STATE OF CONNECTICUT
HEALTHCARE INNOVATION STEERING COMMITTEE

Meeting Summary
Thursday, June 26, 2014

Members Present: Lt. Gov. Nancy Wyman (Chair); Raegan M. Armata; Jeffrey G. Beadle; Mary Bradley; Roderick L. Bremby, Patrick Charmel; Mehul Dalal (for Jewel Mullen); Anne Foley; Bernadette Kelleher; Suzanne Lagarde; Robin Lamott Sparks; Alta Lash; Courtland G. Lewis; Robert McLean; Jane McNichol; Michael Michaud (for Patricia Rehmer); Thomas Raskauskas; Kristin Sullivan (for Jewel Mullen); Jan VanTassel; Victoria Veltri; Thomas Woodruff

Members Absent: Tamim Ahmed; Patricia Baker; Anne Melissa Dowling; Jewel Mullen; Frances Padilla; Frank Torti; Michael Williams

Meeting was called to order at 3:01 p.m.

1. Welcome and Introductions

2. Minutes

Motion – to approve the summary of the June 12, 2014 Healthcare Innovation Steering Committee meeting – Robert McLean; seconded by Thomas Raskauskas.
There was no discussion.
Vote: All in favor.

3. Public Comment

Ellen Andrews, PhD, of the CT Health Policy Project read a prepared statement on the proposal for Medicaid participation in the State Innovation Model Test Grant. Her comments can be found here.

Deb Polun, Director of Government Affairs for the Community Health Center Association of Connecticut (CHCACT), spoke on behalf of Evelyn Barnum, CHCACT Chief Executive Officer. She said that in the initial work of the SIM there was not a role for federally qualified health centers (FQHCs) to play but that with the latest proposals, they would be playing a larger role in healthcare innovation. One example was the teaching health center initiative (IB # 7) which, she said, was succeeding in Danbury and ready to be expanded. While CHCACT has concerns about some of the proposals, they general support the direction of the SIM.

Sheldon Toubman, a staff attorney with the New Haven Legal Assistance Association, said he was pleased that the Practice Transformation Taskforce decided to recommend setting NCQA "Plus" as the standard for the Advanced Medical Home. He expressed concern regarding the proposal for Medicaid participation in SIM. The original proposal was that the Medicaid-Medicare dually eligible population was going to serve as the foundation for change. He said the new approach was based solely on the desire to receive a grant, a decision, he said could harm people. He urged the steering committee to review the proposal and make protections for Medicaid clients a priority.

Correspondence

There was no correspondence to discuss.

Medicaid Participation in SIM

The committee moved this item up in the agenda so that Kate McEvoy, Medicaid Director, could present the proposal for Medicaid participation in the SIM initiative. Ms. McEvoy provided context for the proposal (see narrative here and chart here). Multi-payer alignment is a key component of the SIM. Ms. McEvoy said that others have alluded to alignment on payment reform beginning with the Medicaid and Medicare dually eligible population. The proposal seeks to expand the pool of Medicaid clients that would be impacted by the SIM initiative to an estimated 200,000 to 215,000 Medicaid clients. There is also a proposal to submit a request for an 1115 waiver, which would allow the state to pay for services not currently allowable under Medicaid.

Ms. McEvoy further clarified that the development of the Duals Demonstration was done through a formal process with the Medical Assistance Program Oversight Council and that there may be a proposal to expand the membership of the Complex Care Committee to include single eligible clients. Suzanne Lagarde asked for clarification on how DSS planned to reconcile the parts of the proposal to reach 200,000 Medicaid clients and to issue a request for proposals for providers. Ms. McEvoy said an RFP would be issued and then DSS would attribute the members seen by the providers. There would be additional work needed to flesh out the attribution process. Dual eligible clients are not part of the 200,000 total clients to be impacted January 1, 2016.

Alta Lash expressed surprise by the proposal. She said her understanding was that the community health workers (CHW) initiative is already planned for in the SIM and she did not understand why it would be made into a Medicaid initiative. Ms. McEvoy said the purpose would be to create standardization in the role and to create a pathway for Medicaid to reimburse CHW activities. The 1115 waiver is one method that could be used to pay for those activities. Ms. Lash said she was concerned the 1115 waiver could have unintended consequences and could potentially cause private providers to be leery of taking on additional Medicaid clients. Ms. McEvoy said that there are already initiatives in place to help encourage provider enrollment such as enhanced primary care rates, funding for electronic health records, and the person centered medical home program.

