Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
March 8, 2016

Members in Attendance: Lt. Governor Wyman, Susan Adams, Ellen Andrews, Kurt Barwis, Anne Foley, Margherita Giuliano, Bonita Grubbs, Kate McEvoy, Michael Michaud, Morna Murray, Frances Padilla, Dr. Raul Pino, Hussam Saada, Lawrence Santilli, Gregory Stanton, Kristina Stevens, Bob Tessier, Victoria Veltri, Katharine Wade, Jim Wadleigh, Josh Wojcik

Members Absent: Patricia Baker, William Handelman Gary Letts, John Orazietti, 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 February 9, 2016	Minutes approved
4.	**Cost Containment Model Study**, Megan Burns, and Marge Houy	Marge Houy, Senior Consultant with Bailit Health reminded the Cabinet that the purpose of studying the cost containment models of other states was in response to PA 15-146 and to identify best practices that might be applicable to Connecticut. She went on to discuss Rhode	Next Steps for Bailit Health are to present the best practice cost containment strategies for Oregon and Maryland during the April meeting

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		Island's cost containment model which are Affordability Standards implemented by the Office of the Health Insurance Commissioner (OHIC). Marge explained that the Rhode Island legislature gave OHIC unique areas of authority to encourage fair treatment of health care providers, improve the quality and efficiency of the health care service delivery and outcomes, and to consider the health care system as a whole as it develops policies to advance overall efficiency, quality and access. Using that authority, OHIC developed four separate, but related Affordability Standards that insurers must meet: • Increase the level of primary spending, as a percentage of total medical expense • Support patient-centered medical care expansion among PCPs • Support the Rhode Island health information exchange • Advance payment reform The Affordability Standards which have been in effect since 2010 are viewed as accelerating delivery system and payment reform in Rhode Island. The key success factors in Rhode Island are strong, visionary leadership that built trust among the various stakeholders; solid stakeholder support, developed by stakeholder engagement throughout the development and implementation process and use of an open, public process; and effective use of its enforcement powers,	

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		including use of guidance letters and monitoring powers before implementing regulations. Key challenges for Rhode Island include: • The need to balance promoting meaningful transformation and pushing insurers too far which results in a political response; • Pursuing a policy of strengthening the primary care sector when payers are focusing on ACO contracting; • Engaging providers, over whom OHIC has no regulatory authority, to implement the Affordability Standards and thereby support payer success, and • Have sufficient staff resources to implement the Affordability Standards which involves non-traditional insurance regulatory activities. The Rhode Island governor is moving to build on the successes of OHIC by creating a health policy coordinating office within EOHHC. During the discussion of Rhode Island's cost containment strategies and their possible relevance to Connecticut, the following points were made: 1. Kurt Barwis made the point that the increase in primary care spending that RI focused on was still a fee-for-service payment. 2. Ellen Andrews asked whether specialty or hospital spending declined and Marge said there was no	

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		major change. Ellen also wondered whether RI had an ACO certification program and whether it knew how much insurance risk ACOs were taking and how much of a stretch the Affordability Standards are. Marge replied that the Standards were set as reasonable stretches. She also noted that there is no downside risk in RI at the moment. 3. Frances Padilla asked whether these standards applied to commercial payers and Marge noted that OHIC Affordability Standards only applied to commercial payers, and that OHIC does not have authority over Medicaid. 4. Ellen Andrews noted that RI has just begun to think about consumer protections and she suggested that if a strategy like this were to be adopted in CT, that it would need to be sequenced differently such that consumer protections were put in place first. She also supported the move to more PCMH in CT. 5. Lt. Governor Wyman asked what percentage of budget is RI paying in health care and how does that compare to CT? Megan Burns said she would identify those numbers for the next meeting. 6. Vicki Veltri noted that there is often reluctance to take risk and that the Cabinet is trying to do that. She also noted that RI's public process was quite robust with public hearings, recordings of the proceedings, and a process for feedback. 7. Kurt Barwis wondered whether hospital price increase limitations varied by the underlying cost structure of the hospital and whether it can address price variation and suggested that the	

