

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

BIDDERS' CONFERENCE
MEDICAID QUALITY IMPROVEMENT INSURANCE SAVINGS

JUNE 13, 2016

DEPARTMENT OF SOCIAL SERVICES
55 FARMINGTON AVENUE
HARTFORD, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

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JUNE 13, 2016

1 . . .Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Social
3 Services, Bidders' Conference, held at Department of
4 Social Services, 55 Farmington Avenue, Harford,
5 Connecticut, on June 103, 2016 at 9:00 a.m. . . .
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7
8

9 MS. KATE MCEVOY: How are you? I'm Kate
10 McEvoy. I'm the director of the Division of Health
11 Services here at the Department. I'm the Medicaid
12 director for the State of Connecticut. And I want to
13 welcome you to the Bidders' Conference for the Medicaid
14 Quality Improvement Insurance Savings initiative. This
15 is a very important milestone for the Department in its
16 developmental trajectory on Medicaid reform.

17 I wanted to start by introducing you to
18 Marcia McDonough. Marcia, could you stand? Marcia is
19 the lead contact for the Department. As you've seen in
20 the correspondence and the posting of RFP, all inquiries
21 should be directed to her. We will also be entertaining
22 your questions and your comments this morning
23 memorializing those formally. We welcome very much and
24 thank our transcriber, and we will be publishing those on

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1 a formal basis. So we are ensuring that everyone has
2 access to the same consistent information.

3 I'd also like to introduce Joel Norwood.
4 Joel is a staff attorney in our legal office. Mr.
5 Norwood, please stand up. Joel has been very intimately
6 involved in the model design of MQIISP and I have that --
7 we have others in the room. Ann Simeone from our
8 contracts area. I'm not sure if I'm missing anyone else
9 from the Department. But we've had a large -- I'm sorry.

10 MS. MCDONOUGH: Crystal.

11 MS. MCEVOY: Oh, yes, good morning,
12 Crystal. Yes. We've had a large multi-disciplinary team
13 involved in this. We also have on the phone our
14 colleagues from Mercer Consulting. Mercer has been
15 involved in leading a team that has supported us with
16 actuarial work, development of the insurance savings
17 model and also considerable feedback and guidance on the
18 care coordination and quality aspects of the initiative.

19 I wanted to take just a moment.

20 Michael, please join us. There's plenty
21 of seats. Good morning.

22 I wanted to take just a moment to cite
23 contacts for MQIISP as we have called it to date. We are
24 going to soon rebrand that with a slightly more consumer

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1 friendly name. It's not necessarily tripping off the
2 tongue. So, we'll let you know when that name has been
3 officially published.

4 But to said contacts several years ago as
5 you're aware, we embarked on an ambitious social
6 experiment. Connecticut became one of the first states
7 in the country to migrate entirely away from capitated
8 managed care arrangements to become self-insured. And we
9 have entered into arrangements with four administrative
10 services organizations under which we are jointly
11 managing medical, behavioral health, dental and non-
12 emergency medical transportation benefits. Upon
13 conversion to the ASO which we did very purposely to
14 streamline access to support both for beneficiaries and
15 also for providers, we launched a number of new
16 initiatives that are designed to intervene and support
17 individuals with complex needs to help them identify
18 health goals and achieve better results from a standpoint
19 of health indicators and also care experience.

20 Those started with an intensive care
21 management feature for the ASO's and also developed into
22 a significant person centered medical home initiative
23 that is now serving 40 percent of beneficiaries and we're
24 extremely proud of the development of these bedrock

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1 pieces of our reform agenda.

2 We are very purposely building this new
3 initiative which is a shared savings initiative upon the
4 foundation of that person centered medical home and
5 intensive care management work that we had done. We have
6 -- I hope you'll find them very faithful in observing
7 fidelity to our commitments to that model which is that
8 we have to marry practice transformation at the primary
9 care level in its interactions with different specialties
10 with coordinative supports that can help wrap around the
11 individual and ensure better coordination and outcomes
12 for them.

13 So MQIISP is a further developmental piece
14 in this set of initiatives. MQIISP is an affiliate
15 project of the state innovation model. I want to
16 recognize Fauna Dookh is here representing the SIM PMO in
17 the back. SIM as you know is an initiative, a multi-peer
18 initiative that is championing improved outcomes for
19 Connecticut citizens as well as use of so-called value
20 based payment strategies. And this is the inaugural use
21 of a shared savings methodology for Connecticut Medicaid.
22 MQIISP will represent that.

23 So we hope that you will be very
24 forthright today in offering as I said questions and

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1 comments designed to clarify your understanding of the
2 RFP document. I will just reinforce one more time before
3 segueing back to you, Marcia, to facilitate the meeting
4 that Marcia is the lead and only point of contact for
5 questions and other communication around the RFP. We are
6 in a procurement period and she'll explain more about
7 that.

8 So, thank you very much. We are excited
9 to see so many of you here today and welcome your
10 participation.

11 Marcia.

12 MS. MARCIA MCDONOUGH: Thank you.

13 Good morning, everyone. Like Kate said, I
14 am your one and only contact for the RFP. And I'm happy
15 to be included in this really great innovative
16 initiative. And if you have any questions at all, please
17 never hesitate to pick up the phone to ask me or send me
18 an email.

19 Welcome to the conference and thank you
20 for attending. Before getting to the purpose of being
21 here, I would like to let you know that Crystal in the
22 back can take you to the restrooms if needed as you have
23 to pass through a security gate.

24 This is such a great opportunity for

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1 potential respondents to ask clarifying questions
2 regarding the AFP requirements. The RFP has been posted
3 to the DAS and DSS websites. I would like to call your
4 attention to our court reporter, Gail. We have a court
5 reporter here in order to maintain an accurate transcript
6 of all questions that are asked. I will ask that when
7 you want to ask a question to please raise your hand and
8 then come up and sit in the hot seat and ask your
9 question to that mike so that we can get a good recording
10 of it.

11 I want to point out a few highlights as
12 far as the process. Through this RFP, the Department is
13 procuring Medicaid quality improvement shared saving
14 program for participating entities. What a great
15 opportunity to be innervated in your response to work
16 with the Department to find a successful solution to
17 improve health outcomes and contain growth of healthcare
18 costs.

19 This is a competitive procurement. And
20 there are certain rules and regulations that we must
21 follow to ensure that it is open, fair and competitive.
22 Again, I am your only contact.