Jane McNichol said she found it impossible to process the change and criticized the lack of involvement of the Medical Assistance Program Oversight Council and its Complex Care Committee. She also had concerns about the global cap. Ms. McEvoy said that the biggest challenge at the moment was time but that there is commitment to stakeholder engagement.

Patrick Charmel said the proposal was progressive and responsive to the challenges providers face and that it would create the right incentives to bring together providers who currently operate in a fragmented way. He was concerned that the current rate of Medicaid reimbursement for specialty care could potentially lead to lack of access but that similar concerns were raised about Medicare shared savings and the program have shown improvement in care. Ms. McEvoy said that continues to be a concern that the department continues to examine. One solution may be to determine a way to reimburse e-consults.

Jan VanTassel also expressed concerns about the global cap in the 1115 waiver. Two prior efforts to secure the waiver were unsuccessful. She was also concerned by what she called the lack of meaningful participation by consumer stakeholders and the apparent lack of real transparency. Ms. McEvoy said the department is aware of the history and that the waiver would require careful consideration. The 1115 waiver may not be the only means to fund the proposed activities but it does provide the flexibility to pursue those options. Ms. Van Tassel said that while waivers can have a tremendous benefit, they could also be used in a negative way. She said that more time is needed

to have meaningful consumer input. Mark Schaefer said that there is not a need to commit to applying for and implementing an 1115 waiver in the test grant application but that it is a possible vehicle that could be implemented.

Jeffrey Beadle said that at the last Consumer Advisory Board meeting there was a general consensus that there is a need for concrete plans for monitoring quality and delivery of care with special attention given to under service. He also said there was consensus that there be consumer input into the planning process. He added that he thought there appeared to be an opportunity to do state of the art work in urban and rural communities.

FQHC Participation in SIM

Dr. Lagarde presented on the proposal for Federally Qualified Health Center participation in SIM (see presentation here and CHCACT white paper here). There were no questions about the proposal.

AMH Standards and NCQA

The committee moved back to Item #5 on the agenda. Brody McConnell presented on the Practice Transformation Taskforce's first meeting (page 2 of the presentation found here). Robert McLean asked how the recommendation would affect medical homes recognized by URAC or the Joint Commission. Mr. McConnell said the recommendation only impacts those practices that have not undergone transformation. Dr. Schaefer clarified that that the standards were simply for the purpose of the Advanced Medical Home (AMH) glide path and has no implication for practices that have already gone through the recognition process.

Thomas Raskauskas said he sat on the boards for both NCQA and URAC and that there is a consensus among both accrediting bodies that there are more standards needed. He also noted that the state law allowing APRNs to practice independently is in conflict with the existing PCMH standard, as it does not recognize independent APRNs. He asked whether the group looked at using NCQA or URAC for clinically integrated networks or accountable care organizations. Mr. McConnell said the main focus was on the 2014 NCQA standards and only those practices that are not advanced or clinically integrated.

Victoria Veltri asked for a summary of the discussion. Mr. McConnell said the taskforce overwhelmingly favored the NCQA approach. There were concerns about the timeframe to develop reliable standards that could be implemented quickly. One concern regarding the older NCQA standards was that the process was more static. There was discussion of creating accountability standards. However, more information from NCQA is needed. There are plans to include an NCQA representative at a future meeting of the task force.

Bernadette Kelleher said one of her concerns was that they would create a barrier for smaller groups to participate. Mr. McConnell said the plan was to have transformation vendors and learning collaborative to aid in the transformation process. Alta Lash said that her understanding was that if practices needed financial assistance it would be provided through the SIM. Mr. McConnell said that would take the form of support through vendors rather than lump sum payments. Dr. McLean asked if other states had worked with NCQA to implement state specific standards. Mr. McConnell said that New York and Maryland had, particularly with regard to behavioral health standards.

Mr. Beadle reported that at the Consumer Advisory Board's June 25th meeting, they had passed a resolution to endorse the recommendations of the Practice Transformation Taskforce.

