Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
September 13, 2016

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

Members Absent: Susan Adams, Gary Letts, John Orazietti, Lawrence Santilli, Gregory Stanton); Robert Tessier

Others present: Kate McEvoy (DSS); Michael Bailit, Megan Burns and Marge Houy, Bailit Health Purchasing, LLC

Agenda Item	Topic	Discussion	Action
1.	**Call to order & Introductions**	Lt. Governor called the meeting to order.	
2.	**Public Comment**	The following two individuals provided public comment on the Bailit Straw Proposal • Karyl Lee Hall, Connecticut Public Rights Project, expressed concern about applying downside risk models to Medicaid populations and pursuing an 1115 Waiver. Her detailed concerns are expressed in a letter she submitted. She also expressed concern that her organization had not heard about the proposal until recently, describing the stakeholder engagement process as flawed.	

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		• Gaye Hyre, representing herself, expressed concern that progress made in expanding the number of providers accepting insurance payments will be reversed under a downside risk payment model.	
3.	**Review & Approval of minutes**	There was no vote as there was not a quorum	None
4.	**Discussion of the Feedback Regarding and Alternatives to the Straw Model**	Megan Burns, Senior Consultant with Bailit Health opened the meeting with a review of the meeting's objectives which were to have a productive discussion among Cabinet members about the health care cost control strategies presented during the July 12 Cabinet meeting. Discussion will focus on goals guiding the strategy development, each strategy, identified benefits and concerns, suggested recommendations and proposed alternatives. Megan then reviewed the legislative charge given to the Cabinet to: 1. Develop a framework for monitoring of and responding to health care cost growth, including identifying providers that exceed benchmarks or limits, and providing assistance to such health care providers; 2. Develop a mechanism to identify and mitigate factors that contribute to health care cost growth as well as price disparity; 3. Recommend an authority to implement and monitor delivery system reforms; 4. Recommend processes to develop and promote insurance contracting standards and products, and Recommend implementation of other policy to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care.	

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	Strategy 1: Provide More Coordinated, Effective and Efficient Care	**Goal:** Reduce costs by engaging providers (both professionals and institutions) to provide services in a more coordinated, effective and efficient manner, addressing issues of under use, overuse, misuse and ineffective use, health inequities and social determinants of health, through implementation of delivery system and payment reform models. **Strategy**: Implement risk-based contracts with Consumer Care Organizations using aligned contracting and purchasing strategies for Husky Health and State of Connecticut Employee Health to promote efficient use of services and improve quality. **Modifications Suggested by Stakeholders:** • Explicitly expand the responsibilities of the CCOs to include addressing SDOH and to create better linkages between clinical and social service providers; • Specifically include measures that address population health and prevention; • Include in QI measures, behavioral health measures that are meaningful to the consumers and which don't create incentives to deny nonmedical services; • Allow existing ACOs to be deemed CCOs; • Embed community health workers to address social determinants of health; • Include pharmacists as a set of community-based providers that CCOs would be expected to incorporate into their care teams; • Require CCOs to implement Comprehensive Medication Management standards, consistent with the CT SIM; • Ensure meaningful integration of medical, behavioral and disability services as a CCO responsibility; • The CCO payment model should be aligned across all payers, and	Bailit Health will consider the feedback provided and bring the Cabinet more detailed information regarding CCO design, opportunity costs and experience elsewhere.

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		• Build this model into a long-term plan that has flexibility based on experiences with PCMH+ and other active initiatives. **Alternatives Suggested by Stakeholders** • Continue with the current SIM agenda on use of shared savings program, and use of common quality measures across payers; • Examine experience with PCMH+ and a range of available Medicaid authorities (1115, State Plan Amendment) to plan carefully for implementation of "regional health neighborhoods"; • Continue to increase the percentage of Medicaid payments tied to meeting quality goals; • Pilot bundled payment models, and • Develop targeted Medicaid programs for high-cost, high-need patients. **Discussion:** Participating Cabinet members made the following key points: • Ellen Andrews stated that the state made a commitment to not ever move to downside risk for Medicaid. She believes that things are working well in Connecticut, so downside risk should be taken off the table with the focus being on care coordination and quality measures instead. She stated that since Medicaid managed care did not work, we should be worried about downside risk. We should think more expansively about where we want to go before moving in the same direction as other states. Let's focus more generally about value and supporting providers.	Bailit will summarize the recommended alternatives and present them to the Cabinet for consideration.

