

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

**July 15, 2013
Meeting Minutes**

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

Members Present: Thomas Raskauskas (Co-Chair); Victoria Veltri (Co-Chair); Paul DiLeo; Faina Dookh; William Gedge; David Guttchen; Bernadette Kelleher; Courtland Lewis; Kathy Madden; Kate McEvoy; Michael Michaud; Bill Morico; Susan Niemitz; Chinedu Okeke; Lori Pasqualini; Ron Preston; Mark Schaefer; Todd Staub; April Wang; Joseph Wankerl; Thomas Woodruff; Jill Zorn

Members Absent: Mary Bradley; Melissa Pappas; Robert Smanik; Michael Taylor; Susan Walkama

Meeting convened at 5:30 p.m.

Review updates from care delivery and HIT work groups

Care Delivery has decided on a whole person-centered, population health approach through enhanced access to team-based, coordinated care. Providers would have a low bar for entry and the ability to determine their organizational structure. Health Information Technology has aligned on the development of patient and provider portals, standardized metrics/analytics, and more integrated clinical data exchange. They have also agreed to leverage existing capabilities.

Review working hypotheses on reward structure and metrics from our last meeting

The group reviewed the consensus reached during past discussions. The group has aligned on a two track approach where providers would initially move from a fee for service payment structure to either a pay for performance or total cost of care structure, with increasing numbers moving towards total cost of care over the five year testing period. The group discussed patient aggregation levels with a minimum of 500 patients for pay for performance and minimum of 5,000 for total cost of care. The group also discussed the need for alignment on prequalification criteria and whether providers would have to meet certain milestones before moving to a higher risk model. There was discussion over which work group had oversight of the development of the scorecard. Care Delivery has defined interventions. Payment Reform has refined a list of metrics. There may be opportunity for a joint work group to emerge with representatives from each of the three existing work groups. Provider and consumer engagement is also a key component. There may be refinements as other groups provide input.

Discussion on open topics, including performance aggregation and consumer attribution

The group reviewed potential elements of clinical and legal/financial integration. At one end of the spectrum is a common legal entity. At the other end is an informal relationship. Members were asked to think about how formal the provider integration structures should be. More formal structures provide a legal and financial framework for investment. Informal structures may be easier for providers to join; however, they lack an organizing framework. Additionally, there may be FTC compliance issues that would impact the legality of certain provider integration structures.

The potential models for aggregating provider performance are corporate entities, formal "joint" ventures, virtual panels, and geographic risk pools. The first two options are connected in that all

corporate entities are joint ventures. However, not all joint ventures are formal corporate entities. In a virtual panel, services are only integrated at the payer level. They agree to aggregate data with a payer and share risk but they do not have the legal framework to reinvest or redistribute bonuses. In a geographic risk pool, there would be smaller providers without a large enough pool of patients to aggregate on their own and could participate in payer funded regional public utilities. The group will ultimately need to define the requirements for a formal joint venture. There may be safe harbor provisions that could be impacted as well.

Participants were asked to select their preferred structure. The results of the informal poll were as follows:

1. Corporate entities – 0 votes
2. Formal joint ventures – 18 votes
3. Virtual panels – 1 vote
4. Geographic risk pool – 4 votes
5. Other structure – 0 votes

There was a suggestion that options 1 and 2 be combined as they co-exist. Option 1 involves a merger of assets that does not necessarily have to occur in Option 2. There was discussion that options 3 and 4 could impact competition; however, the payment providers receive is not necessarily the same within each structure. There were concerns that Option 2 would result in a concentration of market power. Those who voted for Option 4 saw it as a counter balance that provided some integration while allowing for competition. Additional details on what is involved in Options 2 and 4 are needed. Members asked if there were geographic risk models they could look at.

Members reviewed guiding principles for consumer attribution methodology and were asked how payers should determine which patients a group of primary care providers are accountable for, as well as which provider types to attribute patients to. The group looked at three different attribution models: prospective consumer selection, prospective auto-assignment, or retrospective claims based attribution. They also reviewed existing attribution strategies from Medicaid, Medicare, Anthem, Cigna, and Aetna. Medicare and PPO-based models rely on retrospective claims based attribution. Medicaid relies on prospective auto-assignment, wherein patients who don't select a provider are assigned to one. The group discussed the importance of expanding the pool of Medicaid providers to distribute risk.

Members were reminded that an additional meeting has been scheduled for July 29. The start time has been moved to 5:45 p.m. to account for the change in meeting time for the State Healthcare Innovation Planning Steering Committee.

Meeting adjourned at 7:30 p.m.