Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes

October 11, 2016

Members in Attendance: Lt. Governor Nancy Wyman, Susan Adams, Ellen Andrews, Patricia Baker, Kathleen Brennan (DSS), Miriam Delphin-Ritmon (DMHAS), Anne Foley (OPM); Demian Fontanella (OHA), Margherita Giuliano, William Handelman, Frances Padilla, Raul Pino (DPH), , Jordan Scheff (DDS), Kristina Stevens (DCF), Shelly Sweatt, Robert Tessier, Victoria Veltri, Jim Wadleigh (Access Health CT) ; Josh Wojcik (OSC)

Members Absent: Kurt Barwis, Kristin Dowty, Bonita Grubbs, Gary Letts, Michael Michaud (DMHAS), John Orazietti, Hussam Saada, Lawrence Santilli, Gregory Stanton

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.	

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2.	**Public Comment**	The following three individuals provided public comment on the Bailit Straw Proposal: • Sheldon Toubman, New Haven Legal Assistance Association, raised concerns that the straw proposal would impose downside risk on Medicaid beneficiaries and providers, cap Medicaid costs in a manner similar to a block grant, and violated the agreement that the State gave to not impose downside risk on Medicaid. He felt that the proposal perpetuated myths about Connecticut's cost being high and that there is no care coordination. He expressed support for the status quo. Lt. Governor Wyman clarified that the promise made regarding downside risk was to not move to downside risk for PCMH+ during the duration of SIM. • Danielle Giordano, Connecticut NAMI, also expressed concern about Medicaid moving to downside risk. Sheila Ander, MAPOC member, expressed the view that the straw proposal does not focus on the key cost drivers which are high use patients and use of high cost diagnostic procedures. She indicated there was a little focus on social determinants of health, co-occurring mental health and substance abuse issues, high labor costs in Connecticut, and the special needs populations. She expressed concern that downside risk would lead providers to get rid of needy patients and that the downside risk models are in their infancy. She also stated that consolidation of state agencies has not worked anywhere and that Connecticut is effectively working across state agencies already, citing the housing program as a prime example.	
3.	**Review & Approval of minutes July 12, 2016**	Motion to approve minutes of July 12, 2016	Approved – No Abstentions
4.	**Review & Approval of minutes September 13, 2016**	No Motion made	Robert Tessier Abstentioned Not approved

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5.	**Meeting Goals**	The Lt. Governor Wyman noted that there are two key topics for today's meeting: complete the discussion of the straw model and discuss new ideas presented by Cabinet members. She also explained that Cabinet members will be asked to vote on strategies at the November 1 meeting, but must attend the meeting to do so, and that a public meeting will be held on November 15 during which time public comment will be received. The draft report will be discussed during the December 13 meeting at which time a final vote will be taken. In response to a question from Frances Padilla about how dissenting opinions will be handled, Lt. Governor Wyman said that dissenting opinions can be submitted and included into the final report.	

6.	**New Stakeholder Feedback**	Marge Houy, Senior Consultant, reported that since the last meeting, Bailit had met with two stakeholder groups, which provided the following input:
		• MAPOC: The four MAPOC members who chose to comment did not support shared risk for Medicaid providers, and would prefer pilot programs focused on high-cost utilizers, not large scale change. One person believed that OPM should have a more central role in policy coordination, and not consolidate state agencies.
		• The Council members who chose to speak, strongly supported the theme of accountability at the state, payer and provider levels, and saw an ACO strategy as consistent with national trends. They specifically recommended:
		  ○ investment in consumer and employer education about the cost of services and of treatment alternatives;
		  ○ elimination of non-disclosure restrictions regarding negotiated prices in provider-insurer contracts;	

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		○ the State lobby Congress to allow Medicare to negotiate pharmaceutical prices; ○ strategies to reward lower price hospitals for staying lower priced, e.g., low cost loans, benefit design incentives, and promotion of transparent, ethically-based discussion about treatment options, particularly around end-of-life care.	
7.	**Strategy 5. Support Providers and Policy Makers with Data**	Marge Houy explained that there were two proposed strategies to support the goal of building data and clinical information infrastructure to support data-driven decision-making at the provider and policy levels: • Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange (HIE). • Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services.	
8.	**Cabinet Discussion of Strategy 5**	During the APCD and HIE discussion, the following comments and suggestions were made: • Ellen Andrews supports the idea of developing an APCD and HIE, but thinks work-arounds are necessary until they are operational. She also supports crowd-sourcing of data. • Pat Baker supports the recommended strategy, and asked that the need for transparency, broad access to data, and to collect data on race and language be included in the recommendation. She expressed concern about an entity outside of state government holding the data and charging for it. • Frances Padilla expressed support for cost and quality transparency as key to making health care "shoppable" and to inform policy decision-making.	Bailit will bring a more detailed proposal regarding APCD and HIE development to the Cabinet for consideration on November 1. Bailit will bring an enhanced proposal regarding comparative effectiveness research to the Cabinet for consideration on November 1.

