CT Health Care Reform Advisory Board

Minutes of May 27, 2010 Meeting

Members Present: Deputy Commissioner Cristine Vogel (Chair), Department of Public Health (DPH); Cathy Bartell, MHA; James Cox-Chapman, MD, ProHealth Physicians, MSO, Inc.; Christopher Dadlez, Saint Francis Hospital and Medical Center; Robert Dakers, Office of Policy and Management (OPM); Commissioner Thomas Sullivan, State Insurance Department (SID); Commissioner Michael Starkowski, Department of Social Services (DSS); Alexandra Thomas, Aetna; Tom Woodruff, Office of the State Comptroller.

Members Absent: Commissioner Robert Galvin, M.D., M.P.H., M.B.A.; Carole Noujaim; Rick Willard, Leadership Council of the National Federation of Independent Businesses; Lenny Winkler, LPN.

I. Review and Approval of Minutes

Deputy Commissioner Cristine Vogel called the meeting to order at 9:15 am.

Approval of the minutes of the May 20, 2010 meeting was tabled by Deputy Commissioner Vogel anticipating that changes may be made in the course of the meeting.

II. Discussion of Health Care System Reform Subcommittee Recommendations

Below are the draft recommendations from the Health Care System Reform Subcommittee as provided in the minutes of the May 25, 2010 subcommittee meeting. Edits made by the Advisory Board are tracked and comments are included under each recommendation. New language is indicated with capital letters.

<u>Medical Malpractice / Tort Reform</u>

1. **Connecticut should apply for funding under the *"State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation"* (P.L. 111-148 section 10607) and should design a demonstration program that includes the following components:**

   a. **Administrative Compensation System**

   Connecticut's demonstration program should utilize the American Hospital Association's "Framework for Medical Liability Reform" which proposes an administrative compensation system that would be created to compensate patients for injuries that could have been avoided during medical care. PARTICIPANTS IN THE DEMONSTRATION SHOULD BE REQUIRED TO PROVIDE RELEVANT

MEDICAL MALPRACTICE DATA TO THE CONNECTICUT INSURANCE DEPARTMENT.

The AHA framework includes the following main components:

- **Claims for injury during medical care would be handled through an administrative process (intentional injuries and criminal acts would remain in the courts).**
- **Compensation would be provided for injuries that could have been avoided and that meet a minimum threshold of harm.**
- **Patients would submit claims to a local panel that would make decisions using explicit nationally established decision guidelines and schedules.**
- **Patients who question the local panel's decision would bring their claim to other sources that might include an expert panel, administrative law judge, or the court system.**

~~**b. Bifurcation of medical malpractice cases into liability and damages sections Bifurcation should be allowed at the request of either counsel.**~~

Discussion:

- Jim Cox-Chapman: Part b. of this recommendation should be made into a separate recommendation.
- Alex Thomas: Is 'minimal threshold of harm' measured in a dollar amount? Chris Dadlez and Jim Cox-Chapman agreed that this term goes beyond monetary and refers to actual harm.
- Jim Cox-Chapman: Connecticut currently has an apology law for patients that have been harmed that has not been tested yet in the courts. The demonstration referred to in this recommendation may provide a mechanism to test this law. This idea could be included in the report narrative rather than captured in a recommendation.
- Since this recommendation is supported by a planning grant that could lead to a grant funded demonstration project, this is a no cost recommendation for the State.
- Tom Woodruff: Has anyone evaluated the medical malpractice law that passed in Connecticut a few years ago? Commissioner Sullivan answered that CID has only limited access to relevant data and there is a need to be careful about conclusions that are drawn from available information. There are federal restrictions on what types of data the State can collect. The State only collects data regarding fully funded cases. The larger portion of claims is generated from providers covered under self-funded plans or captives which are not required to file data.
- Jim Cox-Chapman: Malpractice reform is also a workforce issue and is both a monetary and moral consideration if we want to attract providers to the state.
- Tom Woodruff: Should we have a recommendation to develop a database? Commissioner Sullivan replied that there are federal restrictions on what types of data we can collect. Chris Dadlez suggested that Connecticut could construct a more complete picture by requesting data that cannot be mandated.
- There was agreement on the suggestion that participants in the demonstration proposed in this recommendation be required to contribute medical malpractice data.

NEW - BIFURCATION OF MEDICAL MALPRACTICE CASES INTO LIABILITY AND DAMAGES SECTIONS SHOULD BE ALLOWED AT THE REQUEST OF EITHER COUNSEL.

