

**State of Connecticut
State Innovation Model Design
Payment Reform Work Group
June 17, 2013
Meeting Minutes**

Location: CT Behavioral Health Partnership, 500 Enterprise Drive, Crandall Room,
Suite 4D, Rocky Hill

Members Present: Dr. Thomas Raskauskas (Chairman); Ms. Victoria Veltri (Co-Chair); Mr. Paul DiLeo; Ms. Bernadette Kelleher; Dr. Courtland Lewis; Ms. Kate McEvoy; Ms. Lori Pasqualini; Mr. Robert Smanik; Mr. Michael Taylor; Mr. Joseph Wankerl; Dr. Thomas Woodruff

Members Absent: Ms. Mary Bradley; Mr. William Gedge; Ms. Kathy Madden; Dr. Todd Staub; Ms. Susan Walkama

Meeting convened at 5:30 p.m.

Introductions were made. The main focus of today's meeting is to gather information from the group to determine the optimal reward structure for Connecticut and what metrics will be used.

Continue last week's discussion on the optimal reward structure for Connecticut's payment model

Each group member voted on their beliefs as to whether a one-track or two-track approach should be used to reach the end-state reward structure was given the option the options to vote on reward structure.

The majority, fourteen out of the twenty-one individuals, voted for the two-track approach converging over time (within 5 years): those able to accept gain/risk sharing today can do so; others starting in P4P and progress to gain/risk sharing over time (within 5 years). One reason this structure was chosen was because it has a realistic time frame and a good starting point. Several work group members also noted that the ultimate goal should be full risk sharing. Reasons for electing other options were based upon specialty populations, such as mental illness, poverty, substance dependent and small community-based behavioral health providers. There was a consensus that there is a need to understand the risk involved for providers and determine whether the payment model will include downside risk versus upside only. The group also agreed that parameters should be set and to avoid capitation as it creates disincentives to access to care.

Discuss metrics that can be used to hold providers accountable

The group discussed types of metrics that should be required, including

- Patient experience
- Total cost of care
- Measurement of disparities
- Care transitions
- Assess to care

The group also discussed possible considerations, such as,

- Should these metrics be relative or absolute?
- How standardized should metrics be across payers?
- What structures will be required?

The group discussed that a common set of metrics is needed and that there must be accountability around transition of care. There needs to be a balance, (i.e., chronic vs. curable conditions). Throughout the conversation, emphasis was placed on the importance of considering the impact of metrics on improving consumer experience.

The work group broke out into three smaller groups to discuss the set of interventions to promote within Connecticut that have been outlined by the Care Delivery work group. Each group was tasked with reviewing these interventions, add or revise the suggestions and to indicate if the CMMI core measures were sufficient to measure performance against these interventions, or whether additional metrics would be needed.

Group 1 discussed:

- Need for tactical care plan with goal setting
- The importance of patient engagement
- Questioned degree of prescriptiveness
- The challenge of varying population types
- Possibility of patient providing the provider with a health status “report card”

Group 2 discussed:

- Timeliness of Access
- Patient portal that provides websites (i.e. indicating hours, variety of languages, various apps)
- ED visits vs. admissions
- Ambulatory care sensitive admissions
- Medication compliance

Group 3 discussed:

- With a common set of metrics, can/should providers have a different set of benchmarks?
- An embedded care coordinator in practice or system-too prescriptive

The next meeting will be held at 5:30pm on Monday, July 1st.

Meeting adjourned at 7:35 p.m.