

**State of Connecticut
State Innovation Design Model
State Healthcare Innovation Planning Steering Committee**

**September 17, 2013
Meeting Minutes**

Meeting Location: 210 Capitol Avenue, Room 410, Hartford, CT

Members Present: Lt. Gov. Nancy Wyman (Chairwoman); Victoria Veltri, Mark Schaefer, Raegan Armata; Patricia Baker; Benjamin Barnes; Mary Bradley; Roderick Bremby; Anne Melissa Dowling; Anne Foley; Bernadette Kelleher; Frances Padilla; Thomas Raskauskas; Patricia Rehmer; Tamim Ahmed; Frank Torti; Fredericka Wolman; Thomas Woodruff

Members Absent: Michael Michaud; Jewel Mullen

Meeting convened at 2:30 p.m.

Review developments in Connecticut's proposed Advanced Medical Home (AMH) model and strategy

The committee reviewed the work groups' recommendations. Since work group meetings concluded in July, project leadership has continued to meet with various stakeholders, work group and committee members to try to resolve design issues and gaps. A draft of the plan will be released in October.

The plan incorporates the concept of an Advanced Medical Home (AMH) with the core elements of 1) whole-person centered care, 2) enhanced access, 3) population health management, 4) team-based coordinated care, and 5) evidence-informed clinical decision making. The current plan is to convene a Provider Transformation Workgroup that would develop and define the AMH standards during the pre-implementation phase. That workgroup would include payer representation to ensure cross-payer alignment along with providers and consumer advocates. One of the recommendations is that accreditation might include an on-site validation survey to determine that the standard has been achieved. Transformation could occur in two phases, including a Glide Path phase that would begin with a commitment to transform and a gap analysis. During the glide path phase, providers would be eligible to receive practice transformation support. There are many practices that meet NCQA standards already and might only need to complete the validation survey. Transformation support would be provided to a given practice for no more than two years.

There was a question as to what made the AMH different from a person-centered medical home. Person-centered medical homes are associated with NCQA. The AMH would be specific to Connecticut and tied to the standards developed by the transformation work group. There was also a recommendation that electronic health record adoption be included as a requirement in the Glide Path phase.

In the Glide Path phase, practices would, at a minimum, participate in pay for performance value based payment reform. Practices would only receive payment if they meet quality standards. In order to do that, each provider would need a minimum of 500 attributed consumers. There has not been consensus yet as to whether there would be payments for care coordination during the entire glide path phase, although it is the recommendation of the core team that such payments begin

when a provider has demonstrated readiness to implement care coordination. Provider groups would eventually transition to shared savings program agreements. Under a shared savings program agreement, a provider would share in savings if they improve care (meet quality standards) and reduce spending. Provider groups would need to have at least 5,000 attributed patients in order to participate in a shared savings program.

Committee members were asked to think about two questions.

1. Should the timing of migration to a shared savings program arrangement be decided by each payer and provider, without regard to progress on standards or AMH status?
2. Should there be a validation survey that all existing and future providers would be required to meet as a condition for remaining in shared savings program arrangements?

The core team shared their preliminary recommendation that provider groups be permitted to enter into a more advanced value based payment reform, specifically, a shared savings program, prior to completing the glide path, at the discretion of the payer and provider. These agreements are already being introduced today among the commercial payers and Medicare and it seems unrealistic to propose to undo payment arrangements that are in place prior to SIM. The second is that having payment reforms such as shared savings programs in place actually makes it possible to achieve certain elements of practice transformation (e.g., replacing some visit based activity with phone and e-mail communication, which can increase access and generate revenue through shared savings, and third, the possible effect of slowing entry into shared savings arrangements and thus losing the support of payers and some providers

There was a question as to whether providers could aggregate patients across payers. There was also discussion as to what structure could be put in place between primary and specialty care to ensure that there are savings. The work groups did not prescribe a particular structure. Primary and specialty integration could be achieved by establishing a clinical integrated network.

SIM project leadership recognized that more than half of the state's primary care physicians are in contracts or negotiating contracts that move toward shared savings program arrangements. These PCPs are in 11 providers groups, such as ACOs, IPAs, or clinical integrated networks. The aim is to develop standards across payers that could be adopted that would better enable success towards shared savings goals. The reasoning behind adopting "shared savings program" terminology rather than "total cost of care" is that physicians already understand shared savings programs since Medicare established its Shared Savings Program, which is based on ACOs. Total cost of care has different meanings and could be misconstrued. Shared savings agreements are either upside risk or upside/downside risk. There was discussion as to how those agreements currently work.

