Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes

June 14, 2016

Members in Attendance: Lt. Governor Wyman, Susan Adams, Ellen Andrews, Patricia Baker, Kurt Barwis, Miriam Delphin-Rittmon (DMHAS), Anne Foley (OPM), Demian Fontanella (OHA), Margherita Giuliano, Bonita Grubbs, Gary Letts (via phone), Morna Murray (DDS), Frances Padilla, Dr. Raul Pino (DPH), Hussam Saada, Gregory Stanton, Kristina Stevens (DCF), Shelly Sweatt, Bob Tessier, Jim Wadleigh; Paul Lombardo (CID)

Members Absent: William Handelman, Michael Michaud (DMHAS), John Orazietti, Andrea Ravitz, Lawrence Santilli, Josh Wojcik (OSC)

Others present: Victoria Veltri (Lt. Governor Office); 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**	No public comment	
3.	**Review & Approval of minutes**	Meeting minutes reviewed May 10, 2016	Minutes approved
4.	**Principles**	Kurt Barwis, chair of a subcommittee asked to develop principles for guiding the work of this Cabinet, reported out the following recommendations from the subcommittee: after reviewing several alternative approaches to developing principles, the subcommittee reviewed the Cabinet's existing principles,	• The Office of the Lieutenant Governor will incorporate adopted changes and post the revised principles.

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		adopted December 8, 2011, and recommended adopting them with the following changes: • The Sub-Committee's Stakeholder listing needed to be incorporated (consumers, providers, government, payers and businesses). • The concepts/principles of Transparency and Sustainability need to be incorporated. • The word "mental" in the first sentence should be changed to "behavioral." Upon discussion of the subcommittee's recommendations, Rev. Bonita Grubbs questioned the meaning of "mindful of" in the second principle and accepted the recommendation that the wording be changed to "incorporates." Pat Baker expressed the view that the revised principles represented the founding principles of the Cabinet and, therefore, supported their adoption as the principles to review cost containment strategies. The Cabinet unanimously adopted the revised principles as recommended by the subcommittee, with the change requested by Rev. Grubbs, as those that would be used to evaluate the work of this Cabinet.	• The Office of the Lieutenant Governor will post the adopted principles on its website.
5.	**Introduction to State Agency Presentations**	Vicki Veltri explained that the agenda for the meeting had been adjusted to provide time for key state agencies to make short presentations to explain what they were doing to address cost increases within their sphere of activity. Each agency was asked to address the following questions during their presentations: 1. What are the cost drivers in your program? 2. How are you addressing the cost drivers through policies, initiatives, programs, etc.?	• None

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		3. What are the documented savings and quality improvement for those policies, initiatives and programs? 4. What are your long term strategies for cost containment? Vicki explained that all the presentations from the meeting will be available on the cabinet's website.	
6.	**Presentation by Raul Pino, Commissioner, Department of Public Health**	The Commissioner identified the burden of chronic disease as the key cost driver. He identified six key activities to reduce the chronic disease burden (reduce tobacco use, control high blood pressure, prevent healthcare-associated infections, control asthma, prevent unintended pregnancy and control/prevent diabetes) and 18 evidence-based interventions that are recommended by the CDC. In addition to the CDC recommendations, DPH would like to focus on HIV prevention and increase the use of the HPV vaccine. In response to questions from Pat Baker, Commissioner Pino explained that African Americans have the highest rate of asthma because it is often untreated and undiagnosed because of the lack of insurance coverage. Living conditions and socioeconomic factors also impact the asthma rate. Pat Baker noted that the cost figures in Commissioner Pino's presentation were national figures and she asked whether costs for Connecticut could be identified. Commissioner Pino said that they could. Pat Baker asked Commissioner Pino how he works with peers across departments to work on cross-agency collaboration. His response was that his department works with other departments, the extent to which depends on the initiative and	DPH to develop cost analyses using a pre-post model and send to Vicki Veltri.

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		provided several examples. For example, DPH and DMHAS have worked together on the opiate crisis, and DPH and DCF on fetal alcohol syndrome.	
7.	**Presentation by Kate McEvoy, State Medicaid Director**	Ms. McEvoy identified the key cost drivers of Medicaid to be "high need, high cost" individuals with complex needs and individuals who receive long-term services and supports (LTSS). She identified the following four strategies to address these cost drivers: • Streamlining and optimizing administration of Medicaid • Improving access to primary, preventive care • Coordinating and integrating care • Rebalancing LTSS services • Moving towards value-based payment approaches She reported that through these initiatives the program has seen reduced ED and inpatient services to targeted populations and improved quality. Ellen Andrews noted that the homeless project was not discussed and commended the department for its collaborative approach involving consumers and providers. She also thanked them for focusing on underservice, noting that only 55% of people get recommended care. She noted that high quality care saves money.	
8.	**Presentation by Commissioner Miriam Delphin-Rittmon, Department of Mental Health and Addiction Services**	The Commissioner identified three cost drivers: • ED and inpatient utilization • Skilled Nursing Facility Care for mental health clients • Intersection of Homelessness and Behavioral Health The Commissioner reviewed programs designed to address each cost driver, including ED diversion programs, establishing behavioral health homes, alternatives to hospitalization, and working to address homeless for those who have been in the corrections system. She also emphasized that the department is	DMHAS to develop cost analyses using a pre-post model and send to Vicki Veltri.

