Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
April 12, 2016

Members in Attendance: Lt. Governor Wyman, Susan Adams, Ellen Andrews, Patricia Baker Kurt Barwis, Rod Bremby (DSS), Anne Foley (OPM), Margherita Giuliano, Bonita Grubbs, William Handelman, Frances Padilla, Dr. Raul Pino (DPH), Andrea Ravitz, Hussam Saada, Lawrence Santilli, Gregory Stanton, Bob Tessier, Victoria Veltri (OHA), Katharine Wade (CID), Josh Wojcik (OSC)

Members Absent: Gary Letts, Michael Michaud (DMHAS), Morna Murray (DDS), John Orazietti, Kristina Stevens (DCF) Shelly Sweatt

Agenda Item	Topic	Discussion	Action
1.	**Call to order & Introductions**	Lt. Governor called the meeting to order.	
2.	**Public Comment**	No public comment	
3.	**Review & Approval of minutes**	Meeting minutes reviewed March 8, 2016	Minutes approved
4.	**Cost Containment Model Study**, Megan Burns, and Marge Houy	**Oregon.** Marge Houy, Senior Consultant with Bailit Health, provided an overview of Oregon's four cost containment strategies: delivery system transformation (which is focused on promoting patient-centered medical home adoption), evidence-based coverage policies for health and pharmacy benefits, and creation of coordinated care organizations and transparency. To implement health care	**Cost Containment Model Study**, Megan Burns, and Marge Houy

OFFICE OF THE LIEUTENANT GOVERNOR, STATE CAPITOL
210 CAPITOL AVENUE, ROOM 304 HARTFORD, CONNECTICUT 06106
TEL (860) 524-7384 FAX (860) 524-7304 www.ltgovernor.ct.gov
LtGovernor.Wyman@ct.gov

Agenda Item	Topic	Discussion	Action
		strategies, the Legislature created a consolidated agency, the Oregon Health Authority (OHA), which accounts for almost 30% of the health care spending in the state. The two strategies that are unique to Oregon are the evidence-based approach to benefit coverage and the Coordinated Care Organizations. • In 2012 the legislature created an independent body, Oregon Health Evidence Review Commission (HERC), to review research performed by well-established medical evidence review organizations to assess comparative effeteness of services and pharmaceuticals. The HERC develops detailed reports explaining under what medical circumstances the service or procedure will be most effective. This information is used voluntarily by commercial plans in Oregon to make coverage decisions and to establish management protocol (e.g., prior approval, step therapy, etc.), as appropriate. Marge explained that encouraging evidence-based coverage has the potential of generating cost savings because of the extensive evidence that there is both underuse (which leads to unnecessary and costly complications) and overuse (which generates unnecessary costs). • Oregon Medicaid has created 16 Coordinated Care Organizations (CCOs) responsible for serving Medicaid beneficiaries within their assigned geographic region. The CCOs are at 100% risk for providing medical, behavioral health and dental services. Each CCO is governed by a Board of Directors composed of community, delivery system and risk-holder representatives. Involvement of all stakeholders, particularly consumers, on the Board	

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		has changed the nature of the conversation about how to identify and meet beneficiary needs in a way that is more patient-centered. The state has used SIM funds to create a Transformation Center which provides technical assistance to CCOs on how to build infrastructure and manage their risk. Since being created CCOs have shown improvement in over 3/4th of the quality and financial measures against which their performance is measured. Between 2013 and 2015, the CCOs have exceeded their cost savings target of an 11.5% reduction in actual costs compared to expected costs. Marge identified the keys to Oregon's success as follows: • Leadership at all levels: The Legislature has been proactive in creating an integrated administrative structure, and setting trend caps for state and teacher plans. OHA leadership has pushed to integrate disparate agencies. CCOs are run by Board including consumers, providers and risk-bearing entity representatives. • Consolidated agency: OHA controls nearly 30% of Oregon health care spend, so the state can drive strategic change beyond state government. OHA has data and analytic capabilities to make data-based, thoughtful decisions relatively quickly • Innovation: Examples of their innovative approach includes creating OHA to drive strategic change; creating a single flow of funding to CCOs responsible for integrated care; creating partnerships with academic medical centers to bolster research capabilities; implementing	

