staff (e.g., PCPs, RNs, Medical Assistants, CDEs, RDs, etc.)? May all shared savings earned be distributed back to the PE as an entity, rather than to the individual providers? Does this requirement pertain only to FQHCs?

Response: The use of the word provider for this purpose means within the provider entity or entities that comprise the PCMH+ PE, which means that it does include clinical staff and staff supporting PCMH+ members and program requirements as long as they are part of the PCMH+ PE's provider entities. PCMH+ Participating Entities have a substantial amount of discretion and flexibility in designing their proposed distribution methodology for shared savings payments subject to review by the Department. Non-DSS PCMH primary care practices within a Participating Entity may not receive a portion of any shared savings achieved by the entity.

3. **Question**: We would like to request an estimate of the number of dual eligible patients who would not be excluded, but would be included, in our PCMH+ roster (page 35). In addition, any demographic information about this sub population would be helpful.

   Response: Eligible dual patient populations are not known at this time, and will not be known until the member attribution process takes place. The attribution process will not happen until later this year. The Department will work with Wave 3 PEs to better understand their dual eligible populations after the start of the Wave 3 program period.

4. **Question**: We would like to request baseline data (preferably Calendar Year 2018 and if not available, 2017) on four of the new quality measures. These measures include avoidable ED visits, avoidable hospitalizations follow up after hospitalization for mental illness and follow up after ED visit for mental illness. It would be helpful to have both the numerator and denominator for each.

   Response: The Department will provide the most recently available baseline data to PEs participating in Wave 3. General information on the quality measures including measure properties such as numerator and denominator is featured at the Centers for Medicare and Medicaid Services (CMS) Measure Inventory Tool: https://cmit.cms.gov/CMIT_public/ListMeasures

5. **Question**: In waves 1 and 2, the Quality Measures were based on the patients in the Medicaid population as a whole (minus dual eligibles) as reported by CHN in the Annual Medicaid Profile Report. Will this be the same in wave 3? Likewise, in waves 1 and 2, the cost measures were based on PCMH+ attributed patients, not the Medicaid population as a whole. Will this be the case in wave 3?

Response: Quality measure results are based on the assigned PCMH+ members. Only members with 11-months of claims in both the performance and base years will be included in the shared savings calculation.

6. **Question:** We would like to request the ICD-10 codes for the avoidable ED visits and avoidable hospitalization measures.

   Response: The Department and CHN-CT provide many supports to PCMH+ PEs during the PCMH+ performance period. Medicaid providers may contact their CHN-CT liaison for information regarding proper claiming, ICD-10 coding, and quality measure information.

7. **Question:** On page 32, Section 1 (g), it states "PCMH+ PEs must receive any shared savings achieved and distribute the shared savings to participating provider with the PE, using a written distribution methodology…." Can any achieved shared savings be re-infused back into the program to benefit patients, i.e MUST shared savings be distributed to providers?

   Response: PCMH+ Participating Entities will have a substantial amount of discretion and flexibility in designing their distribution methodology for shared savings payments. PEs may reinvest funds directly into the program, share savings with members of the clinical care team, or individual providers. PEs may distribute awards based on their proposed distribution methodology which is subject to review by the Department.

   Respondent must ensure that the distribution method will not reward a provider for specific contributions to the overall savings of the network, as well as ensure that its means of allocating shared savings payments supports members in receiving appropriate services, as evidenced by individual and aggregate quality measures and measures of satisfaction. Non-DSS PCMH primary care practices cannot be part of a Participating Entity and may not receive a portion of any shared savings achieved by the entity.

8. **Question:** Under the Scoring Measures, it is noted that Avoidable hospitalizations and Avoidable ED visits are measures on which improvement is required to be eligible for shared savings. I would like to bring to DSS's attention that it is possible that a PE could have fairly good baseline metrics for these two measures yet could easily drop a small amount in a particular performance year. You could find yourself with a PE who does well on quality, saves money, yet is ineligible based on a lack of improvement on a measure on which it is already performing fairly well. Has DSS considered this possibility and is there any chance it could modify this requirement in a

way which takes into account "absolute" quality in these metrics, as well as "improvement"?

Response: **Participation in the Individual Savings Pool and Challenge Pool is based on a PCMH+ Participating Entity's improvement on the Avoidable ED Visits and Avoidable Hospitalizations quality measures. If a PCMH+ PE fails to improve in both quality measures, they will not be able to participate in the Individual or Challenge Pool. It is possible that a Participating Entity could perform well on other quality metrics, save money, and also have high performance on the Avoidable ED Visits and Avoidable Hospitalizations quality measures and not be eligible for shared savings if they did not improve on those two measures. This requirement indicates the importance of these two measures to the Department. Although high performance on these two measures is to be commended, and is part of the individual pool quality scoring, improvement on these measures is emphasized and a requirement to participate in shared savings.**

Additionally, any improvement in the rate would be considered improvement. PEs that had the same rate would not be determined to have improved. For example, if a PE had a rate of 40.00 in the prior year and a rate of 39.99 in the performance year, then that would be considered improvement (since lower rates are preferred.) If a PE remained at 40.00 for both years, that would not be considered improvement.

9. **Question: Will PEs have access to their baseline rates for Avoidable hospitalizations and Avoidable ED visits? Can DSS provide definitions of these measures including the specific parameters on which a hospitalization or ED visit is consider to be "avoidable."**

   Response: **The Department will provide the most recently available baseline data to PEs participating in Wave 3 as well as measure definitions. General information on the quality measures is featured at the Centers for Medicare and Medicaid Services (CMS) Measure Inventory Tool: https://cmit.cms.gov/CMIT_public/ListMeasures**

10. **Question: Can DSS provide PEs with their risk data (in the aggregate) for their PCMH+ patient population? Can this be provided at fixed intervals over the course of the performance year and can it be for a recent time frame (ie risk data that is more than 1 yr old is not very helpful).**

    Response: **The Department utilizes the Johns Hopkins Adjusted Clinical Groups (ACG®) Case-Mix and Predictive Modeling System risk score methodology. This is a statistically valid, diagnosis-based methodology that describes or predicts a population's past or future healthcare utilization and**

costs. Risk is based on a member's diagnostic history, age, and gender during a one-year reporting period. Additional information can be found at the Department's website: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/CHN-Risk-slides-for-PCMHplus-Webinar-11012018.pdf?la=en

11. **Question: Can DSS provide us with a list of our "full" Medicaid/Medicare dual eligible members, i.e. those dually eligible members who quality for PCMH+?**

    Response: Eligible dual patient populations are not known at this time, and will not be known until the member attribution process takes place. The attribution process will not happen until later this year. The Department will work with Wave 3 PEs to better understand their dual eligible populations after the start of the Wave 3 program period.

12. **Question: In the RFP it states that all providers in the advanced network must be a PCMH practice. It is recommended that all of the providers in our network are PCMH practices, but there are a few members of our network who are not PCMH recognized because they have a small Medicaid population. Our network contracts with commercial payers and is viewing this as the first opportunity to contract with Medicaid. As you may know this is extremely important to us as these children are the most vulnerable and are 50% of our patient population at Connecticut Children's Medical Center. In our application, do we have to include every provider who is part of our network or can we just submit our application with the practices who are PCMH certified?**

    Response: See the Response to Question 1. All primary care practices (including all individual primary care providers) participating as part of the AN must be current participants in the DSS PCMH program as a PCMH as of the time the entity responds to the RFP and throughout the AN's participation in PCMH+ (including hold/holds Level 2 or 3 Patient- Centered Medical Home recognition from NCQA or an equivalent level of recognition from NCQA under its 2017 and any future standards). Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement.

    In addition, as detailed in the RFP, all primary care providers in the AN must be PCMH certified. Each AN respondent has the flexibility to describe the AN for purposes of PCMH+, which does not necessarily need to include all providers affiliated for other purposes. In all situations, the composition of the AN must be very clear in the RFP Response and also for program implementation, so that there is no confusion about which providers are

participating in the AN, which members are attributed to the AN, and which claims data is associated with the AN.

13. **Question: Our network is made up of the hospital, specialists and primary care providers. Currently, specialists aren't eligible for PCMH designation so should our specialists and hospital not be included in the roster that we submit? Should it only include our primary care providers who are employed by Connecticut Children's and those who are in our advanced network?**

    Response: See the Response to Questions 1 and 12. In addition, as a clarification, only the primary care providers within an AN are required to be PCMH certified, which means that the roster of primary care providers in an AN must all be PCMH practices. However, specialists (also including behavioral health and dental providers) can be part of an AN without being PCMH certified.

14. **Question: Our network is growing right now and we continue to add more providers each month. As we add more providers throughout the contract, how are they added to our attribution and our contract? What happens if a practice chooses to leave the network, how do we inform DSS and remove them from our PCMH+ contract?**

    Response: An Advanced Network can alter its composition of participating health care entities and/or community partnerships at any time, so long as the Advanced Network continues to meet all PCMH+ requirements. The Advanced Network must promptly inform DSS in writing of any such changes and update appropriate documentation accordingly. A health care participant in a network is not obliged to remain with the network through the end of the program period and can leave at any time. However, the departure of a PCMH from an Advanced Network will result in removal of its assigned members for purposes of calculating any applicable shared savings payments.

    Only members with 11-months of claims in both the performance year and the base year will be included in the shared savings calculation. The Department runs the member roster at the start of the program period (November 2019) to capture a baseline. Therefore, if a pre-existing PCMH practice joined an Advanced Network after the start of the performance year, they could not bring their patients into PCMH+. The impact of a new established practice included after the start of the program would be negligible.

    As a reminder, eligible Medicaid members will be assigned to PCMH+ PEs using the retrospective attribution methodology that is used for primary care providers in Connecticut's Medicaid program and for the PCMH program. The PCMH retrospective attribution methodology attributes a Medicaid member to

a PCMH based on the member's active choice of provider (i.e., usual source of care). Eligible Medicaid members will be assigned to only one PCMH+ PE. Medicaid members will be assigned to PCMH+ PEs for each contract period in advance, based on attribution of these individuals to PCMH practices using the Medicaid attribution methodology. In order to be included in shared savings, full PCMH certification must be obtained before the Department runs the attribution list that will be used to assign members for the performance year.

15. **Question: In all of our value based contracts currently, we are provided claims data and other information about the patients that we're responsible for managing. Are the advanced networks provided any data to help networks manage this population?**

    Response: Yes. All PCMH+ PEs (FQHCs and Advanced Networks) are provided with raw claims data on their PCMH+ population through the CHN-CT Portal. The only claim information not available to PEs are claims that are subject to certain legal restrictions on data sharing, such as behavioral health, substance use, and HIV sensitive data.

16. **Question: What happens if practices that are on the glide path are part of our network and then become PCMH certified in 2020 or 2021? Are they added to the attribution of our roster?**

    Response: See the Response to Question 14.

17. **Question: Are we required to provide a budget for one (1) or two (2) years?**

    Response: Two years, for the full performance period (January 1, 2020 to December 31, 2021). Please include any potential costs associated with program closure at the end of the performance period if applicable.

18. **Question: What is the average percentage of patients in primary care with a behavioral health diagnosis across the current PCMH+ FQHCs?**

    Response: This is information is not available at this time. The Department will work with Wave 3 PEs to better understand their populations after the start of the Wave 3 program period.

19. **Question: For Advanced Networks, in multiple places the RFP states that the primary care provider has to hold PCMH recognition from NCQA. Please confirm that DSS will accept Joint Commission recognition for Advanced Network providers.**

Response: NCQA PCMH recognition is required for non-FQHC physician groups. FQHCs can use either NCQA or Joint Commission PCMH recognition, including FQHCs that may be part of an Advanced Network.

20. **Question**: What is the add-on cost per attributed member for FQHCs?

    Response: FQHCs participating in PCMH+ will receive a per-member, per-month (PMPM) payment of $4.50 for providing Care Coordination Add-On Activities as described in Section III of this RFP. Care Coordination Add-On Payment Activities are in addition to the Enhanced Care Coordination Activities required of all PCMH+ PEs. DSS will make Care Coordination Add-On Payments prospectively on a monthly basis to PCMH+ PEs that are FQHCs. Care Coordination Add-On Payments are appropriation-limited; the amount of the payment will depend on the number of PCMH+ PEs that are FQHCs, and the number of Medicaid members assigned to these PEs. If this funding is exhausted during a performance year, no further Add-On Payments will be made.

    Such amounts are subject to the availability of continued state and/or federal funding in the amounts currently projected by DSS. DSS reserves the right to adjust these amounts if necessary to remain within available state and/or federal funding.

21. **Question**: Please provide a list all individuals/organizations in attendance at the bidders conference.

    Response: Please refer to RFP, Section I.C.8. A list of all individuals/ organization will be provided with the transcript of RFP Conference attached to this addendum.

22. **Question**: Please clarify the following sentences where there are either typos or incomplete/unclear sentences:
    a) RFP Page 59: 2.a. Experience: "Describe the Respondent's relevant experience in implementing care coordination for Medicaid members or similar populations, including the types of care coordination interventions utilized, I member participation, and a description of the outcomes that the Respondent has achieved."

    Response: That language is hereby corrected to read as follows: "Describe the Respondent's relevant experience in implementing care coordination for Medicaid members or similar populations, including the types of care coordination interventions utilized, typical member engagement, and a description of the outcomes that the Respondent has achieved. If the PE is an

AN, provide this information for all provider entities that will participate in the AN."

b) RFP Page 59: 2.b. Planned Approach. (ii). SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS. – Please confirm that the "F" should be an "E".

Response: Correct. That language is hereby corrected to read as follows: "SECTION III PROGRAM INFORMATION E. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS."

c) RFP Page 60: (i.) at the top: "Describe the Respondent's will minimum care coordinator education and experience requirements and comment on the Respondent's plans to use non-licensed staff, such as community health workers is desired."

Response: That language is hereby corrected to read as follows: "i. Respondents shall define minimum care coordinator education and experience requirements and comment on plans on the use of non-licensed staff such as community health workers is desired."

d) RFP Page 61: c. Planned Approach (vi): Describe how the Respondent will assist its eligible Medicaid members in maintaining continuous eligibility for Medicaid.

Response: That language is hereby corrected to read as follows: "c. Planned Approach (vi): Describe how the Respondent will assist its eligible Medicaid members in maintaining continuous eligibility with Medicaid."

23. Question: May applicants submit one complete PDF file that includes the narrative and attachments? Or would DSS prefer the narrative to be in a Word document and the scanned forms/attachments in a PDF?

    Response: Please refer to Section I. C. 9. Proposal Due date and Time.

24. Question: Applicants are asked to use tabs to delineate subsections. Please provide clarification on what level of subsection DSS is looking to be tabbed. For example, should applicants use tabs to divide the main sections I.A, I.B, I.C, I.D, I.E, I.F, I.G, II.A, II.B, II.C? Or should applicants use tabs to distinguish the next more detailed level of subsections (i.e., in Section II Main Proposal: II.A.1, II.A.2, II.A.3, etc.)?

    Response: Please refer to RFP, Section I.D.7. Style Requirements: "Dividers: A tab sheet keyed to the table of contents must separate each subsection of

the proposal; the title of each subsection must appear on the tab sheet", and Section IV. Proposal Outline, 1st paragraph of the RFP.

25. **Question: Please clarify all differences between PCMH+ Wave 2 and Wave 3 and provide the reasoning for the changes.**

    Response: Please see section below titled Informal Summary of General Changes from Wave 2 to Wave 3.

26. **Question: Page 48 of the RFP states "Each PE must either sponsor a local community collaborative or participate in an existing collaborative for the purpose of foster understanding." Is this different from the statement in the paragraph above that states that "PEs must enter into relationships (whether contractual or informal) with local community partners"? Can you elaborate on how PEs can meet these requirement(s)?**

    Response: These are two separate requirements. PEs may enter into contractual relationships with community partners as they work to address the needs of the PCMH+ member population.

    PEs must also sponsor or participate in an existing community collaborative for the purpose of understanding available community resource agencies that may assist the PE with social determinants. Community collaborative arrangements often work to coordinate available resources to best assist members in need.