Discussion:

- Jim Cox-Chapman agreed to provide more information to the Board at the next meeting in order to clarify a question regarding the role of the judge in deciding the issue of bifurcation.

<u>Health Care Reform and the Health Workforce</u>

2. **Connecticut should re-examine the limitations of each type of medical licensure to ensure that practitioners are able to maximize their ability to practice at the top of their training and licensure.**

   a. **Connecticut should license medical assistants ("MAs"), a health care professional that is a key member of the primary care team in medical homes. Currently, there is no Connecticut licensure for MAs and their scope of practice is severely limited. Connecticut should develop a scope of practice consistent with national certification in order that the state is able to fully implement federal opportunities for medical home demonstrations.**

   b. **Connecticut should increase access to physician assistants ("PAs") by maintaining the current requirements for physician supervision but eliminating the onsite requirement. Currently, PAs require onsite supervision weekly in the office setting and at all times in the hospital.**

Discussion:

- Jim Cox-Chapman: With more people gaining access to care and no new dollars, there is a need to re-engineer the system and work smarter. Consequently, it makes sense to focus every provider's skills to the top of their license. PAs and nurse practitioners (APRNs) are a key component of the health care delivery team and require a collaborative relationship with physicians. There should be parity between PAs and APRNs.
- Commissioner Michael Starkowski: If there is no onsite supervision for PAs, does that mean they need more malpractice insurance? Jim Cox-Chapman replied that PAs and APRNs are usually covered under either the hospital or physician malpractice coverage.

3. **Connecticut should enact legislation creating a procedure for administrative review by DPH for proposed changes to scope of practice laws prior to being raised in the legislature.**

   a. **DPH should identify and pursue grants/demonstrations available through the PPACA that would assist with funding to implement the proposed scope of practice process.**

Discussion:

- Jim Cox-Chapman: This recommendation creates a process for addressing scope of practice issues in Connecticut. There is a cost to establishing this process and we may be able to apply for a grant. With the implementation of health care reform and efforts to restructure the system, it is a good time to re-examine scope of practice issues.

4. Connecticut should aggressively seek its share of residency slots for the training of primary care physicians.

   a. To qualify for the '*Distribution of Medicare graduate medical education (GME) positions*' (P.L. 111-148 section 5503), identify entities in Connecticut that satisfy the requirements for this program (priority goes to hospitals: in states with low resident/population ratio (70%); in states with a high number of people in health professional shortage areas and/ or located in rural area (30%)).

   b. Develop linkages between teaching hospitals and qualified hospital and physician practices in medically underserved or rural settings.

   c. Address primary care broadly, to include internal medicine, family practice, pediatrics and obstetrics.

Discussion:

- Commissioner Starkowski: Do we meet the percentage requirements to qualify for additional residency slots? Chris Dadlez replied that Connecticut should at least meet the health professional shortage criteria.

5. Connecticut should apply for a '*Health Workforce Development Planning Grant*' (P.L. 111-148 section 5102) to analyze health care labor markets; identify current and projected needs; identify short and long-term workforce development strategies; identify existing Federal, State and private resources for health workforce recruitment, education, training and retention. (This will require a 15% state match.)

Discussion:

- Deputy Commissioner Vogel: Despite all the work on workforce issues in Connecticut over the last 10 years, there is a need to establish a baseline resource.

6. Connecticut should apply for a '*Health Workforce Development Implementation Grant*' (P.L. 111-148 section 5102) to encourage regional partnerships and promote innovative workforce pathway activities. (This will require a 25% match.) This grant will allow Connecticut to address the workforce needs of a reorganized health care delivery systems (i.e. accountable care organizations, medical homes) and address the need to have health care professionals function in new/changing roles.

Discussion:

- Deputy Commissioner Vogel: Recommendations 5 and 6 are for planning and implementation grants that require a state match.

7. DPH should work with the state's community health centers and school-based health centers to maximize the receipt of federal money for the purposes of: maintaining and expanding the number of such clinics; maintaining and expanding the number of such clinics that possess FQHC status; ensuring that these sites provide safety net coverage for the entire state population; and utilizing new methods of integrated care coordination.

Discussion:

- Chris Dadlez: Recommendation #7 does not really belong in the workforce section and should be in its own section.

Linking Service Delivery Reform to Payment Reform

8. Connecticut should join the New England Coalition for the Patient Centered Medical Home. This coalition of all New England states (except Connecticut) has applied for waiver authority from CMS to stage a combined Medicare/Medicaid patient-centered medical home demonstration project.

