Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes

November 1, 2016

Members in Attendance: Lt. Governor Nancy Wyman, Ellen Andrews, Patricia Baker, Benjamin Barnes, Kurt Barwis, Kathleen Brennan (DSS), Miriam Delphin-Ritmon (DMHAS), Anne Foley (OPM), Demian Fontanella (OHA), Margherita Giuliano, William Handelman, Hussam Saada, Frances Padilla, Raul Pino (DPH) , Jordan Scheff (DDS), Kristina Stevens (DCF), Shelly Sweatt, Robert Tessier, Victoria Veltri, Katharine Wade, Jim Wadleigh (Access Health CT) ; Josh Wojcik (OSC)

Via Phone: Gary Letts and Susan Adams
Others present: Kate McEvoy (DSS); Michael Bailit, Megan Burns and Marge Houy, Bailit Health Purchasing, LLC

Members Absent: Kristin Dowty, Bonita Grubbs, Michael Michaud (DMHAS), John Orazietti, Lawrence Santilli, Gregory Stanton

Agenda Item	Topic	Discussion	Action
1.	**Call to order & Introductions**	Lt. Governor called the meeting to order.	
2.	**Public Comment**	None	None
3.	**Review & Approval of minutes September 13, 2016 & October 11, 2016**	Motion to approve-Pat Baker and Bob Tessier 2nd	Approved – No Abstentions

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4.	**Meeting Goals**	Lt. Governor Wyman opened the meeting by reminding the Cabinet members that the cost containment strategy recommendations are statewide and not just for Medicaid. She explained that today the Cabinet would be taking a non-binding vote on each recommendation and would be finalizing recommendations during the December 13 meeting after the public comment meeting on November 15.	
5.	**Request for Additional Strategy Recommendations**	Katie Wade explained that there was activity at the state level to ease restrictions to enable payers to offer narrower networks at lower premium levels and flexible plan designs. Current statues require all hospitals to be in all product offerings. She remarked on the letter that Governor Malloy sent Secretary Burwell that mentioned both items. Commissioner Wade also mentioned activities in other states that might be adopted in Connecticut without the need for legislation. Vicki Veltri asked that Commissioner Wade's comments be included in the report. Ellen Andrews stated that she felt that this recommendation warranted a longer conversation. Jim Wadleigh noted that Access Health CT has created a committee to discuss this topic for the individual marketplace. Ellen Andrews asked that the topic of how to develop trust and improve communications also be discussed. The Lt. Governor Wyman stated that the Cabinet can take up those topics as part of its future work.	
6.	**Strategy Review and Voting Process**	Megan Burns, Senior Consultant, explained that the Cabinet will first review each strategy one-by-one. After each strategy has been presented, the floor will be open for discussion. At the conclusion of discussion, the Cabinet will vote on the strategy. She explained that the strategies fall into the following seven categories: 1. Delivery System and Payment System Transformation	

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		2. Directly Reduce Cost Growth 3. Coordinate and Align State Strategies 4. Support Market Competition by Expanding the AG's Powers to Monitor Health Care Market Trends 5. Support Provider Transformation 6. Support Policy Makers with Data 7. Incorporate Use of Evidence into State Policy Making	
7.	**Summary of Strategies to Transform the Delivery System and Payment Reform**	Megan Burns presented strategies A and C and Kate McEvoy presented strategy B: A. **Provide more coordinated, effective and efficient care through CCOs.** Create organizations that are integrated across the continuum of care, responsible for improving population health that will assume some financial risk for total cost of care. B. **Build on the SIM agenda and current success in the Medicaid program.** Continue with the SIM agenda; (a) Optimize the current Medicaid care delivery reform initiatives; and (b) implement targeted new interventions that address and improve outcomes for high need, high cost Medicaid members. C. **Create community health teams to address complex health care needs.** Develop all-payer, multi-disciplinary community health teams that would serve primary care providers and patients within specific geographic communities Megan explained that key changes made to the CCO strategy as a result of the October 11 meeting are as follows: ▪ The quality model further articulates the goals of reducing health inequities, and improving outcomes of the entire population.	

