Healthcare Cabinet Meeting Minutes

September 18, 2018

Meeting Date	Meeting Time	Location
September 18, 2018	9:00am-11:00am	Legislative Office Building, Hearing Room 1D 300 Capitol Avenue, Hartford

Participant Name and Attendance

Healthcare Cabinet Members					
Victoria Veltri	x	Shelly Sweatt	x		
Pat Baker	x	Joshua Wojcik (OSC)	x		
Susan Adams	x	James Michel (Access Health)	x		
Ellen Andrews	x	Anne Foley (OPM)	x		
Kate McEvoy for Roderick Bremby (DSS)	x	Cassandra Murphy	x		
Nancy Navarretta for Miriam Delphin-Rittmon (DMHAS)	x	Margherita Giuliano	x		
Theodore Doolittle (OHA)	x	Frances Padilla	x		
Members Via Phone					
Paul Lombardo for Katharine Wade (CID)	x	Hussam Saada	x		
Dr. Raul Pino	x				
Others Present					
Allan Hackney (OHS)		Michael Matthews, CedarBridge Group		Tillman Foster (HSP)	
Kelly Sinko (OPM)		Karen Roberts (HSP)			
Kim Martone (OHS)		Ron Ciesones (HSP)			

Meeting Information is located at: https://portal.ct.gov/OHS/Services/Healthcare-Cabinet

	Agenda	Responsible Person
1.	**Welcome and Introductions**	**Victoria Veltri**
	Call to Order The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, September 18, 2018 at the Legislative Office Building Room 1D in Hartford, CT. The meeting convened at 9:08 a.m. Victoria Veltri presiding.	
2.	**Public Comment**	**Victoria Veltri**
	There was no public comment.	
3.	**Review and Approval of the June 12, 2018 Minutes**	**Victoria Veltri**
	The motion was made by Pat Baker and seconded by Shelly Sweatt to approve the minutes of the Health Care Cabinet June12, 2018 meeting. James Michel abstained. **Motion carried.**	
4.	**Introductions:**	**Victoria Veltri**

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	Vicki Veltri welcomed to the Health Care Cabinet Ms. Cassandra Murphy the Executive Director of the Connecticut Coalition of Taft-Hartley Health Funds who was appointed to the Cabinet by Senator Majority Leader Bob Duff. Ms. Murphy will be replacing Robert Tessier. Ms. Veltri introduced Kimberly Martone, Chief of Staff of the Office of Health Strategy, Allan Hackney, Health Information Technology Officer and Mayda Capozzi who will be replacing Laura Morris as the Cabinet's Administrative Assistant.	
5.	**Facility Fees Report – Health Systems Planning ***	**Karen Roberts/Tillman Foster**

The OHS Health Systems Planning annually collects Hospital fees data. Based on previous calendar year report. Format created by the wording set for by C.G.S. Section 19a-508c and amended by the Public Act 18-01. The staff collecting this data has three years information by the filing collected this summer.

A few points were noted to begin this report:

- Any fee charged or billed by a hospital or health systems for OP hospital services provided in a hospital base facility is a facility fee. It has to be intended to compensate the hospital for their operational expenses and is separate from a professional fee. It was presented that, as of January 1, 2017 no hospitals, health system or hospital-based facility is allowed to collect facility fees for outpatient health care services that use a current procedural terminology evaluation and management E/M code.
- The facility must advise the patient in writing of the facility fee and identify the fee as a facility fee and in addition to any professional fee that they might incur during their visit as an additional charge.

The statewide data collected on Facility Fee Net Revenue from Connecticut hospitals was from CY 2015, 2016 and 2017. This data has been a challenge due to the fact that the hospitals have been filing the statutory revenues received instead of revenues charged.

Statements given to HSP from hospitals during their annual filing:

- The payments specific to a facility fee are not and do not appear to be recognized by the hospitals.
- Payments are posted to patient accounts based on total reimbursement not by individual CPT code.
- Hospitals cannot isolate by the CPTT level due to the way the payers pay. Revenue maybe have be given to us by using the contracted rate of the payers using a proration of charges to payments:

The outcome of the Statewide Facility Fee Net Revenue was a decrease of 1.7% from CY 2016 to CY 2017 and an increase of 3% from CY 2015 to CY 2016. The total patient visits for facility fees showed a decreased by 1.5% for CY 2016 to CY 2017 compared to CY 2015 to CY 2016 where it showed an increase of 3%. The Individual Hospital/System CY 2017 Facility Fee Net Revenue showed that the top hospital was Stamford Hospital.

The two handouts that were presented were the following:

Calendar Year 2017, 2016 and 2015 Statewide Facility Fees Received (Net Revenue) and Visits - the same CY.

1. Top Ten sorted procedures sorted by hospitals for which Facilities Fees are charged and related revenues. There are hospitals that do not charge facility fees.
2. CY 2017 Top 20 Statewide Procedures/Services for which a Facility Fee is charged and related revenue sorted by revenue received. Top 20 procedures statewide amounted to $143,708,942. Second hand out is the same procedures sorted by hospitals same procedures.