27. **Question: On page 33 of the RFP, it states "Each PCMH practice may participate in only one AN and cannot change during a performance year, except that upon request from an AN lead entity, as described below, the Department may approve changes from PCMH+ purposes to reflect changes that occurred in the composition and structure of the AN, such as due to mergers, acquisitions, dissolutions, sale, and other changes in the formal affiliation of components of and within the AN."**

    In the event of a merger, what would happen to the attributed patients? Would they remain with the AN for both years of wave 3 since that is how they were originally aligned? Or if a PCMH practice switches entities, the attributed lives would also be transitioned at the time of the merger? Is there a difference if a practice switches from an AN to a FQHC?

    Response: Please see the Response to Question 14. Additionally, each PCMH practice may participate in only one AN and cannot change during a Performance Year, except that upon request from an AN Lead Entity, the

Department may approve changes for PCMH+ purposes to reflect changes that occurred in the composition and structure of the AN, such as due to mergers, acquisitions, dissolutions, sale, and other changes in the formal affiliation of components of and within the AN.

Members are attributed to Medicaid-enrolled primary care providers based on a logic process created for use in the Department's PCMH initiative. Quarterly, the Department's medical ASO, CHNCT runs a Primary Care Provider (PCP)/PCMH attribution report that reflects member's claim information and supplemental data criteria over a retrospective period of fifteen (15) months. This process is one means of identifying members' usual source of care. Alternatively, a member who has affirmatively identified a specific provider as his or her PCP will be attributed to that provider, until another self-selection is made or claims indicate primary use of a different PCP. For PCMH+ purposes, 11-months of claims are needed in both the base and performance years for calculation of any potential shared savings award.

28. **Question: Standard EMR – Define/Discuss intent of Interoperability - (Would all health systems under the VCA (Griffin, Middlesex, St. Vincent's and WCHN) be required to have one single overarching system to connect all EMRs within VCA overall, or would each individual health system within VCA be required to have one overarching system to connect all EMRs within that single health system?**

    Response: Each individual health system must be connected through one overarching system which is generally defined as interoperability. Interoperable electronic health records (EHR) systems allow the electronic sharing of patient information between different EHR systems and healthcare providers, improving the ease with which care can be provided and coordinated. Interoperable systems must be in place at the start of Wave 3 (January 1, 2020.) Any such system must ensure that all clinical and care coordination staff who have a legitimate clinical reason to assist with the care of an individual in any part of the Advanced Network can communicate seamlessly with all relevant parts of the AN for that individual's care, including being able to view the EHR for that individual. The RFP intentionally does not prescribe exact technical methods of how to accomplish that purpose, so long as the Advanced Network can truly function as an integrated network for purposes of its participation in PCMH+.

29. **Question: Require BH Care Coordinator into the Interdisciplinary Team – Does each VCA health system have to hire a BH Care Coordinator or can the VCA hire one in total to satisfy the requirement? Dr. Z to look at what the language states.**

Response: Please see page 36 of the RFP. Each PE will need to make a determination as to what is necessary to ensure the integration of BH Care Coordinator as part of the interdisciplinary team. PEs must employ a care coordinator who participates as a member of the interdisciplinary team. The purpose is to ensure that the BH care coordinator is meaningfully able to assist in collaborating with all of the other care coordination staff throughout the Advanced Network.

30. **Question**: Document BH activities into the EMR – include WRAP, Advance Directives – The 4 VCA health systems do not have EMRs that have the capability to run reports for these documents to submit totals on a quarterly basis. These documents are scanned into each EMR. Is this a finite reporting requirement per contract?

    Response: Wave 3 reporting requirements will require PEs to report to the Department bi-monthly. WRAP and Advance Directive activities will continue to be part of the reporting requirement. If a PEs EMR does not perform this function, the PCMH+ PE can determine the most appropriate way to ensure compliance with the reporting requirement.

31. **Question**: Care Plan Tool: Expand individual care plan tool currently in use to Include a Cultural Competency Assessment to demonstrate impact and assessment on member's health - RFP Pg. 37 - What does this translate to? What is the definition? The VCA needs specifics for EMR requirements for each Pod. This option is not currently built or configured into any of the VCA EMRs.

    Response: The Department is not recommending or endorsing any specific care plan tool. PEs will make their own determinations on what care plan tool best meets patient population needs, while also including a cultural competency assessment. That cultural competency assessment component does not necessarily need to be an automatic component of the EMR, as long as the PE substantively complies with this requirement. Care plans should be accessible to all members of the care team and part of the patient medical record.

32. **Question**: If no Care Coordinator internally, use an outside vendor for Care Coordination Activities – Does each VCA health system need to employ a Care Coordinator internally? What is the expectation? Is there an expectational ratio for care coordinator to PCMH+ members? Please also define "embedded". RFP Pg. 37 B and C.

    Response: The RFP language on Page 37 intentionally does not specify the exact manner in which a PCMH+ PE ensures the provision of care

coordination, which can be provided by staff hired directly as employees or under contract, or any combination. There is no ratio for care coordinators to patient populations. Each PE will need to make its own determination to appropriate staffing levels to meet member needs and where care coordinators would formally be located within the PE's organizational structure. Regardless of the specific formal structure, the substantive expectations for quality care coordination are the same. The RFP states on page 2 as well as page 37 that PEs must ensure care teams are easily accessible to Medicaid members and to utilize on-site care coordination. Effective care coordination is when a member of the care team is able to access electronic health records, care coordination resources, and complete care integration across practice site locations. Despite where a member is seen, care coordination and access to care coordination efforts should be seamless for the member.

33. **Question**: Community Health Worker requirements ratio definition and expectations, training, certification – Is each VCA health system (Griffin, Middlesex, St. Vincent's, WCHN) required to have a community health worker? What are the training requirements and expectations for this position? Please provide the DSS specific definition of "Community Health Worker" to ensure expectations

    Response: Please see Response to Question 32. Additionally, pending DPH certification, the Department is making no recommendation as to the definition of community health worker.

34. **Question**: New Quality Measures: Avoidable ER visits – Please provide DSS Definition of "Avoidable. Will this be based on presenting diagnosis or admitting diagnosis? Or defined by Ambulatory Sensitive Conditions?

    Response: The steward of the measures in question is 3M. The Department is finalizing the contract with 3M and will provide additional information shortly.

35. **Question**: Please highlight the changes from Wave 2 to Wave 3: inclusive of any financial changes.

    Response: Please see Section below, titled Informal Summary of General Changes from Wave 2 to Wave 3.

36. **Question**: Changes in reporting to a bi-monthly cadence – please provide expectations of bi-monthly reporting standards. How will the new template differ from the current template? Please provide an example of new template.

Response: Modifications will be made to the reporting template currently in use for Wave 2. A new template has not yet been created for Wave 3 so we are unable to share at this time.

37. **Question**: With the PCMH+ wave 3 challenge questions having a greater focus on behavioral health, is there any discussion that the PCMH+ claims that are provided to the participating entities would include behavioral health data instead of having these encounter redacted?

    Response: Privacy rules are designed to protect the privacy of an individual and to ensure that health information is only available when needed for treatment and other appropriate purposes. Given the sensitive nature of mental health and substance use disorder information, protections are in place around the sharing of behavioral health information.

    PCMH+ encourages PEs to work with members and to obtain consent to access behavioral health information. The Department will continue to work with PEs in Wave 3 on best practices around the incorporation of behavioral health information.

38. **Question**: Attachment F to the RFP details the PCMH+ Quality Measure Set. We are requesting clarification on the definitions for a) avoidable emergency department (ED) visits, and b) avoidable hospitalizations. Could DSS please provide definitions for these measures?

    Response: The steward of the measures in question is 3M. The Department is finalizing the contract with 3M and will provide additional information shortly.

39. **Question**: Reference Attachment F to the RFP - How does the scoring measure "avoidable hospitalizations" differ from the challenge measure "readmissions within 30 days"?

    Response: The steward of the measures in question is 3M. The Department is finalizing the contract with 3M and will provide additional information shortly.

40. **Question**: Please advise when DSS anticipates releasing the quality measure targets associated with PCMH+ W3.

    Response: Middle of 2020.

41. **Question**: I believe there is a typo in the Proposal Outline listed in Section IV. RFP page 56 lists the forms as G.1 to G.8. The forms should be H.1. to H.8.

    Response: Please refer to Revision Section, 1st page of this Addendum.

42. **Question**: Do applicants need to sign the Acknowledgement Statements requested on RFP page 18-19 or the FQHC Confirmation Statement requested on RFP pages 19-20? Or should applicants just include these statements and indicate that they will adhere to them?

    Response: Please refer to Section I.D.5 (c) and (e) of this RFP. Applicants must include the statements referenced above and indicate that they will adhere to them. In addition, applicants must sign the Acknowledgment Statements and FQHC Confirmation Statements.

43. **Question**: Please confirm that letters of commitment are only required by members of Advanced Networks (ANs).

    Response: Correct. Please reference page 57 of the RFP.

44. **Question**: If letters of commitment are required of applicants submitting a proposal as an FQHC, not an AN, please provide additional detail on what is required (i.e., who should these letters be with or what should they include).

    Response: As listed on page 57 of the RFP, if the Respondent is an AN, briefly describe the composition of the proposed AN including any other providers that will participate in the AN. AN's are asked to submit signed letters of commitment or contracts (if available) for each provider the Respondent proposes to include in the AN.

    If the Respondent is an FQHC, provide an organizational chart showing the existing or proposed structure of functions and positions by title within the FQHC's organization as it relates to PCMH+. Indicate which components of the structure are currently in place and which components are proposed to be created. Include a narrative summary of the proposed collaboration within the Respondent's organization related to PCMH+.

45. **Question**: There are a few different Certification Regarding Lobbying forms available from the link included in RFP page 56 under Forms G.1. Please confirm which certification regarding lobbying form applicants should use.

    Response: Please refer to this link https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Procurement/CertificationRegardingLobbying.doc.

46. **Question**: To prepare an appropriate Response and scope of action, can DSS provide a basic funding formula for planning purposes? Also, the RFP requires respondents to provide information on plans for distributing shared shavings, not having an idea of how much funding is anticipated makes it difficult to respond to this question.

Response: PEs will make their own determinations as to funding needed to launch and run their PCMH+ programs. Each PCMH+ program is very different and is based on how PEs structure the program within their current organizations. Please generally outline funding amounts used to develop and implement your PCMH+ program within your organization.

Additionally, shared savings payment amounts, if any, are unknown and are subject to future performance of all Wave 3 PEs. When creating your distribution of shared savings payments, assume potential receipt of shared savings payments. Distribution of shared savings payments based on percentages verse dollar amounts is acceptable.

47. **Question**: Reference page 56 (Section IV.H – Forms) With regard to required documents, if a responder has completed and updated all associated documents on BizNet, will they still be required to submit/include those documents in the grant proposal? In the alternative, can a reference be made in the proposal document that the documents are currently posted on BizNet?

    Response: Please refer to RFP, Section I.D.1, Section I. D. 6 and Section IV.B.I.H.

48. **Question**: Reference page 20 (Section I.D.8 – Pagination) Is it reasonable to expect to adhere to the header and footer requirements as stated with regard to all the attachments required – especially things like the audits/ financial statements? Can these items be included as attachments without headers pagination?

    Response: Please refer to RFP, Section I.D.8. Pagination: "The respondent's name must be displayed in each page. All pages, from the Cover Sheet through the required Appendices and Forms, must be numbered consecutively".

49. **Question**: Reference page 17 (Section I.D.5 – Minimum Qualification Requirements). This section requires respondents to "provide documentation that reflects receipt of HRSA grant funding under Section 330 of the PHSA…" Please clarify what is considered acceptable "documentation" in this case. Would this include the applicant's most recent Notice of Award from HRSA, or some other type of documentation?

    Response: Please provide the most recent Notice of Award from HRSA.

50. **Question**: Is an LOI required for this RFP? If so, when is it due?

Response: LOI is not required for this RFP.

51. **Question: If an applicant was a participant in W2 can they use the same references as were used for the W2 RFP, or do they have to be different?**

    Response: PEs are encouraged to develop a full and complete proposal for Wave 3. Please carefully read all requirements of this RFP. Incomplete Responses may not be considered by the Department.

52. **Question: Are PEs bound to a specific definition for a Community Health Worker?**

    Response: No.

53. **Question: Page 2, paragraph 2 of the RFP says that on-site care coordination is required, but staff, such as Community Health Workers are typically based out in the community. Can you clarify this requirement?**

    Response: Care teams may be comprised of a variety of members with various staffing levels and are not limited to community health workers. Effective care coordination is when care teams have access to electronic health records, care coordination resources, and is able to demonstrate care coordination integration across practice site locations. Despite where a member is seen, care coordination and access to care coordination should be seamless regardless of which member of the team is performing the work.

54. **Question: Can you provide examples of acceptable means of "supporting" members who wish to prepare psychiatric advance directives and WRAP plans and how this support should be documented?**

    Response: PEs are asked to provide support to members who wish to utilize advance directives and WRAP plans. There are multiple nationally recognized tools that assist patients in the creation and development of these plans. The Department is not endorsing any specific tool but is requiring PEs to support members who want to prepare such a plan. Plans should be documented in the medical record and accessible to all members of the care team.

55. **Question: Is adding Community Health Worker(s) to the care team a requirement?**

    Response: PEs may utilize various different staffing arrangements when developing care teams. PEs are encouraged to look at their patient population and develop care teams that are best able to meet member need. In past PCMH+ Waves, PEs employed a variety of staff members with different

experiences, back-grounds and education ranging from social workers, community health workers, nurses, clinicians etc. In Wave 3, PEs are encouraged to expand the role of community health worker and other care coordinators in support of medical, behavioral health, and social determinants of health needs.

56. Question: In regards to the two new Quality Measures around follow up after hospitalization and ED visit for mental illness, we would like to know if substance use/abuse diagnoses are included in these measures?

    Response: The steward of the measures in question is 3M. The Department is finalizing the contract with 3M and will provide additional information shortly.

57. Question: Is there a page limitation to the Response to the RFP? We note that the Executive Summary is limited to 2 pages, but do not see page limitations on the other sections.

    Response: There is no page limitation to the Response to this RFP, except Executive Summary which should not exceed 2 pages.

58. Question: Where within the proposal should applicants place their audited financial statements? Can applicants place the financial statements in an appendix in the original copy?

    Response: Please refer to RFP, Section I.D.1 and Section IV.B.II.B.1.b. Audited Financial Statements should be placed in the original copy as part of Financial Proposal, not as an Appendix.

59. Question: Does DSS want an electronic copy of the audited financial statements? Or just the one requested printed copy?

    Response: Please refer to RFP, Section I.C.9. Proposal Due Date and Time, 4th and 5th paragraph: "An acceptable submission must include the following:

    - One (1) original submission;
    - Five (5) conforming copies of the original submission; and
    - Two (2) conforming electronic copes (Compact Disk) of the original submission. Flash drives are not acceptable.

    The original submission shall carry original signatures and be clearly marked on the cover as "Original." Unsigned submissions will not be evaluated. The original submission and each conforming copy of the submission shall be complete, properly formatted and outlined, and ready for evaluation by the Evaluation Team. The electronic copies of the submission shall be

compatible with Microsoft Office Word. For the electronic copy, only the required appendices and forms may be scanned and submitted in Portable Document Format (PDF) or similar file format. Flash drives are not acceptable".

60. **Question: The proposal outline on page 56 refers to a supporting document being "letters of commitment". But there seems to be no other mention of these letters in the RFP. Are these optional/required? And who should they be from? What should they commit to?**

    Response: Please refer to RFP, Section IV.B.II.1.a.i.(2)(b).

Informal Summary of General Changes from Wave 2 to Wave 3

NOTE: This informal summary of selected changes was prepared only for readers' convenience. It is a summary only and does not change any provision of the RFP, nor is it a full summary of all changes. Please review the RFP text carefully (including any modifications to the RFP by one or more addenda).