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		▪ The strategy adds CCO compliance with regulation for financial solvency and operational capacity, and indicates that if a CCO ever qualified as a PPN, it would also need to comply with PPN regulations. ▪ Secret shopping and consumer experience of care surveys were specifically added to help mitigate risk of underservice, in addition to existing provisions in the quality model. ▪ Primary care payment reform that helps primary care providers provide more services outside of the traditional office visit, for which they may have been unreimbursed, was introduced. ▪ The strategy no longer includes the voluntary shared-risk option prior to the conclusion of the SIM initiative.	
8.	**Discussion of Strategies to Transform the Delivery System and Payment Reform.**	***CCO Strategy:*** In response to a question by Lt. Governor Wyman, Megan Burns noted that it is possible to pursue CCOs and build on the current strategies. Kate McEvoy and Ben Barnes noted that there are resource and funding constraints and it becomes a matter of priority setting. Pat Baker noted that DSRIP is one possible source of funds for this transformation work. Kate McEvoy explained that Medicaid strategies can impact commercial payers and noted that Medicaid is partnering with the Comptroller on common metrics and that many payers are now pursuing a PCMH strategy, for example. Michael Bailit, President of Bailit Health, also explained in response to a question from Dr. Handelman that PCPs usually are able to join only one CCO, but specialists may join more than one. Ellen Andrews expressed support for the current strategy and noted that Medicaid has been able to accomplish a great deal with few resources and thinks that other payers can implement	

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		similar initiatives more easily than Medicaid because of greater resources. Jim Wadleigh noted that Connecticut has many health plans, but that none are currently participating on the Cabinet. He suggested that their participation would provide an opportunity for Connecticut to learn from them as to what other states are doing and how these initiatives can be brought into the private sector. Megan explained that the vote on Strategies A and B would not be an either/or vote, but would be two separate votes. ***Community Health Teams:*** In discussing the Community Health Team strategy, Dr. Handelman asked who would employ and be responsible for the teams to ensure uniform delivery of services and equal access based on patient needs. In response to a question by Dr. Handelman regarding supervision of the team members and structure of the teams, Michael Bailit explained that in Vermont the team members are employed by the hospitals, that policy and standards are set by the Blueprint staff and that the teams are accountable to the PCPs they serve in the community. He explained that this is an all-payer model with each payer, including Medicaid and Medicare, contributing proportionately. Kurt Barwis observed that this model would be helpful in eliminating today's problem of care managers from plans, from practices, and from hospitals arguing over who is providing the care management services and would eliminate duplication of resources. Michael Bailit explained in response to a question from Ben Barnes as to the reason why payers and providers are not doing	

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		this now if this strategy is so effective, that this integrated team approach does not occur organically because it involves shared resources and needs state leadership to happen. Michael also noted that the composition and focus of the teams can be tailored based on the needs and priorities of the patients, including focusing on behavioral health needs, regardless of insurance or coverage status. Ellen stated that she agreed with Kurt that this could avoid waste. A consolidated utility could allow specialists, for instance, to be available across a wider range if the team were shared across payers. She stated that date showed that the Community Health Teams save money and are very popular with providers. Frances Padilla asked how the Community Health Team model aligns with the SIM CCIP initiative. Vicki Veltri explained that CCIP focuses on networks participating in the PCMH+ program, while the Community Health Teams are broader, but noted that the two programs would need to align. Dr. Pino stated that the CHT goes beyond care coordination and reaches social determinants of health. He referenced the work of Community Health Solutions and the work in partnership with St. Francis Hospital that has reduced ED use. He also noted that Community Health Teams have been successful internationally. Prior to voting, the following statements were made: • Pat Baker spoke in support of the CCO strategy and engaging the Community Health Teams into CCOs, seeing CCOs as critical to engaging multiple payers. She noted that they could be built over time to create an	