Motion to accept the recommendation of the Practice Transformation Taskforce to use NCQA as the AMH glide path standard with NCQA recognition required at the conclusion of the transformation process; that practices with current recognition would be grandfathered in; and further, that the Practice Transformation Taskforce is required to bring back recommendations on added standards – Victoria Veltri; seconded by Robin Lamott Sparks.
Dr. Raskauskas said he accepted using NCQA as the basis but that more discussion was needed about how the "Plus" was developed. He was uncomfortable agreeing to the "Plus" if he didn't know what it was. Ms. Veltri asked how they knew whether NCQA would be willing to agree to changes. Dr. Schaefer said that optional standards could be changed to requirements and the state could pay NCQA to create modules. The taskforce would come back with recommendations. Anne Foley suggested that the taskforce look at how to best include APRNs in their recommendations.
Vote: 14 in favor, 1 opposed.

Update: Primary care transformation strategy
Dr. Schaefer presented an update on the primary care transformation strategy (begins on page 6 of the presentation found here). Dr. Raskauskas said he was in favor of the two pronged approach but the Medicaid proposal covers only 200,000 Medicaid recipients. He said it should cover all networks. Courtland Lewis agreed. He said the state should maintain flexibility and momentum for all networks. Ms. Veltri asked how APRNS fit in. Dr. Lewis said the vehicle is through an IPA but they are not necessarily precluded from inclusion. At this point there is no clarity on the issue, he said.

Discussion of Draft Program Narrative
Brenda Shipley walked through the draft of the program narrative (begins on page 14 of the presentation found here).

Ms. McNichol said more detail on community integration was needed. She also said it read very practice-focused. Ms. Shipley said there needs to be more focus on primary care transformation over practice transformation and indicate more community linkages. Dr. Raskauskas said more work was needed on the average panel size. There was discussion as to whether the panel size would increase over time as there is increased utilization of non-physician practice members, as well as services such as e-consult.

More work is being done on the health information technology (HIT) section and the next draft should be clearer. Ms. Lash asked if it would reference privacy protections. Ms. Shipley said it would be as it is referenced in the Funding Opportunity Announcement. There was discussion as to how information would flow to patients who do not have access to technology. Minakshi Tikoo said examination will need to be made towards areas of blight and there will need to be discussion as to how to best address the problem. Dr. Raskauskas said it is important to highlight state rankings on technological adoption. Ms VanTassel said that there is a disconnect between technical information and what occurs at the community level. She said that people who do have access to technology may not be interested in the information available. There needs to be thought made on how to properly engage people. Dr. Schaefer said that the plan provides a foundation for accelerating effective use of technology but there is recognition that technology can't solve everything.

In terms of stakeholder engagement, Ms. Veltri suggested marrying stakeholder engagement to HIT. She said there is an opportunity to build on the navigator and assister program. There was discussion of how to best feature value based insurance design and community linkages. Dr. Raskauskas asked if the plan was to only subsidize patient satisfaction surveys for the first two years. The proposal is for the program management office to administer the survey process. Other

issues related to the survey were whether there multiple surveys would be required, whether the NCQA survey was required annually, and whether it would be multi-payer. Mr. Beadle suggested having the Consumer Advisory Board review the issue of access and make a recommendation to the steering committee.

Kristin Sullivan, of the Department of Public Health, suggested incorporating social determinants of health into the narrative so that it serves as a foundation. Dr. Lagarde suggested referencing Fair Haven Community Health Center's behavioral health integration program with Clifford Beers.

Dr. Lewis suggested highlighting changes going forward to make the review process simpler. It was also suggested that the next draft include a date or other means to keep track of different version. The program management office does not plan to post a draft of the application online before the submission date, but to provide a copy upon request. Copies can be requested by emailing sim@ct.gov.

Wrap-up/Next Steps
The next phase of the test grant application is to develop the budget and operational plan, the first draft of which is due June 30. The program management office will also be sending out a letter of support template with the goal of compiling them before the deadline. Ms. McNichol asked if the steering committee would receive a full draft of the application before it is submitted. She was particularly interested in health IT, monitoring, and Medicaid. Dr. Schaefer said the program management office can send those sections out once complete. By the following Thursday, the office can release a true second draft. The goal is to have a complete draft of the application by July 10th. That would leave six days to finalize it. Ms. VanTassel asked if the next steering committee meeting could start earlier. Dr. Schaefer said that could be taken into consideration.

Motion: to adjourn –Suzanne Lagarde; seconded by Jan VanTassel.
There was no discussion.
All voted in favor.

Meeting was adjourned at 5:28 p.m.