Electronic Health Records (EHR) Requirements:

- Each participating entity (PE) must have either a unified system using one single EHR among practice sites or an established system that fully integrates multiple EHRs into one unified system, so that care coordinators in any part of the PE have access to relevant information for members for whom they are providing care coordination services.

HUSKY Eligibility

- In Wave 2, Care Coordination Add-On Payments were only made for members who are reinstated to HUSKY eligibility and retroactively have continuous enrollment no later than 120-days after they temporarily lost coverage. In Wave 3, the 120-day period has been shortened to 60 days.

Provider Qualifications

- Wave 3 eliminates the 18-month period to obtain PCMH certification and now requires all primary care providers within a PCMH+ PE to have full PCMH-status at the time of attribution and assignment for each performance year.

Care Coordination

- Enhanced care coordination requirements will be amplified in Wave 3. PEs must develop fully integrated, dynamic, interdisciplinary care teams that work in collaboration across the organization and at each service location where members are seen.
- All members of the care team are to have access to the member records to support seamless care coordination.

Quality Measures

- The Department has refined the core set of quality measures.
- The Department has developed several elective measures, for use in the quality scoring of the Challenge Pool.
- Please see Section III. Program Information, F. Attachments, I of this RFP for the full list of quality measures that will be used in W3.

Quality Measurement Scoring

- The Department has modified the shared savings scoring methods for the purpose of rewarding both high performers and significant improvement. Performance gates have been added in W3 that will require PEs to improve year-over-year in avoidable hospitalizations and ED visits prior to qualifying for the Challenge Pool component of shared savings.
- The Department has moved away from having 2/3 (improve and maintain) of the quality scoring focused on quality improvement.
- A complete explanation of the shared savings calculation is found in Section III. Program Information of this RFP.

Challenge Pool Gate

- The requirement to participate in the Challenge Pool is based on level of adoption of care management interventions, care delivery and other measurable action tied to member care.

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

September 12, 2019

DSS Central Office
55 Farmington Avenue
Hartford, Connecticut

PCHM+ WAVE 3 BIDDERS CONFERENCE

(Transcription from Electronic Recording)

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JOEL NORWOOD	DSS
ROB ZAVOSKI	DSS
LEWIS BEILMAN	CS-HHC
CHRISTINE BIANCHI	StayWell
JOANNE SMITH	SWCHC
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TIM POWERS	Charter Oak Health Center
DR. SUNIL D'CUNAH	Charter Oak Health Center
ED ROBERTS	PMH-CRC
KATHRYN RUSZCZYK	PMH-CRC
CECILIA RODRIGUEZ	Optimus
ALIX POSE	Optimus
CATHY LULY	CCMC
MERLE DICKSON	NHCMB
KIM HAUGABOOK	Beacon Health Options
ANNE KENNY	Generations
GRETCHEN HUTULA	Generations
GEORGIA PELLETIER	VCA
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JEANNE O'BRIEN	VCA
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DIANE DEROCHE	UCFS
CLAIRE SILVA	UCFS
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ROXANNE ROTONDARO	HHC
JILLIAN DUBROSKY	HHC
ROBERT BLOCK	CHCI
TIERNEY GIANNOTTI	CHCI
SHARON RADLER	CHCI

1 (Proceedings commenced at 10:07 a.m.)
2
3 DR. ZAVOSKI: All righty. Good morning
4 folks.
5 ATTENDEES: Good morning.
6 DR. ZAVOSKI: This is the Bidders
7 Conference for PCMH+ Wave 3. If that’s not what
8 you want to be doing this morning then you’re in
9 the wrong place.
10 I’m Rob Zavoski, I’m the Medical
11 Director here at the Department of Social
12 Services. I’m here with Nicole Godburn and with
13 Joel Norwood.
14 You may have noticed that we’re a
15 little technologically challenged at the State.
16 We are trying to record your questions because we
17 will formally respond to all questions so that
18 everybody gets the same answer, including folks
19 who were not fortunate enough to make it here.
20 So we will be handing around a tape machine when
21 you ask a question so that we can hear you. It’s
22 a little bit of an odd way of doing things but
23 unfortunately the batteries in all of our
24 microphones are state issued batteries and
25 therefore to not work.

1 So I'm going to shut up so we can get
2 this started and hand this off to Joel Norwood,
3 our attorney, who will walk through the ground
4 rules.
5 MR. NORWOOD: Sure. And then also
6 Nicole Godburn also from DSS is here as well. So
7 thank you, Dr. Zavoski.
8 I think you all know a bit about PCMH+
9 just from having many of you participated in it
10 for multiple years. Some just recently started
11 participating and some maybe you're just thinking
12 about now.
13 The outline of the program and why
14 we're doing the program is in detail in the RFP
15 itself both at the beginning, and then there's a
16 more detailed section for the middle of the RFP.
17 So make sure you read the entire RFP, follow all
18 of the details. There are some very technical
19 specific things in there. None of us are from
20 our contracts unit so if you have any specific
21 technical RFP questions, please send those to the
22 official contact. That information is listed in
23 the RFP and on the link on the DAS website where
24 the RFP is posted.
25 Please check that DAS portal website

1 frequently. The standard process is as we
2 respond to questions in writing they will be
3 added in a formal addendum to the RFP. If we
4 make any other changes for any other reason they
5 will also be in an addendum to the RFP, so make
6 sure you check that page frequently. I believe
7 you can sign up for alerts that will --
8 UNKNOWN SPEAKER: Well, what's that you
9 could --
10 MR. NORWOOD: You should. If not just
11 check it frequently because there may be changes.
12 The deadline to send written questions
13 again only to the official contact listed in the
14 RFP, not to any of us or anyone else at DSS is
15 September 19th at 2:00 p.m. So I'd encourage --
16 feel free to ask any questions today and also
17 please send any questions you'd like, both the
18 ones you sent today as well as any others in
19 writing preferably by email to the official
20 contact by that date. The soon the better. It
21 gives us more time to discuss and then issue
22 responses.
23 I think that's pretty much it. So the
24 way it will work today is anyone can ask any
25 questions. Again, because our microphones aren't

1 working we'll pass around the recording device to
2 make sure the recording captures every word of
3 it. If it's something we're able to respond to
4 just hand it back to us and we'll respond, give
5 our best attempt to respond.
6 Anything we say verbally today is a
7 tentative response, so we intend to record it,
8 and we intend to put a transcript of this as an
9 addendum, the formal written responses and the
10 formal addendum to the RFP is what really
11 matters.
12 So first off does anyone have any
13 procedural questions about this morning's bidders
14 conference?
15 (No response.)
16 MR. NORWOOD: Okay. Seeing none -- oh,
17 and I forgot to say this bidders conference is
18 today, Thursday, September 12, 2019. We started
19 just a couple minutes after 10:00 o'clock in the
20 morning. It's now just about 10:13 just so the
21 recording has all that information.
22 DR. ZAVOSKI: Tell them where the
23 bathrooms are.
24 MR. NORWOOD: Oh, yes. The bathrooms
25 are through the elevator lobby. You'll just ask

1 the security guard to let you into the bathrooms.
2 And the exits are -- follow the exit signs back
3 the way you came. And I think that's it. Do we
4 have a sign-in sheet?
5 MS. GODBURN: Yes. So if anybody
6 hasn't signed in it's on the back table. So
7 please do so and leave your contact info there as
8 well in case we need to follow up.
9 MR. NORWOOD: Okay. Why don't we start
10 with the sign-in sheet and just go and see in
11 order of the sign-in sheet if anyone has any
12 questions in that order and that might be --
13 MS. GODBURN: Sure. Well, there's a
14 couple of them.
15 MR. NORWOOD: Okay.
16 DR. ZAVOSKI: I'll take the mic.
17 MR. NORWOOD: Sounds good.
18 MS. GODBURN: So we'll start with
19 Jeanne, lucky Jeanne. Jeanne O'Brien, VCA.
20 MS. OBRIEN: You did find me first,
21 that's okay.
22 DR. ZAVOSKI: Can you pass this
23 through?
24 MS. O'BRIEN: Good morning. First
25 question, could you do an overview high level, in

1 the weeds, anything related to EHR and having a
2 single EHR?
3 MS. GODBURN: So the question is for
4 anybody who didn't hear it related to --
5 (Pause.)
6 MS. GODBURN: I know. I have a big
7 voice. So the question relates back to the
8 question of the RFP about the EHR component of
9 it, and Jeanne's question was about a single EHR.
10 So it's not necessarily a single EHR, you can
11 have multiple EHRs but there has to be a
12 component of interoperability.
13 So if you're, for example, a practice
14 that you have one single EHR across all of your
15 locations, that's perfectly fine. If you are a
16 structure that has multiple EHRs across multiple
17 different locations there has to be some system
18 in place where all those systems are able to
19 connect, talk to each other, and someone who is
20 at one location can easily access any medical
21 information about a client who's potentially in a
22 different location. So there has to be that type
23 of connection.
24 Yes? Okay.
25 MR. ROBERTS: Hi, this Ed Roberts,

1 Prospect Coordinator Regional Care.
2 So to that end of what you said about
3 the interoperability, would a population health
4 platform such as we're using, Healthy Intent,
5 would that serve that purpose as long as it
6 answers the questions of the measures that you're
7 looking for, or do you really require to be able
8 to get into individual medical records?
9 MS. GODBURN: So not knowing the
10 nuances of your system, as you explained it to me
11 I would say yes, but I would encourage -- so in
12 your response to the RFP just clearly outline how
13 your system would work so that the evaluators can
14 take a look at that and see if it meets the
15 requirement.
16 MR. NORWOOD: Nicole, why don't you
17 explain a little bit more why we put this
18 requirement in and exactly what it's intended to
19 --
20 MS. GODBURN: Yeah, we both could.
21 Would you like to start or -- yelling?
22 DR. ZAVOSKI: I didn't hear what she
23 said because I was trying to figure out what I
24 was going to do (unintelligible) but they
25 outnumber me.

1 (Laughter.)
2 MS. GODBURN: So the question was so if
3 you're not sure if your system kind of works and
4 meets that requirement just please detail it in
5 your RFP response back so that the folks who are
6 evaluating them can take a look at it and see if
7 it meets the requirement.
8 Now, also the question then connected
9 to why are we putting this component into Wave 3.
10 So based off of -- as some folks know based off
11 of many of the onsite visits we did during Wave 1
12 and Wave 2 and based off lots of the feedback
13 that we received and many of the evaluations we
14 did during PCMH+ Wave 1 and 2, we always have I
15 think made it very clear that the program would
16 improve based off of what we saw happening. So
17 this was one of the pieces that we wanted to kind
18 of strengthen and built out in Wave 3.
19 DR. ZAVOSKI: The guts of this program
20 is care coordination, team based care working
21 together, and if somebody over here can't talk to
22 somebody over here it's not going to work.
23 Everybody needs to be able to talk
24 electronically, be able to coordinate care
25 electronically so everybody is on the same page.

1 MR. NORWOOD: So this is Joel again.
2 Dr. Z, does that mean that anyone in any part of
3 the organization needs to be able to see a
4 member's medical record?
5 DR. ZAVOSKI: If they're part of the
6 team caring for that member, then yes.
7 MR. NORWOOD: Okay. And I would add to
8 what Nicole said, absolutely detail in your RFP
9 response if you do have once single EHR just say
10 that. If you're using a coordinated
11 interoperability system that combines systems so
12 that they can talk to each other, just like Dr. Z
13 said, detail that.
14 If you have a question and you're not
15 sure which side of the line you're on I would
16 strongly recommended that you put together a
17 detailed question very soon and we can try to
18 look at it now so that then you can use our
19 response to that question in potentially
20 adjusting what you decide to put in your RFP,
21 because once it's in the RFP it's in and then
22 either our evaluators agree it meets the
23 requirement or it doesn't. So over the next week
24 is your opportunity to engage in that dialogue
25 and say what you were planning on and for us to

1 be able to take a look at that.
2 MS. GODBURN: Ken.
3 MR. LALIME: Ken Lalime, CHCI.
4 So along those lines there's no way you
5 can put together a list of here are the mandates
6 that we have in this system so we would know
7 ahead of time that the opportunity was there, and
8 we'd hate to see us all go through the process,
9 we can ask the question, but I think that that
10 means everybody asking the different set of
11 questions.
12 If there was one set of questions that
13 we could all actually answer to get to that, yes,
14 this fits the criteria, that would be great. I
15 don't know if that's possible.
16 MR. NORWOOD: Are you suggesting that
17 we put more detail -- I mean so right now we kept
18 it as page 49 on the RFP. We kept it fairly
19 general because we are not technical experts. We
20 don't know what options are potentially out
21 there. We don't want to limit potential
22 participating entities from coming up with
23 creative ways of ensuring that the entire care
24 team can communicate with each other. So if you
25 want we can try to put a little more detail as to

1 what our expectations are. We don't want to be
2 too technical though.
3 MR. LALIME: That's going to come into
4 to the quality or HIE, that's where this is
5 headed, is whether HIE can actually move that
6 data, not to see that data, it's just the
7 timeframes, how fast it would to do it, that's
8 mean it's real time. It's going to certainly be
9 different than if it's a look-up capability in a
10 different system. So the more detail would be
11 very helpful.
12 MR. NORWOOD: Can you please, please
13 put that in a written question soon exactly what
14 details you want us to potentially add to the
15 RFP. So we're taking notes, we'll get the
16 transcript, but if there's specific parameters
17 you want us to weigh in on please let us know.
18 MS. GODBURN: Jeanne, did that answer
19 your question at all or -- I don't want to
20 suggest that --
21 MS. O'BRIEN: It was okay, yeah.
22 MS. GODBURN: Okay.
23 MS. O'BRIEN: No, I have like nine more
24 questions to follow that but I'm hearing that I
25 need to send that in writing in order for you to

1 --
2 MS. GODBURN: Yeah. And part of the
3 reason why we didn't get so technical in the RFP
4 is yes, we're not tech people by any means, but
5 then we also didn't want to, you know, have you
6 guys go out and have to buy a whole new system,
7 you know, to build on top of your already
8 existing platforms. You know, that would just be
9 burdensome as well.
10 So we want to make sure that whatever
11 system you're using you're using and it's in
12 place before Wave 3 gets up and running.
13 MS. O'BRIEN: Right. So I guess a
14 follow-up question, if you're integrating a
15 delivery system with different hospitals that
16 don't have the same PMR, what is your
17 interpretation of that.
18 MS. GODBURN: Right.
19 MS. O'BRIEN: That am I -- have an
20 opportunity to participate or --
21 MS. GODBURN: So if your hospitals, for
22 example, all have different health record systems
23 that's totally acceptable as long as those health
24 systems in some way can communicate with each
25 other. So as Dr. Z said, remember, the Care Team

1 can make sure that --
2 DR. ZAVOSKI: The standard is that
3 people are speaking to each other when they're
4 coordinating care. How you do that we would
5 rather not dictate because the innovators are the
6 people who are looking at us, not the people who
7 are looking at you. You show us and you tell us
8 how you propose to do it. But the standard is
9 that people are talking to each other
10 electronically.
11 MR. NORWOOD: And if one care
12 coordinator in one part of the network can see a
13 member in another part of the network that
14 they're legitimately working on for PCMH+ so
15 there's no HIPAA issues or any of that in terms
16 of in concept.
17 How you get there is up to you but the
18 idea is that they're all, to the extent people
19 are actually working on a patient's care together
20 in different parts of the network for legitimate
21 clinical reasons they have to be able to
22 communicate. Otherwise our view is it's not
23 really a network, then it's a federation of
24 different components. The idea is to the extent
25 there are patients that different parts of the