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		entity that creates ownership with accountability that can address duplication. • Kurt Barwis expressed support for both the CCO strategy and the current SIM work. • Ellen Andrews expressed the view that downside risk is very dangerous and opposed CCOs. • Josh Wojcik saw the CCO strategy as a logical conclusion of the current SIM model if one thinks of a fully developed ACO model, adding on components of managing population health, but he also expressed concern about the proposed implementation timeline and the specifics of the rollout. He said that he thinks of the strategy as more of a long-term strategy as capacity is built with PCMH+ program and ACOs and that this strategy is something the state could build up to. He said there might be some limitations because the state is in a collective bargaining environment and some covered individuals are scattered around the country. Megan acknowledged Josh's concerns and said that when voting, people should take into consideration that details such as those raised by Josh would have to be addressed. • Ben Barnes, expressing concern about resource availability to launch a new program, thought that the state should wait to see what happens with PCMH+ strategy before making a commitment. The vote was taken and all three strategies were approved. This is duplicative of language already included in the meeting summary. See above.	
9.	**Summary of Strategies to Directly**	Megan Burns summarized the two strategies to reduce cost growth:	

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		A. **Adopt a state wide health care cost growth target** that is based on an external economic indicator and that holds <u>providers</u> and <u>payers</u> responsible for keeping total cost of health care growth at an affordable level, with sanctions for noncompliance phase in over time. B. **Set targets for the adoption of value-based payment models.** The targets for the adoption of value-based payment models would be measured in a manner consistent with the Health Care Payment Learning Action Network's Alternative Payment Model framework. Key changes to the cost growth target strategy based on the October 11 meeting discussion include: ▪ The language was changed to refer to a cost growth *target* not *cap.* ▪ Flexibility was provided such that if another database with cost information is available that it, or the APCD could be used to gather information on total cost. ▪ The strategy further clarifies that the target applies to both health plans and providers. Until the APCD or another database is operational, the cost growth target can only be applied to health plans (as they already submit data to the CID). Once all-payer data are available, the cost growth target would apply to advanced networks. There were no changes made to the strategy to establish Alternative Payment Model targets.	
10.	**Discussion of Strategies to Directly Reduce Cost Growth**	***<u>Cost Growth Target</u>***. Lt. Governor Wyman, Vicki Veltri, Katie Wade and Ben Barnes spoke in favor of eliminating any penalties associated with exceeding the cost growth target, including the requirement to submit a plan of correction. Megan Burns stated	

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		that this approach was more consistent with what Massachusetts is doing, and Michael Bailit noted that Massachusetts has significant ACO contracting which makes it easier to apply a cost growth cap in the context of payer – provider negotiations. Kurt Barwis noted that cost growth targets are more difficult for lower cost providers. Vicki Veltri, Katie Wade, Ben Barnes and Pat Baker expressed concern that the necessary data to implement a cost growth cap were not currently available. Lt. Governor Wyman suggested that a vote not be taken on this strategy today and that a summary of today's discussion be posted. The Cabinet members concurred with this suggestion. ***Alternative Payment Model Target:*** Lt. Governor Wyman offered a motion to eliminate this strategy because payers are already working on this strategy. Ellen Andrews seconded the motion. Pat Baker noted that SIM has an Alternative Payment Model target. Megan and Dr. Handelman noted that the SIM target is for PCPs only and this strategy covers all providers. Kurt Barwis noted that the Medicare targets cover specialists. The motion to eliminate this strategy failed, so the strategy was accepted.	
11.	**Summary of the Strategies to Coordinate and Align State Strategies**	Megan Burns summarized the two strategies as follows: • **Create a Health Policy Council** which would report to the Governor and work to implement health care reform strategies in a coherent and consistent manner across the state agencies and across all payers. This is a new strategy developed as a result of the decision at the October 11 meeting not to recommend state agency	

