

**STATE OF CONNECTICUT**  
**State Innovation Model**  
***Equity and Access Council***

**Meeting Summary**  
**Thursday, July 24, 2014**

**Members Present:** Ellen Andrews; Linda Barry; Peter Bowers; Gaye Hyre; Amy Lazzaro; Roy Lee; Donna O'Shea; Robert Russo, Jr.; Victoria Veltri; Keith vom Eigen; Robert Willig

**Members Absent:** Maritza Bond; Darcey Cobbs-Lomax; Barbara Headley; Margaret Hynes; Kate McEvoy; Erica Spatz

**Other Participants:** Mark Schaefer

Meeting was called to order at 6:09 p.m.

**1. Introductions**

Victoria Veltri served as chair for the meeting. Council members and other attendees introduced themselves.

**2. Public Comment**

Sheldon Toubman, a staff attorney with Greater New Haven Legal Aid, spoke about the importance of the work the group is undertaking to develop under-service measures. He said the move to total cost of care could serve as an incentive to limit access to care in order to maximize savings. He pointed to the last sentence of the charter which addresses the idea of intentionality with regard to under-service. He said he was skeptical that measures could be put into place to address under service. He said the measures they develop must be comprehensive, must be data-driven, must have a real time monitoring system, and must be adjustable based on experience. He urged the council members to take their time to do things right. He also said that no shared savings for Medicaid should be implemented until the complete monitoring system is in place that included the four components he referenced.

**3. House rules/executive team**

Ms. Veltri said they were looking to form an executive team to facilitate the work of the council. This model has been used by the Practice Transformation Taskforce and would include one member from each group represented. Executive team members would preview meeting materials and set up effective meetings. They may meet once in between each council meeting. Members were asked to volunteer. The volunteers included Ellen Andrews (consumer/advocate); Peter Bowers (payer); Linda Barry (provider); and Ms. Veltri (state agency).

**4. CT State Innovation Model Test Application**

Dr. Schaefer provided an overview of the council's charge and of the submitted SIM Model Test Grant application ([please see pages 10 through 21 of the presentation found here](#)). Connecticut may be the only state in the nation with a committee dedicated to the problem of under-service. Other items the council could tackle are patient selection, wherein providers do not serve patients less likely to meet targets. Dr. vom Eigen said that as an ACO provider he had personal experience in this area. He said savings are not distributed at the individual provider level but at the level of the organization and the way money is divided is up to the organization. He said what concerns him is

that there seems to be system-wide reduction of services for certain groups of people. He added that budgetary pressures can lead an organization to cut services that bring in the least revenue and are less visible.

Dr. Schaefer said that this council, unlike the Quality Council, is entering relatively new ground. He encouraged members to suggest experts to come to the table. The measures developed should impact all populations beyond Medicare and Medicaid. Dr. Andrews said that she had researched experts in this arena for the past several months and that there is not a lot of information available. She asked about the number of ACOs participating in the Medicaid shared savings program. Dr. Schaefer said the number would depend on the outcome of the Department of Social Services' RFP. He anticipated the number would be between two and five, but this is speculative. The Comptroller's Office and Anthem Blue Cross and Blue Shield believe that there are between 14 and 18 provider entities that are participating in ACO type contracts (i.e., with shared savings) in Connecticut. Dr. Bowers said that some have been certified as medical homes through either NCQA or URAC but others have not and the designation did not mean the practices have actually transformed. Dr. Schaefer noted that there is also an organizational credential that subsumes medical home standards and adds additional standards for capabilities that can only be achieved by larger organizations. For example, NCQA has an ACO credential and URAC has a clinically integrated network credential.