Proposed governance and operating model

There was discussion of the governance and operating structure for the model. The proposal includes a healthcare innovation oversight committee, a program management office, a Healthcare Innovation HIT Taskforce, a Provider Transformation Taskforce, a Quality Metrics Advisory Council, and an Equity, Access and Appropriateness Council. The Healthcare Innovation Oversight Council would be much like the SHIP steering committee. The aim is to maintain a transparent process. The current vision has consumer advocates embedded within the advisory groups. The question was raised as to whether there should be a standalone consumer advocate group.

The Equity, Access, and Appropriateness Council would be responsible for identifying and mitigating outlier behavior such as overutilization, limiting access to certain patients, and underservice. The council could include payers, academic health center faculty, statisticians, and consumer advocates. It was noted that the council should examine race and ethnicity data. There were questions as to what sanctions could be put into place for outlier providers. There will need to be an examination of existing case law in Connecticut to determine which sanctions are appropriate. But the idea is that by increasing the visibility of these behaviors, it will discourage providers from engaging in them. This concept is not highlighted in the plans put forth from the six current testing sites and could be a means to distinguish the state's application.

There was a question about workforce development. The UConn Health Center and the Department of Public Health continue to work together on this area. Oversight may fall under the program management office or a workforce council could be established, but that is still to be determined.

Connecticut SIM savings and investment assumptions

CMMI is looking for a five year projection of the state's level of cost savings across payers. In order to do that, certain assumptions were taken into consideration: the targets for the pace of adoption, the expectations of those who do adopt, the percentage of savings that are reinvested, additional expenses such as care coordination fees, health IT investments, and implementation efforts. The numbers presented were not meant to be a forecast of the future and may not apply to Connecticut.

Research shows that 30% of health care spending is unnecessary. In examining existing models, the level of impact is 10% over the course of five years. It is more difficult to project savings in the first year than it is further down the road. The presentation provided examples from other states that showed an approximate annual savings rate of two percent. It was asked whether it would be worthwhile to use a control group to measure against. There were questions as to how the control group would be defined. The intent is not to do a pilot, the plan is to implement and make adjustments to the model as necessary.

The committee reviewed assumptions regarding the level of payer and provider adoption. The payer side is based on aggregation. The state has direct control over Medicaid and state employees and Medicare is looking to move in concert with the state; together they make up the largest percentage of the population. There is a question as to how to recruit the self-insured groups.

Looking at primary care, the data suggests it is quite fragmented; however, the Comptroller's office has identified that 62% of primary care providers have entered (or are expected to enter) into contractual agreements that move toward shared savings. The committee also examined how to achieve 80% adoption over five years with assumptions made for 2015 and 2019. In 2015, there would need to be broad payer participation with 30 percent of self-funded employers participating. The 2019 projections assume near universal payer participation. Members were asked to consider and provide feedback as to whether the assumptions were too aggressive or not aggressive enough.

The group looked at the potential cost of investment towards transformation support and care coordination. Practice transformation report has typically cost between \$1 and \$3 per member per month across payers. On the care coordination side, it is typically scaled to the actual cost of covered spend between 0.5% and 2%. HIT costs are typically aggregated over three years as a one-time cost at \$20-30 million. That number does not include electronic medical record adoption or it would be higher. The program management office figures range from state to state based on the model supported, between \$5-30 million. Those on the higher end may support multiple models or complex reform strategies such as episode based payment reforms. Connecticut would likely end

up on the lower end. Lastly, the group examined funding investment options. The SIM grant funds would typically be directed to one-time investments. The others listed (in-kind investments, premium tax, payer payments to providers, and “ACO self-funding”) represent what is happening in other states. The goal is to gain specificity as the plan is developed.

There was a request that future steering committee meetings be scheduled to allow time for more in-depth discussion of the complex issues being presented. It was also suggested that the State Innovation Model web page be updated to include a section on critical questions for stakeholders to consider and provide reactions, thereby allowing a richer conversation.

It was also noted that as a result of Medicaid payment reductions to hospitals in the FY 2014-15 biennial budget, the state is working with hospitals to explore ways to help hospitals absorb the reductions while meeting the state’s healthcare reform goals. The discussions are in preliminary stages, focusing on payment reform under which hospital payments would be tied to quality metrics such as reduced readmissions, improved outcomes, etc. It was further noted that this work is closely associated with the envisioned shared savings model in the State Healthcare Innovation Plan. The SHIP steering committee will be kept informed of the progress in this initiative.

Meeting adjourned at 4:10 p.m.