

**STATE OF CONNECTICUT
HEALTHCARE INNOVATION STEERING COMMITTEE**

**Meeting Summary
Thursday, April 24, 2014**

Members Present: LG Nancy Wyman (Chair); Patricia Baker; Jeffrey Beadle; Patrick Charmel; Anne Melissa Dowling; Bernadette Kelleher; Suzanne Lagarde; Robin Lamott Sparks; Alta Lash; Robert McLean; Jane McNichol; Frances Padilla; Thomas Raskauskas; Patricia Rehmer; Jan VanTassel; Victoria Veltri; Thomas Woodruff

Members Absent: Tamim Ahmed; Raegan Armata; Mary Bradley; Anne Foley; Courtland Lewis; Jewel Mullen; Frank Torti; Michael Williams

Meeting was called to order at 10:05 a.m.

Public comment

Sheldon Toubman spoke about Issue Brief #2 and expressed concerns that options B and C could undermine the quality goals of the State Innovation Model. He said case management services are recognized as bringing value and should be funded. He also said that tying shared savings to advance payments could provide a disincentive to offer new services or activities. Mr. Toubman was among a group of advocates who submitted comments on issue briefs (see Correspondence #2 [here](#) and #3 [here](#)).

Approval of April 22 meeting summary

After the Chair welcomed everyone and introductions were made, the committee began to discuss the minutes from the April 22 special steering committee meeting. Due to a lack of time for review, it was decided approval of the minutes will be postponed the committee's next meeting.

Correspondence

The committee received correspondence for review and consideration (see Correspondence #1 [here](#) [#2 and #3 linked above]). The correspondence deals with the workgroup charters and issue briefs. The committee decided to take the correspondence into account later in the meeting when they discussed the charters and issue briefs.

Revised work group charters

The committee reviewed the proposed Equity and Access Council charter, which served as the focus of the discussion. There was concern over use of the word "intentional," with some concerned that this posed too high a standard. For this reason "intentional" was not included in the revised draft. The committee considered whether to use no modifier when referring to under service or to use "systematic" or "repeated" as included in the draft. In discussions, there has been some agreement that "systematic" is the intention. It was suggested that it is important to strike a balance. There was also discussion over the use of the phrase "evidence based" as certain treatments may not fall into that classification. There was concern that evidence based may be too high a standard. There was also concern that the charter considers equity in isolation without taking quality metrics into account. It was suggested that "medically necessary" be used in place of "evidence based" in keeping with the language of the Affordable Care Act.

There was discussion as to whether providers who chose not to participate in Medicaid would be considered to be denying care. That question posed larger issues. Providers who choose not to enroll typically make that decision based payment rates. There is also the potential for greater liability with certain populations. One question raised was what equating Medicaid denial with under service would mean for health plans as a whole, including whether such a measure would prohibit private health plans from deselecting physicians. It was suggested that the work group could examine that issue and provide a recommendation to the steering committee to act on.

Motion to accept “systematic or repeated” as the qualifier of under-service and to include the added sentence “A finding of failure shall not require proof of intentionality or a plan” in the Equity and Access charter – Jane McNichol; seconded by Suzanne Lagarde.

It was suggested that “evidence-based” be left out of the charter for the time being.

Vote: all in favor.

Motion to charge the Equity and Access Council with recommending whether “evidence based” should be included going forward in the measurement of under service – Victoria Veltri; seconded by Thomas Raskauskas.

“Evidence-based” may be the phrase used in the Affordable Care Act and, as such, it was suggested that it may be appropriate to include it in the charter language. Further research may be required and may not apply in all situations.

Vote: all in favor, one abstention.

Issue Brief #4: Strategy/advanced providers/systems

The committee reviewed a presentation on issue brief #4 ([found here beginning on page 3](#)). The issue brief poses two questions: whether to establish additional expectations for advanced networks and FQHCs over and above the core AMH standards; and whether to allocate SIM test grant dollars to provide support to advanced networks and FQHCs.

There was a question as to how a mid-sized practice is defined. The number of physicians per practice has not been defined in the State Healthcare Innovation Plan. In terms of regional extension centers under the ACA it has been defined as 10 or fewer physicians but economically it could be six or seven. A small practice is typically one to two physicians.

There were concerns regarding the ability of small practices to adopt all of the recommended AMH capabilities. There may be the ability to establish community resources to support transformation at the smaller level. Concerns were also expressed that transformation not lead to large scale consolidation. As Connecticut has a large percentage of small physician practices and the goal is to touch 80 percent of state residents, someone suggested the importance of taking a flexible approach to practice transformation. It was suggested that a practice survey be conducted to be able to make a more informed decision.

There was a question about the difference between the CT SHIP’s Advanced Medical Home (AMH) and NCQA’s Person Centered Medical Home (PCMH). It was noted that PCMH has been at the center of Medicaid’s reform efforts. Several reasons were noted including that achieving NCQA certification does not necessarily translate into changes in practice. Additionally, NCQA does not require recertification. The State wanted the flexibility to require standards that aren’t currently in

use by NCQA. In addition, it was suggested that the process can be quite burdensome for a small practice and there is evidence that transformation can be successful without requiring that a practice undertake a formal certification process.

Going forward, there was agreement that the steering committee will need to recognize and address competing issues, and how to best integrate with social services, faith-based groups, and non-traditional primary care entities without causing harm to existing programs.

Issue Brief #3: Glide path administration

The committee discussed the idea of working with the Department of Social Services (DSS) on the glide path program ([issue brief found here](#)). DSS has driven the Medicaid glide path for several years. One idea is to use the DSS infrastructure for glide path enrollment. This would require making the system multi-payer capable without disrupting Medicaid's person centered medical home program. The program management office envisioned that staff support for the multi-payer glide path would be at DSS. The issue brief seeks to frame a potential solution or strategy for existing questions.

One suggestion was allowing federally qualified health centers to join the glide path, as they are prohibited from doing so under Medicaid. It was asked whether the current glide path would be adopted with the only change being to make it multi-system. It was also asked whether practices would have to be NCQA certified. It was clarified that the use of the DSS glide path was to achieve an efficient operational process rather than to adopt DSS' current glide path policies. Practices would not be required to enroll in the NCQA process.

Issue Brief #2: Financing new services – update

Committee members received an update on the first meeting of the ad hoc finance group and reviewed the updated issue brief ([found here](#)). In the discussion with payers, it was apparent that there are different strategies to support meaningful transformation. However, the specifics of the activities providers will be asked to undertake are undefined. There is diversity in the methods that have been employed to encourage practice transformation but the experience of the payers is that there appears some times to be little evidence of benefit and this leads them to be cautious about the approach to financing. Different activities may be funded in different ways but the payers would need to see demonstrated change.

It was mentioned that the banking industry is beginning to provide loans to physicians for practice transformation. It was also mentioned that the problem with shared savings is that it occurs 18 months after the event and, therefore, does not provide rapid cycle feedback and revenue.

There was concern about the language in Option B that ties savings to payments. It was noted that there will be additional work done to better clarify the language. The payers were asked for their feedback on the meeting. There will need to be continued discussion so that the payers understand what activities are being financed before determining the means of payment. More precise definitions are needed.

It was asked whether the steering committee could change its meeting date as Mondays tend to be difficult for providers. A new meeting date will be found.

Meeting adjourned at 12:02 p.m.