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		• Dr. William Handelman emphasized that he did not think it was possible to have quality scoring or value-based payment without these data and thought that the reason that the state had not been successful in developing an HIE, in particular, was due to inadequate funding. Comparative Effectiveness Evidence in Coverage Decisions • Ellen Andrews expressed strong support for this strategy. • Miriam Delphin-Rittmon noted that comparative effectiveness research has not always looked at the impact on diverse racial, ethnic and cultural populations. Anne Foley noted that pharmacy utilization is ripe for cost effectiveness.	
9.	**Strategy 6: Coordinate and Align State Strategies**	Marge Houy explained that this strategy called for the restructure of existing agencies into a single state entity composed of all health-related state agencies. This combined agency would be responsible for aligning all state health policy and purchasing activities.	
10.	**Strategy 6: Coordinate and Align State Strategies**	Marge Houy explained that this strategy called for the restructure of existing agencies into a single state entity composed of all health-related state agencies. This combined agency would be responsible for aligning all state health policy and purchasing activities.	
11.	**Review of Revised Description of CCO Strategy**	Marge Houy summarized that the changes to the CCO strategy included: • Clarifying how the strategy affects all state purchased health care, and how it can evolve to be multi-payer in the future • Clarifying which requirements would be aligned across state purchasers, and which would not • Articulating the risk model and a timeline for implementing the risk model	

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		• Highlighting the differences between the PCMH+ model and the CCO strategy
		  ○ Providers affected
		  ○ Population affected
		  ○ Goals
		  ○ Limitations
		Proposing to regulate ACOs (CCOs, Advanced Networks, etc.) to ensure financial solvency	

12.	**Discussion of the Revised CCO Strategy**	When asked if the revised CCO strategy incorporated the changes that they had requested, the Cabinet members provided the following additional comments: • Pat Baker requested that explicit language be included that the focus needs to be on outcomes. • Ellen Andrews clarified that she is requesting that ACO regulation include other aspects than financial solvency, such as access and quality of care. • Kate McEvoy suggested that the CCO policy should include prerequisites to assuming risk, such as vertical and horizontal integration data tools, previous experience with shared savings, cross disciplinary relationships with providers, care coordination infrastructure, prospective care coordination payments. She also asked that the strategy include strategies to mitigate underservice, including experience surveys and secret shoppers. Frances Padilla stated that that the payment model should have the flexibility to enable providers to think outside of the visit and do such things as hire community health workers.	
13.	**Discussion of Revised Strategies to Limit Cost Growth**	When asked if the revised cost growth cap strategy incorporated the changes that they had requested, the Cabinet members provided the following additional comments: • To clarify a misunderstanding, Marge Houy explained that the proposal is for a soft cap, rather than a strictly	

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		enforced cap. Furthermore, the strategy is not focused on Medicaid, but is most relevant for employer purchasers. • Dr. William Handelman noted that the Federal limit on specialists' fees (referred to as the sustainable growth rate (SGR)) tried to do the same thing and failed, noting that trying to set a cost cap was very difficult to do. • Michael Bailit noted that this was a new strategy without a long track record. Massachusetts is pursuing it and Rhode Island is considering it. In Massachusetts the cost growth target has focused attention on cost growth, and seems to have reset the terms for negotiation between providers and insurers by injecting discipline on the amount of increase agreed to by the parties. Michael Bailit further noted that a cost growth cap differs from the SGR because it tries to address both price and utilization. • Anne Foley questioned why a cost growth cap that addresses both price and utilization is necessary when prices are the key issue in Connecticut. • Michael Bailit noted that hospitals in Maryland increased utilization when subject to a price limitation. • Ellen Andrews supported addressing both price and utilization. She also suggested that the strategy also needs to look at up-coding and the expanding number of services. Discussion of the policy to set a target for achieving alternative payment models included the following comments and suggestions: • Ellen Andrews noted that the Federal LAN model was not the only model available to define alternative payment models. She noted that MACRA also has	

