

STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
February 26, 2015
6:00-8:00p.m.

Location: Connecticut Behavioral Health Partnership (CTBHP), Hartford Room (Suite 3D), 500 Enterprise Drive, Rocky Hill, CT

Members Present: Ellen Andrews; Linda Barry; Maritza Bond; Peter Bowers; Christopher Borgstrom; Arnold DoRosario; Bonita Grubbs; Margaret Hynes; Gaye Hyre; Kate McEvoy; Robert Russo; Donald Stangler; Victoria Veltri; Keith vom Eigen; Robert Willig

Members Absent: Alice Ferguson; Kristen Hatcher; Deborah Hutton; Roy Lee; Katherine Yacavone

Other Participants: Mark Schaefer; Katie Sklarsky; Adam Stolz; Sheldon Toubman; Todd Varricchio

The meeting was called to order at 6:05pm.

1. Introductions

Council members introduced themselves.

2. Public Comment

There was no public comment.

3. Minutes

Christopher Borgstrom moved to approve the January and February minutes. Linda Barry seconded the motion. The council approved the February meeting minutes. Maritza Bond abstained.

4. Report Out on EAC Member Survey Results

Katie Sklarsky of the Chartis Group presented on the EAC Survey results. Ms. Sklarsky gave a brief overview of the survey's main takeaways. More information about the EAC survey can be found [here](#).

5. EAC Phase I Roadmap: Progress to Date and Approach to Completing Initial Report

Adam Stolz of The Chartis Group presented on the EAC's phase I timeline, which included a discussion of the research and evidence review process the EAC has undertaken. Ellen Andrews disagreed with the idea as presented that extrapolating from evidence about the impact of capitated contracts is a fraught proposition in light of structural differences between pure capitation and the value-based contracts presently emerging in Connecticut. She suggested the Council remain vigilant in evaluating value-based contracts. Adam Stolz welcomed rewording of the statement regarding capitated contracts. Sheldon Toubman, Ms. Andrews, and Vicki Veltri discussed capitated contracts in the 1990s. Robert Willig suggested our ability to measure quality today extends far beyond the 1990s capacity. Arnold DoRosario added that there were no recording and reporting requirements during the 1990s. Dr. DoRosario stated that care today evolved to consider patient satisfaction and hold providers accountable. Ms. Andrews agreed that strides have been made to measure quality but there is concern that the data collected is not used effectively to improve the system. She added that there must be political will to make changes and hold people accountable based on the collected data.

Todd Varricchio from Aetna suggested the Council keep an open mind regarding positive intent and asserted that many constituents involved in healthcare reform are working to improve and not beat the system.

Bonita Grubbs agreed that improvements have been made on a provider level and that many people have a desire to improve the system. She also noted that while people are not working to beat the system, the more sophisticated and vocal constituents get more air time than others. Ms. Veltri asserted that consumer experience has not been a central part of healthcare reform. She referred to a personal experience to illustrate the difficulties of everyday consumer experience. There was discussion about the role of consumer participation in their care. Gaye Hyre expressed that patients by definition have “skin in the game” and also stated that the Council should refer to the consumer as a patient as healthcare is not a commodity. Mr. Toubman added that from the Medicaid perspective, the term “skin in the game” refers to a patient’s body and mind and is therefore more about their health than their financial risk. Dr. DoRosario noted that he thinks of “skin” not as financial risk but rather as commitment to actively engage in one’s healthcare, which is essential to quality care. He added that the dedication of time and resources in education to help the public understand the importance of patient engagement is a worthwhile investment.

Mr. Stolz presented on accomplished and forthcoming EAC milestones. Kate McEvoy discussed communication with the Medical Assistance Program Oversight Council (MAPOC) Care Management Committee (CMC). Ms. McEvoy referenced the “Protocol for Work in Support of the State Innovation Model Medicaid Quality Improvement and Shared Savings Program,” a document that was shared by email and in handout form to Council members. Ms. Andrews and Ms. McEvoy act as liaisons between MAPOC and the EAC.

Mr. Stolz discussed the report that will result from the EAC’s work on Phase I of its charter. Chartis will circulate a draft outline for the report as part of the weekly Monday communication the Council receives. Dr. Andrews noted that the Monday reports are extremely helpful.

6. Design Group 1: Patient Attribution and Cost Benchmark Calculation – EAC Second Review

Robert Willig introduced Todd Varricchio, Aetna’s Northeast Region Director of Value- Based Contracting. Mr. Varricchio gave a brief overview of professional experience with other SIM models. Mr. Varricchio gave a high-level presentation on Aetna’s national value-based contracting strategy and then opened the floor to questions.

Ms. Hyre asked if there is a system for benchmarking that ensures the “goal posts” are not being moved each year. Mr. Varricchio responded that Aetna evaluates the benchmarks each year and rewards incremental improvement by providers. Aetna uses clinical input from chief medical officers to identify benchmarks. Once an organization reaches an established goal they can be rewarded for maintaining that level of outcome. Dr. Willig added that a provider does not get rewarded for falling behind in their improvement progression.