23 Any questions regarding the RFP, please
24 direct them solely to me in writing. Please do not put

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1 yourself into a position where you're having
2 conversations with people in the agency regarding the
3 RFP. As innocent as the questions appear, you don't want
4 to put yourself in the position that appears not to be
5 upfront. We need to make certain that every respondent
6 receives the same information across the board. And the
7 only way to do that is to funnel all your questions
8 through me. Be assured if I don't know the answer, I
9 will seek the answer out with the experts here at Social
10 Services.

11 Any questions that you do ask in writing
12 are posted to an addendum to the RFP. After the
13 conference we will get a transcript. And all the
14 questions to work out in answers will be officially
15 posted as soon as possible.

16 If you do not receive alerts via the DAS
17 website, please sign up to receive them. If you need
18 help doing that, email me and I'll forward you the link
19 so that when an addendum is posted, you'll get the
20 addendum right away alerted to your email address.

21 Now, I would like to go over a few very
22 important requirements of the RFP. This is brief.
23 Again, I am your official contact. The information of
24 the RFP is on the DSS and the DAS website which is our

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1 state contracting portal. Again, if you have any
2 problems getting to that, call me, email me. I'll send
3 it to you.

4 Excuse me. Okay. I'd like to also bring
5 your attention to the procurement schedule. Today is the
6 Bidders' Conference. Questions are due Monday, June the
7 20th by 2:00 in the afternoon. We hope to release the
8 answers to those additional questions on June the 30th.
9 The letter of intent is mandatory. That is due July the
10 12th. Please send in your letter of intent. If you do
11 not, you're not allowed to submit to the RFP, okay.

12 The proposals are due July 26th. Please
13 do not be late. I understand you put a lot of work into
14 your RFP and the worst thing is for me to say, "You're
15 late. I can't accept it." The Department realizes the
16 work you do and how important it is. And we hate to
17 disqualify anyone for being a minute or two late.

18 Again the letter of intent is mandatory.
19 Please don't miss it. Send in your questions by June the
20 20th by 2:00 p.m. I went over the proposal due date and
21 also we're looking for one original of your proposal and
22 five copies and two conforming electronic discs. No
23 flash drives, please.

24 Please follow the required outline in the

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1 RFP. There is a cover sheet to start your -- your
2 proposal. Please use that as page 1. Please pay
3 specific information to the electronic -- to the
4 executive summary. The executive summary needs everything
5 in it for you to pass through to be evaluated. That is
6 probably the most important part of this process. You
7 need to meet all the requirements of the executive
8 summary to move into being evaluated. So please pay
9 specific attention to that.

10 And before closing, just one other thing.
11 The minimum submission requirements, they are listed in
12 the RFP. The executive summaries, one of them, but they
13 are to please be on time to meet all the format
14 requirements to follow the outline to be complete. Try
15 not to miss any sections. And to please list everything
16 that's required in the executive summary.

17 To sum up, there's a very special
18 requirement. Be a trailblazer, a pathfinder. Be
19 innovative in your responses. Be a partner with the
20 Department to help our Medicaid participants for improved
21 health outcomes and improved healthcare costs. And I
22 thank you all for attending.

23 MS. MCEVOY: We certainly invite anyone
24 who has a question or comment to come up. Don't stand on

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1 ceremony.

2 MS. MCDONOUGH: Does anyone have any
3 questions you'd like to share and come up and sit in the
4 hot seat? Would you come up?

5 MS. SUZANNE LAGARDE: Definitely.

6 MS. MCDONOUGH: It's easy up here.

7 MS. LAGARDE: So these are some very basic
8 questions about the --

9 COURT REPORTER: Would you state your
10 name, please?

11 MS. LAGARDE: Oh, I'm sorry. Suzanne
12 LaGarde. Some very basic questions about just the
13 submission, Marcia. So in the RFP, it refers several
14 times to the page limit and I could not find that.

15 MS. MCDONOUGH: There's only a page limit
16 with the executive summary.

17 COURT REPORTER: I can't get you unless
18 you're on the mike.

19 MS. MCDONOUGH: Okay. Sorry.

20 COURT REPORTER: Thank you.

21 MS. MCDONOUGH: There's only a page limit
22 with the executive summary.

23 MS. LAGARDE: Okay.

24 MS. MCDONOUGH: The rest is open to -- it

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1 was very hard to try to get a page limit from different
2 entities, advanced networks versus not. So, the only
3 page limitation is the executive summary.

4 MS. LAGARDE: Okay.

5 MS. MCDONOUGH: And the attachments are
6 not included in the executive summary.

7 MS. LAGARDE: Okay.

8 MS. MCDONOUGH: Because there are quite a
9 few attachments to it.

10 MS. LAGARDE: This may seem very trivial,
11 but I might as well clarify it all. You talk about
12 dividers by subsection and I'm wondering if you could
13 just define -- if you look at the proposal list, there
14 are sub subsections.

15 MS. MCDONOUGH: Right.

16 MS. LARGARDE: And I'd like to know what
17 that refers to.

18 MS. MCDONOUGH: Right. In the outline,
19 toward the very end of the RFP, there will be bolded A,
20 B, C, and then subsections within. It would be great if
21 you did provide a mini-tab with those subsections. Think
22 about it as making it as easy as possible for the
23 evaluator. They'll appreciate that, that they can go to
24 your proposal and just open it up and the find answer and

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1 find your response to what we ask in the RFP.

2 MS. LARGARDE: Okay. And then there's one
3 other question that I -- I know a couple of us have, and
4 it has to do with FQHC's and letter from DSS affirming
5 our PCMH status within the Connecticut DSS PCMH. And I'm
6 wondering, I don't know if that needs Kate to clarify.

7 MS. MCDONOUGH: I think Kate or Joel. Ah.
8 Confirmation of PCMH status comes from CHN. We will
9 clarify in writing exactly that mechanism for doing that.
10 But you should have at the time of initial recognition
11 received a letter. And if you need to confirm that or
12 have it reissued, we will clarify in the written
13 responses how that will occur.

14 MS. LAGARDE: Thank you. So I have one
15 other question if maybe Kate or -- or Marcia, you could
16 clarify your vision for the -- the advisory group and how
17 that would take place because obviously it can't get
18 formed until the entity is already a part of the -- is
19 accepted into MQIISP, and I'm just wondering if there --
20 a few minutes of clarification of that would be -- would
21 be appreciated -- and on that note.