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		Cabinet's recommendations also address price variation. 8. Frances Padilla noted that Affordability Standards must also address affordability to the consumer, including premiums and out-of-pocket costs. Ellen Andrews agreed. 9. Larry Santilli wondered how the Cabinet will know whether the Affordability Standards will work and Kurt noted that there should be more savings. Marge noted that the PCMH standards that were first put into place were not strong enough, and that is a lesson learned from RI. They are now going back to correct the issue. 10. Bob Tessier remarked that is it important to measure total health care expenditures and noted that RI's initiative goes back several years and it doesn't have an overall cost of care measure. 11. Lt. Governor Wyman stressed the need for immediate action. Megan Burns discussed the cost containment strategy of Massachusetts by first noting that a theme emerging from the states that have been reviewed is the time that it takes to implement effective cost containment models. Megan noted that Massachusetts has a very active legislature and Governor and both are willing to make health care policy decisions. She noted there are three broad strategies that the state has pursued: (1) payment reform; (2) transparency aimed at the market place, not consumers; and (3) "light touch" regulation with the constant threat of "heavy handed" regulation.	

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		Megan also described the role of the Attorney General, the Health Policy Commission and the Center for Health Information and Analysis (CHIA) and how each played a role in the three strategies. Keys to success for Massachusetts include: • The state's culture of perseverance in transforming the health care system, which has taken decades to do. • The providers in the state are culturally attuned to payment reform. • Personal relationships among individuals with various entities help advance issues forward. • The state has committed a significant amount of financial resources to managing health care data; and it continues to do so. • The state is very transparent with data and regularly publishes information to help inform the market participants – providers, plans, employers, and to a more limited extent, consumers. Key challenges that Massachusetts will face include: • Meeting the health care cost growth benchmark on an annual basis; • Reducing provider price variation; • Ensuring that APMs are accessible for all market participants;	

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		• Formally coordinating health care strategies across state entities. During the discussion of Massachusetts' cost containment strategies and their possible relevance to Connecticut, the following points were made: 1. Bob Tessier supported the creation of an annual statewide cap. He noted that even when it was exceeded, attention is drawn to the high costs of care. He also noted that to be successful, there needs to be other pieces in place around delivery system transformation and consumer protection. 2. Ellen Andrews supported creating a total cap for Connecticut and creating a strong data capability. She was concerned that people are obsessed with APMs which can be successful only if underlying infrastructure is built. She argued that APMs should be implemented after the infrastructure is in place. 3. Frances Padilla expressed a need to better understand the different types of APMs, the evidence regarding their impact, and what are the strategies that have the highest impact. She is hoping that the Cabinet will identify the big implementation steps for achieving cost containment. 4. Kate McAvoy emphasized that the Medicaid program is developing a shared savings program. She noted that Medicaid has recently experienced a PMPM reduction in costs.	

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		Kurt Barwis asked that more cross-state comparative information regarding Medicaid payment levels for services be provided.	
5.	**Hospital Panel – Discussion and reaction to Zack Cooper's presentation** Marna Borgstrom, Yale New Haven Health System; Rocco Orlando, MD, Hartford HealthCare; Seth Van Essendelft, Lawrence + Memorial Hospital; David Whitehead, Hartford HealthCare	Marna Borgstrom spoke to unprecedented changes in healthcare; drivers for change, preparation of changes in healthcare for organization/communities; Yale New Haven only has 3 of 28 state hospitals; after the merge with St. Raphael's hospital, YNNH reported more than $200 million in sustainable savings and preserved 3,000 jobs; She stated that YNNH system receives $.28 on the $1.00 of cost to treat patient from Medicaid; pays $180 million in taxes to CT; is taxed on revenue not profit like other industries. She said that as result of decline in Medicaid reimbursements, which represents the highest percentage of patients, carriers have to pick up some of the extra. True quality – safety vs cost to provide care Dave Whitehead stated that: total cost of care is now the focus; to provide high quality, hospitals need to integrate new strategies; hospital integration keeps them afloat in this economy; and that the industry is moving from consolidation to convergence , where it competes more on cost/quality Dr. Rocco Orlando stated that we need to spend dollars more rationally – better quality will lead to lower cost; Hartford Healthcare has 20,000 Medicare beneficiaries in its Medicare SSP; had great success-top 28% for cost and quality of services, returning over $5,000,000 in savings to CMS; came at cost for Hartford Health -$20 million investment in capabilities for quality care, managed care, coordination of care; staff to manage/provide care.	.