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		evidence-based coverage; implementing VBID designs for state and teacher plans (not discussed during the presentation); and supporting local transformation through the Transformation Center (CCOs) and the Patient-Centered Primary Care Institute Marge identified the following challenges that Oregon continues to face: • CCOs: Most CCOs sub-capitate services to existing providers, preserving old silos; some CCOs are now working to implement integrated models of care. CCOs are not using the flexibility they have to deliver non-traditional services. Managing 16 CCOs is challenging for the Medicaid staff, particularly around actuarial soundness and sustainable rate of growth. CCOs have been slow to adopt APMs and when adopted (such as primary care capitation arrangements) they are not often linked to quality outcomes. It is challenging to get patient-level data to CCOs and providers. • State employee and teacher plans: They have had low inflation rates in past 3 years, but 2017 premium increases will likely increase between 5% and 10% (depending on plan), exceeding 3.4% cap. Cost increases are due primarily to skyrocketing Rx costs • Commercial insurers: Alignment with state strategies is less robust than hoped, so OHA is restarting alignment talks in April. • Transformation support funding after SIM ends: The Transformation Center is hoping for legislative support. The Patient-centered Primary Care	

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		Transformation Institute is trying to develop sustainability model. During the discussion of Oregon's cost containment strategies and their possible relevance to Connecticut, the following points were made: 1. Bob Tessier asked what percentage of the CT budget is spent on health care. Action Required. 2. Vicki Veltri asked whether the state was mandating commercial plans to use the evidence-based standards put forth by the Health Evidence Review Commission, to which Marge responded "no." 3. Ellen Andrews said that we should learn from Oregon and that we need to be smarter on how services are used. She supported the CT Medicaid's glide path to get practices into PCMHs. 4. Pat Baker noted that when Oregon was having issues with cost of drugs for the Medicaid program there were public town meetings all over the state and the public was engaged in the decision making. She said this was a critical lesson and that when tough decisions need to be made, the public has to be informed. 5. Pat Baker also requested more detail on the 21 different funding sources that support the CCO, and whether public health dollars are part of those funding sources. She noted that blending and pooling of dollars could speak of structural changes, too. Action Required. 6. Kurt Barwis asked how are housing and public health agencies integrated into the governance of the CCOs? Action Required. 7. Dr. Bill Handleman asked how providers are paid by the CCOs. Marge noted that there is a substantial	

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		amount of FFS with P4P, and there is also some primary care capitation to give providers flexibility. He would like more information about CCO reinsurance and risk-adjustment. Action Required. 8. Ellen Andrews noted that she spoke with Oregon advocates last summer and that the CCOs provide a good connection to the community because there are baked-in requirements for the CCOs to do so, the meetings are transparent and they collectively come up with a community health plan. The said advocates said by and large that it does work. 9. Frances Padilla requested more information on how they built capacity to collect and report data to the state; and how the state collects and reports data publicly. Action Required. **Maryland.** Marge Houy, Senior Consultant with Bailit Health, identified two major cost containment strategies being used by Maryland: promotion of a patient-centered medical home model and a CMS waiver agreement that places a limit on the all-payer rate of per capita health care cost increases. Because of time limitations, Marge focused her discussion on the cost increase cap, but noted that the dominant commercial carrier (CareFirst BCBS) has implemented a robust PCMH initiative that has resulted in cost savings. The CMS agreement to limit cost increases has three major requirements: • Limit total hospital per capita revenue growth for all Maryland residents to 3.58% per year for the next five years. • Generate Medicare savings of at least $330 million.	

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		• Improve patient quality of care, including reducing preventable conditions by at least 30%. Phase I of the implementation strategy was launched in January 1, 2014 with the implementation of all-payer hospital global budgets. All payers pay the same rates for inpatient and outpatient services at individual hospitals. The hospital's budget for each year is set and fee-for-service rates are adjusted up or down to generate targeted revenue, regardless of volume. Rates vary by hospital and are based on base year revenue with adjustments for quality and market volume changes. Under this payment model, hospitals are incentivized in the short-term to reduce readmissions, complication rates and length of stay. In the longer term, hospitals must partner with community-based providers to prevent hospitalization, inappropriate ED utilization, manage highest cost patients and improve population health. First year results have been positive with the all-payer growth rate coming in below 3.58% and the Medicare-specific growth rate for Maryland coming in below the national Medicare growth rate. Under Phase II, Maryland is required to expand the model to contain per capita cost increases to the full spectrum of services and providers by 2019. The state's vision is all-payer total cost of care budgets with quality targets. Marge identified the following challenges that Maryland is addressing: ▪ Hospitals lack timely data on costs and utilization outside of the hospital; they can't identify and manage highest cost patients. Maryland's HIE	