1 network need to see and work together on, that
2 the electronic capability needs to be able to
3 support that. How you get there is up to you.
4 If you want more details on what our
5 expectations are please send out in writing just
6 because we're not the technical last words on
7 this. We'll need to dig in with people who are
8 to get a better sense of what that really means.
9 MS. GODBURN: All right. So let's try
10 to spread the love with questions. So let's go
11 to Dr. Pose.
12 DR. POSE: Yes.
13 MS. GODBURN: Yes. Did you have any
14 questions? Because you were next on the list.
15 DR. POSE: Yes.
16 MR. NORWOOD: Pass the mic.
17 MS. GODBURN: Yeah. You have one of
18 those nice lovely soft voices.
19 UNKNOWN SPEAKER: Yell if you want to.
20 MS. POSE: Ask my kids.
21 (Laughter.)
22 MS. POSE: Sorry. So yeah, because you
23 ask us to do community partnerships. My
24 question, number one, is it the same type of
25 partnership that was the case in Wave 1 and Wave

1 2, or do you want us to go towards the PSI grant,
2 which is like formal and financially exchange,
3 you know, monetary exchange with the community
4 partners? That was my question.
5 UNKNOWN SPEAKER: (Unintelligible.)
6 MS. POSE: It's the same grant, yeah,
7 so there kind of -- there's a contract and a
8 monetary exchange with the community partner.
9 Yes/no? Or we can go back to our quiet regular
10 partnership with community partners?
11 DR. ZAVOSKI: I don't want this to be a
12 full employment for lawyers.
13 MS. POSE: Okay. Thank you. I got my
14 answer. Thank you.
15 DR. ZAVOSKI: The reason for these
16 formal agreements as (unintelligible) folks know
17 (unintelligible - away from mic).
18 MS. POSE: Okay. So the same type of
19 agreement that we had in previous waves.
20 And I apologize, I read the things but
21 I had only two days to read it. What is the main
22 difference between Wave 1 RFP and Wave 3 RFP?
23 MR. NORWOOD: On this topic?
24 MS. POSE: No, in general.
25 MR. NORWOOD: Oh, in general. Oh, just

1 between Wave 1 or between Wave 2?
2 (Unintelligible.)
3 MS. POSE: Right. Wave 2 -- I
4 apologize. Wave 2 and Wave 3. Just that would
5 help.
6 MS. GODBURN: So, I mean really off the
7 top of my head I would say the piece of the
8 (unintelligible) would be one of the changes.
9 Some of the components of the shared saving
10 calculation are different. Quality measures are
11 different.
12 MR. NORWOOD: Care coordination.
13 DR. ZAVOSKI: I think that's a good
14 question for us to respond in writing so we don't
15 miss anything.
16 MS. GODBURN: Yeah. Yeah, because I'll
17 miss something if I -- yeah, okay.
18 So the question was what are the
19 differences between what was in Wave 2 to Wave 3.
20 We'll do a checklist of what it is.
21 MR. NORWOOD: In general, the general
22 theme is our expectations in all rounds have
23 increased a bit. So just overall our
24 expectations for the whole program are increasing
25 in basically every round. Not a lot in certain

1 areas but as providers get more experience we're
2 just trying to raise the bar a little bit in each
3 of the areas. That's the general theme.
4 UNKNOWN SPEAKER: Can we just ask
5 (unintelligible).
6 DR. ZAVOSKI: Yes. The question --
7 UNKNOWN SPEAKER: Well, whatever the
8 budgets target, whatever their financials
9 (unintelligible).
10 DR. ZAVOSKI: The request is that we
11 would add the financial changes as well and we
12 will do that.
13 I think she ran off with the list.
14 MR. ROBERTS: Can I ask a question?
15 MR. NORWOOD: Please say your name each
16 time too. Just for the recording.
17 MR. ROBERTS: Ed Roberts from Prospect.
18 Can we expect to see some kind of
19 financial grant such as the CSEP (phonetic) grant
20 to support this?
21 DR. ZAVOSKI: The quick answer is no.
22 MR. NORWOOD: And that's because the
23 federal grant --
24 DR. ZAVOSKI: The answer is would the
25 advanced networks be expecting another grant or

1 financial support from the SIM program, and that
2 grant -- that program is ending shortly.
3 You ran off with the list?
4 MS. GODBURN: No, I went to go yell --
5 DR. ZAVOSKI: Yeah, I know.
6 MS. GODBURN: -- at next
7 (unintelligible). So I think they got it.
8 There was a question, yes.
9 MS. ROTONDARO: Roxanne Rotondaro from
10 Hartford Healthcare Medical Group.
11 One of the changes that you talked
12 about over the summer when you introduced
13 possible changes to Wave 2 was that dual eligible
14 would be part of the program. It appears from
15 reading this that they are a part of the program.
16 I just want to validate that. Because the
17 exclusions written here is those that opted out
18 of PCMH+ and members with extensive in-depth care
19 needs, but it doesn't specifically say dual
20 eligible.
21 MS. GODBURN: Right.
22 MR. NORWOOD: Do you have the page
23 reference for the --
24 MS. ROTONDARO: Page 31, under
25 intensive care management.

1 MR. NORWOOD: Oh, that's for purposes
2 of intensive care management. For duals
3 generally -- I don't remember what section that's
4 in. So it's in a different types of members that
5 are excluded, a lot of duals are out, a small
6 subset are in there, yeah.
7 MS. ROTONDARO: Yeah, page 35.
8 MR. NORWOOD: 35. That's right. So
9 anyone who is a partial dual because they don't
10 have full Medicaid, so that would be QMB only or
11 SLMB or ALMB because they're actually on full
12 Medicaid. Anyone in Medicare Advantage, anyone
13 in a Medicare ACO, and then anyone who is in 1915
14 NC waiver, 1915I or 1915K as Community First
15 Choice, in a nursing home or other institution.
16 So you add all those up but there aren't a whole
17 lot of duals left but if someone is a dual who is
18 not on that list then they do have the option of
19 being in PCMH+.
20 You may have noticed in the budget that
21 was passed by the General Assembly there is a
22 proposal to look at adding duals to PCMH+ for a
23 future wave or potentially midway through this
24 one. But that's less realistic given the amount
25 of time it takes to plan changes. So that's on

1 the horizon for a potential future change, but it
2 would probably be for a future wave and hasn't
3 even been designed yet.
4 MS. ROTONDARO: Thank you.
5 MS. GODBURN: Sue.
6 MS. LAGARDE: Is there a resource to
7 help me know where my duals reside? I don't know
8 that I know which of my duals are partial and
9 which are not.
10 MR. NORWOOD: Well, do we have this for
11 purposes of knowing who's excluded, and how do we
12 do the excluded population right now?
13 MS. GODBURN: That's done in -- so the
14 exclusions are actually done in CHN's house.
15 They have the conditions when they create your
16 roster.
17 DR. ZAVOSKI: Read the question into
18 the tape and we'll see if we can do that.
19 MS. GODBURN: Yeah. Sue, I would say
20 put that in writing because we would have to
21 reach out to CHN since, you know, they can kind
22 of earmark and tag who's a dual and who isn't.
23 So we would have to kind of touch base with them
24 to see.
25 MR. NORWOOD: Well, but my question for

1 you, Nicole, is does the existing CHN portal
2 already exclude whoever is excluded and falls
3 into an excluded category?
4 MS. GODBURN: So currently as it stands
5 the member roster that practices get who are
6 currently participating already excludes all
7 those folks.
8 MR. NORWOOD: Okay. But I think Sue's
9 question is about how can I kind of understand
10 who my population is going to be for Wave 3.
11 MS. LAGARDE: Exactly.
12 MR. NORWOOD: Oh, okay.
13 MS. GODBURN: Right.
14 MR. NORWOOD: Right. So if they're not
15 on the roster they're in one of the current
16 excluded categories.
17 MS. LAGARDE: But I wouldn't know that
18 until (unintelligible).
19 MR. NORWOOD: Right, right.
20 MS. GODBURN: Right.
21 MR. NORWOOD: We have to take a look --
22 I mean obviously we know on our system who's in
23 what category, but I don't know --
24 DR. ZAVOSKI: It's eligibility. Don't
25 look at the (unintelligible).

1 MR. NORWOOD: No, no, I'm not an
2 eligibility expert either.
3 So a partial dual you would know that
4 because they're not on full Medicaid. Medicaid
5 just pays the Medicare cost share or whatever
6 portion of it. But all the other categories,
7 you're right now they're --
8 MS. GODBURN: You wouldn't know.
9 MR. NORWOOD: You wouldn't know.
10 MS. GODBURN: You're not going to know
11 until you're already in it. So, Sue, if you want
12 to put that question in writing, what we'll do is
13 we'll reach out to CHN and see if there's a way
14 that we can kind of -- because we can give you a
15 general estimate of what we think your number
16 generally will be, but to narrow it down on who's
17 a dual, who's a --
18 MS. LAGARDE: So when Joel says that
19 it's a small pocket remaining who are not
20 excluded, do you know a rough percentage? I mean
21 you could look at our percent (unintelligible),
22 because if our percentages are the same which
23 probably not a fair assessment, but it gives us a
24 ballpark.
25 MS. GODBURN: Yeah.

1 MR. NORWOOD: I just said that
2 conceptually. And I don't have -- actually I
3 have no idea what the numbers are.
4 MS. GODBURN: So I just yesterday
5 happened to look at all the practices that are in
6 Wave 1, all the practices who are in Wave 2 and
7 looked at what your PCMH minus the plus
8 populations were prior and then what your PCMH+
9 populations were, and average 10 percent. So
10 some people were closer to 7 percent, some were
11 around 11, but it was kind of averaging around 10
12 percent of your PCMH population will be excluded
13 and then the remaining will be for your PCMH+.
14 That's what --
15 MR. NORWOOD: So are you saying on
16 average for a typical PD 90 percent of the PCMH
17 attributed members are going to be in PCMH+?
18 MS. GODBURN: Right.
19 MR. NORWOOD: 10 percent are excluded;
20 that's a rough, very, very rough figure. It will
21 vary widely by provider and practice location and
22 over time. A lot of the people who are excluded
23 are likely to be duals, but not all because many
24 of the exclusion categories primarily will
25 involve duals, but a few of them won't. I really

1 depends on each one.
2 UNKNOWN SPEAKER: On page 18 it says we
3 can ask for their (unintelligible) in the numbers
4 so we'll know did we get 2,500, whatever. But
5 all of those issues that just got addressed will
6 be part of that validation of that number?
7 MS. GODBURN: So when you ask it will
8 be a rough estimate minus that 10 percent, but we
9 can go again, you know, put that in writing. We
10 can go to CHN and see if they can get us a more
11 concrete number. So --
12 UNKNOWN SPEAKER: Great.
13 MS. GODBURN: So we left with -- let's
14 see. CHS, other folks from CHS, do you guys have
15 any questions?
16 UNKNOWN SPEAKER: Not in particular.
17 MS. GODBURN: No.
18 UNKNOWN SPEAKER: (Unintelligible.)
19 MS. GODBURN: Still learning the
20 waters?
21 UNKNOWN SPEAKER: Yes. A lot of my
22 questions were concerns about what -- or
23 impressions about what was different this time
24 around.
25 MS. GODBURN: Okay.

1 UNKNOWN SPEAKER: So we did make a
2 proposal for Wave 2 and weren’t selected to
3 participate in that. So I guess I just to make
4 sure we --
5 MS. GODBURN: Okay.
6 UNKNOWN SPEAKER: -- do what we need to
7 do this time in that proposal.
8 MS. GODBURN: Yeah.
9 UNKNOWN SPEAKER: You know what I mean?
10 If there was a significant difference.
11 MS. GODBURN: Okay. Yeah. And again
12 so the question pertaining to what are the
13 differences between Wave 2 and 3, so again we’ll
14 --
15 UNKNOWN SPEAKER: We’ll let you know
16 the --
17 MS. GODBURN: Yeah, we’ll give
18 something more detailed and post that as an
19 addendum to the RFP.
20 So after -- Wheeler, anybody Wheeler
21 have --
22 MS. DELLAS: Yeah, I had a couple of
23 questions. So with the FS network in a couple of
24 places in the RFP it states that the primary care
25 provider has to pull the PCMA track

1 (unintelligible) from NCQA but doesn't mention
2 joint commission, and I wasn't --
3 MS. GODBURN: Yeah.
4 MS. DELLAS: It does for the FQHCs
5 under the advanced network -- I guess I didn't --
6 if it does I didn't see it , but I definitely saw
7 it --
8 MR. NORWOOD: Well, we'll clarify that
9 in an addendum. So most advanced networks are
10 private practices. Obviously in your case FQHC
11 is. We just mean that every primary care
12 provider who is part of your network is PCMH
13 certified, so it's an FQHC with joint commission,
14 that's fine.
15 MS. DELLAS: Make sure nothing changed
16 in that regard.
17 DR. ZAVOSKI: Nope.
18 MR. NORWOOD: And then we will double
19 check. If you could send your question in
20 writing identifying the specific page and
21 paragraph where it's unclear, we'll clarify that.
22 That was not our intent.
23 MS. DELLAS: Thank you.
24 And then I had a question about the
25 add-on cost for attributed member, I don't

1 believe it was listed in the RFP what the amount
2 was per member per month?
3 MS. GODBURN: Oh, the PM for member --
4 MR. NORWOOD: (Unintelligible) FQHC --
5 MS. GODBURN: Right. So --
6 MS. DELLAS: Right.
7 MS. GODBURN: Yep. So the PMPM payment
8 is for additional care coordination requirements
9 for FQHCs only, and that will stay the same as it
10 was in Wave 1 and 2. So $4.50 per member per
11 month.
12 MR. NORWOOD: Unless there is such
13 robust participation that the total amount
14 exceeds the appropriation in which case it might
15 be a little less potentially. That's unlikely,
16 but this sets a dollar amount.
17 MS. GODBURN: Yes, right.
18 MR. LALIME: Would that be done at the
19 end of the bucket of dollars, let's say 5 million
20 dollars is allocated. You run out of that 5
21 million, does it stop or you guys try to predict
22 based on attribution of membership that the 4.50
23 needs to be 4.25? Which is that going to go?
24 MS. GODBURN: So, yeah, we've had this
25 conversation in Wave 1 and 2, and we've kind of

1 proposed as you said, Ken, you know, so if we're
2 starting to run out of funds we would have to
3 come and talk to everybody who is receiving the
4 PMPM and see if folks would be willing to
5 decrease the 4.50 would be my assumption. But
6 we've always put in the caveat that we only get a
7 bucket of money from the Legislature. It's not a
8 bottomless bucket, so once that money runs out
9 and if we're still in the middle of a wave it's
10 gone.
11 MR. NORWOOD: Well, we'd actually make
12 a decision before the contracts were signed --
13 MS. GODBURN: Yeah.
14 MR. NORWOOD: -- whether it was 4.50 or
15 something different. I think if we projected
16 that because of super robust participating that
17 it would run out for everybody in October, then
18 we'd want to bring it down a little bit so that
19 it would be spread out and be a more even stream
20 of revenue more predictable. But we'd have to
21 take a look at it. This is all theoretical.
22 It's just a caveat that we operated within the
23 pocket that we were given and so -- hey, look,
24 you divide it out evenly either way.
25 MR. LALIME: Thank you.

1 MS. GODBURN: Any other questions? No?
2 MS. DELLAS: Thank you.
3 MS. GODBURN: Where am I next?
4 Tierney, did you guys have any questions?
5 MS. GIANNOTTI: So I wanted to ask you
6 about the distribution of shared savings to
7 providers. Is there an expectation that all will
8 be shared, a percentage, and some understanding
9 of the rationale for not including other members
10 of the care team who are intimately involved in
11 this work?
12 MR. NORWOOD: Can you give examples of
13 (unintelligible - not at mic)?
14 MS. GIANNOTTI: Nurses, medical
15 assistants, CHWs, care coordinators, et cetera.
16 MS. GODBURN: So for folks who didn't
17 hear, and correct me if I capture your question
18 incorrectly, so Tierney's question related to if
19 you're awarded shared savings and then you go to
20 distribute the awards among your team, why are
21 some folks excluded from receiving any portion of
22 the reward.
23 I, off the top of my head, don't think
24 we changed the distribution of any awards in any
25 way from Wave 1 or Wave 2.