Discussion:

- Jim Cox-Chapman: The fact that Connecticut is not participating in this New England Coalition may have more to do with missed communication. Both the Sustinet Board and this Board have indicated that Connecticut should participate. Dr. Craig Jones from the New England Coalition has indicated that they are open to having Connecticut join them.
- Commissioner Starkowski: The Department of Social Services has been interested, but at some point the discussions broke down and the department has been trying to reconnect. Jim Cox-Chapman indicated that he would talk with Dr. Jones to communicate Connecticut's interest.

9. Connecticut should encourage policies for formation of Accountable Care Organizations in Connecticut linking payment reform to these new care delivery models FOR THE BENEFIT OF PATIENTS.

Discussion:

- Deputy Commissioner Vogel: The recommendation is very broad and should be narrowed down.
- Alex Thomas: Suggested adding" "for the benefit of patients."
- Chris Dadlez: We could say that the state would facilitate these efforts and help remove barriers. However, it is too early in the process to be more specific.

- Bob Dakers: Currently, we have a fee-for-service system that values volume over quality. We need to start moving in the direction of accountable care organizations to be able to address issues of cost and quality.
- Deputy Commissioner Vogel: Recent legislative changes to the certificate of need process should align with efforts to restructure the health care delivery system.

10. Connecticut, through the Department of Social Services, should pursue payment reform demonstration projects included in the new federal legislation, including *'Medicaid Demonstration project to evaluate integrated care around a hospitalization'* (P.L. 111-148 section 2704) and *'Medicaid global payment system demonstration project'* (P.L. 111-148 section 2705).

Discussion:
- Commissioner Starkowski: We agree with this recommendation. Changing the payment system will impact providers producing winners and losers. In order to preserve access, we need to pay attention to the effects on various providers.

Prevention and Wellness / Patient Participation

Discussion:
- Cathy Bartell: It is not enough to define healthcare reform as getting people insured. It is equally important to address access to care and improving the health status of the community. As part of health care reform, the Governor should establish a Health Improvement Advisory Board.
- Deputy Commissioner Vogel: What is the state role? Wellness programs are either employer driven or offered by health plans.
- Bob Dakers: Wellness is more of a public health issue that an insurance issue.
- Deputy Commissioner Vogel: A discussion of the need to address wellness and community health can be placed in the narrative of the report and is covered in the Guiding Principles. It is difficult t know how government can address this issue. The Sustinet Board is doing an excellent job of addressing this issue from the point of view of creating a health plan. We don't want to create a redundant activity.
- Cathy Bartell: There is redundancy, but it may be of benefit to convene a group for six months and collect information on the issue and current efforts.
- Deputy Commissioner Vogel: Sustinet is meeting on June 1st to have their subcommittees report their findings. This provides a good opportunity for us to see if and how they are addressing these issues.
- Chris Dadlez: Do we want to be bold and say Connecticut should be the healthiest state in the nation and address how to accomplish this? How do we get people to take responsibility for their health? We should have all sorts of free screening program in an organized fashion throughout the state.
- Jim Cox-Chapman: We cannot assume that just because people have access to health care insurance means they will take advantage of screening and prevention.

- Deputy Commissioner Vogel: I will work with staff to craft a new recommendation that relates directly to the Executive Order regarding improving the health status of citizens.

Jim Cox-Chapman offered his gratitude to Alexis Fedorjanczenko for synthesizing the broad ideas provided by the Health Care System Reform Subcommittee and making them into crisp recommendations.

III. Discussion of Proposed Recommendations from the Previous Advisory Board Meeting

The Advisory Board reviewed the recommendations discussed at the May 20, 2010 meeting. Edits made by the Advisory Board are tracked and comments are included under each recommendation. New language is indicated with capital letters.

(1) The exchange should offer one-stop shopping that promotes consumer choice ~~and empowers them~~ THROUGH DIRECT ACCESS TO OR LINKAGE with:

- **Clear information comparing plans and offering plan specifics;**
- **Real-time decision support tools ~~that include web linkages to the participating plans~~;**
- **Eligibility determinations for PUBLIC subsidies, Medicaid/HUSKY A, SCHIP/HUSKY B, CHARTER OAK HEALTH PLAN, or other programs;**
- **Estimations of premiums once subsidies are applied; and**
- **Easy enrollment in or purchase of coverage.**

Discussion:

- Commissioner Starkowski suggested technical changes.

(2) The exchange should encourage plan competition, innovation, quality and cost control by:

- **Promoting a variety of distribution methods, as provided in federal law, and allowing for broad plan participation in the exchange;**
- **Promoting the sale of coverage inside and outside of the exchange by supplementing the current market, thus enhancing consumer options;**
- **Implementing federal regulations related to quality improvement, adequate provider networks, and costs for plans offered throughout the exchange in a manner that improves quality and controls costs, but which do not impose requirements that are not proven methods of achieving these goals.**

No discussion.