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		developed one. She raised the question about what we really mean by alternative payment models. • Megan Burns suggested that the Cabinet members do not need to get into this level of detail and that would be a key implementation topic.	
14.	**Discussion of Strategy to Create the Office of Health Reform**	Marge Houy suggested and the Cabinet members agreed that this strategy be revised in light of the earlier, but related, discussion of the strategy to consolidate state agencies (Strategy 6).	Bailit will update the strategy to Align State Policy and Strategies to include the Cabinet's requested changes.
15.	**Discussion of the Strategy to Enhance the Investigative Powers of the Attorney General**	Lt. General Wyman said that she would speak with the Attorney General about this strategy and suggested that the Cabinet await taking any action until the Attorney General has been consulted.	
16.	**Introduction to Discussion of Alternatives Suggested by Cabinet Members**	Megan Burns thanked Ellen Andrews, Frances Padilla and DSS for submitting written alternatives. She explained that all these suggestion have been organized into categories of health care system transformation. To identify which of the strategies to bring to the Cabinet for discussion, Bailit applied the following criteria: • Does the strategy directly relate to the legislative charge? • Might the strategy reasonably reduce costs? • Might the strategy lay the foundation for future cost containment? Megan Burns further explained that after the alternatives are presented and discussed, the Cabinet will be asked to identify which they would like to tentatively include in the final report. Bailit will work the person(s) proposing the strategy to flesh it out by determining: • How will the strategy reduce costs for the state? • How should this strategy be implemented? How does this strategy fit with other strategies the Cabinet is considering?	

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17.	**Alternatives for Delivery System Transformation**	Megan Burns presented two alternatives to the CCO strategy • Coordinate Care with Community-based Organizations. Better coordinate community-based organization offerings with medical care, through the use of community health teams that work directly with primary care providers to assess patients' needs and provide multidisciplinary care (e.g., Vermont Blueprint for Health or Colorado's RCCOs). • Pursue Current Strategies: Continue with Medicaid's current strategies on enhancing primary care through PCMH+. Continue with Medicaid's review of claims data to identify the high cost, high need individuals and develop specific interventions to address their care needs.	
	Discussion of Alternatives for Delivery System Transformation	In discussing the alternative strategies, the following comments and suggestions were made: • Ellen Andrews expressed support for both alternatives. She also noted that there are Medicaid strategies that could be adopted by commercial payers to make it an all-payer strategy. • Pat Baker expressed the need for an all-payer strategy, such as the CCO strategy. She said that the current strategy approach was palatable, although she wants to aspire to the CCO strategy. • Secretary Barnes noted that the PCMH+ strategy was intended to ultimately be an all-payer strategy. • Frances Padilla expressed support for Community Health Teams, as did Pat Baker. • Dr. William Handelman expressed concern that Community Health Teams exclude small practices, to which Megan Burns responded that Community Health Teams were specifically intended to help smaller practices.	Bailit will update the Alternatives for Delivery System Transformation strategy to include the Cabinet's requested changes

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		Megan Burns summarized the discussion by noting that there was support for the current strategy direction, and that the community health strategy should be incorporated into both the CCO strategy and the current strategy direction.	
18.	**Presentation of Alternatives for Payment System Reform**	Megan Burns presented three alternatives to the shared savings/shared risk and APM target setting strategy • New PCP Payment Models: Introduce more flexibility around primary care payment to allow PCPs to deliver traditionally unreimbursed services (e.g., health coach, or community health worker). This strategy could be coupled with PCMH+. • Other New Payment Models: Study more closely MD and VT's movement toward all-payer global budgeting and determine what initial steps CT could take to move toward global budgets Pursue Current Strategies: Continue to implement PCMH+ (shared savings) in the waves currently planned and evaluate effectiveness. Increase the amount of pay-for-performance in use. Create bundled payments for maternity care that incentivize providers to streamline care delivery, thereby reducing costs and improving outcomes (currently being considered by Medicaid).	
19.	**Discussion of Alternatives for Payment System Reform**	In discussing the alternative strategies, the following comments and suggestions were made: • Vicki Veltri expressed the need for all strategies to be coordinated with SIM so that SIM is not "derailed". • Ellen Andrews expressed support for the current strategy. She also noted that any alternative, such as a PCP cap would need to be linked to quality goals. Megan Burns noted that there was no support for alternative PCP payment models, but that there was support for the Office of Health Reform to study and follow the development of	Bailit will update the Alternatives for Payment System Reform strategy to include the Cabinet's requested changes