1 MR. NORWOOD: But you do need to put it
2 in your contract which DSS will need to approve.
3 So if an organization applies to RFP, is selected
4 for an opportunity to negotiate a contract, one
5 of the things you'll do is -- or is it even in
6 the RFP response what the distribution
7 methodology is?
8 MS. GODBURN: No, it comes up in the
9 contract, period.
10 MR. NORWOOD: Okay. So if you're
11 selected to have the opportunity to negotiate a
12 contract at that point you would send us what
13 your proposed distribution methodology is. And
14 there's some things it can't do, like it can't
15 reward individual practitioners for their
16 contribution to individual savings. So that's
17 one thing it can't do for example. And you can
18 only share savings within your organization but I
19 don't know that we'd ever come up with a question
20 of could you share it with the various other
21 folks. I would say maybe.
22 MS. GIANNOTTI: Is it in Wave 1 or 2?
23 MR. NORWOOD: I don't remember it
24 coming up.
25 MS. GODBURN: Yeah. I don't --

1 MS. GIANNOTTI: It was new to us but --
2 UNKNOWN SPEAKER: We haven't seen
3 anything.
4 MS. GODBURN: Okay. Yeah, because the
5 distribution that was part of the contracting
6 period that the Department just has to review it
7 and do a back and forth if there's any questions
8 or concerns.
9 MS. GIANNOTTI: Okay.
10 MS. GODBURN: But that would all be
11 done through the contract period.
12 DR. ZAVOSKI: But I Tierney's question
13 also was, was there essentially a floor that had
14 to be distributed out of the shared savings.
15 MS. GIANNOTTI: I recall you could
16 cover some admin cost --
17 MS. GODBURN: Yeah.
18 MS. GIANNOTTI: -- like you could
19 decline an admin cost that was covered first and
20 then you could define your methodology after that
21 as well.
22 MS. GODBURN: Yep.
23 MR. NORWOOD: If you want in a written
24 question now you could say here's what we're
25 thinking or distribution methodology, what we

1 might want to do for that, is that something that
2 you would probably be okay with at the
3 contracting stage.
4 MS. GODBURN: Yeah.
5 MR. NORWOOD: I don't know that we
6 could definitively say one way or the other now
7 but we could certainly give you a sense. I don't
8 remember this coming up. I don't know that we'd
9 have any particular issue with it. If they're
10 members of the care team that are in your
11 organization, they're not being awarded for their
12 individual contribution for savings, I don't know
13 that we'd have -- I can't think of why we'd have
14 a problem with that. But --
15 MS. GIANNOTTI: Just the wording is
16 confusing because you said provider.
17 (Unintelligible crosstalk.)
18 MR. NORWOOD: Okay. In your question
19 please reference the specific page and paragraph
20 that seems confusing.
21 MS. GIANNOTTI: Sure.
22 MR. NORWOOD: We use the word provider
23 maybe more broadly than providers do.
24 DR. ZAVOSKI: (Unintelligible) confused
25 in that sentence meaning the organization.

1 MR. NORWOOD: Yeah, I think that's what
2 I mean. We think of provider as the
3 organization.
4 MS. GIANNOTTI: Okay, okay. That's
5 helpful.
6 MS. GODBURN: Sue, any clarity on that
7 or --
8 MS. LAGARDE: Yeah. We must, it said
9 we must distribute to these two providers, it
10 can't be used to enhance another program. These
11 shared savings must go to providers?
12 UNKNOWN SPEAKER: As a minimum
13 qualification.
14 MR. NORWOOD: Is your question or --
15 DR. ZAVOKSI: That's a separate
16 question, please.
17 MR. NORWOOD: That's a separate
18 question. Please put that in writing too,
19 exactly what part seems contradictory. I don't
20 know. I don't remember even discussing that
21 question before.
22 MR. ZAVOSKI: No.
23 MR. NORWOOD: No. We'll take a look at
24 it. We don't know.
25 MS. GODBURN: Yeah.

1 MS. GIANNOTTI: Another topic?
2 MS. GODBURN: Oh, absolutely.
3 MS. GIANNOTTI: Avoidable ER visits and
4 hospitalization -- no, not -- well, those two I
5 have questions about the diagnosis codes. It's
6 much harder to get the 3M specifications than
7 some of the others, so we're working on that. So
8 if there's any assistance or links or whatever
9 that would be great. But the other two are the
10 ones for mental illness, those two new measures,
11 follow-up for patients with ER visits and
12 hospitalizations for mental illness.
13 Given the sensitivity of diagnoses and
14 the -- many of us use patient pain, what are the
15 thoughts around how we're going to identify those
16 patients in a timely manner, and will we have to
17 do 7 and 30-day follow-up for those patients?
18 DR. ZAVOSKI: (Unintelligible - away
19 from mic) put on the website the specific codes
20 that are out there and how the measure is
21 calculated.
22 MS. GODBURN: And -- does that answer?
23 MS. GIANNOTTI: Yep, the first one.
24 And the second --
25 MS. GODBURN: And the second piece?

1 DR. ZAVOSKI: The second one is?
2 MS. GIANNOTTI: The sensitivity of
3 mental health diagnosis and getting that
4 information in a timely manner so we can --
5 MS. GODBURN: Do the follow-up.
6 MS. GIANNOTTI: It's hard to --
7 DR. ZAVOSKI: I know. It's a stretch.
8 That's why we're doing this.
9 MS. GIANNOTTI: Okay.
10 MS. GODBURN: Did everybody catch that
11 question and the response? No? Okay.
12 So the original question was regarding
13 the quality measures that were in there and how
14 the qualify measures are based, the steward is
15 3M, and the request for more information about
16 how to properly capture on the claim all that
17 will be needed to capture that in the measure,
18 and we will get that information posted publicly
19 so you guys can be more aware of how to correctly
20 code that.
21 And then the second part of that
22 question pertains to sensitivity around getting
23 information about behavioral health and mental
24 illness issues and to do the follow-up to --
25 please correct me, I'm not a doctor -- and so to

1 do the --
2 DR. ZAVOSKI: (Unintelligible.)
3 MS. GODBURN: Okay, good. All right.
4 And to do the follow-up for the quality measures
5 that require the follow-up afterwards and --
6 MS. GIANNOTTI: The transition to the
7 care.
8 MS. GODBURN: Thank you.
9 DR. ZAVOSKI: We recognize that that
10 particular measure is going to be hard for
11 everybody because it's a measure and it's a
12 problem upon which we all do not perform well.
13 And so it's in there because we want everybody
14 working together to perform better.
15 I'm not putting -- we didn't put
16 measures in that we knew that you would slam them
17 out of the park; we're putting things in there to
18 make it a little harder because it's something
19 that we as a state need to do a better job of and
20 for our members and our patients.
21 MS. GODBURN: Tierney, any other
22 questions or --
23 MS. GIANNOTTI: Not right now. Thank
24 you.
25 MS. GODBURN: Okay. Sure.

1 UNKNOWN SPEAKER: Can I ask a question?
2 MS. GODBURN: Yes.
3 UNKNOWN SPEAKER: I think that's a
4 superb question because we spoke with that in
5 other areas as well. Would you maybe have access
6 to other states that have come up with other
7 strategies that may be useful to at least be
8 aware of and to read about as we're formulating
9 our thought process?
10 DR. ZAVOSKI: I can ask. I'll be
11 honest with you, Connecticut tends to be ahead of
12 the curve most of the time on these sorts of
13 things and other states, because they use managed
14 care arrangements, their answer to all of this
15 is, you know, it's proprietary and they won't
16 share it. But I will -- if you send that request
17 in to give me a reminder I will see if I can get
18 a response from one of my colleagues.
19 UNKNOWN SPEAKER: Thank you.
20 UNKNOWN SPEAKER: Or at least define
21 from a patient side what attribution means. So
22 you're in this program, by being in this program
23 it allows for more resources to be available to
24 you. Those resources are beyond your hospital
25 team. There are care teams that will provide for

1 you, so they will have -- they do have access to
2 your information and it's okay or -- if they're
3 opting out then there's our opt out, right? But
4 where is the attribution? We're trying to make
5 the case to educate our system as if there's
6 patients assigned to this program we all get to
7 talk about because we're all part of that care
8 team.
9 MS. GODBURN: Right.
10 UNKNOWN SPEAKER: So how can we maybe
11 look at creating a statement in this for the
12 patient side to have them understand that being
13 in this program provides access to additional
14 resources that will help you in and out of your
15 healthcare visits and in the community.
16 DR. ZAVOSKI: I think what I'm hearing
17 is that you're asking that the notice we sent out
18 to all the potential members who would be
19 involved in this program should have language in
20 there that says that we're doing a little bit
21 more in the behavioral health realm now and that
22 --
23 UNKNOWN SPEAKER: Um-hum. As a value
24 statement.
25 DR. ZAVOSKI: -- opting in means that

1 we're going to work harder to make sure that your
2 behavioral health is coordinated with your
3 medical health. Is that what I'm hearing?
4 UNKNOWN SPEAKER: I think you picked up
5 on that very well, Dr. Z.
6 DR. ZAVOSKI: Okay. So we'll have to
7 have an attorney write that out.
8 (Laughter.)
9 DR. ZAVOSKI: We will take that as a
10 note and when we send that notice we'll take
11 whack at that.
12 UNKNOWN SPEAKER: I think it will help,
13 and I think that that also provides us a standard
14 of work and a standard of care to be able to help
15 it through our systems.
16 DR. ZAVOSKI: The challenge for full
17 disclosure is our notices, particularly with this
18 program, tend to be political statements --
19 UNKNOWN SPEAKER: Yeah.
20 DR. ZAVOSKI: -- that we have to
21 balance with the concerns of others outside this
22 room and so we may have to mitigate things a
23 little bit because of that.
24 UNKNOWN SPEAKER: We have a focus group
25 of us here that can help you with that, right?

1 DR. ZAVOSKI: Okay. And that's
2 appreciated.
3 MS. GODBURN: So going back to the list
4 -- let's see if it's anybody here. No. Let's
5 see. CCMC, do you guys have any questions?
6 MS. LULY: No questions right now.
7 MS. GODBURN: Okay. Let me see. Who
8 else do I have here. Generations?
9 MS. KENNY: Couple of questions.
10 MR. NORWOOD: Everyone, please say your
11 name right before you ask your question. Even if
12 you said it before because the person
13 transcribing won't be able to see your face.
14 Thank you.
15 MS. KENNY: Anne Kenny, Generations
16 Family Health Center. Can I ask like three
17 questions?
18 MS. GODBURN: Oh, absolutely.
19 MS. KENNY: So the first one is does
20 the population defined at the beginning of the
21 year attributed, does that remain static for the
22 entire year?
23 MS. GODBURN: Yes.
24 MS. KENNY: It does?
25 MS. GODBURN: Well, unless -- okay,

1 yeah, there's caveats to everything we do. Yes,
2 but members have the right to opt out; members
3 could potentially fall into an exclusion category
4 so then they are pulled off your member roster.
5 So basically folks could --
6 MR. NORWOOD: Or they could leave
7 Connecticut Medicaid.
8 MS. GODBURN: Exactly. They lose
9 eligibility.
10 MS. KENNY: Okay.
11 MS. GODBURN: So essentially the answer
12 to your question is your number will never go up;
13 it can only go down.
14 MS. KENNY: Okay. That answers my
15 question.
16 The quality measures set, there is the
17 very first one, the avoidable emergency
18 department visits, it looks like it's the only
19 one that has to be improved upon to be eligible
20 for shared savings; is that correct?
21 MS. GODBURN: So there's the footnote
22 cites, there's the two hospitalizations, there's
23 the ED and then the avoidable hospitalizations.
24 MS. KENNY: So it says 5, denotes
25 measures on which improvement is required to be

1 eligible for shared savings?
2 MS. GODBURN: Right.
3 MS. KENNY: And then the only one I see
4 a 5 next to is the avoidable emergency visits.
5 MS. GODBURN: Right. And then the
6 footnote --
7 MR. NORWOOD: And the (unintelligible)
8 says the same thing.
9 MS. GODBURN: Yeah. 6 is the same
10 footnote.
11 MS. KENNY: Oh, okay. And the next one
12 is the 6. Okay.
13 MS. GODBURN: Page 50.
14 MS. KENNY: Yep, yep.
15 MR. NORWOOD: There's more detail in
16 the bottom of the RFP explaining that.
17 MS. KENNY: Okay. So those two,
18 they're new, how are we going to define the
19 baseline for that and when will we know what our
20 baseline is?
21 MS. GODBURN: Yes, we will tell you.
22 So the question was posted in here and
23 I'll come back because I know you have more
24 questions, so for folks who didn't hear the
25 question pertaining to the measures that are on

1 page 50 of the RFP, those are the quality
2 measures and pertaining to the first two which
3 are avoidable ED visits and avoidable
4 hospitalizations, and please reference the
5 footnote towards the bottom of the chart which
6 says that measures on which improvement is
7 required to be eligible for shared savings. So
8 folks have to improve on those two measures to be
9 eligible to get shared savings.
10 Now, what does improvement mean was the
11 question. So we will share information with you
12 if you make it into the process, so that your
13 improvement -- and hang on, I just got to
14 reference the RFP because I was taking notes last
15 night. Where is that --
16 (Pause.)
17 MS. GODBURN: So, and we can give a
18 better detailed response because we're going to
19 have to bring in the actuaries on this one just
20 to make sure I get this correct, but generally --
21 UNKNOWN SPEAKER: What page are you on?
22 MS. GODBURN: So I am referencing page
23 44. Hey, Brad, are you still on the phone?
24 BRAD: Yes, I'm here. Can you hear me?
25 MR. NORWOOD: Yes.

1 MS. GODBURN: Yes. So Brad, the
2 question, I don't know if you caught it, the
3 question goes to the two measures, the ED and the
4 hospitalization, PEs must show improvement on
5 those two measures to qualify for shared savings.
6 So what's the standard of improvement, what is
7 the definition of that?
8 BRAD: So both of those measures are
9 reported as a rate and we would like to see that
10 rate move in one direction which is reducing the
11 number of avoidable ED and reducing the
12 hospitalizations that were avoidable. So as long
13 as both of those rates decrease from the prior
14 year calculation to the performance year
15 calculation that will be considered improvement.
16 So it's the rate of avoidable emergency
17 department visits moves from 40 avoidable
18 emergency department visits in the first year and
19 then it goes down to 39.9, that's the rate that
20 would be considered improvement.
21 MS. GODBURN: Okay. So there's no like
22 threshold or minimum that a practice would have
23 to hit to be considered an improvement. It would
24 just be a movement in the positive direction for
25 decreasing.