22 MR. JOEL NORWOOD: Joel Norwood, DSS. So,
23 there's a couple spots. The question was to elaborate a
24 little bit on how the advisory body -- the oversight body

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1 would work. There's a couple of spots in the RFP in
2 terms of the requirements. Page 42 is where most of it
3 is. And for FQHC's, the oversight body could potentially
4 be the FQHC's board itself so long as the FQHC's board
5 meets all of these requirements. Certainly in terms of
6 actually engaging with MQIISP itself, that wouldn't be
7 possible until the entity was -- if the entity were
8 selected as a participating entity and once it began.
9 But we're just looking for what you as a FQHC or advanced
10 network plan to do in terms of how you would implement
11 it. If you have an existing board or other body or
12 advisory body that you anticipate would fulfill this
13 requirement, that would be great to include that type of
14 information.

15 Basically when you're framing it, think
16 from a perspective of how the evaluator would see how you
17 would implement it, how you have experience in
18 implementing it in a similar or almost identical manner
19 already and then any changes you plan to implement to
20 what you're already doing or any new -- new proposals.
21 Again is connected with what Marcia referenced, the
22 entire proposal's intended to foster innovation and
23 engaging directly with the people we all serve is an
24 important part of that.

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1 MS. MCEVOY: And I would just like to add
2 -- I totally agree with everything that Joel said as
3 central to it, just to reinforce what we discussed in the
4 planning process was engagement of members, meaningful
5 participation, feedback, ongoing participation. So as
6 opposed to appointing someone on a ceremonial basis who
7 is unable to attend or can't really meaningfully
8 participate because of a range of factors including
9 potentially feeling intimidated by an environment of
10 experts on a board of directors. We want you to be
11 facilitative of Medicaid member participation. That's
12 extremely important. So, I would definitely urge you to
13 think through that in terms of the means of making that
14 happen.

15 COURT REPORTER: Just state your name,
16 please.

17 MS. KATHY YACAVONE: Kathy Yacavone. Hi.
18 I was wondering, Marcia or Kate or Joel, if you could
19 just describe your vision for the reference letters.
20 That would be very helpful to clarify that.

21 MS. MCDONOUGH: Okay. Yeah, for the --
22 excuse me. Okay. For the RFP, we're asking you to
23 provide three specific programmatic references for the
24 respondent. They should be individuals that are able to

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1 come on your ability to perform. Again, this is in the
2 RFPM, page 51.

3 MS. YACAVONE: Hmm hmm.

4 MS. MCDONOUGH: The reference shall be
5 familiar with you and its day to day performances. They
6 cannot be current -- I'm sorry. References cannot be
7 respondent's current employees, officers, directors, and
8 principals if the respondent has provided services
9 directly or indirectly through a contract or subcontract
10 to the State within the past three years. The
11 organization shall include the state reference that will
12 be acceptable. They should be able to comment on the
13 following categories. Your capability to -- to implement
14 MQIISP, your organizational approach and your ability to
15 problem solve.

16 So if -- if you meet all the requirements
17 what's listed here, your letters of reference will be
18 accepted.

19 MS. YACAVONE: I think the next section
20 would be -- would be more my question. If you ask an
21 individual as a reference, they would have to be able to
22 rate each category on a scale. So I'm -- I'm just again
23 trying to get clarity. These would be we give the names
24 and -- or are you looking for written reference. I'm

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1 just a little --

2 MS. MCDONOUGH: Okay.

3 MS. YACAVONE: -- unclear here about how
4 this ranking --

5 MS. MCDONOUGH: I apologize.

6 MS. YACAVONE: -- goes.

7 MS. MCDONOUGH: This is not letters of
8 reference. If you supply the three references, we will
9 be calling your three references. I apologize for being
10 misleading thinking it was letters of reference.

11 MS. YACAVONE: Okay.

12 MS. MCDONOUGH: We do so many RFP's. Some
13 are letters of reference. Some are references. In this
14 case, I will be calling your references.

15 MS. YACAVONE: Okay.

16 MS. MCDONOUGH: So provide me with three
17 that meet the qualifications that are listed here, okay?
18 I hope -- does that answer your question now?

19 MS. YACAVONE: Yes. That was a little
20 more clear. Thank you very much.

21 MS. MCDONOUGH: Okay. Thank you.

22 MS. LAGARDE: I know. I'm sorry. I'm
23 sorry.

24 MS. MCDONOUGH: You should not apologize.

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1 MS. LAGARDE: Sorry. Sue Lagarde. Just
2 to follow up on Kathy's question. In terms of the state
3 reference, if we do our best and give you a reference
4 that we think is not involved in this RFP, but then you
5 believe that it is a conflict, would you give us the
6 opportunity to then give you another reference? I mean
7 how -- you know how carefully do we have to vet the state
8 reference I guess?

9 MS. MCDONOUGH: All right. I will work
10 with you if -- if we feel it could be a possible
11 conflict. We don't want to, of course, do that. I'll
12 work with you to call you, give me another reference.

13 MS. LAGARDE: Okay.

14 MS. MCDONOUGH: Especially with this RFP,
15 we want to be partners. We want to work together on
16 this. So --

17 MS. LAGARDE: Okay.

18 MS. MCDONOUGH: -- any problems like I
19 said, give me a call, write me an email. We'll work it
20 out.

21 MS. LAGARDE: Right. Thank you.

22 COURT REPORTER: State your name, please.

23 MR. ARVIND SHAW: My name is Arvind Shaw.
24 And I work at Generations Family Health Center. Can you

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1 hear me? Thank you.

2 So, I have some fundamental questions.
3 One of them is about how this program can sustain itself
4 and sustaining itself I think is an important thing. And
5 I'll come back to this later on.

6 So, I'm speaking of the economics,
7 strictly the economics. It's an expensive program to
8 implement. I see there is a threshold of four and a half
9 million dollars that will be spent. But I'd like to see
10 how this actually -- actuarially works from the point of
11 view of DSS and also from the point of view of the PCMH
12 FQHC. Would you please?

13 MS. MCEVOY: Yes.

14 MR. SHAW: Thank you.

15 MS. MCEVOY: So, I appreciate the question
16 especially in context of our present budget
17 circumstances. First I would like to say that we have a
18 commitment within the biennial budget for the funding
19 that is memorialized in the RFP that is funding for the
20 supplemental payments to the FQHC's that will be selected
21 as participating entities. So the governor and the
22 legislature have agreed that this is an important
23 threshold investment in what we need to do to underwrite
24 the costs of implementing enhanced care coordination

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1 practice in the FQHC environment that presumes that an
2 FQHC has already demonstrated either NCQA or JACO
3 recognition as a person centered medical home. So we
4 identify that as the threshold requirement and then also
5 build on that with the care coordination investments that
6 we're making.

