

**State of Connecticut  
State Innovation Model Design  
Payment Reform Work Group**

**June 3, 2013  
Meeting Minutes**

**Location:** CT Behavioral Health Partnership, 500 Enterprise Drive, Rocky Hill

**Members Present:** Dr. Thomas Raskauskas (Chairman); Ms. Victoria Veltri (Co-Chair); Dr. Peter Bowers (for Bernadette Kelleher); Paul DiLeo, William Gedge; Dr. Courtland Lewis; Ms. Kate McEvoy; Ms. Lori Pasqualini; Mr. Robert Smanik; Dr. Todd Staub; Ms. Susan Walkama; Mr. Joseph Wankerl; Dr. Thomas Woodruff

**Members Absent:** Ms. Mary Bradley; Ms. Kathy Madden

**Meeting convened at 5:40 p.m.**

**Review SHIP guidance and progress of care delivery and HIT work groups**

The work group reviewed the vision for the initiative developed by the State Healthcare Innovation Planning Team. The goal is to develop a model that brings together a fractionated health care system focused on the whole person. The model should resolve health disparities, integrate primary care behavioral health, and be supported by all payers. The Care Delivery group is focusing on developing a population health based care model that takes into account team based care and patient engagement. The Health Information Technology group is developing technological solutions that will support the Care Delivery and Payment Reform models.

**Review guiding principles and strategic design decisions discussed in payment model work group kickoff**

The model must move away from a focus on provider needs and towards a focus on patient needs. The payment model must be financially sustainable and improve health care access and equity. The model must align across all payers. The group discussed establishing incentives to encourage providers to work together to gain shared savings. They also discussed how to encourage smaller providers to participate and how to align their incentives. The group would likely want encourage continued provider independence, but could reward clinical integration.

The group reviewed key questions around metrics, payment, attribution, and rollout. They discussed developing different smaller models related targeted to particular populations (i.e., developing different payment models for providers treating oncology obstetrical care for bundled services, rather than recommending bundled payments for all care models). The Centers for Medicare and Medicaid Innovation are looking for a total cost of care model. One of the discussions was whether the structure of the model was focused on one destination and how to provide onramps to support smaller practices in adopting the model.

**Discuss data around industry/provider landscape and payment model reward structures**

The group reviewed reward structures and the requirements, benefits, and limitations of each (fee for service, pay for performance, upside gain sharing, downside risk sharing, prospective payment, and also per member per month). There was lengthy discussion regarding provider clinical integration, the administrative, contractual, and legal implications of increased provider clinical

integration. A large percentage of employers use self-insurance. With changes to the State of Connecticut employee health plan, the focus was on improved quality and cost control. There has been feedback from other employers at exploring a similar model.

Relatively few providers in Connecticut have the capability to use the downside risk sharing model. There was discussion whether it would be feasible for all providers to implement that model within the same time frame. The need to discuss metrics was highlighted as the metrics implemented will impact the structures providers will put into place.

The group also discussed developing multiple tracks that would allow providers to implement at a reasonable level of risk with the potential to expand going forward. The model must expand access to primary care, so the method must include high enough hurdles to make a difference but not so high that the goal is impossible.

**Discuss consumer attribution methodologies. Discuss structures, processes, and quality/outcomes metrics to measure under new payment model**

The group briefly reviewed definitions and benefits of structural, procedural and outcome-based metrics and approaches to using defined metrics to hold individuals accountable (reporting, conditions for participation, contingency for reward, considerations for setting reward levels).

**Align on next steps**

The group will need to discuss metrics going forward. Members will discuss examples of metric score cards. The group will also look further at Medicaid's Glidepath reimbursement model for person centered medical homes. The group will also discuss whether providers would be rewarded based on gradients (i.e., only rewarding those at a particular level, or providing rewards as providers show improvement) or absolutes (percentage of preventive and chronic disease metrics successfully attained), and how much time to allow for provider quality of care improvement.

**Meeting adjourned at 7:40 p.m.**