1 MR. NORWOOD: Now, what about
2 calculating the target for the absolute
3 performance?
4 MS. GODBURN: So Joel has a question
5 about calculating the target for the absolute
6 performance.
7 BRAD: So that would be a separate
8 calculation in order to do some of the scoring
9 but would not be kind of the baseline requirement
10 to be eligible for any shared savings.
11 MS. GODBURN: Right. So that's done if
12 you qualify for shared savings, then that
13 calculation is done further in for those who
14 quality.
15 BRAD: Correct.
16 MS. GODBURN: Got it. Did that answer
17 -- I'll be right with you. Did that answer?
18 MS. KENNY: Well, yes and no. I'm
19 still not really clear when our baseline would be
20 defined.
21 MS. GODBURN: So for folks who are
22 chosen and get into the program, Brad, did you
23 have a sense of when that the folks -- their
24 baseline would be given to them?
25 BRAD: Yeah, so it will be a 2019

1 calendar year baseline score since the
2 performance year score, the 2020. For these
3 measures generally to use six months of runout, I
4 would assume it would be the same for both of
5 these 3M measures which means after the end of
6 2019 you’d have six months of runout and then
7 some data processing time, so probably in third
8 or fourth quarter of 2020 you would know what
9 your 2019 score is and then in the third or
10 fourth quarter of 2021 you’d find out what your
11 2020 score is.
12 MS. GODBURN: Okay.
13 MS. KENNY: Is there any data on 2017
14 that we could look at and have a sense of --
15 MS. GODBURN: 2018? Right. Yeah, so,
16 Brad --
17 MS. KENNY: Somebody is going to tell
18 me that’s not been easy.
19 MS. GODBURN: Yeah, I know.
20 So Brad there was chuckles in the room
21 obviously because finding out what your baseline
22 would be like three-quarters of the way into your
23 calendar year is kind of tough. So is there a
24 sense that we can give folks earlier -- I think
25 we might have to look into that a little bit more

1 of trying to get previous calendar year baselines
2 and see if that would even be applicable.
3 BRADY: Yeah, and we've discussed that
4 a little bit with DSS and would likely want to
5 look at earlier data periods. I think having at
6 least some baseline even as since your 2018
7 calendar scoring knowing where you're at would be
8 very helpful on that and knowing kind of
9 generally what your target will be around might
10 be helpful. I don't know if the Department has
11 committed to share any of that data yet, Nicole,
12 but I think it's something we want to look at and
13 we'll probably run.
14 MS. GODBURN: Yeah. Dr. Z is shaking
15 his head saying like yes, that is absolutely
16 something we can work on and get put together for
17 folks. So, yeah, okay. Yeah, you got happiness.
18 Sue? And then I'll come right to you.
19 MS. LAGARDE: I just want to follow up
20 on that question.
21 MS. GODBURN: Sure.
22 MS. LAGARDE: So I want to be clear
23 that we are saying that a participating entity if
24 they don't improve on either -- on both of those
25 rates, there's no way they share in any shared

1 savings even if their absolute value on either of
2 these rates is above the average.
3 MS. GODBURN: Correct.
4 MS. LAGARDE: So in other words if
5 you’re already (unintelligible), avoiding
6 avoidable ED hospitalizations and there is not
7 much room to improve because we’ve already
8 improved, then --
9 UNKNOWN SPEAKER: You’re screwed.
10 UNKNOWN SPEAKER: -- then you’re --
11 yes, yes.
12 UNKNOWN SPEAKER: You’re screwed.
13 (Laughter.)
14 MS. GODBURN: So the question was about
15 that, yes, you have to improve on both of these
16 to even be eligible for shared savings, and yes,
17 that’s true this is a gate in a sense to get into
18 the shared savings.
19 And then the question once you, well,
20 what if we’re already doing a great job on these
21 two measures. How can we improve if we’re
22 already at the top? And --
23 MR. NORWOOD: Have to do little better.
24 It doesn’t have to be a lot.
25 UNKNOWN SPEAKER: Like he said, 0.1

1 percent.
2 UNKNOWN SPEAKER: But like did you guys
3 when selecting these have any data that said this
4 is, you know, we're performing terribly on this
5 so it needs to be the focus or --
6 DR. ZAVOSKI: The person who made the
7 decision was our new Commissioner.
8 UNKNOWN SPEAKER: Okay.
9 DR. ZAVOSKI: She felt that were a
10 little too easy the first turns around and so she
11 felt very strongly that we needed to make this a
12 gate. Are we doing overall poorly in some of
13 these measures? As a program, no. We're
14 actually improving, but we need to do better.
15 MR. NORWOOD: But again feel free to
16 put more detail in your written question.
17 DR. ZAVOSKI: Please.
18 MR. NORWOOD: If you have -- question
19 or comment, if you have a comment on that feel
20 free to put that in writing and we will take a
21 look.
22 MS. GODBURN: Did that answer your
23 question, Ed?
24 MR. ROBERTS: I'd like a part B. Thank
25 you, I had that question Sue had. As well as is

1 the methodology absolutely baked in and I realize
2 parts of it are for that, but in terms of the
3 baseline time period many, many of the other
4 shared savings programs that we're in they back
5 up six months so that they would consider the
6 baseline July 1st of 2018 through June 30th so that
7 you get your results for which you were based
8 upon more timely and can actually work towards
9 making -- this is about making a difference. So
10 if we got the information too late we're not
11 going to help you, we're not going to help the
12 patients, and certainly not going to be -- it's
13 not going to incent us to what to perform for the
14 rest of the program because we've already blown
15 it to some extent.
16 MS. GODBURN: Right, right.
17 DR. ZAVOSKI: Absolutely legitimate
18 concern, Sue, we can do with --
19 MS. GODBURN: Yeah. I would say make
20 that a comment and send that in. I think it's a
21 very valid one.
22 MR. NORWOOD: And generally, ask
23 questions if you have questions. If you have a
24 comment or you're suggesting that we do something
25 different from what we said, be as specific as

1 possible in what you're suggesting and the
2 reasons for it and we'll take a look at that too
3 as part of the same process.
4 MS. GODBURN: Um-hum.
5 MR. NORWOOD: Again, the more specific
6 the better.
7 MS. GODBURN: Saw your hand up?
8 MR. DIXON: Hi, Mark Dixon, Hartford
9 Medical Group.
10 Along those lines there's also a
11 requirement for shared savings eligibility to
12 meet your underservice prevention requirements.
13 What are those requirements? Is that detailed or
14 outlined?
15 MS. GODBURN: So underservice. What is
16 an underservice and how would we know somebody's
17 underserving?
18 MR. NORWOOD: Never. But there's a
19 separate document that outlines the Department's
20 underservice prevention strategy which is --
21 MS. GODBURN: It's a five-prong
22 approach.
23 MR. NORWOOD: Is it posted on --
24 MS. GODBURN: It is posted currently on
25 the PCMH+ webpage but we can dig that back up and

1 put that into the RFP as an addendum or
2 attachment or something just to kind of refresh
3 that.
4 DR. ZAVOAKI: We need to respond
5 appropriately to that.
6 MS. GODBURN: Yes. Yeah.
7 DR. ZAVOSKI: Okay. Thank you.
8 MR. NORWOOD: Yes. Go ahead.
9 UNKNOWN SPEAKER: It's (unintelligible)
10 locations it seems to be a requirement, so --
11 MS. GODBURN: Yeah.
12 MR. NORWOOD: It is. So there's our
13 strategy is in that document. I don't know that
14 there's a whole lot more --
15 DR. ZAVOSKI: Let's respond to --
16 MR. NORWOOD: Well, of course. We'll
17 respond to everything in writing but --
18 MR. ROBERTS: Thank you.
19 MS. GODBURN: Did you have any
20 additional questions or are we kind of --
21 UNKNOWN SPEAKER: Well, I have three
22 pretty simple questions. On the screening tools
23 for STOH, is there a list of nationally
24 recognized tools that we can use? We already
25 have them built into EHR but I'm not sure that

1 we're using a nationally recognized set of screen
2 tools.
3 MS. GODBURN: Okay. So the question
4 related to social determinants of health and the
5 section of the RFP that references that and the
6 use of national screening tools. And the
7 question was about which are the national
8 screening tools, is there a list of recommended
9 ones. And I don't -- we're not --
10 DR. ZAVOSKI: I'm not going to make
11 recommendations. It's up to the experts.
12 MS. GODBURN: Yeah. There's -- to my
13 knowledge I know there's a ton of tools out there
14 and we do have some of them posted on the PCMH+
15 webpage. And of course we can throw this into
16 the responses, but we're not telling folks use
17 one vs. another. You know, we want you guys to
18 -- you understand your patients and your
19 practices the best, so what works best for you.
20 And the ones that we've posted on our webpage
21 kind of came out of collaborative meetings that
22 we've had where folks were talking about which
23 ones were best and kind of integrating them into
24 their systems. So we're not making a specific
25 recommendation.

1 Sue -- I'm sorry, Polly.
2 POLLY: Polly (unintelligible) from
3 Yale.
4 On page 2 it says participants will be
5 required to use onsite care coordination. So the
6 NAMJ advanced network has over 50 practices.
7 Some have, you know, a smaller attribution, some
8 have larger attributions, so I'm just curious
9 when you say onsite, you know, I mean there will
10 be employees, there will be connectivity, but not
11 every practice is going to have an embedded
12 onsite care coordinator. So I just want to see
13 clear about what the expectation there is.
14 DR. ZAVOSKI: We will respond formally
15 to that too.
16 MS. GODBURN: So, let's see, where are
17 we at now. So Cornell?
18 MS. SWIFT: Yes.
19 MS. GODBURN: Hi, Rose. How are you?
20 MS. SWIFT: Good. How are you?
21 MS. GODBURN: Good.
22 MS. SWIFT: So I have two questions.
23 Okay, one, are there required budget forms. It
24 references us providing a budget but there are no
25 budget documents referenced.

1 MS. GODBURN: Right, correct. So the
2 reference to a budget was we just generally --
3 and it can be just a very quick Excel
4 spreadsheet, it doesn't have to be fancy, just
5 very generally what you think your internal
6 budget for support of PCMH+ would look like.
7 Would you be using -- just throwing off the top
8 of my head, so you would be using -- what type of
9 resources you would be internally using? Would
10 you have to -- using current existing staff, are
11 you going to have to go out and hire, are you --
12 just kind of really just general outline.
13 MS. SWIFT: With a dollar breakdown.
14 MS. GODBURN: Sure. Yes, please.
15 Yeah, it doesn't have to be crazy detailed. You
16 don't have to call your accountants to do it. It
17 can just be a very like high level look at
18 resources, financial resources used to support
19 the program.
20 MS. SWIFT: Okay. Check the program.
21 MS. GODBURN: Yes, yes. Oh, no, no, we
22 don't want to know all the ins and outs of
23 everything else that you're doing, just when it
24 comes to PCMH+.
25 MS. SWIFT: Okay. And I have a

1 specific question relating to page 1. Bullet 4
2 seems to have left out some words.
3 MS. GODBURN: Oh. So page 1 at the
4 very bottom, yeah, we will -- we'll have to issue
5 an addendum. So it looks like some of the
6 bullets may have been short. I'm wondering --
7 MS. SWIFT: Yeah, this one seems to be
8 missing some words or have an extra word.
9 MS. GODBURN: Okay. We'll go back --
10 yeah, okay. We'll go back and just make sure
11 that everything is in there that needs to be in
12 there.
13 MS. SWIFT: Okay. And going back to
14 the shared savings question, would it be possible
15 to use those costs entirely -- those savings, to
16 put them entirely back into the program as
17 opposed to sharing them with providers?
18 MS. GODBURN: Absolutely. Yep.
19 UNKNOWN SPEAKER: But that's the point
20 I think --
21 (Unintelligible crosstalk.)
22 MS. GODBURN: Okay. So the question
23 was so if you're awarded a shared savings is it
24 appropriate to take your entire dollar amount
25 that you've won and put it back into your

1 program, and the answer is yes. But --
2 UNKNOWN SPEAKER: That's not how it
3 reads.
4 (Unintelligible crosstalk.)
5 UNKNOWN SPEAKER: What is the
6 definition of a provider? If it's the facility
7 and --
8 MR. NORWOOD: What page is --
9 MS. GODBURN: Yeah,
10 UNKNOWN SPEAKER: 33 and 34. Okay, I'm
11 sorry, top of page 33H.
12 UNKNOWN SPEAKER: Because they talk
13 about participating providers within the PE. So
14 that's where it sounds like --
15 MR. NORWOOD: We'll clarify that.
16 MS. GODBURN: Oh, okay. Yeah, we'll
17 clarify that. I think --
18 MR. NORWOOD: I think what we'll do is
19 combine G and H and make it more coherent.
20 Because they're really the same topic and I see
21 how one says one and one says the other and --
22 MS. GODBURN: Right. Okay. Thank you,
23 yep.
24 MR. NORWOOD: Read G and H together for
25 a better sense of what we really mean and we'll

1 take another look and clarify our expectations,
2 and then again the actual, you're actual
3 distribution methodology will end up being in
4 your contract. So it will be crystal clear at
5 that point. I understand as part of the RFP
6 process you want to know a better sense of
7 (unintelligible).
8 MS. SWIFT: And it's also a question in
9 the RFP how are we going to ensure that there
10 isn't underservice and how are we going to use
11 the shared savings in relationships
12 (unintelligible) before a contract in order to
13 keep us plus.
14 MR. NORWOOD: Yes.
15 MS. SWIFT: Thank you. That's all of
16 my questions.
17 MS. GODBURN: Let's see. UCFS?
18 UNKNOWN SPEAKER: I don't think we had
19 any additional questions right now.
20 MS. GODBURN: Okay. Let me see. I
21 think we've touched on everybody. Now, is there
22 anybody like -- I guess let's just open it up.
23 So Ken, you had your hand up first.
24 MR. LALIME: Yes. A quick one on page
25 10. This has to do with attribution. Is it a

1 member has the ultimate right to pick who their
2 provider is except if claims override that. So
3 how can that be a -- if I'm a patient, I pick you
4 as my provider, I get a claim somewhere else in
5 the system and I get pushed because my claim but
6 I want you as my provider.
7 MS. GODBURN: Yeah.
8 MR. LALIME: It should be the patient
9 has the ultimate --
10 MS. GODBURN: They do.
11 MS. SWIFT: I think they're referring
12 to where the patient goes as opposed to where the
13 patient said they're going to go.
14 MR. NORWOOD: Well, I thought it is --
15 doesn't it work that -- let me see if this is
16 your question now. Doesn't it work that a member
17 can request a provider or PCMH, but then if after
18 that date they go somewhere else --
19 DR. ZAVOSLI: Yes.
20 MR. NORWOOD: -- they go somewhere else
21 repeatedly, that those later actions will
22 override their previous election. Is that right?
23 UNKNOWN SPEAKER: Unless they
24 reelected.
25 MR. NORWOOD: But if they reelected

1 again because --
2 (Unintelligible crosstalk.)
3 DR. ZAVOSKI: If you have a member
4 before -- the way it starts, we will attribute
5 based upon the claims. They can at any time say,
6 no, I don't want to go to you, I want to go to
7 her. We will make that change. Once the wave
8 starts they're attributed to you.
9 MR. LALIME: No matter what choice they
10 make.
11 DR. ZAVOSKI: They can change but for
12 the wave they're entered.
13 MR. NORWOOD: Well, and then -- if it's
14 -- well, it's each year.
15 DR. ZAVOSLI: It's each year.
16 MR. NORWOOD: Each calendar year resets
17 again for purposes of PCMH+.
18 (Unintelligible crosstalk.)
19 MR. NORWOOD: No. That was an inherent
20 heavily negotiated part of the program design.
21 UNKNOWN SPEAKER: So a patient is
22 attributed January 1st, if on January 31st they go
23 to somebody else and (unintelligible) they're
24 still attributed to us.
25 MR. NORWOOD: Yes.

1 UNKNOWN SPEAKER: And you get the
2 benefit of them going to that --
3 (Unintelligible crosstalk.)
4 MS. GODBURN: Right. It goes both
5 ways, I mean -- yeah.
6 UNKNOWN SPEAKER: It doesn't mean that
7 we have no control over it.
8 MR. NORWOOD: So for those --
9 MR. LALIME: The way that it reads it's
10 just -- you might want to talk a look at -- I'll
11 submit the question after -- the paragraph that
12 it reads there's a member who has affirmatively
13 identified a specific provider as his or her PCP
14 will be attributed to that provider until another
15 selection is made or claims override that.
16 MR. NORWOOD: Okay. Those are
17 effectively later decisions.
18 MR. LALIME: But it doesn't change for
19 the attribution.
20 MR. NORWOOD: Well, attribution is
21 different from assignment. And that's what we
22 should have said. Attribution rolls over time in
23 accordance with the process.
24 MR. LALIME: This is under attribution.
25 MR. NORWOOD: No, I know, but the way

1 PCMH+ works is we take attribution in a fixed
2 point in time for everyone in late fall and then
3 that will be the assignment for the whole
4 calendar year for PCMH+, and then we'll do that
5 again next year for the following year. So we're
6 just taking a snapshot at that point in time and
7 it's giving a sense of all the things that may
8 change during the next 12 months.
9 DR. ZAVOSKI: But I think the point
10 that the language is --
11 MR. NORWOOD: We'll take another look
12 at the language, sure.
13 DR. ZAVOSKI: A little creative there.
14 UNKNOWN SPEAKER: So I think the
15 example is you're attributed in Hartford but you
16 move to Bridgeport and now you're getting your
17 care in Bridgeport. Are we telling the client to
18 call and say this is my new PCP?
19 MR. NORWOOD: No, they don't have to.
20 UNKNOWN SPEAKER: You can do that but
21 it won't matter.
22 MR. NORWOOD: Well, it depends when it
23 happens. If they've done -- it depends when it
24 happens because for purpose of PCMN+ we take a
25 snapshot at whatever date we're going to take

1 that snapshot. I don't remember offhand. So
2 depending on what the attribution shows as of
3 that moment that's what will be reflected for
4 PCMH+. But it's a fundamental part of the
5 program design that was important for a number of
6 the advocates to make sure that every
7 participating entity would have an incentive to
8 really take care of someone for the whole year
9 and really invest long-term for coordination
10 resources. And the idea is in the end it's a
11 wash. People will move in, people will move out.
12 Nobody can control that. That's going to happen.
13 I don't know.
14 UNKNOWN SPEAKER: So, is the intention
15 to incentivize, you know, providers to care for
16 patients in a year or is the expectation or hope
17 to go -- that entities would go even further and
18 continue to provide that care coordination for
19 the client even if they're receiving care
20 elsewhere either directly with the client or with
21 the new entity that they have transferred to, so
22 that added layer of coordination.
23 DR. ZAVOSKI: The intention is that
24 your customer service be such that they don't
25 want to go anyplace else.