7 We have as a matter of policy in the state
8 decided that it is important to invest additional funds
9 enough to achieve for those purpose to enable the types
10 of behavioral health integration, cultural competence,
11 disability competence and the like that are memorialized
12 in the care coordination requirements that we're
13 expecting participating entities to fulfill and there is
14 a prospective commitment for that same investment of
15 supplemental funding over the course of the SIM grant
16 period which spans into the next biennium.

17 Our hypothesis is that investing in this
18 way will enable us as we have presently already
19 demonstrated we can improve outcomes and in doing so by
20 appropriately coordinating care, that is the means by
21 which we will control the rate of growth in Connecticut
22 Medicaid. And we have evidence over the last full year
23 of financial trend in reduction in PMPM expenses of six
24 percent. We have seen a downward trend in PMPM for the

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1 last eight quarters and we believe that the MQIISP
2 intervention will continue to allow us to further improve
3 on that trend. And for each one percentage point of --
4 of improvement there, we are saving an enormous amount of
5 money in our -- in our over \$6.2 billion dollar budget.

6 So that is the proviso. We have to
7 investigate whether we achieve the results that we expect
8 and this is, as I said, a development on our current
9 investments in PCMH. It's also additive. We will
10 continue to make the PCMH payments eligible practices.
11 We will continue to make the investments in the primary
12 care rate increase that we've continued and we will also
13 make the MQIISP payments.

14 So that is the policy agenda of the
15 administration. I know it is a reasonable question to
16 ask and on certain budget times what is -- what does the
17 future hold -- that we are excited to bring these
18 resources to bear in this way and as I said, examine the
19 results on the outcomes both from the standpoint of
20 outcomes on people and then also the rate of (ambulance
21 sirens)

22 MR. SHAW: So, Kate, can I have you for a
23 second more?

24 MS. MCEVOY: Yes.

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1 MR. SHAW: I did some calculations and it
2 worked out to be like \$1.87 PMPM.

3 A VOICE: That's high.

4 MR. SHAW: Is that high? And the way I
5 did it it wasn't anything that was very scientific. I
6 just took 215,000 lives and divided it by 4 and a half
7 million dollars. And I'm just wondering has anybody in
8 the country ever been able to do case management for as
9 low as \$1.87?

10 Mike, you say yes?

11 A VOICE: Yeah.

12 MR. SHAW: It's a good -- it's a good
13 number?

14 A VOICE: That's a good number.

15 COURT REPORTER: I'm sorry. You're not on
16 the record.

17 A VOICE: Sorry.

18 MR. SHAW: No, that's okay. I -- I
19 received confirmation from somebody who says -- knows a
20 little bit more about this.

21 I have some very specific questions if I
22 can just ask about those. So, care coordination. What's
23 the difference between care coordination and enhanced
24 care coordination activities in their reporting their

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1 expectations?

2 MS. MCEVOY: The care coordination
3 responsibilities are listed in the RFP. I'd ask you to
4 consult the RFP. I think they're very clearly
5 articulated. We also have been very clear about which
6 attach to FQHC's and which attach to advanced practices.
7 So, if there are specific questions, I will ask Joel to
8 come up and actually answer those based on the RFP
9 document that we did our best to be very clear to say
10 what those duties would be. The premise of MQIISP is
11 that we're building on the limited embedded care
12 coordination that is a feature of PCMH practices.

13 MR. SHAW: There is a specific RAP tool on
14 page 46 and I was wanting to know if there was any other
15 alternative tool that could be allowed.

16 MS. MCEVOY: We have been very careful in
17 our development of these care coordination standards in
18 consultation with Mercer and also our stakeholder body
19 that care management committee of MAPOC to consider
20 really best practice across the country first examining
21 PCMH expectations. Also the imbedded expectations around
22 care coordination that HRSA has promulgated for FQHC's
23 and then a range of other reference points in the
24 literature. Mercer is on the phone and I would invite

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1 them to comment further if they would like to.

2 But our best place rising out of that set
3 of discussions was to make recommendations in the areas
4 of focus that we have identified. We do have a
5 preference for some specific tools that I think we would
6 certainly be amenable over time to feedback from the
7 participating entities that are selected if those inhibit
8 flexibility or innovation at the local level. So I would
9 invite you to submit comments on those if you would find
10 that to be a useful part of the discussion ongoing. But
11 we did in some cases, it is correct, Arvind, express a
12 preference for specific aspects of fulfilling those care
13 coordination standards.

14 Mercer, would you like to comment further?

15 MS. MAGGIE WOLFE: Hi, Kate, Cindy's on.
16 I just didn't hear the question fully. I want to make
17 sure I understand the full question.

18 MS. MCEVOY: Yeah. I'm not sure about the
19 mechanics of them commenting. Can they do that?

20 COURT REPORTER: No, I'm fine. I can
21 hear.

22 MS. MCEVOY: Okay. So the question was
23 from Arvind about the specific RAP tool that we are
24 expecting participating entities to use in the enhanced

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1 care coordination standards. His question was, could
2 there be some flexibility on that? And what I had
3 remarked is that we canvass literature and made reference
4 to other standard sets including PCMH and HRSA and that
5 we were interested in adherence to that set of standards.
6 But we would also entertain comments about firm
7 participating entities about the need for flexibility in
8 innovations.

9 So, I wondered if you'd like to say
10 anything more about the specific selection of that RAP
11 tool.

12 MS. CINDY WARD: Yeah. The selection of
13 that RAP tool wasn't necessarily to lock a provider in to
14 utilizing one tool. But what we do know is there are a
15 lot of behavioral health providers that utilize that tool
16 and to the extent that we wanted to coordinate with --
17 with a plan that had already been developed by another
18 provider, specifically a behavioral health provider, this
19 was an effort to build some capacity and competencies
20 within the primary care side of the house to understand
21 those tools, to ask about those tools and to start a
22 conversation with members about what might be on those
23 plans.

24 MS. MCEVOY: Thank you, Cindy.

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1 MR. SHAW: Thank you. On page 38 to 41,
2 there's a discussion about the CCIP program requirements.
3 However, Appendix C excludes PTM participants from
4 completing the questions. So can you clarify what the
5 expectations are for CCIP?

6 MS. MCEVOY: I would like to reserve
7 formal issuance of a response on that when we collaborate
8 with the SIM PMO. We will issue that in writing. I
9 think that would be our preference for today.