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		• Anne Foley expressed concern that there would not be much interest among providers for a downside risk model. • Kate McEvoy summarized the key initiatives Medicaid has implemented or is in the process of implementing; noted that while 1115 waivers are neutral vehicles, they have been used in other states to disadvantage Medicaid beneficiaries, and stated that Medicaid is not ready to do risk-based contracts. • Pat Baker suggested that the Cabinet articulate the pace for adopting risk-based contracting, taking Kate's comments into consideration. She wants the Cabinet to focus on timing, vision and mechanisms to get to the vision. She noted that it is critical that this be multi-payer and built on current transformation activities in Connecticut. She reminded attendees that the state is facing budget issues and asked Cabinet members to think about how the opportunity can be used to do good, rather than lead to draconian measures. She also emphasized the need for multi-payer strategies to address affordability for the commercial population, too and sees CCOs as a vehicle for doing so. • Morna Murray, Frances Padilla, Pat Baker and Kurt Barwis stated that they did not want to take downside risk off of the table. • Frances Padilla noted that providers outside of Medicaid were moving to downside risk and that there was an opportunity cost to Medicaid for not doing so. She noted the importance of timing and sequencing. • Kurt Barwis stated that including quality incentives in a downside risk arrangement is important. He also asked that Medicaid payment to specialists, which is so low	

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		that he subsidizes their fees, should also be addressed in order to improve access to specialists.	
	Strategy 2: Directly Reduce Cost Growth	**Goal:** Reduce cost growth by setting a limit on annual increases and developing mechanisms to 1) track actual costs against a target, 2) identify key cost drivers, and 3) make data transparent to the public. **Strategy:** (1) Cap advanced network cost growth; (2) set targets for APM adoption, and (3) create the Office of Health Reform to implement, and act as an independent body of experts. **Modifications Suggested by Stakeholders:** ▪ The Office of Health Reform should have the Certificate of Need authority to ensure Advanced Networks can be formed. **Alternatives Suggested by Stakeholders:** • Establishing a cost growth cap without the Office of Health Reform, and base the cost growth cap on Medicare's growth rate; • Expand CID authority to require plans to meet a cost growth cap; • Leave the monitoring of risk arrangements under the jurisdiction of the CID; • Regulate ACOs for financial soundness and appropriate delivery of care, and • Better control Rx costs by such programs as value-based benchmark pricing, indication-specific pricing, P4P contracts with manufacturers, medication therapy management, drug price transparency legislation.	**Action Step:** Bailit Health will consider the feedback provided and bring the Cabinet more detailed information regarding setting and implementing a cost growth cap, setting and monitoring an APM target, and creating an Office of Health Reform.

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		Discussion: Growth Cap • Josh Wojcik from the Office of the Comptroller stated that setting a goal is important and that expanding the analytic capacity to set the cap is also important. Having a cap and tracking achievement will allow targeting initiative directed towards cost contributors. While Medicaid and the state employee plan have good data, Connecticut does not have state-wide data. • Ellen Andrews expressed concern about unanticipated consequences. She believes that high cost patients should remain in the calculation, because often they receive lots of care, but not the right types of care and there are significant cost savings opportunities. • Pat Baker supported setting a statewide cap and developing the necessary data analytics to support the initiative. She recommended applying a comparative effectiveness lens when looking at costs. She asked that we look to Maryland to learn from their experience. • Margherita Giuliano noted that transparency is very important in setting and implementing a cap. • **Summary:** There was general support for setting a cap, based on an external economic index. It should be statewide to include providers and payers. The necessary data analytics infrastructure and transparency are key components of the recommendation. **Discussion: Alternative Payment Model (APM) Targets** • Ellen Andrews stated that results regarding the effectiveness of APMs are mixed and setting targets is premature and too prescriptive. She suggested focusing on trust and engagement, rather than telling people what to do.	

