



STATE OF CONNECTICUT  
LIEUTENANT GOVERNOR NANCY WYMAN

## Health Care Cabinet: Delivery System Innovation Work Group

Monday, December 5, 2011  
Meeting Minutes

**Cabinet Attendees:** Co-Chairs: Patricia Baker and Patricia Rehmer; Mark Borton; Margaret Smith; Victoria Veltri; Ellen Andrews; Alfreda Turner; Nneka Mobisson-Etuk; Judy Stein; Joanne Walsh

**Office of Health Reform & Innovation:** Alexis Fedorjaczenko; Jennifer Castillo

**Office of the Healthcare Advocate:** Africka S. Hinds-Ayala

**Guest:** Mark Schaefer (Department of Social Services)

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Co-chair Patricia Baker opened up the meeting by welcoming new attendees and members. The minutes were approved with some corrections by Alfreda Turner to give to Africka S. Hinds-Ayala.

The singular agenda item for today's meeting was to receive a presentation from Mark Schaefer, Director of the Medical Care Administration from CT Department of Social Services. He presented on their experience implementing delivery and payment reform and innovation for Connecticut's Medicaid population. The presentation can be found at this link: [Public Sector Healthcare Service Delivery & Purchasing Reform](#).

Mark Schaefer presented specifically on DSS's migration of intensive care management through the integration of a Medical Administrative Services Organization, Person-Centered Medical homes, and Integrated Care Organizations (for Dual Eligibles). A single statewide Medical ASO allows for the ability to effectively track local providers' experiences, outcomes, and costs by incorporating informatics, cost and data aggregation. DSS has designed a glide path to incentivize and support practices that want NCQA recognition as a PCMH; support includes some financial provision, ASO support, and gap analysis. The ICO program model is focused on creating dynamic and innovative systems of care and support that rewards for providing better value over time. More detail can be found in the presentation included above.

Several questions arose throughout the presentation. Questions regarding the Medical ASO targeted the following:

1. Risks: Single-managed care organizations assume many risks, but this is not necessarily true in an administrative model. ASOs are self-insuring and have the necessary tools to mitigate the risk impact. Furthermore, DSS has a modest profit margin to reward performance if they meet certain objectives.
2. Emphasis on integration: The workgroup recognizes this is a long-standing challenge. DSS has worked towards eliminating fragmentation of oral health, behavioral health, mental health, and other services with the simplification of dedicated ASOs for the entire covered population. The State needs to establish specific coordination mechanisms and performance measures to identify successes and failures.

Questions from the Person Centered Medical Home focused on:

1. Recognition: DSS chose NCQA because it is the most widely recognized and accepted standard. NCQA is also multi-payer compatible. However, DSS is open to considering other standards.
2. Treatment of Medicaid patients is not limited to NCQA accredited PCMHs. This is just a special designation. DSS will continue to have an entire network of physicians and hospitals available for the covered population.
3. Branding: There is concern over the consumer understanding of “medical homes.” The term “health care home” was suggested to be more appropriate.
4. Risk adjustment: This is currently beyond the scope of DSS. There is some reward for treating more “high-risk” populations, but a risk-adjusted methodology has not yet been developed for launch. The payment system is naturally risk-adjusted so that providers seeing sicker patients receive more reimbursements than those seeing healthier patients. DSS anticipates migrating to a prospective PMPM by 2014.

During the ICO segment, questions were asked on the following:

1. Differences between ACO and ICO: There is no natural fit between an ACO and ICO; DSS views an ICO as an “ACO plus.” DSS is developing 2 ICO models organized around health homes and ACOs.
2. Benchmarks: As of yet, these are not assessed individually but are based on the entire state. The lack of risk-adjusted methodology makes it difficult to determine what is being factored in.
3. From a dual-eligibility focus, Medicare fee-for-service rules supersede all other rules. In an ICO, dual-eligibles are entitled to the same Medicare coverage as they would be outside of an ICO.

Co-Chair Patricia Baker requested DSS recommendations for the workgroup to consider and discuss further.

1. Coordination amongst the payers to set up compatibility. This not only relates to performance measures, but to the standards and expectations of our initiatives.
2. There is some concern over current Medicare shared plans. As it stands now, an ACO and PCPI program may have more to gain financially if patients are admitted to a nursing home. They both reward Part A and Part B reductions, but they also allow for – and encourage – more Medicaid and Part D pharmacy spending.

The workgroup unanimously agreed to meet sometime in January; Africka S. Hinds-Ayala will coordinate the scheduling. Patricia Baker acknowledged Alexis Fedorjacenko’s departure from the Office of Health Reform and Innovation, thanking her for all her hard work. Victoria Veltri suggested a presentation from provider organizations to consider their concerns and suggestions. Joanne Walsh specifically recommended hearing from Middlesex Hospital.

Patricia Baker then opened the floor for public comment. There were no comments from the public.

Meeting concluded.