10 But generally our aim is not to duplicate
11 the technical assistance that is available to entities in
12 Connecticut that are working towards the common purpose
13 of practice transformation. So we don't want to overlap
14 with CCIP and the practice transformation network grants
15 from CMMI. So, I'm going to ask that you indulge us in
16 issuing a formal written response and pointing back to
17 Fauna(phonetic) who's representing the PMO. But I think
18 it would be most suitable since the SIM PMO is the
19 architect of the C sub-standards for us to do that in
20 writing. Thank you.

21 MR. SHAW: Thank you.

22 MS. MCEVOY: Joel is just urging that I
23 clarify a previous response which I think is very helpful
24 and that is that the figure that is listed in the RFP for

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1 the supplemental payments represents only the state share
2 of the payments that would be made. We also have a
3 federal match of the same amount that we anticipate. And
4 we are in active discussion with CMMI and CMS about the
5 authority under which we will make both the supplemental
6 payments and also enter into shared savings arrangement.
7 So, it's an important clarification that Joel is giving
8 in terms of the overall amount that's available.

9 MS. JAQUEL PATTERSON: Jaquel Patterson
10 with CHR. For FQHC's that receive the add on care
11 coordination fee, are they able to subcontract for some
12 or all their care coordination activities?

13 COURT REPORTER: I'm sorry. Your name
14 again.

15 MS. PATTERSON: Jaquel Patterson.

16 MS. MCEVOY: That does appear to be an
17 area that we have not effectively articulated in the RFP
18 so we would like to respond in writing on that. I
19 appreciate you raising that question.

20 MS. PATTERSON: Okay.

21 MS. MCEVOY: I will say our expectation is
22 that the entities that are selected will themselves be
23 involved in practice transformation and direct oversight
24 of the care coordination benefits to members. So I think

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1 it would be fair to say that the Department's preference
2 is that you have a very direct involvement in that work,
3 that we would like to consult internally and release a
4 formal response on subcontracting. And I appreciate the
5 question.

6 MS. PATTERSON: Okay. Thanks.

7 MS. MARGARET FLINTER: Margaret Flinter,
8 Community Health Center.

9 If I've missed it, I apologize, but
10 there's a lot of reference to the practice or a practice,
11 a coordinator for the practice. And I think we have a
12 huge range in Connecticut from a single location to large
13 locations, a few providers to dozens or hundreds in both
14 behavioral health and medical. I didn't see anything
15 about ratios. Did I miss that?

16 MS. MCEVOY: We have not.

17 MS. FLINTER: Great.

18 MS. MCEVOY: Yeah. We have not included
19 any specific ratios and I think that is definitely an
20 opportunity for individual entities that are applying to
21 articulate their capabilities. We wanted to take a -- an
22 approach that 1) did not foreclose any type of entity,
23 and 2) give an opportunity for entities to show how they
24 have adapted or applied innovative practices on a local

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1 level that won't take the same form across all -- all of
2 the states. So, depending on your own composition,
3 depending on your own organizational structure, that
4 could be very different.

5 MS. FLINTER: Okay.

6 MS. MCEVOY: So we anticipate that and
7 we're not asking for homogeneity across the applying
8 entities for that.

9 MS. FLINTER: Great.

10 MS. MCEVOY: Yes.

11 MS. FLINTER: And just one other --

12 MS. MCEVOY: Yes, absolutely.

13 MS. FLINTER: -- quick question if I can.
14 I raise this all the time in all meetings around patients
15 who are admitted to psychiatric hospitals and substance
16 abuse facilities admissions. Is that an admission as we
17 look at admissions and 30-day readmissions because we
18 have a terrible time getting that data.

19 MS. MCEVOY: That's a very good question.

20 MS. FLINTER: And CHN does not get that
21 data as part of their fee to us on readmission.

22 MS. MCEVOY: So it's an important note to
23 the Department in terms of the data that you will need in
24 order to perform on this. We're going to reserve for our

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1 written comment --

2 MS. FLINTER: Okay.

3 MS. MCEVOY: -- but I very much appreciate
4 that. I think it's a useful thing --

5 MS. FLINTER: Great.

6 MS. MCEVOY: -- to raise to our attention.

7 MS. FLINTER: Perfect. Thank you.

8 MS. MCEVOY: By the way, I'll just say,
9 we do have all that data because we as a -- as an
10 organization now have a fully integrated claims data stat
11 for all of the covered services of Medicaid according to
12 how we pay for them and then all covered lives.

13 Margaret raises an interesting question
14 about what data is currently going to PCMH practices and
15 how we could augment that and I really appreciate that as
16 we talk about integration, what features we need to do to
17 enable that on a local basis. So thank you.

18 MS. YACAVONE: Hi, Kathy Yacavone. One
19 clarification, Kate. Under the enhanced care
20 coordination on page 46, there's a requirement for
21 advanced care planning for children and youth with
22 special needs. Now currently if the organization is not
23 serving clients that fit specifically in that category,
24 is the expectation that we -- that once attribution is

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1 determined if there are children or transitional age
2 youth that fit into the category, then it's an
3 expectation obviously the organization would develop that
4 capacity.

5 Speaking for my organization, we don't
6 have children who fit into that who have now so we have
7 not engaged in development of these services. So, I just
8 would like to be clear what is the Department's
9 expectation around that.

10 MS. MCEVOY: I appreciate the question.
11 And our intent with the care coordination standards is
12 first that participating entities did develop those
13 capabilities as a sort of part of your toolkit of
14 strategies for --

15 MS. YACAVONE: Okay.

16 MS. MCEVOY: -- members and then also
17 apply them specifically with attributed members. I would
18 like to have discussion with Mercer about the specific
19 aspect of it being evaluated and scored upon measures
20 that may not attach because of the question that you
21 raised, Kathy, about a lack of individuals who fit into
22 that category. So I appreciate you raising that
23 question.

24 MS. YACAVONE: Okay.

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1 MS. MCEVOY: Cindy, would you like to
2 comment at all on that or other Mercer colleagues? I'm
3 sorry. I didn't mean to foreclose any other response.

4 MS. WOLFE: Thank you, Kate. I think that
5 is a wise takeaway for us to go back and reconsider.

6 MS. MCEVOY: Thank you, Kathy. Great
7 question.

8 MS. YACAVONE: Thank you.

9 MR. SHAW: I have another question about
10 the quality measures on pages 57 to 58. And I wanted to
11 know if dual eligibles are captured in this information.