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		• Kate McAvoy reported that 44% of Medicaid beneficiaries are in HCP-LAN Category 2 due to the PCMH model and that Medicaid is implementing LAN Category 3 model with PCP+, which is a shared savings model. She recommends adopting the LAN framework for defining APMs. • Pat Baker and Morna Murray also supported setting APM targets and recommended that the targets be tied to the SIM objectives. • Kurt Barwis urged that measures used in APM payment arrangements be aligned in order to reduce the difficulties providers have in meeting so many different targets. **Discussion: Office of Health Reform** • Ellen Andrews opposed creation of an Office of Health Reform because of the lack of needed funding and because she believes that there is no state entity that could do the job because of lack of trust. • Margherita Giuliano and Frances Padilla expressed support for the creation of an office within state government that was responsible for overseeing strategy development and implementation and was responsible for driving change. • Frances Padilla noted that it would be in the state's long-term interest to develop this capability. She stated that the function needs to be robust and accountable.	
	Strategy 3: Support Provider Transformation	**Goal**: In recognition that implementing delivery system reform in a manner that improves health care and reduces costs is very difficult for providers, provide them with financial, infrastructure and technical support needed to change their care delivery models.	Bailit Health will consider the feedback provided and bring the Cabinet more detailed information regarding available state matching

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		Strategy: Pursue a Section 1115 Medicaid Waiver, and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment **Modifications Suggested by Stakeholders:** ▪ Current provider taxes could be used as funds to offer for federal matching. **Alternatives Suggested by Stakeholders:** • Continue to optimize present Medicaid care delivery reform programs (PCMH, behavioral health homes, LTSS rebalancing agenda) and launch Medicaid programs in active development (optimizing care for justice-involved individuals, health home for children with complex trauma, etc.). **Discussion:** • Pat Baker supported Kate McEvoy's statement that the 1115 Waiver is a neutral mechanism, which is neither good nor bad. She further acknowledged that there is anxiety and concern around 1115 Waivers, but also has heard how waivers can further provider transformation. While safeguards are important, Pat thought that Oregon was using an 1115 waiver in a positive way, and is intrigued by DSRIP funding and investing in providers. • Kate McEvoy noted that Medicaid needs to asses available matching funds. She noted that the waiver needs to be cost neutral over the 5 year period that it is in effect. She said that Medicaid investigated a DSRIP opportunity 3 years ago and many of the care delivery vehicles available were characteristic of Medicaid's	funds and whether a state plan amendment-approach to implementing CCOs is feasible.

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		current approach. Instead, Medicaid recommended that it build in quality-based payment models for hospitals. Medicaid can also get enhanced federal matching funds through a Health Home and trauma-informed care model for traumatized children. • Kristina Stevens further noted that the early DSRIP analysis concluded that DSRIP did not offer long-term sustainability. • Ellen Andrews offered that the Cabinet needed to figure out our goals before deciding on a "big huge nuclear bomb." In response to a question from Frances as to whether the CCO strategy was linked to an 1115 Waiver, Megan indicated that Bailit needed to explore whether a state plan amendment would allow a CCO strategy.	
	Strategy 4: Address Variation in Provider Payment	**Goal:** Address variation in provider payments by developing a better understanding of provider (particularly hospital) practices. **Strategy**: Give the Attorney General additional subpoena powers to collect confidential information from plans and providers to examine and report on trends in costs to improve transparency and promote competition. **Modifications Suggested by Stakeholders:** • Increase the AG's role to also improve transparency of prescription drug costs, and • Increase regulatory role over increase in health care prices, specifically regarding mergers and acquisitions.	Bailit Health will consider the feedback provided and bring the Cabinet more detailed information regarding expanding the AG's subpoena powers and expanding the AG's authority over mergers and acquisitions.

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		Discussion: • Pat Baker, Frances Padilla and Margherita Giuliano supported the strategy of expanding the AG's subpoena powers. • Kurt Barwis stated that he did not oppose the strategy in general, but expressed concern about making the data public in the wrong form. He noted the need for strong analytic capabilities in order to use the data obtained in a meaningful manner. He believes funding is an issue and therefore does not support the strategy unless done in the right way. • Anne Foley noted that giving the AG more regulatory authority over mergers and acquisitions should be aligned with the work of the separate work group looking at the CON process, which is also being chaired by the Lt. Governor. The end date for this work group to complete its recommendations has been extended to January 15.	
	Strategies 5 and 6	Strategy 5 (Support Providers and Policy Makers with Data) and Strategy 6 (Coordinate and Align State Strategies) will be discussed at the next meeting.	
5.	**Next Steps**	Next meeting will be held on October 11, 2016 at the LOB, Room 1D from 9:00 AM – 12:00 PM	
6.	**Adjourn**	Motion to adjourn	Anne Foley motioned and Frances Padilla seconded