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		consolidation, but desiring a mechanism for coordinating strategies across state agencies. • **Create and Office of Health Strategy** that would effectively develop and implement key components of the State's cost containment strategy. The key changes to the Office of Health Strategy made in response to the October 11 meeting discussion are as follows: ▪ The name was changed to "Office of Health Strategy" from the Office of Health Reform and is distinct and separate from the Health Policy Council. ▪ The Office was given new responsibility to study, and then potentially recommend other payment models, including global budgets, study rate setting, and study whether consumer affordability can be included in the CID's rate review process. ▪ The Office was given the task of collaboratively creating a health care vision for the state. ▪ The Office was given the ability to create authentic consumer groups consisting of all consumers in the state who can provide the state with feedback on any strategies raised by the Office.	
12.	**Discussion of the Strategies to Coordinate and Align State Strategies**	***Health Policy Council.*** Discussion among all participants articulated the following concerns: • That the body is duplicative of existing bodies and is not needed; • That the Governor can already call agency directors together from time to time; • That a formally constituted body such as proposed would be subject to the Connecticut open meetings law	

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		and any effort to not meet in public would not be received well by consumer advocates; • That agencies are already meeting to coordinate strategies • That there is a need to consolidate existing advisory boards and having just another meeting is not beneficial, and • That the Cabinet could serve this coordinating function if its membership were more balanced and included payers and more providers. Lt. Governor Wyman stated that the strategy as presented was clearly not supported by the Cabinet, and the strategy was withdrawn. She noted that the Cabinet members expressed a strong desire to have better representation on the Health Care Cabinet, which would have to be done by statute. Frances recommended that the Cabinet serve as an advisory group to the Office of Health Strategy and that the Cabinet make specific recommendations regarding how its membership should be changed. ***Office of Health Strategy:*** Kurt Barwis and Bob Tessier expressed support for the strategy, seeing it as a critical and essential piece in reducing healthcare costs. Shelley Sweatt asked about how the budgeting for the office was developed. Ben Barnes, Katie Wade and Ellen Andrews opposed the strategy because of lack of funds available to establish the Office. Ellen Andrews also opposed it as "premature." Jim Wadleigh made a statement in support of the strategy and asked how can we not think differently about a problem that impacts 25% of our gross state product. The Cabinet voted to adopt this strategy.	

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13.	**Summary of the Strategy to Support Market Competition by Expanding the Attorney General's Powers**	Megan Burns summarized the strategy as follows: The strategy aims to give the Attorney General the necessary authority to monitor health care market trends by collecting information from any provider, provider organization, private or public health care payer to **examine health care costs, trends, the factors that contribute to cost growth, and the relationship between provider costs and payer premium rates.** The AG and the Office of Health Strategy would hold public hearings and make the investigation results transparent.	
14.	**Discussion of the Strategy to Support Market Competition by Expanding the Attorney General's Powers**	Vicki Veltri reported that the Attorney General is interested in this strategy, but cannot do the required investigations with existing funds. Lt. Governor Wyman thanked the Attorney General for supporting this strategy, if he has the funds to undertake it. There was no discussion and the strategy was adopted unanimously.	
15.	**Summary of Strategies to Support Provider Transformation**	Megan Burns summarized the DSRIP strategy and Kate McEvoy summarized the current strategy to support provider transformation as follows: A. **Augment Existing Funds and Programs to Support Provider Transformation through Applying for Federal DSRIP Funds.** Provide new capital and support through a Delivery System Reform Incentive Payment (DSRIP) program allowing the state to access new federal funds to support Medicaid providers in infrastructure development, system redesign, clinical outcome improvements and population-focused improvements. Funds would augment existing transformation funds available through SIM and DSS.	