12 MS. MCEVOY: Mercer, may we ask you to
13 confirm our belief that those individuals are excluded?

14 MS. WOLFE: Kate, this is Maggie. I'm
15 sorry. I didn't hear the question.

16 MS. MCEVOY: The question is we're being
17 asked on the quality measures set whether the assessment
18 would include dual eligible individuals. It is our
19 working presumption that it would not because they are an
20 excluded population for MQIISP.

21 MS. WARD: Yes, Kate, this is Cindy. That
22 is our understanding that duals are excluded both from
23 the population and from the quality measure set.

24 MS. MCEVOY: Thank you.

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1 MR. SHAW: Thank you.

2 MS. MCDONOUGH: Any other questions?

3 MS. MARIE MONILE: Marie Monile from
4 Community Mental Health Affiliates.

5 We're a behavioral health provider in
6 central Connecticut mostly with services in Torrington
7 and Waterbury. We would have a role in the -- or could
8 have a role in the community, partners in integration
9 piece, but just would like to have an avenue to connect
10 with FQHC's and primary patient centered medical homes
11 who might be interested. What would be your suggestion
12 on how to do that? I know that there's a list on the DSS
13 website, but I don't know if there's any others in
14 progress that are moving towards it that may be eligible.
15 What's the best way to connect because we certainly have
16 a lot to offer in that way?

17 MS. MCEVOY: I sincerely appreciate that
18 question and I'd like to consult internally about what,
19 if any, role the Department could take in offering a
20 forum for that purpose.

21 MS. MONILE: Great.

22 MS. MCEVOY: We've certainly talked about
23 the importance in the RFP of the community linkages and
24 especially around behavioral health integration. So

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1 we'll consult with Marcia about what would be permissible
2 for us in terms of establishing a forum and I really
3 agree it would be very useful and I think certainly you
4 broadcasting that to interested parties of responding
5 would be another avenue today. So thank you.

6 MS. MONILE: Great. Thank you. And I did
7 -- do you have an estimation of the covered lives that
8 would be served by FQHC's versus other primary patients
9 and their medical homes?

10 MR. NORWOOD: Great. Thank you for that
11 question. Joel Norwood, DSS.

12 I don't have the information handy but we
13 certainly have access to that information. We actually
14 very recently internally discussed the total potential
15 attribution. First there's a total number of Medicaid
16 members. Then out of that, a subset of those members
17 have seen primary care provider in a way that our
18 attribution methodology attributes them to a practice of
19 any type, PCMH or otherwise FQHC or otherwise. Then
20 within that, there are the various primary care practices
21 and FQHC's that are PCMH practices. So then that limits
22 the universe a little bit further. And then there's the
23 division between the two different types.

24 Kate and I were just saying off the cuff,

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1 we don't have specifics at hand right now, but about
2 215,000 or so are FQHC's and then I believe the balance
3 would be the other practice types. But again without all
4 the data, I wouldn't want to quote any more specific
5 numbers than that and that's just a very rough estimate.
6 But we can certainly get that information and I imagine
7 we'll be discussing it further publicly as well in terms
8 of what the total attribution may be.

9 MS. MONILE: Okay. And do you have
10 projections on the amount of shared savings you're aiming
11 for or expect? Is it six percent or something similar,
12 another six percent or -- ?

13 MS. MCEVOY: Mercer, would you come in?
14 The question is whether we have developed specific
15 projections at the level of savings that we expect to
16 achieve?

17 MS. WOLFE: Kate, this is Maggie. I don't
18 believe that we have specific projections by entity if
19 that was the question that was being presented.

20 MS. MCEVOY: I think the question, Maggie,
21 is overall what would be reasonably expected to project
22 for savings for this type of project, and I don't know if
23 Mercer would like to come in, or we could certainly
24 respond in writing.

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1 MS. WOLFE: Yes. I think this is a
2 question, Kate, that we should take away and respond in
3 writing if that's possible.

4 MS. MCEVOY: Yes. Thank you very much.

5 MS. MONILE: Okay. Thank you.

6 MS. ALIX POSE: Good morning, Alix Pose,
7 from Optimus Health Care. I have a Kate question --

8 COURT REPORTER: What's your name again?

9 MS. POSE: Alix Pose, P-o-s-e from
10 Optimus.

11 Page 16, I have a question related to the
12 oversight body that is one of the requirement. Can you
13 define more the role of this oversight body, the type of
14 members requested to be and the requirements on do you
15 need to see minutes, things like this? And who should be
16 the members? FQHC's are usually like already a lot of
17 committees, board of directors, performance and
18 performing committees. So I was wondering is it an extra
19 committee that you want like a mix of committees? Or
20 could one of these committees take the role of --

21 MR. NORWOOD: So we discussed it a little
22 bit earlier in this --

23 MS. POSE: I'm sorry.

24 MR. NORWOOD: -- Bidder's Conference. Not

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1 at all. And in addition to page 16, I think page 42 also

2 --

3 MS. POSE: Right.

4 MR. NORWOOD: -- has a little bit and
5 there may be another reference as well and my apologies
6 that I don't have it offhand.

7 So to answer your second question first,
8 this oversight body absolutely could overlap with one of
9 your existing board or advisory committee or such other
10 group as long as it meets these requirements. And beyond
11 these requirements, our expectation is you'll simply
12 describe more detail in your response how you plan to
13 meet those and the types of things you suggested
14 certainly are ways you might do that. But, we're
15 intentionally not being too detailed a prescriptive. We
16 want -- we want the respondents to describe how you plan
17 to meet these requirements.

18 MS. POSE: Okay.

19 MS. LAGARDE: Sue Lagarde. So, Attorney
20 Joel, if you could just clarify a little bit because
21 there seems to be a little bit of an inconsistency about
22 this board -- about this governing advisory body in that
23 what you stated earlier and what I can appreciate is that
24 you would like us to think creatively and innovatively

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1 about how we create and that patient engagement is a
2 critical piece of that. And that although this could be
3 somehow a part of our board that the issue of patient
4 engagement might be problematic in that context and
5 perhaps be, you know, a factor and be feeling intimidated
6 in that environment.

7 But then further on down you want this
8 body to have its own set of bylaws which sets -- seems to
9 become a little more -- I don't know -- although that's
10 possible, that's a complexity that -- that then makes one
11 think, well, maybe the easier or the -- I don't know if
12 the easier but the -- the preferred course of action is
13 to go the board route but then there are those other
14 disadvantages that you pointed out. So I was wondering
15 if you could try to, you know, meld those two somewhat
16 inconsistent statements.