(3) The exchange should consider ways to provide information on provider and health care quality.

No discussion.

(4) The exchange should focus efforts on individuals and small groups (e.g., those with 50 or fewer employees, unless otherwise prohibited by federal law) because individuals and small employers with less than 50 employees are those most in need of additional access to insurance.

- **Focus on small employers with 50 or fewer employees in the exchange until the deadline of moving to 100 or fewer employees in 2016;**
- **Any decision to include businesses with over 50 employees before 2016 or businesses with over 100 employees after 2017 should be made by the legislature and not delegated to the exchange and should only occur following a full assessment of the impact of this and other market changes under the federal health care reform law. (See #8)**
- **Assure plan solvency and a level playing field by ensuring that every plan in the exchange is regulated equally, subject to the same statutory and regulatory standards.**

No discussion.

(5) The exchange shall study the impact of federal health care reforms on the State, its residents and stakeholders before layering on any additional requirements (see #8) because:

- **Many of the new requirements do not exist in the State today, the details of which are still to be promulgated by HHS, and their effects will need to be measured;**
- **The need to balance coverage with premium affordability as well as the state issue that state has fiscal liability for adding on mandated benefits.**

No discussion.

(6) The exchange should be allowed, as provided in federal law, to contract with other State and private entities ~~as appropriate,~~ to handle exchange functions, AS APPROPRIATE, such as:

- **"Contract" with DSS FOR ELIGIBILITY DETERMINATION SERVICES FOR DSS COVERAGE PROGRAMS INCLUDING PREMIUM SUBSIDY AND COST SHARING TAX CREDITS FOR INDIVIDUALS REFERRED BY OR THROUGH THE EXCHANGE, WITH THE EXCHANGE SERVING**

IN A FACILITATION ROLE ~~to do determination work associated with eligibility for federal premium and cost sharing tax credits~~;

- **Subcontract with entities, ~~as is done by the Massachusetts Connector, to do work related to enrollment, premium billing and collection, etc,~~ as well as potentially with one or more exchanges currently operated by business associations for small businesses to address this market.**

Discussion:

- Commissioner Starkowski suggested technical changes.
- Alex Thomas: Requested that the second bullet be kept broad by deleting references to specific functions.

(7) The director of the exchange should report annually to the Governor and the legislature regarding the effects of reform on, including but not limited to, small employers, other group markets, individual policy holders, rates of uninsurance and penalty enforcement and results; and the effect on the delivery system as a whole.

No discussion.

(8) It is recommended that the exchange shall have a multi-stakeholder "Board of Directors," providing it with the range of expertise and points of view that will bring a balanced and workable approach to carrying out its functions. The membership of the board should include:

- **The Secretary of the Office of Policy and Management (ex-officio), who will serve as chair;**
- **An actuary, a health plan benefit specialist, and/OR a health care economist;**
- **Representatives from a small business, a large business, and labor;**
- **Representatives of the insurance industry, providers and consumers; and**
- **The Commissioners of Social Services, Public Health and Insurance, and the State Comptroller, or their designees (ex-officio).**

The non-ex-officio board members shall be appointed for four year staggered terms, a majority of whom shall be appointed by the Governor.

THE BOARD OF DIRECTORS SHOULD BE ESTABLISHED WITHIN 120 DAYS OF ACCEPTANCE OF THE ADVISORY REPORT BY THE GOVERNOR.

Discussion:

- This recommendation regarding the 'Board of Directors" replaces a proposed recommendation that was tabled at the May 20 Advisory Board meeting.
- Deputy Commissioner Vogel: Instead of getting bogged down on determining the exact composition of the Board of Directors, it is important at this point to recommend that it is a multi-stakeholder board.

- Jim Cox-Chapman: Suggested using and/or in recommending "An actuary, a health plan benefit specialist, and a health care economist" to provide some latitude.
- Alex Thomas: Suggested putting a deadline on the formation of the board. Commissioner Starkowski further suggested inserting: "within 120 days of acceptance of the Advisory Report by the Governor."

(9) [NEW] It is recommended that the exchange(s) be administered by a State authority, similar in structure to the Massachusetts Connector. The duties of the authority would be to carry out the functions of the exchange identified in federal reform legislation. While the exchange authority would need to be granted some flexibility in administering these functions, broader policy issues affecting the insurance market, including regulation of the market, should remain with the Governor, the General Assembly, and the Department of Insurance.