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		• Congestive Heart Failure hospitalizations are down due to better care; fewer readmissions • Embedding MH care into primary care offices Seth Van Essendelft states: • Prices/charges does not equal cost • Variation – bell curve – depends on patient, contractual rates, size of hospital • There is a difference between profit and non-profit hospitals • Hospitals need good credit ratings to keep cost down – need competition • If there is too much competition – certain segments will be filtered off • There is a tremendous shift going on– push back from employers to keep cost down for employees, options for a rational market; can't look at pricing in isolation must look at the whole. Some Immediate steps we can take now: • Moving to more collaboration • Trusted business partners • Payment set on actual cost to create rational reimbursement policy • In the state, maximize federal dollars available to us, reinvest in our healthcare delivery system • Creating more collaboration and being more transparent Lt. Gov asks panel asks "if you sat down and said let's make changes who would be at table?" We're going to fix the	

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		healthcare system. Changes need to be made now don't have years to wait… Jennifer Jackson stated-hospitals, providers would be at the table… Morna Borgstrom adds—need to look at Medicaid for instance (efficiency of funds—provide better care and outcomes): • 2 groups (disproportionate) insured by State come to mind--Chronic behavioral problems and • Children with chronic disease Take one of these groups, get into a room—providers, physicians who understand these issues, OPM, consumers/patients doing this; Let's ask - How much money to take care of children w/chronic diseases; what segments of these illnesses are using State resources; get agreement on what better life/outcome would be like? Chart a path, implement and be prepared to make adjustments. Bonita Grubbs states that during her time this is the best Medicaid system since she's been involved. But what stands in our way of doing what you are proposing? Issues surfaced a long time ago; How do we truly engage consumers and make it a positive experience? Morna Borgstrom replies that up until now there has been no really commitment to do this; for past 3-4years asked parties to come together to discuss how to reform Medicaid; interest starts off strong and then diminishes; guarantees to put best people at table – needs genuine commitment from all	

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		Ellen Andrews – took away from Zach Cooper's presentation was that hospitals charge whatever the market will bear. When the State was doing better why didn't private costs go down? Jennifer Jackson says – Not criticizing Medicaid program, it's the reimbursement rate that is issue; Morna Borgstrom agrees with Jennifer Jackson – price/charges in healthcare driven by costs – indirect and direct expenses; insurers can't keep absorbing costs – makes hard to sell products to employers because it costs too much; business model doesn't work- Yale New Haven - 25% of their patients insured by State of CT, that's 9% of revenue; Medicare Trust Fund not enough resources going forward; CT has older population than other states Bob Tessier – Wasn't sure why hospital panel here – just in response to Zack Cooper's presentation or for broader work on healthcare system reform and finding ways to reduce cost of healthcare. Hopefully they will come again when everyone is prepared for a broader discussions but my perspective is we are not just here because of recent cuts in Medicare funding. We're here because the cost of healthcare in CT as in most of the country is unsustainable. Whether it's the growth of 2 very large health systems in the state and the other hospitals finding ways to partner up with larger entities. We all need to find ways to reduce cost – it's not just about medicaid; we all have to be involved as it's not going to be the shift in private sector because that's not sustainable; for years and years hospitals increased cost while insurers increased premiums; ending up with millions not insured at all.	

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		David Whitehead is in agreement with Mr. Tessier's thoughts; Says we need to find ways to bring costs down while increasing quality of care.	
5.	**Next Steps**	Next meeting will be held on Tuesday, April 12, 2016 9:00 AM – 11:00 AM at the Capitol – Room 310	
6.	**Adjournment**		