Draft Healthcare Cabinet Meeting Minutes

Chair: Deidre S. Gifford, MD, MPH
Date: January 23, 2024
Time: 2:00 p.m. – 4:00 p.m. Location: Zoom Call

Attendance:

HCC Member	Present	Regrets		HCC Member	Present	Regrets
Robyn Anderson		x		James Michel	x	
Ellen Andrews	x			Danielle Morgan	x	
Andrea Barton Reeves	x			Cassandra Murphy	x	
Kurt Barwis		x		Nancy Navarretta	*	
Jeffrey R. Beckham	*			Hassam Saada	x	
Claudio Capone		x		Sean Scanlon	*	
Vanessa Dorantes	*			Jordan Scheff	x	
Manisha Juthani	x			Shelley Ann Stokes Sweatt	x	
Alan Kaye	x			David Whitehead		x
Sean King	x			Anthony Yoder	X	
Andrew Mais	*					

*Represented by a designee

Designees Present:		
Claudio Gualtieri, OHS	Collen Harrington, DMHAS	Paul Lombardo, CID
Nicole Taylor, DCF	Laura Manzione, Comptroller	

Others:		
Alicia Novi, OHS	Elisa Neira, OHS	George Miller, Altarum
Corey Rhyan, Altarum		

	AGENDA	Responsible Person(s)
1.	**Welcome/Call to Order**	**Deidre S. Gifford**
	The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, January 23, 2024, via Zoom. The meeting convened at 2:05 p.m. Deidre Gifford presiding. Attendance taken by roll call.	
2.	**Approval of September 27, 2023, Minutes**	**Members of the Healthcare Cabinet**
	The motion was made to approve the September 27, 2023, minutes by Deidre Gifford. Moved by James Michel and seconded by Claudio Gualtieri.	
3.	**Certificate of Need (CON) Regulatory Process – Public Comment**	**Alicia Novi, Staff Attorney, Office of Health Strategy**
	Dr. Gifford introduced Alica Novi who presented on the Certificate of Need Regulatory Process. **Agenda:** • Statutory Authority to write regulations • Connecticut General Statutes and Rules for the Legislative Review • Rules and Regulations Process • Timeline for the Regulations process • eRegulations - Home (ct.gov)	

Where do we get the authority to make rules and Regulations?

- Connecticut General Statute §19a-638 Certificate of need. When required and not required…… Polices, Procedures and Regulations.
  - (d) The executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the executive director holds a public hearing prior to implementing the policies and procedures and posts notice of intent to adopt regulations on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

- Connecticut General Statute §-639a Certificate of need application process. Issuance of a decision. Public hearings. Policies, Procedures, and Regulations.
  - (g) The executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the executive director holds a public hearing prior to implementing the policies and procedures and posts notice of intent to adopt regulations on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

What governs rules and regulations?

- Regulations are adopted in Connecticut pursuant to the UAPA Chapter 54 of the General Statutes
  - CGS §4-168 through §4-174 Chapter 54 - Uniform Administrative Procedure Act
- Rules of the Legislative Regulation Review Committee (LRRC).
  - Legislative Regulation Review Committee - C G A - Connecticut General Assembly

The Process

1. Submission of Regulations to OPM for review and approval
2. Regulations submitted to the Governor's office for approval
3. Notice of Intent to Adopt Regulations
   - Must be sufficient to notify the public what you are regulating and where the purposed regulations are on the eRegulations portal
4. Public Inspection/Comment period
   - submitted in written form or orally if a public hearing is held
   - All written/oral comments must be responded to and uploaded to the portal
5. Attorney General Review for legal sufficiency
   - AG will either approve, deny, or reject without prejudice
6. Be approved by the LRRC
   - Will be voted on at the meeting scheduled for the following month
7. Filed with the Secretary of State's Office

Timeline for the process

- Review By OPM and Governor's office
  - 3-6 months or longer.
- Notice of Intent
  - Uploaded with the purposed regulations
- A comment period for regulations
  - At least 30 days, if a public hearing is requested this step will take longer
- AG review
  - AG must give notice of legal insufficiency within 30 days, or the regulation shall be deemed approved.
- Regulations submitted to the LRRC
  - must issue a decision within 65 days of date of submission or deemed approved. For previously rejected regulations timeline is 35 days.

