Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
February 9, 2016

Members in Attendance: Lt. Governor Wyman, Dr. William Handelman, Margherita Giuliano, , Miriam Delphin-Rittmon, , Frances Padilla, Patricia Baker, Victoria Veltri, Ellen Andrews, Katharine Wade, , Kristina Stevens, Dr. Raul Pino, Bonita Grubbs, Gregory Stanton, Bob Tessier, Jim Wadleigh
Members Absent: Shelly Sweatt, Margaret Smith, John Orazietti, Gary Letts, Joanne Walsh, Linda St. Peter, Steven Hanks, Kevin Lembo, Roderick Bremby, Joette Katz, Larry Santilli, Ann Foley, Morna Murray

Agenda Item	Topic	Discussion	Action
1.	**Call to order & Introductions**	Pat Baker called the meeting to order.	
2.	**Public Comment**	Dr. Fred Hyde, MD discusses dependency on Medicare info for knowledge of hospital prices; states that publications of data assured readers that Medicare pricing differentials would parallel commercial pricing differentials. With full access to B/C information prices paid to larger monopoly health systems compared to prices paid at smaller hospitals. To quote Jon Leibowitz, former Chair of the FTC "If you want to do something about controlling costs in health care, you have to challenge anticompetitive hospital mergers". Understanding Financial Impact of Hospital Acquisitions: Three (3) suggestions:	

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		• Execs of acquired organizations believe that they will be moving up; part of larger organization who are paid more and will be on a career path toward success • Narrative of leverage – price variations are not correlated to: a) quality of care; b) sickness/ complexity of population; c) extent of provider's responsibility for Medicare/Medicaid patients; 4) provider academic teaching or research facility; 5) price variations not adequately explained by differences in hospitals costs-delivering similar services at similar facilities. Price variations are correlated to market leverage measured by relative market position of a hospital or provider group, compared with other hospitals/providers groups within a geographic region or academic medical centers. • Narrative of bad intent – acquisitions precisely for purpose of raising prices Savings results from these consolidations; there is no evidence of any. Impact of hospital consolidation: a) you buy your competitor; b) eliminate capacity to bargain independently; c) eventually close part or all services; d) sell the remaining services at higher prices Representatives from two unions expressed concern over plans by New London's Lawrence + Memorial Hospital to join the Yale New Haven Health System could lead to higher prices and reduced access to services	
3.	**Review & Approval of minutes**	Meeting minutes reviewed from January 12, 2016	Minutes approved
4.	**Presentation by Zack Cooper, Yale University, "The Price Ain't Right? Hospital Prices and Health**	Key findings from presentation: • Low correlation between Medicare an private spending per person • Price explains large portion of national variation in inpatient private spending • Substantial variation in prices, both within and across markets • Higher hospital market concentration is associated with higher hospital prices	

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	Spending on the Privately Insured"	Cooper noted that the average price of health coverage averaged $17,545 for a family of four. Cooper examined three geographic areas of the state. He explained how Medicare prices are set, comparing prices in varying geographic areas of the country and state. Cooper's analysis showed that two out of three regions in the state had higher than average spending for Medicare and private coverage. Cooper's research shows that spending variations for private health coverage are dictated by price, which is based on contract negotiations between health plans and hospitals. Prices also depend on competition in the hospital's geographic region, With 15.3 percent higher in markets with no competition versus markets with four or more hospitals. Cooper's research also showed that bigger, high-tech hospitals have higher prices, while quality and price were not closely correlated. During the Q &A after his presentation, Cooper suggested that price transparency could allow patients to seek less expensive care, even if those patients had to travel farther for care. Several Cabinet members agreed that while transparency is useful, that many consumers are not equipped to use transparency as a method to provide meaningful choice in making care decisions. Cooper opined that there might be areas of regulation -- e.g, setting maximum emergency room fees. He stated that policymakers could explore price setting in areas where there is no competition. He also pointed to anti-trust enforcement as a mechanism to address prices. Cooper's full presentation is available at: http://healthreform.ct.gov/ohri/lib/ohri/20160207_connecticut_hc_cabinet.pptx.pdf	
4.	**Cost Containment Model Study**, Michael Bailit, Megan Burns, and Marge Houy	Megan Burns, Senior Consultant with Bailit Health, discussed two key aspects of Vermont's cost containment strategy. First, the Blueprint for Health is a statewide Patient-centered Medical Home initiative that was initiated by the legislature in 2006. It consists of five key components:	.

