

SustiNet Health Partnership Board of Directors

Co-Chairs
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State Comptroller

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State Healthcare Advocate



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Board of Directors Regular Meeting

September 22, 2010

Meeting Minutes

Board Attendees: Nancy Wyman, Comptroller, Co-chair; Kevin Lembo, Healthcare Advocate, Co-chair; Ellen Andrews; Doreen Del Bianco; Bruce Gould; Paul Grady; Bonita Grubbs; Jeffrey Kramer; Marie Spivey; Cristine Vogel; Paul Lombardo (designee for T. Sullivan – DOI); Alex Hutchinson; Marie Smith; Margaret Flinter; Joseph McDonagh

Office of the Healthcare Advocate: Africka Hinds-Ayala; Vicki Veltri

Office of the Comptroller: David Krause

SustiNet Advisor: Stan Dorn (via phone)

SustiNet Consultants: Linda Green; Katharine London; Anya Rader Wallack

Absent: Michael Critelli; Jeannette DeJesus; Norma Gyle; Nancy Heaton; David Henderson; Jamie Mooney; Lucy Nolan; Rafael Perez-Escamilla; Andy Salner; Marlene Schwartz; Todd Staub; Thomas Sullivan; Tory Westbrook; Estela Lopez; Sal Luciano; Michael Starkowski

Kevin Lembo opened the meeting by welcoming all attendees and asking Board members to introduce themselves. Minutes from the September 8, 2010 meeting were approved with no changes.

Anya Rader Wallack, Linda Green, Katharine London and Stan Dorn gave a presentation regarding SustiNet – Healthcare Delivery Systems and Payment Reforms. To access the presentation, [click here](#).

Paul Grady said he thought the Health Information Technology (HIT) recommendation didn't require funding from SustiNet to promote the adoption of electronic health records. Anya said this was still an open question, adding that there were lots of federal incentives for providers to invest in this. It would be necessary to evaluate this over time to determine what additional investment would be needed and to what extent it would be an appropriate SustiNet function. Standardization will occur, and there will be some investment at the provider level as a result of funds that are now available. Stan said that 2009 legislation called for using CHEFA's bonding authority to help overcome the capital formation barriers facing providers. The providers would potentially subscribe to repay the bond over time. Marie Smith added that the

Board of Directors

Bruce Gould • Paul Grady • Bonita Grubbs • Norma Gyle • Jeffrey Kramer
Estela Lopez • Sal Luciano • Joseph McDonagh • Jamie Mooney

SustiNet Health Partnership

HIT Committee made a recommendation that when the decision about funding is made, the Board should be fully informed of other activities and decisions being made for funding through other avenues in the state. Alex Hutchinson commented that HIT and Patient Centered Medical Home (PCMH) are so intricately linked that whatever payment reform is built in has to recognize the upfront investments that practices and providers are making, so there is a multilevel approach to looking at this. Marie Spivey mentioned the importance of considering the providers' education and training needs.

There was discussion about Pay for Performance (P4P). It was mentioned that this could be called Pay for Improvement because it's more about improvement from providers at the bottom of the scale than it is about asking providers who have already reached those benchmarks to improve their performance. Anya said that different thresholds can be set so that everyone improves according to an individualized baseline. This is more complex, but more sophisticated and provides a better way of doing things. There are many different ways to structure this. Bruce Gould said that studies that have looked at pure P4P have found that high functioners tend to get higher and those at the bottom tend to stay where they are or sink. He suggested being creative with the P4P model in order to bring the bottom up yet keep the top feeling good about what they are doing. Margaret Flinter said there is a need for practices to have access to predictive modeling, adding that this ties to the issue of care coordination. Most people don't need care coordination, but it's important for practices to identify patients who are at high risk for hospital admissions. In addition to pay for performance, this is about identifying opportunities for the greatest savings and reduction in suffering and misery. Margaret emphasized the importance of having good data in order to address this.