1 UNKNOWN SPEAKER: Right. But they move
2 and --
3 DR. ZAVOSKI: I know that.
4 UNKNOWN SPEAKER: Let's assume, let's
5 assume the scenario that they move, right?
6 DR. ZAVOSKI: Okay.
7 UNKNOWN SPEAKER: Is the -- so if
8 someone chooses to leave, customer services
9 purposes, right, you're unlikely to continue to
10 provide care coordination because they're
11 probably disinterested. But in the event that
12 someone is no longer coming to you because of
13 other reasons, is the hope, goal, expectation,
14 possibility that the entity would continue to
15 provide some of that sector coordination directly
16 to the client and/or the new provider, in concert
17 with the new provider.
18 DR. ZAVOSKI: That would be an
19 approach. We're not encouraging that. We're
20 discouraging that. I think that would be a
21 discussion with the member and with their new
22 provider. The purpose here is to encourage
23 circumstances where nobody wants to leave you and
24 that nobody -- that no entity here has far more
25 members leaving them than any other entity.

1 MR. NORWOOD: Now, because of the way
2 it's designed in that situation you would have an
3 incentive to at least coordinate with their new
4 provider so that they would be as healthy as
5 possible for the balance of that year even if
6 they're in the other provider. Obviously there's
7 a limited expectation of what you'd be able to do
8 if they're no longer your patient because they
9 now live an hour and a half away. But I think
10 the program is designed to provide an incentive
11 to have a smooth handoff and help them reengage
12 as much as possible with whoever the new provider
13 is. But that's just the incentive structure.
14 We're not dictating one way or the other.
15 UNKNOWN SPEAKER: So we know where the
16 risk to us -- the dollars stay with you based on
17 that first round.
18 MR. NORWOOD: Exactly.
19 UNKNOWN SPEAKER: Where does the data
20 go? Is the data driven -- I can look up the
21 data, now that person does select me even though
22 they're in Bridgeport and I'm in Hartford, do I
23 get the data now because the patient has self-
24 selected Hartford? Does his data follow the
25 patient selection or does it follow the original

1 attribution?

2 DR. ZAVOSKI: For the purposes of PCMH+

3 the data goes with the original attribution.

4 Because if the member chooses to go someplace

5 else that PCP can get their data just like any

6 PCP can.

7 MR. NORWOOD: So for the whole rest of

8 the program it's not PCMH+. Yes, obviously the

9 data follows the person.

10 UNKNOWN SPEAKER: So we would no longer

11 have access to that patient's data through the

12 CHA. For example, if we went into care analyzer

13 and we looked at our EP utilization, that patient

14 is no longer going to show up for us so we would

15 not be able to really have any idea what that

16 patient is doing.

17 DR. ZAVOSKI: We will verify that.

18 UNKNOWN SPEAKER: I'm sorry?

19 DR. ZAVOSKI: We will verify that.

20 MS. GODBURN: Georgia, I saw you had a

21 hand up?

22 MS. PELLETIER: Yes.

23 MS. GODBURN: Yes.

24 MS. PELLETIER: So I have like a two-

25 part question related to number 4.

1 MS. GODBURN: Shooting your best Maine
2 accent, go.
3 MS. PELLITIER: By golly, I guess
4 could, dear.
5 (Laughter.)
6 MS. PELLITIER: So this is Georgia
7 Pelletier from Value Care Alliance. I have a
8 two-part behavioral health question. The first
9 part you require a behavior health care
10 coordinator into the interdisciplinary team. So
11 with VCA being a unique entity, would we be
12 required to have a behavioral health coordinator
13 for them, one for each health system or could it
14 be just one overall?
15 MS. GODBURN: Did you catch that
16 question?
17 DR. ZAVOSKI: I caught it. I have to
18 look and see what the language says.
19 MS. GODBURN: Yeah. And I think that
20 in a sense kind of relates back to Polly's
21 question about do you have to have somebody in
22 each one of the locations. So --
23 MS. PELLETIER: Yeah, that would incent
24 -- it read like as long as you had one, but I
25 wasn't sure if there was any kind of ratio to

1 membership or --
2 MS. GODBURN: Right.
3 MS. PELLETIER: So our four health
4 systems don't talk to each other, so if we put
5 one, like say Danbury, then the rest are out. So
6 we do need that clarified.
7 MS. GODBURN: Yeah, okay.
8 MS. PELLETIER: And then the second
9 part, documenting the behavioral health
10 activities in the EMR so there's going to be a
11 renewed focus on RAP and advanced directives. So
12 for reporting purposes those documents, our EMRs
13 don't support that nomenclature so those
14 documents would get scanned in. So how can we
15 report on that?
16 MS. GODBURN: So the question went to
17 the behavioral health requirements and as it
18 relates to RAP, and then ensuring that any of
19 those behavioral health components are part of --
20 integrated into the record and accessible to
21 those who are members of the care team. And the
22 question is -- and please correct me, so the
23 question is if you have a system that maybe
24 doesn't fully support that or is able to do that
25 because you're having to scan in those types of

1 documents?
2 MS. PELLETIER: Correct. So there
3 would be no -- there would be no easy way to run
4 a report to state how many patients actually have
5 those documents. They would certainly have them
6 because they are addressed but they just get
7 scanned in so there's no way to run a report to
8 tell you in the twice-monthly, you know, every
9 two months coming.
10 MS. GODBURN: Okay.
11 MS. PELLETIER: So, and that's
12 something we've been struggling with since the
13 onset, is that we just have no way to report.
14 MS. GODBURN: Yeah. We'll have to --
15 yeah, we'll have to get back to you. So put that
16 one on your list of questions to us and so you
17 can formally address that.
18 MS. PELLETIER: Okay.
19 MS. GODBURN: Yes?
20 MS. RAAB: Hi, Tracy Raab with Value
21 Care Alliance.
22 So to sort of piggyback on Georgia's
23 question I do notice that there is a difference
24 in the cadence in terms of the reporting so it's
25 recorded, now they're bi-monthly. So wondering

1 if there's a form developed or a track that you
2 can possibly share so we can understand with the
3 expectations are around the reporting as we go
4 into this.
5 MS. GODBURN: So, and for folks who
6 participated in Wave 1 and Wave 2 you're probably
7 very familiar. For those who are new the
8 Department has created an Excel spreadsheet that
9 the practices are required to fill out and then
10 send back to us and it's a way for us to be able
11 to monitor and check and see how progress is
12 going within the program. And so Tracy's
13 question was about do we have a form set up for
14 Wave 3 as in something that maybe folks -- we
15 could share so folks can take a look at, and the
16 answer is no.
17 We haven't created -- it's not going to
18 be too far off from the ones from Wave 1 and Wave
19 2, and if folks are interested you can go to the
20 PCMH+ webpage to see all of the -- we've been
21 very transparent in person, everybody's completed
22 reports up there so you can kind of get a take on
23 the flavor of them. But yes, we'll be making
24 some modifications in Wave 3 based on the
25 feedback that we've heard from practices in Wave

1 1 and Wave 2 on better ways to gather information
2 and to do reporting, so there will be
3 improvements to it. But it shouldn't be too far
4 off from what you're already experiencing.
5 MS. RAAB: Another question since
6 you're here.
7 MS. GODBURN: Sure.
8 MS. RAAB: So my next question, one of
9 the new requirements, expand the individual care
10 plan tool currently in use to include a cultural
11 competency assessment to demonstrate impact and
12 assessment on member's health. What does that
13 really mean if our current EMR is not set up to
14 have that addition?
15 MS. GODBURN: I turn to the doctor.
16 MS. RAAB: Okay.
17 (Laughter.)
18 MS. GODBURN: What page?
19 MS. RAAB: It's page 37.
20 MS. GODBURN: 37? Okay.
21 MS. RAAB: So how would we demonstrate,
22 how would we turn that around to show you the
23 impact.
24 MS. GODBURN: Right.
25 MS. RAAB: What are you looking for?

1 And then while he's looking I have another
2 question.
3 MS. GODBURN: Sure.
4 MS. RAAB: What is the community health
5 worker requirement? And I'm asking for selfish
6 reasons. For four separate health systems do we
7 need community health workers at each of the four
8 separate health systems?
9 MS. GODBURN: Yeah. So then that will
10 be part of -- we'll reply to that one formally
11 about that. Is your question also connected to
12 the definition of what a community health worker
13 is?
14 MS. RAAB: No.
15 MS. GODBURN: That wouldn't -- okay.
16 MS. RAAB: I got that.
17 MS. GODBURN: Okay.
18 MS. RAAB: Okay. And then let me see
19 if I got -- same thing with the care coordination
20 requirements. Do we need to have care
21 coordinators at all four health systems? So if
22 that's yes --
23 MS. GODBURN: Yes.
24 MS. RAAB: -- then if no, they have to
25 use an outside vendor? That's a hard stop. They

1 have to use an outside vendor for care
2 coordination?
3 MS. GODBURN: No. We will do that one
4 in writing.
5 MS. RAAB: Okay.
6 MS. GODBURN: And that's on page 33 as
7 well -- 4.
8 (Pause.)
9 MR. NORWOOD: What was that one again?
10 MS. GODBURN: So pertaining back to the
11 similar questions about do you have to have the
12 care coordinator, behavior health component
13 onsite.
14 MR. NORWOOD: Oh, what does onsite
15 mean?
16 MS. GODBURN: Right. And then also to
17 use of outside vendors.
18 MS. RAAB: Yeah. So it's page 37 at
19 the bottom.
20 MS. GODBURN: On 37, Joel.
21 MS. RAAB: B and C.
22 MS. GODBURN: Okay. I see hands going
23 up. Sue?
24 MS. LAGARDE: I have two questions
25 about -- around risk. So reading this can we

1 assume that the risk methodology is going to be
2 the determination of risk will be the same? No?
3 But there will be a risk determination.
4 DR. ZAVOSKI: There will be, yes.
5 MS. LAGARDE: And so the question that
6 I have is, is there any way since the -- if I
7 understand it correctly the way the risk, each of
8 our risk rates were determined was what we get
9 every year with our (unintelligible) reports, our
10 risk number, but then it gets normalized through
11 the comparison group. And since we do have some
12 control over how you calculate risk in terms of,
13 you know, how we encourage coding, et cetera, is
14 there any way early on that we could get some
15 sense of where our risk scores are? That would
16 be extremely helpful.
17 DR. ZAVOSKI: Number one, I think would
18 be (unintelligible - away from mic) going
19 forward.
20 UNKNOWN SPEAKER: I can’t hear him.
21 MS. GODBURN: Brad, are you on the
22 phone still?
23 BRAD: Yeah, and I heard Sue’s
24 question, I didn’t hear Dr. Z’s response.
25 MS. GODBURN: So he’s wondering if you

1 could weigh in.
2 DR. ZAVOSKI: My response, Brad, is
3 that you're going to be giving them a better idea
4 in one of the responses on how we're going to be
5 using the risk adjustments going forward.
6 BRAD: Yes. So currently the risk
7 scores are run based on the specific PCMH+
8 assignment once a year. Currently there isn't
9 any plan to have any more frequent reporting than
10 that and it is a somewhat large process. But I
11 think as been stated before if you think that
12 that's something that needs to change or there's
13 a suggestion to have that reported more
14 frequently for the assigned members, that's
15 something we'd probably want in writing as
16 comments for suggested improvement for the
17 program. But as of right now it's only supposed
18 to be once a year for the assigned population.
19 MS. LAGARDE: And when in the year is
20 that?
21 BRAD: So for Wave 3 for the 2020
22 performance year we won't have those final
23 results until fall of 2021.
24 MS. LAGARDE: So it can't -- what I'd
25 like to see is is there a way we can get any

1 indication in advance or as we go along what that
2 number is because we do have -- I mean obviously
3 we can't change the risk of our patients, but we
4 can change, you know, we can work more with
5 providers if we got in coding since the risk is
6 based very strongly on the health code.
7 MR. NORWOOD: But I mean you'll get --
8 I mean obviously we're lagging in time, but for
9 any provider that participated in or currently
10 participates in Wave 2, in not too long we'll be
11 sending out all the results for Wave 2 year one,
12 calendar year '18. I know that's lagging a lot
13 but --
14 MS. LAGARDE: A lot. I mean could we
15 move it up by one year even? Like '19 or for
16 '20?
17 DR. ZAVOSKI: I think what we need to
18 do is to come up as I said before with a better
19 explanation of how we're going to use it and then
20 I think in addition to that, Brad, a good
21 explanation of how to calculate it. And I think
22 that probably would give you the guidance you
23 need to move forward.
24 MS. GODBURN: Did you catch that, Brad?
25 BRAD: Yep, that sounds correct.

1 MS. GODBURN: Okay. All right. So
2 Brad, is that something that we can turn around
3 to be able to put into the RFP responses?
4 BRAD: Yeah. I think a think a
5 specific question would be helpful and --
6 MS. GODBURN: Okay.
7 BRAD: -- also different type of
8 questions and other questions related would be
9 helpful
10 MS. GODBURN: Okay. So, Sue, if you
11 want to put that into a question, then we'll make
12 sure that it's part of the responses back.
13 Yes?
14 MS. BIANCHI: I have a couple
15 questions. I'm Christine Bianchi from StayWell
16 Health Center.
17 The first is that there's, you know,
18 reference, frequent reference to Wave 3 being
19 guided by learning and improving upon Wave 1 and
20 2. Having not participated in 1 and 2 can -- and
21 you talk about transparency, are there -- is it
22 expected that all relevant documents would be on
23 the PCMH+ website? Are there other things that
24 should be shared with applicants in terms of
25 what's been learned from PCMH+ 1 and 2 that are

1 not on that document that would be helpful to
2 respondents?
3 MS. GODBURN: Did you catch that?
4 DR. ZAVOSKI: No, I didn't.
5 MS. GODBURN: Okay. So the question
6 pertains to the statements in the RFP talking
7 about how changes in Wave 3 are reflective of
8 things that we as a department learn during Wave
9 1 and Wave 2. And so the question was about some
10 of those documents, some of the things that we
11 learned and some of the things that helped inform
12 us, is that available for folks who have not
13 participated to be able to review.
14 DR. ZAVOSKI: Would it be fair as to
15 list the changes from Wave 2 to Wave 3 that we
16 offer an explanation of why we made those
17 changes?
18 MR. NORWOOD: Well, the website
19 actually has a lot of information.
20 MS. BIANCHI: That's for you to tell
21 me. I don't know. I mean I don't know what the
22 process was, you know, the learning process. I
23 don't know. So I don't know what documents,
24 studies, discussions, analysis, et cetera, were
25 done in 1 and 2 that those of us who didn't

1 participate were not privy to and how helpful
2 that is in now responding to Wave 3, so --
3 MR. NORWOOD: I mean there is a lot on
4 the website.
5 MS. GODBURN: Yeah.
6 MS. BIANCHI: So I didn't -- yes, I
7 guess.
8 MR. NORWOOD: Yeah.
9 MS. GODBURN: And we can respond
10 formally, you know, but generally I can tell you
11 because at the Department we did -- and everybody
12 who participated in 1 and 2, you know, can
13 understand. I mean we did onsite visits, we did
14 desk audits of member files. There's the
15 required monthly and quarterly reporting that the
16 practices had to send to us. We do collaborative
17 meetings where all -- everybody is participating,
18 gather together and discuss what's working,
19 what's not working, are there things that we can
20 do help support, what can we improve on. So it's
21 been a very open and transparent process.
22 Lots of that also played out in the
23 Legislative committees like MAYPOC and care
24 management, and all of that is catalogued
25 chronologically and documented on the webpage.