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		Vermont's and Maryland's strategies to implement global, all-payer budgets.	
20.	**Presentation of Alternatives for Limiting Cost Increases**	Megan Burns presented the following three alternatives for limiting cost increases: • Regulate Market Mergers: Require that cost growth limits be included in any future merger approvals. Limit monopoly power by restricting further CON approvals for market mergers • Rate Setting: Review hospital budgets and set rates, as was done in CT from 1976-1994, using lessons learned from MD and VT. Consumer Affordability: Include consumer affordability into the CID's rate review process.	
21.	**Discussion of Alternatives for Limiting Cost Increases**	In discussing the alternative strategies, the following comments and suggestions were made: • Vicki Veltri and Lt. Governor Wyman noted that the CON Task Force is looking at market mergers and suggested that the Cabinet ask that group to consider the first strategy. • Secretary Barnes expressed support for rate setting, but acknowledged that it was difficult to do. • Pat Baker, Bob Tessier and Josh Wojcik expressed support for a strategy that focused on total cost of care, rather than prices. The Cabinet asked that the Office of Health Reform be tasked with the responsibility to consider rate setting and consumer affordability strategies in the future.	Bailit will update the strategy for Limiting Cost Increases to include the Cabinet's requested changes
22.	**Presentation of Alternatives to Support Provider Transformation**	Megan Burns presented one alternative to provider support for provider transformation: Continue with the Current Strategy: Utilize current SIM investments and plans to support providers.	
23.	**Discussion of Alternatives to Support Provider Transformation**	In discussing the alternative strategies, the following comments and suggestions were made:	Bailit will update the strategy to Support Provider

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		• Ellen Andrews raised concerns about DSRIP funding and 1115 waivers. Megan Burns asked Ellen Andrews to provide a list of possible negative outcomes that concerned her, so that guard rails to protect against them could be added to the DSRIP/1115 strategy. • Kristina Stevens noted that there were other ways to support providers. • Pat Baker noted that it will take more funding that SIM has available to support provider transformation. She noted that other states have pursued DSRIP funding successfully and that Connecticut should do the same. • Secretary Barnes noted that Connecticut has a low Medicaid PMPM and asked why a Medicaid strategy was being pursued. Megan Burns suggested that the state organize a small group to discuss the current provider support. She will also work with Pat Baker to further develop the DSRIP proposal.	Transformation based on the Cabinet's discussion and the work of the smaller group.
24.	**Presentation of Alternatives to Support Market Competition**	The Cabinet decided to hold discussion of this strategy until after Lt Governor Wyman has had a conversation with the Attorney General, since some of the proposed strategies include expanding the Attorney General's investigative powers.	

25.	**Presentation of Alternatives to Address Rising Pharmaceutical Costs**	Megan Burns presented two alternative proposals for addressing rising pharmaceutical costs, noting that it was not included in the Straw Proposal:
		• <u>Possible Strategies to Pursue</u>:
		  ○ Pursue multistate prescription drug alliances for all state-purchased drugs (already in effect for Medicaid).
		  ○ Enact a therapeutic substitution law that would allow a pharmacist to substitute a less expensive, but equivalent brand name drug for another.
		  ○ Expand medication therapy management.	

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		○ Use value-based benchmark pricing in drug negotiations as a hard stop. ○ Use indication-specific pricing for drugs. Take up Pharmaceutical Costs in 2017: Given the existing time limits, the numerous strategies, and importance of the topic, make it a feature for the Cabinet's 2017 work.	
	Discussion of Alternatives to Address Rising Pharmaceutical Costs	In discussing the alternative strategies, the following comments and suggestions were made: • Marghie Giuliano asked that the strategies not be pushed off and that finding of medication management strategies for pharmacists be included. Megan noted that that strategy was part of the SIM CCIP, to which the CCOs must comply. • Ellen Andrews expressed concern that medication adherence and good stewardship (appropriate use of antibiotics) were important, but not part of pricing concerns. • Dr. William Handelman supported the prohibition of automatic refills and noted that Maine has an academic detailing program. • Megan Burns suggested that the topic be addressed by the Cabinet in 2017, and Secretary Barnes urged that it not be delayed. Lt. Governor Wyman asked Marghie Giuliano, Secretary Barnes, Marie Smith and Susan Adams to help Bailit Health develop pharmacy strategies for the Cabinet to consider on November 1.	Bailit Health will convene a small work group to develop strategies to address rising pharmaceutical costs for presentation at the November 1 meeting.
26.	**Next Steps**	Megan Burns reviewed the next steps: • At the November 1st meeting, and after additional discussion and review of the strategies we flesh out based on today's conversation, the Cabinet will vote on which strategies to include in the final report.	

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		• The November 15th meeting will be reserved for public input on the strategies that the Cabinet approved. The public can also submit written comment until November 15th At the December 13th meeting, we will discuss the draft Cabinet report that will include public feedback, and if needed, re-vote on particular strategies, or perhaps vote on the final report. If we do not vote on the final report on December 13th, we will have a special teleconference meeting shortly after to vote on the final report.	
27.	**Next Meeting**	The next meeting of the Healthcare Cabinet will be held on Tuesday, November 1, 2016 at the LOB, Room 1D. The meeting time is **1:00 PM – 4:00 PM**	
28.	**Adjourn**	Motion to adjourn	Lt. Governor motioned and All agreed