There was discussion about pilot programs, including the state employee PCMH pilot. Katharine said that this provided a great demonstration of what is possible. Nancy Wyman said that it provided a good base from which to go forward. Katharine said large practices will be easier to convert to medical homes than small practices. Paul commented that healthcare in CT is largely comprised of small practices, so it will be slow to roll out PCMHs here. Katharine said this would prove to be a challenge, although it's not insurmountable. Independent practices can work together on care coordination if they choose to. Cristine Vogel said three quarters of CT's physicians belong to groups of less than three. There is already some movement in communities where small groups will be able to join together in order to become part of a larger network, while still maintaining their autonomy. Cristine asked when the state employee pilot would start and when data would be available. Nancy said it's being worked on presently, having been started in July. Alex mentioned that Connecticut Medical Society (CMS) IPA is conducting another initiative called the Patient Centered Practice Model, a patient centered medical home. There are over 1,200 physicians and 400 practices, both primary care and specialty, that are participating, and about 2,000 members through Medicare contracts. Alex said CMS is trying to organize the small practices to provide infrastructure, support and training for medical homes. Bonita Grubbs suggested adjusting the model to include incentives for small practices to participate. Bruce said it would be important to have a public utility as part of this, because residents coming out of training tend to choose larger group practices. This generation of clinicians seeks benefits, and doesn't want to be required to be available 24 hours per day/7 days a week with no backup in a two or three person practice.

There was discussion about potential recommendations for HIT. Stan suggested the Board explore how to financially support the development of HIT without recourse to general fund dollars, i.e. using CHEFA's bonding capacity and through negotiating on behalf of the state's providers for reduced cost software and vendor support. It may make more sense for this to

SustiNet Health Partnership

be addressed by HITECT rather than SustiNet. Marie Smith said that HIT encompasses a wide array of activities, so it is important to emphasize the use of EHRs.

Paul suggested there be collaboration with other payors to ensure equitable approaches to payor fees, and this should be addressed in the recommendations. Stan commented that the PPACA presents some extraordinary opportunities for states to pursue aligned multipayor initiatives. One option is to seek a Medicare waiver from the Center for Medicare and Medicaid Innovation to include Medicare in whatever payment reforms are being implemented. Another option is to use the exchange, and include a restriction that plans can't offer their products in the exchange unless they implement certain reforms. By doing this, the state can present providers with aligned incentives in similar practices across the board, and this can be a very powerful tool.

An unidentified speaker commented that perhaps language should be included in the recommendations regarding improving the health literacy of SustiNet consumers.

Cristine said that any demonstration projects involving Medicaid will require the Department of Social Services to be the lead agency rather than SustiNet. Stan agreed, saying that formally DSS will be the applicant, but DSS could operate in the context of the SustiNet plan. Anya added that some pilots are more provider-driven, where a provider or group of providers asks to implement certain measures, so SustiNet won't always take the lead but could be part of it. Cristine mentioned that concerning P4P, practices would not be able to have any incentives for Medicaid patients unless the state and CMS were involved, so this becomes complicated and limited. She added that there are competitive demonstration projects and that SustiNet would need to choose carefully to get the largest demonstration project with the least cost to the Medicaid system, due to the current deficit. Anya added that historically, federal demonstrations have always required budget neutrality, which is a limiting factor, but there is an exemption for Medicaid ACO, so there is a bit of flexibility. Stan said beginning 1/11/11, there will be planning money available for states to implement PCMHs, providing states with a 90% federal match for chronically ill Medicaid patients for the first eight calendar quarters of implementation. This is unaffected by budget neutrality or any other waiver consideration. The Center for Medicare and Medicaid Innovation also provides many opportunities for funding.

Anya welcomed additional suggestions from Board members on the recommendations outlined today. She said the October 13th meeting would address administration and governance, the November 10th meeting will cover costs and financing, and the December 8th meeting will be a review of the draft report.

Kevin asked to change the date of the November meeting from the 10th to the 18th and there were no objections. He said that Douglas Gould & Company, the communications consultant, is on board to assist with planning the community forum and articulating SustiNet more clearly for the public. Kevin said that forum dates will be posted on the website once determined, and information to be used at the forum will be reviewed by the Board beforehand.

Meeting was adjourned.

Next meeting will be 10/13/10 at 9:00 am in LOB Room 1B.