Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

# Healthcare Cabinet Meeting Minutes

November 15, 2016

**Members in Attendance:** Lt. Governor Nancy Wyman, Susan Adams, Demian Fontanella (OHA), Ellen Andrews, Kurt Barwis, Kathleen Brennan (DSS), Katharine Wade (CID), Miriam Delphin-Ritmon (DMHAS), William Handelman, Frances Padilla, Raul Pino (DPH), Jordan Scheff (DDS), Jim Wadleigh (Access Health CT) ; Josh Wojcik (OSC)

**Members Via Phone:** Margherita Giuliano, Shelly Sweatt

**Members Absent**: Gary Letts, John Orazietti, Hussam Saada, Lawrence Santilli, Gregory Stanton, Michael Michaud (DMHAS), Patricia Baker, Benjamin Barnes (OPM), Roderick Bremby (DSS), Bonita Grubbs, Kristina Stevens (DCF), Bob Tessier

**Others present:** Victoria Veltri (Lt. Governor Office); Kate McEvoy (DSS); Anne Foley (OPM); Anne Foley, Michael Bailit, Megan Burns and Marge Houy, Bailit Health Purchasing, LLC

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| 1. | **Call to order & Introductions** | Lieutenant Governor Wyman welcomed everyone to the meeting. She noted that the purpose of the meeting was to receive public input on the preliminary recommendations that the Cabinet voted upon on November 1, 2016. She asked the commenters to keep their remarks to two minutes each. | |
| 2. | **Public Comment** | • **Supriyo B. Chatterjee, private citizen who resides in West Hartford,** made three comments regarding the preliminary recommendations. (1) He suggested the Office of Health Strategy also address health equity. He noted that there are three offices of health equity within various state agencies and the fragmentation can lead to gaps in services, measurement and distribution of funding to address health equity. (2) He thought that the strategy requiring the Attorney General to provide an annual report on cost trends and health services disparities was good and that it would provide insight. (3) Lastly, he said that it is critical to have a robust data infrastructure that contributes to health policy decisions, and that it should include social and behavioral health data.<br>• **Dr. Tim Elwell, President and CEO of Qualidigm** described Qualidigm and its role in providing technical assistance for the state's Advanced Medical Home (AMH). He supports the Cabinet's desire to shift from volume to value, and to move to risk based contracts in line with the rest of the US. He believes the Medicaid savings in Connecticut are overstated and that the state would fall behind other New England states resulting in lower payment and access problems. He supports the APCD and increased transparency, as well as increased accountability among state agencies. He further applauds the Cabinet's Office of Health Strategy | |

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| | | proposed efforts to increase collaboration across departments.<br>• **Kimbirly Moriarty, Chief of Network Strategy for Yale Medicine** spoke on behalf of Yale Medicine, the medical faculty practice at Yale School of Medicine. She clarified that Yale Medicine is a separate entity from Yale New Haven Health System. Ms. Moriarty described the role that academic medicine plays in the health care system, noting that Yale Medicine cares for a disproportionate share of Medicaid patients and that current payment levels do not support them. She asked the Cabinet to keep the unique nature of academic medicine in mind when making their final recommendations.<br>• **Patricia Checko, Co-Chair of the SIM Consumer Advisory Board** stated that she wanted to add her independent support of the recommendations that were voted upon. She said that the state needs to continue to transform health care delivery payment systems by implementing CCOs, thereby building upon the SIM agenda and success in the Medicaid program. She urged the state to continue to pursue cost containment efforts and not to abandon value-based payment. She expressed concerns about the vagueness of the proposed role of the Office of Health Strategy and that it might be another powerless advisory board. She urged legislators to increase the powers of the Attorney General. She also expressed support for pursuing the Delivery System Reform Incentive Payment (DSRIP) program, noting that other states have used these payments effectively and have appropriately mitigated risk. She urged the Cabinet to formally adopt the recommendations as final to improve health and lower costs. | |

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| | | • **Deb Polun, Director, Government Affairs / Media Relations, Community Health Center Association of Connecticut (CHCACT)** expressed concern about the results of the federal elections and that until the answers are known, CHCACT cannot fully support or oppose the Cabinet's recommendations. However, she suggested that an inventory of all state cost containment programs be done, and that the Cabinet consider expansion of those programs that have been successful. She urged the Cabinet to avoid duplication of existing services, creation of new state agencies or expansion of existing agencies without funding. She also expressed concern about downside risk in the CCO model, and suggested that the Cabinet be cautious of moving forward before lessons from the PCMH+ program are understood.<br>• **Jill Zorn, Senior Policy Officer, Universal Health Care Foundation,** noted that the need to address affordability given the outcome of the federal elections is more important than ever. She said the challenge in Connecticut is related to the price of health care and that the Cabinet should address price regulation and budget regulation in a manner similar to Vermont and Maryland's global budgeting programs. She requested that the Cabinet do more to consider pharmaceutical strategies, and that affordability should be part of the Commissioner of Insurance's review process. Her organization supports the recommendations that increase the AG's powers, implement a cost growth target, and establish the Office of Health Strategy. She expressed disappointment that further state agency coordination was not approved by the Cabinet. Lastly, | |