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		focusing on mining data to better understand what programs are impacting these drivers. In response to a question from Ellen Andrews, the Commissioner confirmed that cost savings accrue to Medicaid. She also responded to a question from Pat Baker that doing pre- and post- intervention analyses on cost is an important next step.	
9.	**Presentation by Kristina Stevens, Administrator, Clinical and Community Consultation / Support Teams, Department of Children & Families**	Ms. Stevens identified two high cost populations: • High utilizers of ED and inpatient services • Youth who remain in congregate facilities beyond their treatment needs. Her department is implementing the following strategies to address these areas of concern: • Standard practices to strengthen families • Implement differential responses regarding removal of children • Adopt policy of using congregate care for treatment, not placement • Increase support for children at home and in communities • Enhance support for schools to work with traumatized children • Improve PCP access to mental health consultation. In response to a question by Pat Baker regarding the availability of pre/post initiative cost evaluations, Kristina indicated that her department and others are starting to do more financial mapping to understand internal costs and savings and eventually those across departments. Ellen Andrews inquired whether financial mapping of expenditures and cost savings across state agencies has occurred. Vicki affirmed the interest in obtaining that data across agencies.	DCF to develop cost analyses using a pre-post model and send to Vicki Veltri.

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10.	**Presentation by Paul Lombardo, Insurance Department Actuary**	Mr. Lombardo spoke about the Department's transparent rate review process. He noted that CID is seeing some market innovations to address costs, including use of provider tiers, VBID designs, and use of primary care providers to coordinate care. He also explained that CID will now be doing pharmacy formulary reviews along with network adequacy reviews. In response to a question by Ellen Andrews, Mr. Lombardo explained that the VBID plans are being reviewed to assure that they are not discriminating against people with high medical needs Bob Tessier asked whether CID cost changes tied to individuals with chronic conditions. Paul said to some extent they are, but it is much broader than just for individuals with chronic conditions. He said carriers want to see results. Demian Fontanella asked how the CID will assess if tiered networks include equitable access to high quality providers. Paul noted that payers are implementing tiered networks, not narrow networks and that CID is focusing on assuring that a sufficient number of providers are in each tier. He explained to Margherita Giuliano in response to her questions about drug pricing transparency that the actuaries receive aggregate information and that the CID does not get involved in specific drug pricing. Kurt Barwis asked whether high deductible plans were a driver of cost savings. Mr. Lombardo responded that he thought young people who don't need services buy these plans, so they save money. Jim Wadleigh, Pat Baker and Ellen Andrews challenged that statement, noting research that indicated that people on high deductible plans delay receiving needed care. Pat also	None.

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		noted that often people have no choice about which plan they buy because the employer is making the choice. Kate McEvoy reported that her department is exploring group purchasing options and saw potentials there. She noted that joining a group purchasing program for pharmaceuticals was not possible because of the CMS requirement that any willing provider be allowed to participate and PBMs do not always follow that approach. She had pursued an exception from CMS, but was not successful.	
11.	**Presentation by Mark Schaefer, Director of Healthcare Innovation**	Mr. Schaefer identified wasteful spending, including practice variation and misuse, overuse and under use of services as key cost drivers. He noted that Connecticut has health care spending that is the fourth highest per capita level of all states. He also noted that quality is uneven and that health disparities remain a major concern, which point to the need to more effectively address social determinants of health. The SIM initiative is pursuing four strategies to achieve the triple aim: • Improve population health through health enhancement communities, prevention service centers, community health measures. • Implement payment reform through Medicare and commercial shared savings programs, Medicaid QISSP, and quality measure alignment • Transform care delivery through community and clinical integration program, advanced medical homes, and community health workers initiative • Empower consumers through value-based insurance design, public quality scorecard and consumer outreach. The Cabinet members did not have any questions for Mark.	None.

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12.	**Presentation by Marge Houy, Bailit Health consultant, in lieu of the State Comptroller's Office**	The Comptroller's Office implemented a VBID plan for employees and dependents in 2012, which focuses on encouraging enrollees to obtain suggested screenings and other prevention care, and for those with chronic conditions to better manage them. A recent assessment of the first two years of the initiative found that the rate of preventive services increased; utilization of the ED decreased, while office visits increased, and overall medical costs decreased 3.2%. There were also increases in screenings and testing for chronic disease, but improved lab numbers were not evident. There were no questions for Marge.	None.
13.	**Next Steps**	Next meeting will be held on Tuesday, July 12, 2016	
14.	**Adjournment**		Meeting Adjourned