

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

**July 29, 2013
Meeting Minutes**

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

Members Present: Thomas Raskauskas (Co-Chair); Victoria Veltri (Co-Chair); Paul DiLeo; William Gedge; David Guttchen; Bernadette Kelleher; Courtland Lewis; Kathy Madden; Kate McEvoy; Lori Pasqualini; Todd Staub; Joseph Wankerl

Members Absent: Mary Bradley; Melissa Pappas; Robert Smanik; Michael Taylor; Susan Walkama; Thomas Woodruff

Meeting convened at 5:50 p.m.

Consider approach and level of standardization required on consumer attribution

Group members received an update on the status of the plan development. The state has applied for, and expects to receive, a 60 day no-cost extension to complete and submit the plan. There is a need for additional consumer engagement. The goal is to have a draft plan complete by Labor Day. There will be additional focus groups and e-surveys. There is nothing official to share yet. When group members see the draft, many details will be elaborated. There was a question regarding when the model would be implemented. An overview of the work ahead was provided. The innovation plan will be submitted to CMMI in December. There is an expectation that CMMI will release grant guidance in December. The grant application will be based on the plan but will include more technical details. If Connecticut is awarded a testing grant, it would likely come through in the summer of 2014 with a limited amount of funding available in the first few months. However, there is nothing that says the state has to wait until 2014. Some of the details will need to be finalized, such as what aspects of the plan should be earmarked for grant funding. The expectation is that January 2015 will be the earliest payers will come on board. Payers may need to amend their existing agreements to align with the common scorecard.

The group reviewed its prior discussion regarding potential models for providers to manage total cost of care and quality. The feedback has been in favor of a formal structure as opposed to virtual patient panels. There are concerns that encouraging providers to enter into formal partnerships may foster an environment of wholesale consolidation and eliminate competition. There may be third party vendors that can provide technical solutions; there may also be alternatives to Accountable Care Organizations (ACOs), such as geocentric utilities that smaller providers could utilize, thus preserving independence. There was discussion as to whether there could be an integration path where providers start out in loose independent practice associations and then move towards more formal corporate entities. There are existing programs and opportunities that may help to support provider integration, including CMS initiatives. There have also been ongoing discussions regarding improved behavioral health integration.

An informal survey has shown that approximately half of all primary care providers are already in some sort of formal affiliation. Some of those affiliations may be in name only, others may just be in terms of purchasing office supplies, but there may be the groundwork for further integration.

There may be a need to more firmly establish the necessary requirements for integration. There are plans to further examine existing provider relationships, with a report available by the end of September.

The group reviewed guiding principles for consumer attribution. There are three potential methodologies: prospective consumer selection, prospective auto-assignment, and retrospective claims based. Under auto-assignment and claims based attribution, specific rules need to be put in place with regard to time frame, plurality of visits and minimum frequency. One insurance provider does attribution through claims as clients don't always provide updates. The payer will honor the physician listed for 13 months and then they will assign them based on the actually providers they visited. In terms of behavioral health, there has been discussion about dual attribution where the behavioral health provider may serve as the "organizer" with the ability to bring in primary care. Medicaid allows for OB/GYNs to serve as primary care providers to reproductive aged women. There was discussion as to whether, in the model, attribution should be limited to only primary care (internal medicine, pediatrics, family medicine). There was also discussion as to the timing of attribution. It was suggested that it may be difficult to make a decision until the network and practitioner level standards are determined. Attribution remains a critical component, as it can impact assets.

There was a question of how to attribute those who may be receiving care that is not through a primary care provider. Currently, most attribution is done retrospectively. In Rhode Island, insurers assign clients to a PCP through a policy lever. The end goal is not just to assign people to a primary care provider, but that primary care is available to them. There may be a need for an educational component that encourages people to choose a PCP and teaches them why it is important. Retrospective attribution gives people the ability to choose their primary care provider. Providers may not want to be responsible for a patient they have not seen. One insurer found that clients were not happy with geographic based auto-assignment because they may live in one area and work in another. For those who don't have an assigned PCP, it may be beneficial to assign them to one initially to establish a relationship. If attribution is based on which provider a patient saw most, it may encourage PCPs to provide better quality care to encourage patients to come back. There remain a number of details to work out on this issue, which the work group members will revisit in September.

Review our recommendations on payment model design

The group briefly reviewed the summary of recommendations. The draft plan will be built based on those recommendations. Members were asked to provide feedback if they believed recommendations did not reflect the consensus of the work group. The group will likely regroup in January to provide feedback on the plan. The SIM core team and program planners will continue to work through the areas where further detail is required. There are also plans to institute a work group devoted to metrics. The metrics work group will work on further developing the scorecard. The scorecard may not be completed by the time the plan is submitted but the goal is to have it completed by March 2014 when testing grant applications may be due. There was a request to receive the summaries of recommendations from the other work groups.

Discuss process for ongoing refinement and broader syndication

Group members were thanked for their time and asked to provide their thoughts on the process. Members were encouraged to send e-mails with additional comments. The target for the release of a preliminary draft is after Labor Day.

Meeting adjourned at 7:50 p.m.