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| | | she said the CCO strategy is worthy of consideration but noted that it will be complex to implement.<br>• **Susan Yolen, Vice President of Public Policy and Advocacy Planned Parenthood of Southern New England, Inc.** supports the CCO strategy that the Cabinet preliminarily adopted on November 1, 2016. She noted that providers need support for care transformation and sustainability under shared risk through funding resources. She noted that total cost of care strategies fail to adequately take primary care into account and that improved patient outcomes often take years, or decades. It's unreasonable to expect primary care alone to affect the total cost of care in the short term. She commented on the pharmacy strategies, noting that 340B discounts are being misused to pass savings to PBMs and that this was not Congress' intent. She cautioned the Cabinet to be careful about 340B proposals before moving forward.<br>• **Daniela Giordano, Public Policy Director for NAMI Connecticut** expressed the desire for the Cabinet to recommend building upon the PCMH+ model and reviewing its results before moving forward with CCOs. She expressed concern about moving Medicaid recipients into downside risk and noted that the administration had made a commitment not to do so. The Lt. Governor said that a promise had not been made, except during the SIM test grant period. Daniela went on to say that NAMI CT is concerned for people with complex needs and that financial risk should not be placed on health care providers since it is untested and unproven. She worried that downside risk would also drive down provider participation. She asked the Cabinet to consider the recommendations made to the | |

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| | | Cabinet by a number of advocates in October. Lastly, she worried that the Office of Health Strategy would subsume DSS and take away authority from DSS, which would violate federal law.<br>• **Stephen O'Dell, President, Coordinated Regional Care at Prospect Medical,** supports the work of the Cabinet and the recommendations to create CCOs, and their move toward more shared risk. He said that the Cabinet's recommendations don't go far enough and that Prospect Medical was willing to accept 95% of what Medicaid pays on a per capita basis to guarantee the state a savings of 5%. He said that Prospect Medical is just one of many organizations supportive of this payment model and that the "case for capitation" has been made in a Harvard Business Review article. He noted that some providers are willing, capable and experienced with shared risk, and asked the Cabinet to support population-based payment.<br>• **Tom Swan, Executive Director, Connecticut Citizen Action Group** does not support CCOs taking on downside risk and incentivizing the rationing of care. He said his organization believes the Cabinet's recommendations on transparency and coordination are steps in the right direction. He also suggested that there is a need to develop pharmacy strategies, to focus on consolidation as being a driver to cost, and to consider hospital cost containment and global budgeting (like in Maryland). Lastly, he noted a lack of accountability and not strong enough rule of government over the health care system.<br>• **Deb Hoyt, President and CEO, Connecticut Association of Health Care at Home** shared her support of the cost containment strategies that were voted upon on | |

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| | | November 1, 2016. She noted her support of the Medicaid LTSS rebalancing agenda, and her organization was committed to it and other similar programs. She stated that home based providers have saved money according to 2015 data and that the proposed CCO structure should learn from those lessons. She said home health care should be central to CCOs, and that home and community based providers need a seat at the table in order to be part of the cost containment solution.<br>• **Karen Buckley, Vice President of Advocacy, Connecticut Hospital Association** encouraged the Cabinet to bear in mind that the consultants' recommendations were based on the experience of other states, and did not take into account Connecticut's low Medicaid reimbursement. She said the success of the CCOs will depend on implementation details such as attribution models and that a multi-stakeholder work group should assist with these implementation details. She said her organization believes there is a need to fix the reimbursement environment for Medicaid before implementing a cost growth target. She expressed her organization's support for the Office of Health Strategy.<br>• **Jennifer Herz, Assistant Counsel, Connecticut Business and Industry Association** said her members were concerned with health care costs and that the majority were small employers. She said that the creation of community health teams certainly needs further investigation and review, and noted that some work has already been going on in the state with community health workers. Regarding the Office of Health Strategy, she said her organization was supportive of coordination and alignment, but that creating another entity might | |

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| | | not be effective, but certainly continuing the conversation will be. She thought the recommendation to make evidence-based decisions was good, but was uncertain of the role of a stakeholder body to advise that group if the group's decisions are based on evidence. She is supportive of the CID's letter regarding innovative networks, and not supportive of new health benefit mandates imposed by the legislature.<br>• **Arvind Shaw, CEO of Generations Family Health Center** expressed appreciation for the Cabinet's work in developing a cohesive plan to guide the state. He wondered what the plan was for funding charity care. He noted there is an acute shortage of physicians and that homeopaths and pharmacists should be licensed as independent practitioners. He commented that there are lengthy wait times for receiving psychiatric care due to workforce shortages. He said there needs to be better coordination across state agencies. Lastly, he asked the Cabinet how it plans to address the opiate crisis, funding of charity care and hospital consolidation.<br>**Sheldon Toubman, Staff Attorney, New Haven Legal Assistance** noted his role in working to remove risk-based MCOs in Medicaid and that he opposed downside risk in Medicaid. He said he opposes the CCO recommendation, and the Office of Health Strategy having jurisdiction over Medicaid. He noted that the PCMH program is good because it pays providers as honest brokers and any recommendations should build upon this program. | |
| 3. | **Review & Approval of minutes November 1, 2016** | The Cabinet approved the November 1, 2016 minutes. | Approved – No Abstentions |
| 4. | **Next Steps** | The Cabinet was informed that a draft report will be sent to them for review prior to the next Cabinet meeting. | |

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| 5. | **Next Meeting** | The next meeting of the Healthcare Cabinet will be held on Tuesday, December 13, 2016 at the LOB Room 1D. The meeting time is **9:00-12:00PM** | |
| 6. | **Adjourn** | Motion to adjourn | Kurt Barwis motioned and Demian Fontanella seconded. |

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