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		1. Advanced primary care practices serving as medical homes; 2. Support from multidisciplinary community health teams; 3. Support from a network of self-management programs; 4. Comparative reporting from statewide data systems; and 5. Locally-led Regional Community Collaboratives, charged with improving the population health of a specific geographic area. All payers in the state, as well as Medicare, are participating in the Blueprint. One critical success factor for the Blueprint are the multi-disciplinary community health teams, which can include nurse coordinators, social workers, nutrition specialists, community health workers, Medicaid care coordinators, home and community-based care coordinators and public health specialists. The teams are responsible for supporting local primary care practices in delivering whole-person care. A second critical success factor is the availability of data to the practices and the community health teams that provide practice profiles using a core measure set, and patient-specific information. The data reporting will be incorporating ACO contract measures and integrated clinical data. Second, the Green Mountain Care Board (GMCB), established by the legislature in 2011, is a five-person, independent board appointed by the legislature is charged with performing three functions: 1. To regulate insurance rates, hospital budgets and major hospital expenditures 2. To Innovate with respect to payment and delivery system reform 3. To evaluate the impact of innovation has had on Vermont's economy and of proposals for funding the health care system. The GMCB is in the unique position of integrating their decisions regarding hospital budgets into their review of insurer rate increases. The GMCB estimates that the insurance rate review process has saved the state residents $66 million. The GMCB is exercising its innovation authority in three ways: 1. Vermont Shared Savings Program pilot, which was implemented with the state's three ACOs and includes common program standards, performance measures and payment model.	

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		2. All-Payer payment model which creates a single ACO with a single payment model for the entire state. The target start date is January 1, 2017. 3. Pilots focused on smaller payment and delivery system reform innovations, such as an oncology PMPM payment model in one community. Megan identified the key success factors that enable Vermont to undertake these wide-ranging reforms as: 1. Culture: Vermont has had a long history of collaboration around health care reform, built on mutual respect between the GMCB and providers. This is supported by a culture of transparency. 2. Leadership: Vermont has committed leaders driving reform, including the Governor, members of the Legislature, the GMCB and provider organizations. 3. Regulation: the GMCB has broad powers to regulate health care rates, hospital budgets and to compel providers to participate in payment and delivery system reform. During the discussion of Vermont's cost containment strategies and their possible relevance to Connecticut, the following points were made: 1. Commissioner Wade noted that insurer insolvency was regulated by a different state agency (the Department of Financial Regulation) from the premium rates (the GMCB), which could result in an incongruous decision with respect to any one payer. 2. Ellen Andrews asked why Vermont was moving to a single ACO, since they have the Blueprint and robust data. Michael Bailit explained that because the state was so small, the only way to get sufficiently large numbers to manage a capitated payment model was to create a single ACO. 3. Dr. Handelman asked who determines how the shared savings will be distributed and how out-of-state payments are addressed. Michael Bailit explained that the state is a convener and facilitator for joint negotiations on how to distribute the shared savings, which is, therefore, ultimately decided by the plans and the providers. Out-of-state payments are included in the calculation of total costs of care. He further explained that under the new all payer model, PCPs will receive a capitation payment for primary care services, and hospitals will receive a fixed revenue budget that covers all services	

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		provided including services provided by employed physicians. Pharmacy costs are not included, but in the future will likely be included. 4. Frances Padilla noted that Vermont has been working on these initiatives for at least a decade. She also noted that Connecticut has a PCMH initiative in Medicaid, and a SIM strategy to enhance the PCMH initiative. She noted that Connecticut may need regulatory change independent of rolling out transformation initiatives, particularly with regard to mergers and acquisitions. 5. Pat Baker noted that Connecticut is not Vermont and asked what the precursors were to getting to the point of driving change. She noted that there is an opportunity to build on the SIM alignment and noted the critical importance of a robust data collection and reporting strategy. Michael Bailit identified three key precursors. First is leadership, which requires that health care reform be a high priority for the legislature, the Governor and the stakeholders. Second is a culture that acknowledges that health care costs are a common problem for everyone and that it is in everyone's best interest to work on the issue together. Third is trust among the stakeholders which enables competitors and former "enemies" to enter into partnerships for the common good. 6. Pat Baker asked if these three precursors are not present, what can prompt progress. Michael noted that provider can often be motivated by fear. With a strong leader able to bring stakeholders together to address their fear, a state can move forward. 7. Vicki asked several specific questions about the Vermont calculation of savings included in the presentation. Megan explained that the ROI calculation in the Blueprint savings estimate is an overall ROI, and that the 3.5% cap for the All-Payer Model was an overall cap.	
5.	**Next Steps**	Next meeting will be held on Tuesday, March 8, 2016 at 9:00 AM – 12:00 PM at the Lyceum	
6.	**Adjournment**		