

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

**July 1, 2013
Meeting Minutes**

Members Present: Dr. Thomas Raskauskas (Co-Chair); Ms. Victoria Veltri (Co-Chair); Mr. William Gedge; Ms. Jennifer Hutchinson (for Mr. Paul DiLeo); Dr. Courtland Lewis; Ms. Kate McEvoy; Mr. Bill Morico; Ms. Susan Niemitz; Dr. Chinedu Okeke; Ms. Lori Pasqualini; Mr. Robert Smanik; Dr. Todd Staub; Mr. Michael Taylor; Ms. Susan Walkama; Ms. Cheryl Wamuo; Ms. Deremius Williams (for Bernadette Kelleher); Dr. Thomas Woodruff

Members Absent: Ms. Mary Bradley; Ms. Kathy Madden; Mr. Michael Michaud; Ms. Melissa Pappas; Dr. Mark Schaefer; Ms. April Wang, Mr. Joseph Wankerl

Meeting convened at 5:30 p.m.

Review working hypothesis on reward structure from our last meeting

The group reviewed the meeting agenda. They will revisit their past discussion regarding a version of a medical home score card. They will further discuss quality measurement and how to reward performance. One of the key decisions the group discussed was whether to reward absolute performance or performance improvement. Additionally, they will try to discuss provider/payer fragmentation.

At the previous meeting, the group aligned on a two-track approach to a reward structure that will enable providers to adopt the innovate reforms. Currently in the state, a majority of the consumer population is being served by providers paid for by a fee for service structure, with some paid by a pay for performance structure and fewer still paid through a total cost of care structure. The first three years of the model would see providers moving away from fee for service, with most adopting a pay for performance structure and an increased number moving towards total cost of care. In years 4 and 5 of the model, the majority of providers will have moved to total cost of care. This would be a bonus payment system that would sit on top of a fee for service structure. In pay for performance, the model is driven off of bonus payments tied to quality and utilization. It was noted that some practices may not move from pay for performance to total cost of care by year 5. The goal remains that, by Year 5, there will be total cost of care accountability for 80% of the state's population.

Continue last meeting's discussion on quality measurement in Connecticut's payment model

The group also began creating a scorecard for performance metrics. The group looked at CMMI's measures and suggested some that were Connecticut specific. The group will need to look at the initial scorecard and narrow the list to select a subset of the current list, as well as look at staging for each year of the model. The Payment Reform and Care Delivery work groups can begin working to bring their pathways together. The group favorably looked at the Choosing Wisely campaign as a means of consumer-provider engagement to make right choices.

Discuss the level of performance we wish to reward

The group voted on which criteria should be met in order to qualify for rewards. The results were as follows:

Option 1: Providers should be rewarded for improving quality, and experience independent of impact on cost/utilization – **1 vote**

Option 2: Providers should be rewarded to creating savings for the system, independent of impact on quality/experience – **0 votes**

Option 3: Providers must create savings for the system and achieve standards for quality/experience to earn rewards – **4 votes**

Option 4: Providers may receive rewards for quality alone in year one, but must achieve quality and savings in future years – **11 votes**

Option 5: Another option – **1 vote**

Members who selected Option 3 said there needed to be savings to pay for the rewards and that pay for performance is not new. Those who selected Option 4 said that it fits in with the direction Medicaid has been moving and that quality should be a principal driver. In Medicaid's dual eligibility initiative, the focus was first on quality and then on cost. Members said the problem with Option 3 was wording and that quality must come before cost. Option 4 also fits in with the idea of the two reward tracks, allowing for an on-ramp system. There was concern that one year for quality improvements may not be enough, particularly with behavioral health. Additionally, with the potential for increased enrollment due to the opening of the insurance exchange, costs will initially increase.

It was asked who would monitor consistency after year 1. If the state's grant application is approved, there would be an oversight committee responsible for overseeing the transformation. The group also discussed the need to include technical assistance within the grant proposal to guide providers through the transformation process.

The group took a vote on the level of performance that should be rewarded for each reward track. The results were as follows:

Option	P4P Votes	TCC Votes
1. Absolute performance	2	2
2. Performance improvement	2	1
3. Both absolute performance and improvement (e.g. progressive rewards)	14	13
4. Another option	1	0

Those who selected Option 1 said provider thinking needed to change and the model should encourage dramatic shifts in improvement. The model should encourage competition. The group discussed what is currently used in the state – HEDIS measures. In Connecticut, providers fall between 25% and 50% on HEDIS measures. Other states start at 50%. There was discussion as to whether the goal should be an absolute target (everyone at 50%) or whether they would be rewarded for substantial shifts (e.g. an improvement from 15% to 30% as opposed to improvement from 50 to 55%). There was also discussion on whether a minimum quality bar must be met before a provider can qualify for a performance improvement payment (e.g., no reward beneath 25% regardless of improvement or a reward if performance is improved from 5% to 20%). There was concern about discouraging providers if they didn't move "high enough." Benchmarks should be realistic. Those already at a high level should be rewarded as well.

There was discussion on which providers would be impacted by this transformation. The initiative would impact providers who take responsibility for managing the care a population of patients. This could occur on a continuum from a formal accountable care organization structure to loosely coordinated transition contracts. However, by Year 5 of the initiative, 80% of the consumer population should have their care provided to them by providers being held accountable for the total cost of care.

Discuss provider/payer fragmentation in Connecticut

As the group is building a common scorecard across a series of measures, they discussed tying metrics to patient population. They examined a recommendation for the size of each population group: low is below 100 patients, moderate is 100 to 1,000, and high is 5,000 and above. In order to reward on processes and outcomes, a broader population pool is needed. It was recommended that the total cost of care model use a high population pool. The pay for performance model could use a moderate level (500 patients). Less than half of primary care physician office sites have the 5,000 patients needed to support the total cost of care model. While all providers had enough patients to support the pay for performance model, there would need to be cross-payer data aggregation in order to support total cost of care.

The group looked at options related to purchaser aggregation and provider aggregation. On the purchaser side, the employer could agree to pool data with a certain payer, such as all Anthem clients. The group talked about employee incentives. As access to services is a key element of the grant application, those incentives should not come at the cost of another group (e.g. setting different hours for patients based on their payer). There can be no disparate treatment or denial of care on the provider side. The group will need to further examine how aggregation can occur. Similar employer groups could pool together. Medicare, Medicaid, and Anthem had large enough pools to be able to aggregate on their own but that may be more difficult for the smaller payers. There is a need, however, to look across payers to ensure there is quality of care and no disparate care.

Review decisions made in our meeting and next steps

At the July 15th meeting, the group will spend additional time discussing provider aggregation. This was described in simplified terms: geographically grouped providers, an ACO model (a contractual agreement between otherwise independent providers working together that defines reward distribution), and a virtual model (payer aggregates providers and determines the reward distribution). In addition, the group will look at the formality of the structure. There may be some legal issues to examine. Also, any savings must be reinvested.

With much work remaining, it was decided that an additional meeting would be added on July 29.

Meeting adjourned at 7:30 p.m.