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		partially meets these data needs by providing real-time information regarding admissions, discharges and transfers, which helps with identifying utilization patterns. ▪ Currently hospitals have all the risk and it is unclear how to distribute risk to other providers who are still on a fee-for-service model and meet the requirements of the CMS all-payer agreement. Maryland may need to get more flexibility from CMS to develop alternative payment models with non-hospital providers. They are considering pay-for-outcomes, global capitation and bundled payment models. There is uncertainty on how to build on the PCMH model to align with All-Payer Model. ▪ Hospitals must develop a new culture and new skills to implement population health-focused care delivery by building relationships with community-based providers; looking beyond a focus on hospital costs; developing infrastructure to manage and share risk, including data systems, care management functionality; changing their culture to a population-based perspective. • Medicaid is looking at ways to integrate payment models that control non-hospital costs with the all-payer global hospital budget model. Marge identified the following keys to Maryland's success as follows: • Leadership: Legislature has been supportive of and respectful of rate-setting role of HSCRC. HSCRC leadership has remained largely free of regulatory	

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		capture. Legislature has supported PCMH initiatives. • Quasi-independent Regulatory Agency: HSCRC has strong, capable leadership to develop, implement and adjust a complex rate setting and now a global hospital budget system. The agency has sufficient staffing and a sophisticated system to oversee and implement its work. • Innovation: Rate setting models have gone through numerous iterations to meet changing market dynamics. A broadly written enabling statute allows for innovation without political complexities. Moving to Global Hospital Budget Model is unique among states. During the discussion of Maryland's cost containment strategies and their possible relevance to Connecticut, the following points were made: 1. Ellen Andrews asked for more information regarding the incentives for providers to participate in the PCMH programs. Action Required. 2. Kurt Barwis noted that he was a hospital administrator in Maryland and experienced the rate setting model. He liked the HSCRC structure; its leadership; its goals. He noted that it was a trust worthy organization. He said the HSCRC was very supportive and positive. He liked the ability to have price transparency since each hospital received the same rates from all payers. It helped the hospital create an ability to understand the relationships between costs and price. He said the proposed changes to the Maryland model toward population health are critical, and the next few years will be important to the state.	

Agenda Item	Topic	Discussion	Action
		3. Dr. Bill Handelman inquired as to whether outpatient services are included in the cap, to which Marge responded "yes." He also asked whether there was a predetermined profit margin and Kurt noted that if a hospital became a high cost hospital under this system the HSCRC would put the hospital on a spend down and require it to reduce costs. 4. Pat Baker asked Kurt to speak about the environment in Maryland and whether there was significant consolidation. Kurt responded that there had been a lot of consolidation. 5. Ellen Andrews wondered whether the global budgeting model came out of a response to hospital consolidation and Kurt said the evolution to a global budget was because Maryland's waiver was at risk of not being renewed. 6. Dr. Bill Handelman wondered whether the model provided hospitals with a disincentive to develop new services, and Kurt provided an example of when he partnered with competing health systems to plan for a radiation oncology system that benefited the community. 7. Frances Padilla noted that one key theme that has emerged from the state review is innovation. Strategies and rule making were adjusted to allow evolution as time goes on. She said there is a tension between regulation, legislation and rule making and that trust is a huge challenge. 8. Pat Baker noted that the regional concept is critical in that it allows new partnerships to form. 9. Bob Tessier said we have a burning platform and he noted that trust in the state is an issue. He said that 20 years ago there was a regulatory rate review Commission that was effective, but that it was	

Agenda Item	Topic	Discussion	Action
		eliminated when the hospitals and insurers jointly agreed that it didn't meet their need. We need to be mindful of the history and need to build that trust. 10. Frances Padilla noted that in October the Foundation co-sponsored a meeting on cost reform and that one participant said "change happens at the speed of trust." 11. Pat Baker said that as we think about making changes we need to think about not giving up because we don't have it, but rather how do we build it. 12. Rev. Bonita Grubbs said that we need to look at the state of CT as a whole, while recognizing that there are certain parts of the state that are very rural and that there are significant variations in the state.	
5.	**Next Steps**	Next meeting will be held on Tuesday, May 10, 2016 9:00 AM – 11:00 AM at the Capitol – Room 310	
6.	**Adjournment**		