#### **5. Round table discussion – initial thoughts on under-service**

Gaye Hyre said that under-service does exist in the form of access barriers and it is more pervasive than people realize. She said a patients could spend days calling potential specialty providers only to be denied access because they do not accept the patient's insurance. She said that by the time a patient can get an appointment, he or she could wind up at the emergency room. She is concerned that a concierge system is emerging. Robert Russo, Jr. said that physicians drop in and out of insurance plans and that can be a challenge for referrals. He said he sometimes will not know the quality of the doctor he is referring a patient to, or the doctor is more than 15 miles away. He said he had noticed the flight of primary care physicians off the busway in Bridgeport. While there are clinics available, they do not have the same patient touch. He asked if there was data available as to where people receive care and what the quality of that care is. Dr. Barry said in her experience, having Medicaid for insurance could be akin to having no insurance with respect to access. Patients couldn't get a primary care provider or had to wait 14 to 16 weeks for an appointment. They also don't know what resources they have available, she said. Roy Lee agreed. He asked how they could get consumers talking about education and opportunities. In his experience, people have encountered serious access barriers and they don't believe they have options.

Donna O'Shea said the council had a big task to tackle. She said she didn't think they have good under-service measures. Dr. vom Eigen said that, as a provider, it is difficult to define an appropriate level of service. He said there is patient-driven under-service where people do not care and are not plugged into the system. Dr. Bowers said it is a new era with many more people with access to coverage in a system that was already struggling with access issues. He said he spent a lot of time with providers and had never met one who looked to deny people. What he found was that they felt it was financially beneficial to take care of the sick rather than the well because of risk adjustment. Ms. Hyre asked how SIM could address the access issue. Dr. Schaefer said that there are strategies such as team based care and e-consult that can increase productivity and the capacity for a provider to see more patients. Dr. Willig said that the team approach is a solution to many access scenarios as not everyone needs to see a physician.

## **6. Equity and Access Charter**

The council reviewed the draft charter ([found here](#)). The charter is meant to provide a clear definition of the task at hand. Dr. Schaefer said that if there are serious problems in the charter language, it could be refined. The group discussed what kind of data could be used to detect under service. Dr. Willig said that payers can use claims data to determine a patient's diagnosis and see what services they have and haven't had. It is harder to figure out who might need services and can't get it, he said. It is even more difficult with people who are considered healthy. Ms. Veltri asked about pairing claims data with electronic health records. Dr. Bowers said that is the direction where things are moving but that it will take considerable time to get there. Dr. vom Eigen asked why the group was limiting under service monitoring to just shared savings. Dr. Bowers said the question is whether the new model is performing better.

Dr. Schaefer asked if there are analytic methods that are less transparent to the provider that could be used to detect fraud and abuse. Dr. Andrews asked if there are effective consumer education materials that can be provided at teachable moments. Ms. Veltri said that the state employee health care had success with that as it teaches what to ask and what treatments are needed. Dr. Russo said that they were incentivized to ask those questions. Dr. Bowers said that the Choosing Wisely program is one potential means but that it tends to focus on over-utilization.

Dr. Schaefer asked the payer representatives to look at the first question in the charter regarding what evidence exists with regard patient selection and under-service. Dr. Bowers said that he could point to a plan and delivery system that had succeeded and explain why it succeeded but he couldn't tell you whether there was under-service. They had done a better job taking care of people up front. Dr. O'Shea said that some providers will purposefully take the sickest patients because that was where the best opportunity for improvement was. Dr. Barry suggested they look at issues such as gender and race as there is unconscious bias that occurs.

Dr. Schaefer noted that the EAC charter focuses the work of this group primarily on under-service that is a consequence of payment reforms, except that the charter also asks the group to ensure that at-risk and underserved populations benefit from the proposed reforms. Improving access, for all and for populations with special access barriers (such as Medicaid recipients) is a quality goal under SIM and developing measures of access and health equity is part of the charge of the Quality Council. Dr. Schaefer will share the comments of this group with the Quality Council.

The payer representatives were asked for the next meeting to look at what methods may be in use nationally. All group members were asked to come up with three to five ways that a primary care physician or specialist may try to under-serve in order to save money. These questions will be communicated to the group in writing within the next few days.

## **7. Principles of method selection**

This was not discussed due to a lack of time.

## **8. Next Steps**

The executive team may caucus in August. The council's next meeting is September 18.

Meeting adjourned at 8:04 p.m.