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

**Meeting Summary**
**Thursday, September 18, 2014**

**Members Present**: Ellen Andrews; Linda Barry; Peter Bowers; Barbara Headley; Margaret Hynes; Gaye Hyre; Roy Lee; Kate McEvoy; Keith vom Eigen; Robert Willig

**Members Absent**: Maritza Bond; Darcey Cobbs-Lomax; Amy Lazzaro; Fernando Morales; Donna O'Shea; Robert Russo, Jr.; Erica Spatz; Victoria Veltri

**Other Participants**: Katrien Derycke-Chapman; Demian Fontanella; Mark Schaefer; Sheldon Toubman

Meeting was called to order at 6:15 p.m.

## 1. Introductions
Linda Barry chaired the meeting. Participants introduced themselves.

### 2. Public Comment
Katrien Derycke-Chapman said she had read about Medicaid expansion and the lack of access to physicians. She asked how the state was addressing this problem. Kate McEvoy said there has been an increase in Medicaid participation and that she understood the concern. The Council on Medical Assistance Program Oversight (MAPOC) is looking at network outages. Tools made available under the Affordable Care Act and electronic health record funding have both lead to an uptake in participation.

Sheldon Toubman, a staff attorney with New Haven Legal Assistance Association, said that one of the concerns with the State Innovation Model plan is there may be a disincentive to provide care due to shared savings. He said most under service will be subtle and neither the patient nor the provider may recognize it is happening. He cited the latest drug for Hepatitis C, which is very expensive. A physician may not tell the patient about the drug because of the cost and the patient would never receive a denial letter. He said there may be a potential conflict of interest in the Office of the Healthcare Advocate investigating under service claims as they push the SIM program.

### 3. Minutes
***The Council unanimously approved the minutes of the July 24, 2014 meeting.***

### 4. Principles
The Council's first set of objectives is to define under service. Mark Schaefer said it may take more than a couple of meetings to complete this task. In discussions with the executive team, the thought was to spend more time building a foundation of experience and knowledge to be in a better position to define under service.

Dr. Schaefer reviewed the agenda for the evening. Ellen Andrews will talk about the MAPOC Complex Care Committee's Under Service Workgroup. Peter Bowers will talk about gaps in care. Demian Fontanella, General Counsel for the Office of the Healthcare Advocate, will present on its

role in addressing access to care. Dr. Schaefer discussed the various roles the Connecticut Insurance Department (CID), Department of Public Health (DPH), and Office of the Healthcare Advocate (OHA) play in healthcare. CID regulates the health plans. DPH regulates provider licensing. Dr. Vom Eigen noted that the legislature directly affects these and other executive branch agencies. OHA is a resource for consumers who have been denied coverage or access to care. The plan is to hire a dedicated nurse consultant within OHA to specifically work with consumers who feel they have been under served. Dr. Schaefer asked members to think broadly about who is making and impacting decisions. CID, for example, would not regulate plans that are exempt under the Employee Retirement Income Security Act (ERISA). Dr. Andrews suggested that once the Council has an idea of the changes that are needed they can look at the best way of implementing those changes. A copy of the hand written diagram developed during the meeting that illustrates these entities and their roles/capabilities is attached.

**5. MAPOC Complex Care Committee, Under Service Workgroup**

Dr. Andrews presented on the work of the MAPOC Complex Care Committee's Under Service Workgroup (see presentation here). The workgroup was developed in response to a health neighborhoods pilot for Medicare-Medicaid dually eligible beneficiaries. Ms. McEvoy said the presentation captured the current trajectory. The pilot recognizes strains providers are under and will enable real time monitoring. She asked how the care metrics would be obtained when there are a variety of electronic health record systems. Dr. Andrews said that CHNCT has claims data available. There is not a metric for the amount of time people wait to access care but there are surveys. The Department of Social Services has relied on a mystery shopper program to get information on care experience as well. Ms. McEvoy said that because DSS uses a consolidated model with one administrative services organization, there is consolidated data available.

The health neighborhoods have not been selected yet as a memorandum of understanding is still being developed with CMS. There will be a request for proposals issued to select the neighborhoods.

**6. Payer Analytics – Closing Care Gaps**

Dr. Bowers presented on gaps in care (see presentation here). It has been asked whether under service can be detected. Dr. Bowers said it is challenging to determine using claims data as it is designed for payment and not for clinical use. The group discussed communications methods. Much of Anthem's communications are done via "snail" mail as it is difficult to do effective outreach using electronic means. There is now an online secure web portal that shows providers what services are due, past due and completed with a focus on issues such as diabetes, heart disease, COPD and asthma. The information is based on claims data. There is early indication of improvement but it is still early. Dr. Bowers cautioned that care delivery and payment reforms should improve these methods, perhaps by doing it at the ACO rather than the individual practitioner level. Individual providers may have half a dozen portals to look at, which one member remarked can make the current system more of an annoyance than a help. A multi-payer solution would take time but could be beneficial.

**7. OHA methods for addressing denial of service complaints**

Mr. Fontanella presented on the role of OHA (see presentation here). Dr. Schaefer said that much of OHA's work deals with medical necessity. If a payer denies a procedure as not medically necessary, the consumer has recourse for appeal. In the scenario the Council is considering, the patient does not know they have options. He asked members to consider what their recourse should be. The proposed solution is to establish a nurse consultant to look at under service. He asked members to think about other means to assist patients. Keith vom Eigen said he created a table of all of the

different levels in the system including various impactors, barriers and measures. He offered to share it with the group.

**8. Roadmap for future sessions**

Dr. Schaefer said they would work to make sure the next meeting was not overbooked. There are plans to have a webinar on the work of Crystal Run. The group will need to look at a process for under service detection. It was noted that it may be difficult to determine why under service occurred from claims data.

Meeting adjourned at 8:31 p.m.