17 MS. MCEVOY: I appreciate the question and
18 I know everyone wants to be pragmatic and really boil
19 this down to how you get an act -- you know, actualize
20 what we have in mind. We, as Joel said, did not take a
21 prescriptive approach. We -- we want to make sure that
22 we leave ourselves receptive to different types of
23 entities to apply, may have different existing
24 organizational structures already. It is absolutely true

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1 what Dr. Lagarde said about it existing board that
2 already has constituted bylaws could serve that function.

3 But what we're challenging you to do in
4 the context of practice transformation is either to help
5 reimagine that present functioning of your board as it is
6 already established or develop either an affiliate or a
7 standalone body that would very meaningfully represent
8 the rights and interest and preferences of members.

9 So, we don't have a -- we don't have a
10 declarative statement to make as a department about which
11 is the best path. I can say if it useful from an
12 illustrative standpoint that the most successful body
13 that's affiliated with a department in engaging and
14 maintaining consumer participation over time has been
15 "the money follows the person" steering committee.
16 That's been a model that in its inception set very
17 assertive benchmarks for the level of consumer
18 participation as a proportion of the membership and also
19 used facilitative means including paying for
20 transportation and other supports like interpreters to
21 help make sure that individuals could meaningfully
22 participate in the discussion. Also they used tools like
23 work groups to prepare individuals to be part of more
24 policy oriented discussions. I would identify that as a

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1 best practice, the money follows the person approach. So
2 that is -- there is considerable materials on the
3 Department website about that that may inspire your
4 thinking about this. But just to reinforce, we do not
5 have a one size fits all model in mind in terms of how
6 you actually build that into your proposal and the
7 proposal represents an opportunity to tell us what you
8 want to do and to be persuasive on that.

9 So thank you very much for the question.

10 MR. NORWOOD: And just on one addendum,
11 you're right, it does reference that bylaws that reflect
12 the body's structure and define its ability to support
13 the MQIISP's objectives. The idea there is since this is
14 intended to be a formal models of whichever entities end
15 up applying and then being selected to have a formal
16 paper trail way of showing how it's implemented but
17 you're writing the bylaws. You can decide how formal or
18 informal to make those bylaws. They don't necessarily
19 have to be as formal as your official governing board's
20 bylaws. You decide. So, you're right, it does say
21 bylaws. There is attention there. But we're not saying
22 anything about what the bylaws have to say specifically
23 and we welcome your creativity.

24 MS. FLINTER: Margaret Flinter still. I

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1 think we all totally appreciate what you're trying to do
2 there. But if -- if I may ask, it seems in -- in direct
3 conflict with the HRSA requirements that we're obliged to
4 live under as a federally qualified health center. We
5 can't have another group of people that has authority.
6 It all resides with the board. And I know you probably
7 had conversation with HRSA about this and I wondered if
8 you could clarify their position on it. We certainly --
9 many of us have advisory committees. Our boards have --
10 are able to appoint standing committees. The standing
11 committees can take on a lot of work. But things like
12 having a set of bylaws that gave them any authority that
13 wasn't the authority of the board, I just don't think is
14 consistent with the HRSA requirements. So, I wonder if
15 you could just give us some assurance on that. Thanks,
16 Kate.

17 MS. MCEVOY: Thank you, Margaret. We
18 don't in any way mean to go against the HRSA
19 requirements. An advisory body would be fully within the
20 scope of our expectations. I think bylaws seems to have
21 raised kind of red flag for everybody. But we think of
22 bylaws as sort of organizing document that would describe
23 the scope and role of the entity. It really is an
24 emphasis on the advisory piece advising the organization

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1 on this particular initiative and to be facilitative of
2 expression of those types of observations for members.

3 So we don't mean to arbitrarily relay a
4 structure. We mean to augment what you already have in a
5 way that is meaningful to members. So I appreciate the
6 question.

7 MS. ROSE SWIFT: Rose Swift. Okay, my
8 question pertains to page 33. There's mention that
9 MQIISP participating entities will only receive the
10 shared savings payment if they meet the identified
11 benchmarks and measures of under service. What kinds of
12 things are being considered as appropriate under service?

13 MS. MCEVOY: I appreciate the question
14 very much. We will establish benchmarks for the quality
15 measures that are listed within the body of the RFP. We
16 will also be publishing a range of strategies designed to
17 address -- actually, I should start by saying prevent,
18 address and ameliorate under service if we see evidence
19 of it. There has been concern expressed through the
20 development of the model design, very sincere concern
21 about the potential for assuring and savings influencing
22 provider behavior in terms of either denying or reducing
23 needed care.

24 So what we have described our agenda is

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1 about here a range of strategies some of which relate to
2 the measures we have chosen in that they describe
3 preventative services. We have also discussed using
4 tools like mystery shopper which is already a feature of
5 our ASO model. We have proposed using caps to describe
6 care experience. We have proposed using our claims data
7 to do various population studies. We have proposed
8 examining the grievance and appeals information and data
9 that we received through the ASO's. Also potentially
10 establishing a standalone entity to handle calls and
11 grievances around MQIISP in particular and that's still
12 under consideration. And also this will be continued to
13 be discussed by the care management committee of MAPOC
14 over the next several months to fully articulate the set
15 of expectations.

16 But I hope that would give you a sense of
17 where we're focused. It really is around use of the
18 claims data, use of care experience data, populations
19 studies and then the sort of proxy for access issues that
20 is served by using the mystery shopper.

21 MS. SWIFT: Okay. Thank you. All right.
22 And on page 38, it mentions that there will be monthly
23 and/or quarterly reports. What types of information will
24 be requested?

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1 MS. MCEVOY: That's an excellent question.
2 We will be relying predominantly on claims information
3 for evaluation of your performance on the quality
4 measures. One important note is that we are relying
5 exclusively, as of now, on claims measures but as we
6 develop through the SIM initiative, the functionality to
7 solicit and to synthesize clinical measures, we will go
8 that route. So that may inform the wave to -- of -- of
9 MQIISP, a future wave. But presently our capabilities
10 around the claims measures.

11 For the reporting that we've included, we
12 could see there might be features such as helping us
13 understand the role and the work of your advisory body,
14 your consumer engagement, the pieces around operational
15 ease or barriers, those types of things as we roll out
16 the program the way in which you are experiencing the
17 success or the challenges associated with member
18 communications. We will definitely publish a specific
19 set of expectations and we'll memorialize those in the
20 contract but it will not be about reporting on the -- the
21 claims piece. We will do that through the process of
22 your billing. We won't expect you to be documenting that
23 data in that way. It's more around the sort of
24 application and implementation of the program.