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		Cabinet member concerns regarding budget neutrality were addressed by noting the two approaches to budget neutrality: reduce costs through the programs Medicaid and SIM are currently pursuing, and / or through strategies proposed by the Cabinet OR through reallocating existing funds, as opposed to requesting new ones. Cabinet member concerns about using an 1115 waiver to the harm of Medicaid members were addressed by putting "guardrails" around the waiver on what it cannot do with the waiver. B. **Support Provider Transformation through Existing Funds and Programs**. This is a new strategy developed collaboratively by Kate McEvoy, Mark Schafer, and staff within DMHAS as a result of discussions during the October 11 Cabinet meeting. The strategy recommends the continuation of existing financial support programs to assist providers and specifically refers to: – DSS's PCMH program, – DSS's Electronic Health Record Incentive Program – DMHAS's Behavioral Health Homes – SIM's Advanced Medical Home Initiative – SIM's Community and Clinical Integration Program These programs will continue with or without formal Cabinet endorsement	
	Discussion of Strategies to Support Provider Transformation	Dr. Handelman noted that current programs do not include specialists except for behavioral health specialists. Pat Baker	

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		said that many states have effectively used DSRIP funds to support transformation and that Connecticut needed to think about where the funding is going to come from. Josh Wojcik expressed reluctance to support DSRIP in the absence of DSS evaluating the opportunity to find matching funds and would prefer to wait on making a decision until that evaluation is completed. Ben Barnes explained that the Legislature would need to approve the 1115 application. He expressed reluctance to support the strategy without understanding the opportunity costs. Megan Burns noted that DSRIP funds could be used for a variety of purposes and were not limited to provider transformation. Vicki Veltri recommended changing the strategy to read "The state should study and strongly consider applying for DSRIP funds." The Cabinet voted to accept the revised strategy regarding DSRIP funds. Since current initiatives will continue, Lt Governor Wyman noted that no vote was needed on strategy B.	
16.	**Summary of the Strategy to Support Policy Makers with Data**	Megan Burns explained that while this strategy has been discussed during earlier meetings, it has been further articulated in writing. The strategy calls for the following: The HIE and APCD are already in development; therefore, this strategy supports the to-be-appointed Health Information Technology Officer to provide the Office of Health Strategy with data necessary to examine health care cost trends in the state, and to appropriately set the cost growth targets.	
	Discussion of the Strategy to Support Policy Makers with Data	Ellen Andrews noted that this strategy was linked to the creation of the Office of Health Strategy, which she opposed. The Cabinet voted to accept this strategy.	

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17.	**Summary of Strategy to incorporate Evidence-based Research into State Policy.**	Megan Burns explained that while this strategy has been discussed during earlier meetings, it has been further articulated in writing. The strategy calls for the following: creation of a new committee that would be responsible for leveraging well-established, medical evidence review organizations (including two specific to Medicaid programs) to determine the safety and effectiveness of medical devices, procedures and tests. This committee would make recommendations to DSS and OSC for inclusion in their covered services. Robust stakeholder input and transparency is included as part of this strategy.	
	Discussion of the Strategy to Incorporate Evidence-based Research into State Policy	Dr. Handelman noted that Medicare already does this, so the policy is redundant. Kate McEvoy noted that the Medicaid Chief Medical Officer participates in a multi-state group of medical directors who discuss coverage. Josh Wojcik noted that the employee plan does not do this type of analysis in making coverage decisions and noted that they were limited by collective bargaining contracts. Ellen Andrews likes comparative effectiveness research, but thinks it is a payer decision and sees no value in adopting the strategy. Dr. Handelman expressed support for the strategy if it averted the legislature from passing bills mandating coverage for services that are not efficacious. The Cabinet voted to adopt this strategy.	
18.	**Next Steps**	Megan explained that changes to the strategy document would be made as a result of decisions made during the meeting. The November 15 Cabinet meeting will be an opportunity for Cabinet to hear public comments. The December 13 Cabinet meeting will be devoted to finalizing recommendations and reviewing a final report. Vicki noted that there will be a notice of the public comment opportunity posted on the Cabinet's website. The amended strategies will also be posted.	

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		Lt Governor Wyman noted that there will be an opportunity for a minority report.	
19.	**Adjournment**	Motion to adjourn- and 2nd.	Meeting adjourned

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