Discussion:

- Alex Thomas: Suggested including the following statement: "The exchange does not set up its own regulatory framework. This would add an unnecessary and costly bureaucratic layer and could create solvency or other problems for consumers." There was debate regarding whether this was a necessary statement considering that CID has regulatory authority.
- Discussion followed regarding the possibility that a new Board of Directors might want to set up their own processes, even if they were duplicative. Commissioner Starkowski suggested the following statement: "The Authority Board of Directors is encouraged not to set up and duplicate functions established in other areas of government." Commissioner Sullivan indicated a concern that there be a level playing field and that additional bureaucracy and duplication not be created; perspectives that could be included in the narrative. Tom Woodruff stated that a new entity might need information that is not currently being collected and suggested that instead of stating this in the negative (avoid duplication), encourage collaboration between entities and the two-way flow of information.
- Deputy Commissioner Vogel committed to working with staff on including these issues in the report. Board members who had additional issues with this recommendation were invited to bring alternate language to the next Advisory Board meeting.

(10) [TABLE RECOMMENDATION] Between the passage of the federal Patient Protection and Affordable Care Act and 2014, strong executive leadership is needed in the establishment of the exchange. The Governor, through the state agencies (Executive Order 43), should be actively pursuing federal grants for the establishment of the exchange and all aspects of state implementation of federal health care reform.

- **Such funding must be used for dedicated staff for planning and implementation, to establish the exchange;**
- ~~**The Board of Directors for the exchange should be established no later than July 1, 2011.**~~

Discussion:

- The second bullet was deleted because it is addressed in Recommendation #8.
- There was discussion regarding who appoints the Board. Deputy Commissioner Vogel stated that if a Board is to be created in 120 days, it would need to be done under Executive Order. If we wait for legislation Connecticut will be behind in this activity and not receive federal funding.
- Commissioner Starkowski: Legislation is required to establish an Authority. It will need to be a legal entity to apply for federal funding.
- Bob Dakers: A state agency – the Governor's Office, OPM or other state agency – is eligible to apply for federal funds to plan the exchange. Commissioner Sullivan added that the federal government is giving states flexibility either to apply as a state agency or other entity. According to Commissioner Vogel, other states are applying as a state entity with a board to receive planning money.
- Commissioner Starkowski: Withdrew the 120 day recommendation to set up the Board of Directors. He suggested that a state agency acquire federal funds to plan. The Advisory Board should recommend the structure and a "no later than date" (January or February 2011).
- Deputy Commissioner Vogel: Executive Order #43 has charged the Cabinet with establishing the Exchange. Compared with other states, Connecticut is on time with its efforts. She suggested a recommendation regarding coordinating current efforts (short Term) and developing an Authority (long-term).
- Tom Woodruff: This recommendation goes beyond the Exchange to address health care reform broadly. However, Executive Order #43 does not include the Comptroller.
- Deputy Commissioner Vogel suggested redrafting this recommendation and keeping the Authority recommendation (#9).

IV. Additional Proposed Recommendations

The Advisory Board turned its attention to a discussion of recommendations offered by Cathy Bartell.

1. Connecticut should consider gradual increases in provider reimbursement based on the number of patients a doctor sees.

Discussion: The group agreed that it is premature to make a specific recommendation on a provider reimbursement strategy and that this issue will be considered in applications to restructure the health care system. The aim of future demonstration projects will be to restructure provider reimbursement. Deputy Commissioner Vogel reminded the group that recommendations will need to be cost out in their report. Cathy Bartell noted her concern that individuals will have sufficient access to care in the short term.

2. Consider ways to make Connecticut a primary care provider friendly state and to keep retired physicians in the workforce.

Discussion: The group agreed that this issue has already been addressed in more detail in the Health Care System Reform Subcommittee recommendations. With regard to retirees, Chris Dadlez finds that physicians are staying in the workforce and postponing retirement because of the economy and does not see a large pool of retirees to tap. He sees tort reform as a more important strategy for attracting physicians into the state.

3. Connecticut should relieve physicians' offices of the burden of collecting the patient's deductible by having the insurance companies collect it. They already collect premiums and already define the deductible.

Discussion: The group agreed that the neither the insurance companies nor the exchange have the legal purview to collect the deductibles required of patients. In addition, there was no consensus on how the state could address the issue of patient responsibility for payments.

V. Next Steps

All recommendations accepted and amended above will be moved to the Boards draft final report.

The next meeting of the Advisory Board will be on June 17th from 9:00 to 11:00 am.

The meeting was adjourned at 12:27 pm.