4.	**Overview of State Health Improvement Plan (SHIP)**	**George Miller, Altarum**

Dr. Gifford introduced Elisa Niera, Senior Director of Health Equity for the Office of Health Strategy to the committee members. Ms. Niera introduced George Miller who presented the Overview of State Health Improvement Plan

What Is the SHIP?

- A "roadmap for promoting and advancing population health and ensuring all people in Connecticut have the opportunity to attain their highest potential for health"
- Published in 2021 as part of Healthy Connecticut 2025, a five-year state health planning initiative
- Addresses issues raised in the 2019 State Health Assessment (SHA)
- Focuses on equity and the social determinants of health (SDOH) rather than clinical services

SHIP Covers 6 Key Measures and 4 Priority Areas

Key Impact/Surveillance Measures

- Obesity
- Suicide
- Drug overdose and substance misuse disorders
- Domestic violence/sexual violence
- Percent insured
- Emergency room visits

Priority Areas (containing strategies designed to affect impact measures)

A: Access to health care
B: Economic stability
C: Healthy food and housing
D: Community strength and resilience

Approach

- Expanding the Plan narrative to discuss relationships between facilities and services availability and healthcare access

- Highlight identified gaps in access to care (Plan includes availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, and primary care)

- Expanding analysis to include SDOH drivers and healthy equity measures including transportation, food, and housing
  - Address in the Plan how SDOH drivers influence the need for health care services and health outcomes
  - Identify in the Plan the role of healthcare providers in promoting SDOH initiatives
  - Address in the Plan how access to care can be influenced by economic stability and community strength and resilience
- Addressing progress toward key strategies of the SHIP that align with the Plan
- Recommending specific actions to address identified gaps in underserved communities

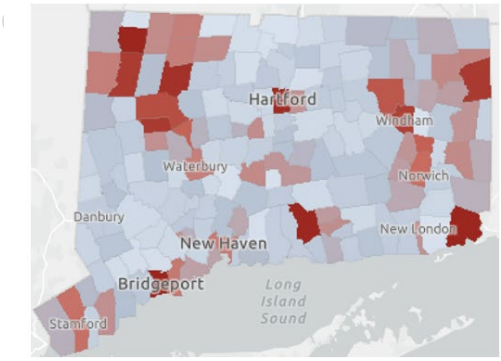
Example 1: Expanding the Plan Narrative
Strategy A6.4. "Explore options to expand Medicaid and subsidized insurance coverage to ineligible individuals that remain uninsured or underinsured (e.g., low income, parents of HUSKY recipients, immigrants)."

- Discuss impact of recent expanded coverage on needs for facilities and services

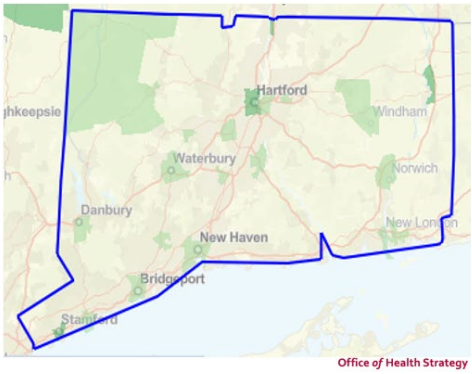
Example 2: Measuring Status of Initiatives
Strategy A1.1. "Expand affordable, quality broadband internet and cellphone access across the state, and seek public or subsidized broadband access program for geographic areas and lower income residents, so telehealth can be expanded."

- Plan can incorporate maps from Connecticut Broadband Mapping Hub to show extent of broadband adoption across the state
- Plan can overlay with locations of HRSA primary care shortage areas to indicate need for better access

Broadband Adoption Map



Primary Care Area
Health Professional Shortage Areas



Ellen Andrews expressed her interest in staying informed about any regulatory decision made by OHS regarding approval, support and/or subsidizing health services. She thanked Dr. Gifford for her feedback and appreciated the collaboration with DPH. She noted the potential overlap between the SHIP and the Statewide facilities and services plan, and the need to optimize the impact of both initiatives.