1 But I also think, you know, Dr. Z's
2 point about putting in the changes in the why
3 we're doing that, because the why relates back to
4 the lessons, I think that would also help
5 clarify.
6 MS. BIANCHI: Great. And that somewhat
7 ties into my next question. On page 21 for the
8 evaluation criteria and weight, unusually it
9 states that the weighting is confidential. I
10 guess my question is about weighting has to do
11 with the language in the RFP about creative
12 responses, you know, and solutions and
13 particularly not having participated in 1 and 2
14 and is there any idea, any way that we can be
15 given an idea in terms of the weight or
16 importance or relevance of how creative we should
17 be? And is it expected that the creativity, that
18 the creative activity is to then be implemented
19 or this is an exercise in gathering options and,
20 you know, choosing what you like and saying
21 implement or don't?
22 MS. GODBURN: So, Joel, for reference
23 on page 21 -- so part of this is a contracting
24 question and none of us are from contracts so
25 we're not able to answer the first part. So the

1 question for folks who didn't catch, on page 21
2 it talks about how the evaluation of the RFPs is
3 going to take place and there's going to be a
4 weighting in the actual evaluation process and
5 that's confidential.
6 So that goes to contracts. We can have
7 them respond to that question. I don't think any
8 of us are able to answer that or if even
9 contracts will be able to share how they evaluate
10 the RFP. And then --
11 MS. BIANCHI: It's more about trying to
12 figure out how creativity ties into this, so, you
13 know.
14 MS. GODBURN: Right. So and then which
15 led to your other point and I looked to Dr. Z
16 because as he likes to say, you know, this is all
17 about innovation, this program. So the question
18 tied to you, how creative should you guys be when
19 you're developing your programs and what should
20 your programs look like. And as we all have kind
21 of said along the way, and I know you're brand
22 new so you might be hearing this for the first
23 time, you guys know your populations and your
24 practices best. So PCMN+ outlines generally what
25 we're looking for.

1 How you implement that within your
2 practices, we're kind of leaving that to you
3 because you know your structures, you know your
4 people, you know your resources. You guys know
5 how best that you are able to do that. And, you
6 know, I turn to Dr. Z because he originally as
7 he's working and creating this program didn't
8 really want it to be kind of a hammer over the
9 head type of program.
10 MS. BIANCHI: No, but I guess it -- I
11 mean if in the answers you can give some guidance
12 as -- I'm trying to weigh innovation versus
13 incorporating what you've learned in Wave 1 and
14 2. And they feel to me to be, you know,
15 contraindicated to one another in terms of a
16 response. And so, you know, how much innovation
17 are you looking for as opposed to us implementing
18 some, you know, evidence or experiential-based
19 success that you've learned thus far.
20 DR. ZAVOSKI: PCMH+ is part of the
21 larger state innovation model program. And the
22 state innovation model program was very directive
23 as to how you should innovate, which I think is a
24 contradiction that if you're going to innovate
25 they don't tell you how to innovate because then

1 you get one innovation maybe.
2 What I want is as many innovations
3 potentially as we have people in this room, or at
4 organizationally. So for us to say this is how
5 many innovations we expect from you, that's not
6 what we're doing. What we're saying is that
7 we've learned some lessons over the past three
8 years with (unintelligible). We've made some
9 changes based upon what we've learned with
10 (unintelligible) but some of the political
11 dictates we have to work through. And so we've
12 made some changes in the RFP. There are some
13 standards there but we're purposefully not
14 dictating how you make meet those standards.
15 And as a former person who's created
16 and written grants, you hate seeing that because
17 it's a pain in the neck. You don't know what the
18 person who issued the RFP is really thinking or
19 if they are thinking.
20 The folks who have not dealt -- the
21 organization is like a (unintelligible). I'm not
22 going to tell you how to innovate because it's
23 contrary to (unintelligible), it's a
24 contradiction. What I would like to say that,
25 you know, answer each of the standards, address

1 everything that's in the RFP that's required, and
2 if you're thinking about how to do that
3 creatively let us know about that. I shouldn't
4 say anything --
5 (Unintelligible crosstalk.)
6 MS. BIANCHI: Well, is it fair to say
7 you're looking a balance?
8 MR. NORWOOD: Yep.
9 MS. BIANCHI: Okay.
10 MR. NORWOOD: But the bottom line is
11 we're working to the shared goal of keeping our
12 collective members' patients have the healthiest
13 lives they can whatever way you go about that,
14 and then you just explain that in the RFP. And
15 so whether it's based on what you've been doing
16 for a long time that's been working really well
17 or new ideas to make it even better, that's up to
18 you to explain it. And even you haven't been in
19 PCMH+ for what will have been the past two or
20 three years, you've still been caring for your
21 patients that whole time and presumably trying to
22 do things that whole time also.
23 DR. ZAVOSKI: Where there is some
24 restrictive language in the RFP because we had
25 some advocates who think that you spend your

1 nights dreaming up ways to make more money at the
2 expense of our members. And so we have to put
3 some protections in there. And I'm sorry about
4 that, but at the same time we don't want to
5 dictate how you care for your members. I, you
6 know, I used to practice myself and I do not like
7 that when the state told me that, and I'm not
8 going to do it here now that I'm a
9 (unintelligible).
10 MS. BIANCHI: I have one last question.
11 MS. GODBURN: Sure.
12 MS. BIANCHI: So again for those who
13 haven't participated in 1 and 2, looking at all
14 of the measures and there's a lot of language
15 about improving and building upon, you know,
16 where folks have already grown, so I'm just
17 trying to figure out if a new entity entering
18 into PCMH+ where their baseline is -- is it
19 solely -- is it our data, is it based on where
20 the --
21 DR. ZAVOSKI: You're competing against
22 yourself.
23 MS. BIANCHI: Okay, just some of the
24 language seems -- okay.
25 MR. NORWOOD: Oh, for how shared

1 savings payments will be calculated.
2 DR. ZAVOSKI: You're talking about the
3 data or the shared savings numbers?
4 MR. NORWOOD: Or entrance in being
5 selected in RFP, those are three different
6 questions.
7 MS. BIANCHI: Knock yourself out. You
8 can answer them all.
9 DR. ZAVOSKI: We will formulate it all.
10 MS. BIANCHI: Well, I think that's the
11 issue, that there's a lot of language in the
12 various parts and what's the standard for each.
13 MR. NORWOOD: We're not -- this is an
14 open RFP to any qualified -- any provider entity
15 that meets the qualification in the RFP. So if
16 you haven't participated you're just as available
17 to reply as anyone else.
18 MS. BIANCHI: Right, but I do think
19 there are some sections, for example, that it's
20 unclear if the existing groups have grown in
21 certain measures is the starting measure here.
22 But --
23 DR. ZAVOSKI: I have a question that
24 calls those out so we can start taking -- and
25 hopefully clearer about what the finding --

1 MS. BIANCHI: Right. As you said
2 they're shared savings --
3 MR. NORWOOD: And we've been keeping
4 track of the measures for all providers whether
5 or not they're in any grant or reporting.
6 MS. BIANCHI: But then as you said,
7 then there's the shared measure question where we
8 starting in self -- I'll put it in writing.
9 MS. GODBURN: Yeah. I thought I saw
10 hands.
11 MS. RUSZCZYK: Hi, I'm Kathryn Ruszczyk
12 from Prospect Medical. I had two questions. The
13 first related to the quality metrics. I think
14 that the bane of my existence and I'm sure
15 everybody else in the room, so if I don't speak
16 for you let me know, will the portal offer any
17 other opportunities as to how we can migrate data
18 from it? So we currently go in, we have our
19 attribution list, we have our patients who are
20 assigned to us, but the reporting methodology is
21 for all Medicaid patients served by our entities.
22 So I'm currently having to do a lot of slicing
23 and dicing to find my diabetics who are in my
24 PCMH program to be able to outreach them to get
25 their A1Cs done.

1 Is there any other plan for data
2 migration from the portal, whether it be ADT feed
3 capabilities, as we're looking at entities how
4 are we going to leverage our technology to be
5 able to work with the portal a little bit more
6 efficiently?
7 DR. ZAVOSKI: There are the constraints
8 placed on CHN by the Department that I hope will
9 be lifted shortly that will make their systems
10 more facile to be used.
11 MS. RUSZCZYK: Okay.
12 DR. ZAVOSKI: And I hope that that
13 would be shortly.
14 MS. RUSZCZYK: Okay.
15 DR. ZAVOSKI: I would ask the specific
16 question that you want us to ask CHN about,
17 whether they can do that. But I would also say
18 that all of the information about your diabetics
19 we get from you. And so we have an idea who your
20 diabetics are but you should know who your
21 diabetics are. And you have AMR and things to be
22 able to do a lot of those things that actually
23 should be better than what we have.
24 MS. RUSZCZYK: And I appreciate that.
25 I think what I'm trying to find is how do we pull

1 the most efficient data that matches -- that
2 allows for discrete data fields to be met and
3 pulled over.
4 DR. ZAVOSKI: And to a certain extent
5 CHN has been laboring under our constraints and I
6 hope that will be changed shortly but ask a
7 specific question and we might be able to
8 (unintelligible).
9 MS. RUSZCZYK: Okay.
10 MS. GODBURN: Jeanne, did you have a
11 question or --
12 MS. O'BRIEN: I did, I did.
13 MS. GODBURN: Oh, I'm sorry. I'll come
14 right back.
15 MS. O'BRIEN: I think you had two
16 questions, right?
17 MS. RUSZCZUK: I did, but that's okay.
18 MS. O'BRIEN: Okay. Go ahead.
19 MS. RUSZCZYK: So the other component
20 for the social determinants of health, as a
21 hospital-based system the Connection Hospital
22 Association is leveraging the Unite Us platform
23 to be able to work through social determinants of
24 health screening. Can we replicate that tool so
25 that it can be the standard of care of us in the

1 PCMH+ program?
2 So until we get up into Unite Us can we
3 ask --
4 DR. ZAVOSKI: That's a good question.
5 We'll have to look at it. I don't think the
6 timeframe is (unintelligible).
7 MS. O'BRIEN: Okay. All right. Okay.
8 MS. RUSZCZYK: Well, they have -- I
9 mean they have a select set of the questions that
10 they're asking folks to ask. So to the earlier
11 question of will that count as our standard set
12 of questions, I mean I would hope that would
13 count so that we can kind of comply with that as
14 well as producing that from the PCMH+ --
15 UNKNOWN SPEAKER: Yeah.
16 DR. ZAVOSKI: We don't have access to
17 the question so if somebody can --
18 UNKNOWN SPEAKER: I can find them.
19 MR. NORWOOD: As part of their formal
20 questions.
21 UNKNOWN SPEAKER: Yes.
22 MS. GODBURN: Yes. Such a good lawyer.
23 (Laughter.)
24 MS. GODBURN: Jeanne?
25 MS. O'BRIEN: Question. Before we --

1 Jeanne O'Brien from VCA. Wave 2 we just rolled
2 over some of the information, but here we need
3 new audited financial statements, we need
4 references. Is that something we have to go back
5 and do all over again?
6 MS. GODBURN: That's -- and that goes
7 to the Contracting Unit and unfortunately nobody
8 is here today. Because this is a brand new RFP
9 then, yes, that's a requirement.
10 Tierney?
11 MS. GIANNOTTI: So just a clarification
12 to the point of the data on care analyzer and
13 looking at you PCMH+ patients for example who
14 need an A1C, my understanding is that we're being
15 evaluated for the quality measures on our
16 Medicaid population, not that PCMH+ specific
17 panel. The cost is on our PCMH+ panel, but our
18 quality measures are on our Medicaid population
19 that we get our annual CHN report from. So I
20 just want to make sure I'm right and I think that
21 helps, you know.
22 MS. GODBURN: Right.
23 MS. GIANNOTTI: We want to know anyone
24 one who is in Medicaid.
25 MS. GODBURN: Hey, Brad, are you still

1 on the phone?
2 BRAD: Yeah. I wasn't able to hear all
3 of that.
4 MS. GODBURN: So Tierney's question
5 related back to -- so when you're doing the
6 shared saving -- so you were doing the shared
7 savings calculation, your costs are based off of
8 your PCMH+ population but you quality measures
9 are based off your entire Medicaid population.
10 BRAD: So that's a change that we're
11 expecting to make moving from Wave 1 to Wave 2
12 where we will have a subset of PCMH+ members only
13 being tracked for quality, and that will be for
14 the performance and for the prior year.
15 MS. GODBURN: For 2. What about for 3?
16 BRAD: And that's also the expectation
17 for 3 is that it will just be for your assigned
18 population.
19 MS. GIANNOTTI: So that is not in the
20 RFP and should be.
21 MS. GODBURN: Okay.
22 MS. GIANNOTTI: That's a big change.
23 MS. GODBURN: So, Brad, did we have
24 that in the shared savings calculation? We may
25 need to clarify that better.

1 MR. NORWOOD: (Unintelligible.)
2 BRAD: It wasn't specified either way.
3 We wanted to leave flexibility in the hopes that
4 we would be able to get there, but we did not put
5 in prescriptive language one way or another in
6 case we were not able to get that capability.
7 MS. COGBURN: Okay. Tierney, you want
8 to put that in a comment/question?
9 MS. GIANOTTI: Um-hum, in which case it
10 would be really important to have our quality
11 measures on just our PCMH+ members.
12 MS. GODBURN: Okay.
13 BRAD: (Unintelligible.)
14 MS. GODBURN: Yeah, okay. So then
15 Brad, we'll do a formal response to that then.
16 BRAD: Okay. That sounds good.
17 MS. GODBURN: Off the loop in CHN. I'm
18 learning too today.
19 Any other questions?
20 All right. 11:50.
21 MR. NORWOOD: Last call. Any other
22 questions?
23 MS. GODBURN: Okay.
24 All right, Brad. I think we're
25 wrapping up. Thank you.

1 MR. NORWOOD: All right. Seeing that
2 no one has any other questions it's just about
3 11:51 in the morning and we'll stay here until
4 12:00 o'clock in case anyone changes their mind
5 and has a new question or if anyone else comes
6 in, but if that doesn't happen we'll be closing
7 this bidders conference.
8 Thank you all again.
9 (Proceedings concluded at 11:51 a.m.)
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1 CERTIFICATE

2

3 I hereby certify that the foregoing 97

4 pages are a complete and accurate transcription to the

5 best of my ability of the electronic recording of the

6 PCMH+ Bidders Conference held at the offices of the

7 Department of Social Services, 55 Farmington Avenue,

8 Hartford, Connecticut, on September 12, 2019.

9

10 ____________________________

11 Suzanne Benoit, Transcriber Date: 9/25/19

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Addendum 1 Acknowledgment

State of Connecticut
Department of Social Services
Person-Centered Medical Home Plus Program Wave 3
(PCMH+W3 RFP)_09062019

Addendum 1 issue date: 10/02/2019

This Addendum acknowledgement must be signed and returned with your submission.

____
Authorized Official Signature

____
Name of Authorized Official

____
Name of Organization