Linda Barry asked how often Aetna revisits the national standards the targets are based on. She pointed out that efficiency and cost control do not always go hand in hand. Mr. Varricchio explained that Aetna uses a core team to look at national and CMS statistics on a regular basis. Targets are reconsidered annually. Dr. DoRosario offered a caution that if guidelines change it can be very expensive for providers to substitute entirely new metrics in their data systems. Dr. Barry asked how Aetna monitors quality of care at the next level of depth; for example, if a provider orders colonoscopies for all patients required to receive them, but does not order more extensive testing appropriate for some of those patients, who then get cancer.

Mr. Varricchio remarked that Aetna has a national measures repository and errs on assessing the providers in a positive manner. Dr. Willig remarked that some measures do not change on a yearly

basis. If a measure changes dramatically, Aetna reestablishes the target. Ms. Andrews asked if the measures were the same for all members and if a measure is retired once a provider reaches its target. Mr. Varricchio explained that Aetna establishes measures based on the provider type and circumstance i.e. applicable to the provider's patient population. Mr. Varricchio added that a measure is only retired if it is no longer an industry standard. If a provider achieves the target for a given metric, it is still measured for maintenance of performance.

Robert Russo remarked that Aetna is addressing the equity portion of the Council's charge but not access. He asked about the impact of value-based contracting on patient access to a broad network of providers as opposed to only providers in those contracts. Mr. Varricchio commented that of the contract types presented, only the ACO products would require the use of narrow networks. He also noted that, in order to participate in value-based contracts, a provider group must have a patient population large enough to generate statistical sufficiency for measuring outcomes. Dr. Willig added that if providers do not see enough patients, they cannot hit their quality measures. Maritza Bond commented that it would have been helpful to learn about the effectiveness of the value-based program implementation. Dr. DoRosario asked if the Council is talking about access for the underserved or access in general.

Ms. Veltri asked how Aetna is helping providers move along the transformation process as described in the presentation. For example, is Aetna funding the transformation? Dr. Willig explained that Aetna has many different types of support mechanisms. Mark Schaefer added that Aetna's approach to quality measurement has relevance to the Council's concern with patient selection. Since providers are rewarded for continuous improvement, they are less likely to be penalized for caring for a particularly challenging population – as opposed to if providers are measured against average performance across a broad market area.

Mr. Stolz presented on the recommendations on Patient Attribution that emerged from Design Group 1's workshop discussions. Mr. Stolz suggested the Council review, discuss, and propose edits to the recommendations which will then be included in the EAC's final report. Dr. DoRosario asked why the Council is going through this exercise when CMS and people who study the ACO community have already done this. A discussion ensued about the value of an independent assessment and the nature of the EAC's charge within SIM. Dr. vom Eigen noted that CMS is funding the SIM initiative for the specific purpose of coming up with its own ideas. Dr. DoRosario and Dr. vom Eigen discussed CMS's attribution model. Mr. Stolz added that the goal is to look at what CMS and ACOs are doing and finding, through the lens of guarding against underservice.

Mr. Varricchio noted that there is a significant cost for payers to customize their payment models for different states. Dr. vom Eigen remarked that not every payer will do what the council will suggest. Ms. McEvoy suggested the group achieve a common understanding about what is feasible. Rev. Grubbs remarked that SIM's purpose is to look at similar national standards and improve the process. Mr. Varricchio remarked that this will be difficult for national payers as many states have SIM programs that are suggesting different approaches. Mr. Stolz remarked that SIM's benefits from the perspectives of different constituencies. He explained that the Council is charged by the Steering Committee to assess these issues, but does not have any legal ability to require that payers, including Medicaid, adopt its recommendations. Dr. Andrews remarked that she is not a fan of standardization. Mr. Varricchio remarked that standardization does not exclude continuous improvement and Dr. Willig expressed that standardizing the industry on the right ways to deliver care is fundamental to achieving better outcomes. A discussion ensued regarding the definition of attribution.

Ms. Hyre reminded the group that some patients are not capable of engaging in their own care. She suggested that a medical ethicist might be appropriate to get involved in these topics. Ms. Veltri added that engagement may be dictated by a patient's barriers and that hopefully this new model will take into account the role of community health workers. Ms. Hyre asserted that patients' lack of medical degrees makes them inherently vulnerable in the patient-provider relationship. Rev. Grubbs

added that the course of disease can make a patient less capable of comprehending what their provider is advising them.

Ms. Bond asked for clarification regarding the thought process that went into the recommendations. Mr. Stolz provided background. Mr. Varricchio asked if the project is focusing on primary care physicians. Dr. Schaefer responded that the project is focused on health systems or neighborhoods. Mr. Stolz suggested the group work through the recommendations one by one. The group discussed the meaning and origin of recommendation #5 concerning settings of care in which attribution can take place. Ms. Bond suggested rewording and Ms. McEvoy asked for more background information on the New Jersey and Minnesota models of ED attribution. Dr. Barry suggested that based on the outstanding issues and lack of time, if the Council could look at the recommendations through email. Dr. vom Eigen suggested all comments be sent by email. Ms. Bond asked that if something is referenced it be made clear so the Council members can research the items and then be given a deadline to provide a response. Mr. Stolz said that the recommendations will be circulated for comments and feedback to the group.

7. Design Group 4: Retrospective and Concurrent Monitoring and Detection – EAC First Review

This item was tabled for discussion at a later date.

8. Closing Comments

Closing comments were taken offline due to time constraints.

Vicki Veltri motioned for the meeting to adjourn. Linda Barry seconded the motion. The meeting was adjourned at 8:01pm.