James Michel emphasized the importance of community engagement. He wondered if there was a plan to involve the communities we aim to assist, by soliciting their input and engaging them in the decision-making process to ensure that they are committed and empowered to take the next steps to improve their health.

Elisa Niera responded that ongoing dialogue with colleagues at DPH to discuss community engagement strategies are happening. She said that the current group was one step, but there would likely be more opportunities to incorporate community feedback into the process. She stated that these conversations were driven by a genuine commitment to community involvement and a recognition of its importance. As a state, she said, there were already many avenues across different agencies where community engagement occurs.

Manisha Juthani added the importance of collaboration and partnership in addressing complex challenges, acknowledging it may be difficult to fully integrate all aspects, but the commitment to identifying connections and working together remains strong; challenges persist, especially regarding social determinants of health. She gave an example of housing being identified as a critical area, even though DPH lacks direct control over specific levers. However, she said, by leveraging collaborative efforts across agencies, there's significant potential to make a positive impact and collectively address these issues.

Elisa Neira responded to Ellen Andrews' remark on the community health needs assessment and said that it would be part of this work and process.

Brent Miller said that OHS was reviewing the community health needs assessments that hospitals submitted in the 21 and 22 cycle and would collaborate with Altarum to analyze the data and link it with the facilities and services plan.

Deidre Gifford expressed her gratitude to George Miller for his presentation and promised the members that she would keep sharing OHS' work with stakeholders and ask for their input as they worked on the plan. Altarum would also do more work to get feedback from stakeholders and they might ask them to connect with those community organizations.

Anthony Yoder inquired about workforce issues.

Corey Rhyan said that workforce was a component, not only the availability of facilities but also the capacity to staff them and the number of staffed beds and offices. The plan was to use all the data that OHS had to assess the workforce. They would also look at other data sources; HRSA's shortage areas were a good example of other areas that they could consider when addressing the social determinants.

Deidre Gifford said that OHS is finalizing a report on behavioral health that includes workforce components. She also said that DPH has a primary care office that identifies workforce shortage areas and that the governor has a big initiative on healthcare workforce training and pipeline issues, licensure compacts, etc.

5.	States Advancing All-Payer Health Equity Approached and Development (AHEAD) Briefing	Deidre S. Gifford, Office of Health Strategy

AHEAD Model Introduction

- The Advancing All-Payer Health Equity Approaches and Development (AHEAD) is a CMMI-funded, voluntary, total-cost-of-care (TCOC) model that offers selected states the opportunity to take accountability for population health, health equity improvements, and all-payer and Medicare fee-for-service TCOC growth.
- The model is scheduled to operate for a total of 11 years. If Connecticut is selected to participate in the first cohort of states, the 18-month pre-implementation period will begin in July 2024, with performance year 1 beginning in January 2027.

AHEAD's Three Primary Components

- Cooperative Agreement Funding: States will receive funding to plan initial implementation activities for the AHEAD model, including recruiting hospital and primary care practices to participate.
- Hospital Global Budgets: AHEAD will offer participating hospitals located in participating states annual Medicare FFS global budgets, which will be set prospectively, and cover inpatient and outpatient services.
- Primary Care AHEAD: Primary care providers can choose to participate in Primary Care AHEAD, which will align with ongoing Medicaid transformation efforts within each participating state

AHEAD Stakeholders: Roles and Responsibilities

- **State leadership** is expected to work closely with CMS on model implementation and will be held accountable for statewide targets that align with model goals for Medicare FFS and across all payers. States will also be accountable for meeting statewide quality and equity targets and are expected to align with CMS in hospital global budgets and primary care transformation.
- **Hospitals**: As part of the global budget methodology, hospitals will be required to meet performance measures for quality and health equity.
- **Primary Care Practices**: Primary care practices participating in the model will be required to engage in state-led Medicaid transformation efforts and the aligned Medicare Primary Care AHEAD program and will receive a Medicare care management fee to meet care transformation requirements for person-centered care. Primary care practices will be responsible for reaching performance goals on model quality measures.