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1 MS. SWIFT: Thank you.

2 MS. MCDONOUGH: We still have a good 15
3 minutes if anyone has any other questions. Please don't
4 hesitate. Now is your time for any kind of clarification
5 at all of the procurement or the program itself. Please
6 come forward if you'd like.

7 MR. MICHAEL HUNT: Michael Hunt, St.
8 Vincent's Health Partners.

9 You're asking for a very intelligent care
10 coordination system. So in order for us to find success,
11 what kind of data sources a) will be available to the
12 entities if they get awarded and number two, with
13 behavior health being included in the potential of that
14 care coordination, would we find any support in sharing
15 that behavioral health data for those members?

16 MS. MCEVOY: I really appreciate that
17 question. So what we will do in written responses for
18 anyone who is not already aware or accustomed, is detail
19 the data points that we share presently with PCMH
20 practices. CHM, our medical ESO does regularly push out
21 data on the panel of individuals served by PCMH practice
22 that is participating in the DSS Medicaid PCMH program.
23 And we will discuss internally what is feasible given
24 confidentiality laws in terms of building in reference

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1 points around behavioral health. It's a very good
2 question and harkens back to the earlier question of the
3 admissions to psychiatric facilities. We will see what
4 we can do to broker getting that information and/or
5 entering into specific data agreements for that purpose.
6 But it is already a feature of our PCMH program that we
7 are affirmatively pushing that data so that you'll be
8 intelligent about the panel with which you're working.
9 So, thank you.

10 MS. YACAVONE: Kathy Yacavone. One basic
11 question. I apologize if you said it in the introduction
12 and I missed it. But there is no formal date for
13 awarding contracts. So I'm making the assumption you
14 would let the -- what's the word -- the awardees know in
15 significant period of time because then that involves the
16 real PCMH attribution process which I assume CHM will
17 have an active role in so we'll need sufficient time to
18 develop all these infrastructure pieces.

19 MS. MCDONOUGH: Well, yeah, right now it
20 is to be determined as far as letting who actually gets
21 the right to negotiate a contract with in mind the
22 contracts start the day of January the 1st. We're hoping
23 to give some kind of notice. I would say hopefully by
24 the month of October. And that is like -- that's a

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1 guesstimate on my part but not knowing how many
2 submissions are received, how long the evaluation process
3 will take. But a perfect date I would say for you would
4 be to let you guys know by October for a January 1st
5 start date.

6 MS. YACAVONE: Okay. Thank you.

7 MS. MCDONOUGH: You're welcome.

8 Just FYI, there will be an addendum out as
9 soon as possible and there will -- it will include a list
10 of all the attendees and we're here until 11:00. So if
11 you still have some questions, feel free to come up.

12 COURT REPORTER: Name, please?

13 MR. THATCHER DUNI: My name is Thatcher
14 Duni. I'm from Life Designs in Shelton.

15 I have a lot to offer Medicaid and
16 Medicare. I'm an innovator. I'm not part of any
17 community health care plan, but I think what I'm doing
18 needs to be in those plans, in those centers. But I
19 don't know how to do it. I mean I have been running a
20 business for 35 years in Shelton that works specifically
21 with the disabled, primarily Medicaid. I do work with
22 the ABI waiver and the money follows the person program
23 doing ILST work.

24 But what I work on is

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1 neurological recovery, and people with complicated
2 comorbid problems that go beyond even discussion. And I
3 get them to stand and walk and toilet and get into cars
4 long after they have gone through basically the best
5 programs in Connecticut and have failed. I think I can
6 save Medicaid millions of dollars a year and I can even
7 make community health centers millions of dollars a year.

8 The program is operational. I have a
9 complete training manual. I'm not here to sell anything.
10 I'm here to offer my help. But I don't know how to do it
11 because I'm an outsider. I'm self-employed. My wife and
12 I have worked together for 35 years. She is a registered
13 physical therapist. We have learned each other's skill
14 sets. I'm a neuroscientist and a movement scientist.
15 And I'm an entrepreneur. And I just wanted everybody to
16 know that I'm here. And I want to help.

17 And if I can offer anything, if I can talk
18 to you, Kate, or Marcia. I don't want to violate any
19 issues regarding privacy or anything regarding this RFP
20 process, this procurement process. But what would be the
21 next steps for me, Kate?

22 MS. MCEVOY: Let us consult internally
23 about that.

24 MR. DUNI: Yeah. I agree.

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1 MS. MCEVOY: I first want to say thank you
2 very much for your work on behalf of individuals served
3 by the waivers. That's very significant and we very much
4 appreciate that. I will clarify individuals served by
5 the waivers are not part of this particular initiative.
6 So that's an important threshold consideration. But I --
7 I acknowledge what you're saying in terms of your
8 interest in caucusing with us and let us come up with the
9 best means to do that.

10 MR. DUNI: Sure.

11 MS. MCEVOY: And if you can leave your
12 contact information with Marcia, we'll definitely be in
13 touch with you.

14 MR. DUNI: All right.

15 MS. MCEVOY: Thank you.

16 MR. DUNI: Thanks a million.

17 COURT REPORTER: Your name, please.

18 MR. SEBASTIAN MOTTA: Sebastian Motta from
19 Pro Health Physicians.

20 I just wanted maybe a little clarification
21 on the core requirements and the elective requirements
22 related to both tracks -- related to both tracks one and
23 two. What are -- what are the specific deliverables that
24 -- that are being expected in 2017? Thank you.

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1 MS. MCEVOY: May I ask you to join us
2 again just to clarify your question? Are you referring
3 to the CCIP standards?

4 MR. MOTTA: Yes.

5 MS. MCEVOY: Okay. Again, and I do
6 apologize because the CCIP standards are overseen by the
7 SIM project management office, I would prefer that we
8 respond in writing to your question. So thank you very
9 much. We'll memorialize that and definitely we'll
10 communicate with you in a formal response. Thank you
11 very much.

12 MR. MOTTA: Thank you.

13 MS. MCDONOUGH: It's three minutes to 11.
14 We'll be shutting down the conference. If anyone has any
15 other questions, now is the time to ask because we're
16 shutting down. Thank you all. Thank you.

17

18 (Whereupon, the conference adjourned at
19 10:58 a.m.)

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