

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

Monday, May 20, 2013
Meeting Minutes

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

Members Present: Dr. Thomas Raskauskas, Chairman; Victoria Veltri, Co-Chairwoman; Deputy Commissioner Paul J. DiLeo; Bernadette Kelleher; Dr. Courtland Lewis; Kathy Madden; Kate McEvoy; Lori Pasqualini; Robert Smanik; Dr. Todd Staub; Susan Walkama; Joseph Wankerl; Dr. Thomas Woodruff

Meeting convened at 5:30 p.m.

Introductions and Connecticut SIM project context

After participant introductions, an overview of the initiative was provided. The goal of the SIM is to create a model that transforms the way health care is delivered in the state by addressing issues such as access and quality of care. The model must touch 80% of the state population across carriers (Medicare, Medicaid, commercial) within five years. The model must be patient centered. Three work groups have been established to tackle particular aspects of the model: Payment Reform, Care Delivery, and Health Information Technology with work group decisions flowing up to the State Healthcare Innovation Planning team. A reference document containing terms and acronyms was introduced. The purpose of the reference document is to ensure that everyone has the same understanding of terms being used going forward.

Discussion exercise on current fee-for-service payment model in Connecticut

The participants broke out into small groups to discuss their personal and professional experiences with the fee-for-service structure and the pitfalls they have experienced as a result of this model.

Group 1 talked about the grey areas in the system. There is poor coordination of care which leads to a high cost to the state with little incentive to stop. The whole person is not at the center of this system. Primary care focuses more on triaging which impacts the effective use of physician's time.

Group 2 talked about care coordination and moving away from working in silos in order to better attend to those with complex care needs, particularly those with psychiatric conditions. They also discussed systems management and creating a system that addresses primary care but also incorporates populations with greater health complexities and poorer outcomes.

Group 3 discussed the unavailability of after-hours service, the lack of coordination, long waiting times for five minute long visits; and the lack of sharing of electronic health information. Payment is focused on actual visits so that there are services that are performed but not paid for. The system doesn't capitalize on potential intervention areas.

Group 4 discussed the discrepancies in the fee structure based on location and payer. There is a financial disincentive to providers to handle more than one issue in a visit. There was discussion of providing more effective incentives based on outcomes both to the provider and to the patient to encourage better decision making. They also talked about the need to encourage input from consumers.

Guiding principles for payment reform

The group discussed guiding principles for payment model reform, including the principles that:

- Providers should be rewarded for effective behaviors (quality and cost)
- If successful, providers will be held accountable for elements within the scope of provider control
- Payment model must be financially sustainable
- Payment model should help improve – not detract from – patient access and health equity
- Payment model should complement and enable the care delivery model
- Variation in payment model should be based on patient needs, not the needs of the health system
- The payment model should leverage and be complementary to ongoing initiatives in the state

Strategic design decisions for payment model design

The group discussed four design considerations: metrics, payment, attribution, and rollout.

Participants highlighted patient incentives, as well as patient and employer public education as key considerations moving forward. It was also suggested that patient engagement incentives should be incorporated as well.

There was discussion of how to achieve buy-in from payers. In addition to Medicare, Medicaid, and commercial carriers, many employers provide coverage through self-insurance. There are differences in care among all of those groups. Rhode Island established affordability standards. In Connecticut, however, the system is voluntary. In order for health disparities to be addressed, solutions will need to be tailored toward specific populations. The model must be based on patient needs and not the needs of the healthcare system.

Joint alignment on work group's scope of work

The group reviewed the work ahead. Members were asked to bring their perspectives to future meetings. The goal at the end is to develop a model that is conceptually aligned without necessarily being one-size-fits-all. Members were also asked to provide suggestions for the reference document.

Meeting adjourned at 7:30 p.m.