Health Equity Efforts Included in AHEAD

- All participating states will be required to develop a Statewide Health Equity Plan to define and guide Model activities aimed at reducing disparities and improving population health.
- Participating hospitals are required to create hospital health equity plans.
- Payment methodology for hospital global budgets and Primary Care AHEAD will include adjustments for social risk. Hospitals will also be eligible to earn a bonus for improved performance on disparity-focused measures.
- Participating hospitals and primary care practices will enhance demographic data collection and utilize health-related social needs screening to connect beneficiaries to community resources and address social needs.

AHEAD Model Governance Structure

- Participating states are expected to create a Model Governance Structure to guide model implementation. The structure will also be used to convene stakeholders with a wide range of perspectives to inform model activities and build partnerships to support model goals.
- These structures must include representation from any relevant state agencies, community-based organizations from underserved communities; health care payers, clinicians and provider organizations, and any other entities whose policies influence population health (e.g. food insecurity, housing, etc.)

Proposed Model Governance Structure for Connecticut

- Create a subcommittee of the Health Care Cabinet (HCC) to serve as the Model Governance Structure.
    - Co-led by OHS and DSS, in consultation with relevant state agencies i.e DPH, CID, OSC
    - Include some current HCC members and other stakeholders to meet AHEAD requirements
- Per CMMI requirements, the Model Governance Structure would assist with Model implementation by:
    - Providing diverse perspectives
    - Providing input into the selection of statewide population health measures, quality measures, and equity targets
    - Developing a statewide Health Equity Plan and assessing progress on the Plan annually
    - Assisting with the review of Hospital Health Equity Plans
    - Providing input on the use of Cooperative Agreement funding to support Model activities

Deidre Gifford asked the Healthcare Cabinet members if they had any comments or questions.

James Michel said he was glad to see the focus on underserved communities, as they have faced long-term health challenges that need to be addressed. He offered his support and assistance as OHS develops the strategy for the services. He also mentioned that Access Health has data on health disparities in CT, if needed. He suggested that involving the community and local organizations would be beneficial for this issue.

Deidre Gifford thanked him and said that OHS and DSS are working closely together on this application, as Medicaid is a key component of both the global hospital budget and the primary care programs. She said that qualified health plans are also potential partners in the global budget and primary care models, and that they would be looking for exchange plans to join them in these initiatives.

James Michel said that they have started the process for 2024 and that they are exploring ways to reduce co-pays and deductibles for certain chronic diseases that affect the underserved communities.

Deidre Gifford said that she thinks the global budgets would help with those challenges by expanding some services that may not be covered by traditional payment models.

	Ellen Andrews stated that global hospital budgets have both advantages and disadvantages. She expressed her worry that the early adopters might be the ones who are already performing well. She said that more information is needed about the payment models that fall under CMI. She also raised doubts about the readiness of our data systems for this change, and how to ensure the safety of people. She wondered if there was an option to go back to the previous model in case of failure. Deidre Gifford responded that one possible way to address the issues she mentioned is to improve our payment models, our measurement methods and our targets. We can learn from our experience with value-based payment models and advance payment models and how we measure their outcomes. We need to balance between what is easy to measure and what is important to measure. The global budget aims to increase access to services, not reduce it. We have to make sure we use the right access measures and involve the community. **Due to disruptions from a member of the public the meeting was adjoined early and no request for public comment was made.** Jim Iacobellis wanted to share his opinion in the public forum, but because of the disturbance, Dr. Gifford requested that Jim submit his feedback in writing to be addressed at the next meeting.	
6.	**Public Comment**	**Members of the Public**
	n/a	
7.	**Adjournment**	
	Motion to adjourn was made by Jordan Scheff and seconded by Nicole Taylor. The motion passed unanimously by voice vote. The meeting was adjourned at 3:27 p.m.	