Some hospitals were allowed to restate last year figures in order to create an accurate 3 year trend.

Some hospitals are listed individually but some are filed by their owners systems where they are filed.

Vicki Veltri asked to explain the difference between the systems reporting and the individual hospital reporting. Ms. Roberts responded that as the hospitals report the filing, each has been filing by individual systems. Since the law is written as systems or hospitals it is a little unclear. As long as they file all of the information for their systems how they depict is HSP is flexible on it.

The information reported is for off campus only and are for services and procedures were both facility fee and a professional fee is charged. The filings are charges that the patient or payer might receive are a fee from the hospital/system and one from the professional staff. The filing is set up according to the statutes.

Note: * Please note that subsequent to the meeting revised slides were posted online for the Facility Fees. Individuals' filings are up on our website through access by web base portal. Main page of OHS. HSP Portal /Other notifications

https://portal.ct.gov/OHS/Health-Systems-Planning/Hospital-Financial-Data/Hospital-Reporting-System

Q & A's

Ted Doolittle mentioned that it was a lot of good information and further asked that if he were a hospital and wanted to charge a facility fee, do I set the rate myself or are there guidelines? CSM restrictions on the amounts? Karen Roberts responded that we currently do not know if CMS has restrictions on the amounts.

Ellen Andrews inquired if the hospitals reports were estimated reports not audited statements self-reported by Hospitals. Karen Roberts agreed with that statement.

Vicki Veltri reported that when looking at the data, the total revenue is reviewed to get the total visit. But it does not give us the information by procedures types. OHS will be exploring to review the charge side and are currently working with Rob Blundo to develop a process and will come back to give the outcome analysis.

Ellen Andrews noted that hospitals were not reporting Medical Errors reporting.

Pat Baker inquired as to what is done with this information? Are you prepared to tell us what this data means to you how do you explain the difference between Stamford Hospital and the rest of the system? What are you doing with this data how does it inform us of the issues of facility fees? Consumers have a big discomfort with facilities fees when they feel that they don't have a choice often in this issue.

Vicki Veltri responded that this is one of the reasons we wanted to publicize it. It is important since we are looking at state wide spending trend and this is one of the pieces of materials that factors into state wide spending trends. By being transparent we are raising questions that get to whether the current law as drafted is getting what we need to get out of the reporting we are getting. It will help us determine better to what is appropriate and in appropriate cost. Consumers are heavily affected by the facility fees. It is very important that we take this information and do something with it.

Ted Doolittle notes it was a great report. Ted asked if we knew anything regarding any state entities that are engaging in compliance or review around facility fees. The facilities fees requirement are complex. He noted that a minority are actually in compliance with their notice compliance. Any state oversight of facility fee requirements?

Karen Roberts responded that she did not believe there is a structured way of looking in this regard and other parts of the law rather than the filings. Our annual filing specifically do not require them verification of other requirement of Section 19a-508©.

Vicki Veltri stated that Office of Health Strategy does not have enforcement authority in the statue. OHS is going to be looking into the notice requirement.

Ted Doolittle asked if there are any there other state agencies that do take this factor into consideration.

Vicki Veltri responded none we are aware of.

James Michel noted that the trend for Stamford and New Haven Hospitals, the more visits they have the more money they make per unit due to the fixed costs. Do we ever ask them to explain to us why the revenue per unit per visit is going up?

Karen Roberts response - It all varies on the hospital sites and locations. The Net Revenue is an estimation and a methodology is not something that it can be exact. In total it would be better to look at type of service. Do we ever ask them, no, we don't other than clarification to make sure that their report is correct.

Vicki Veltri stated that under Public Act 51. 46, eliminated Facility Fees for certain codes. It could be the reason the facility fees and facility fees revenue has been reduced, but we cannot conclude it is the exact reason. Facility fees are only associated with off campus sites and asked are there any with on campus service that we are not capturing?

	Karen Roberts's response - No currently they are not capturing facilities fees information on campus site. Vicki Veltri asked to explain Karen's comment "Drop in the bucket". Karen Roberts responded, the examples of the 10 procedures listed in the handouts generated a large amount of monies they are only a drop in the bucket. There are many more facility fees for different procedures that are not listed on the handout. Karen Roberts also noted we also capture the number of visits, allowable fees and net revenue received by payers and facility fees. Information and total amount revenue fee for that location. We can take all of the information and we can create a report on the total amount specific to that location. Vicki Veltri noted that because we are not asked to collect this information under that statue, we are not collecting the data on procedures at that level and that is one of the reasons we are currently working with APCD. Ellen Andrews noted that just posting the data helps out. Concerns about location fees and how it varies from location to location. Vicki Veltri stated that we will be able to report with an analysis of the locations' information. Including looking at some gaps that should be remedied maybe through legislation. In terms of what is collected, to be able to share the information and have it be meaningful. Vicki Veltri thanked Karen and Tillman for presenting this type of information	
6.	**Financial Stability Report Preview – Health Systems Planning**	**Karen Roberts/Ron Ciesones**
	In the Office of Health Strategy the Health Planning Systems' group has been reporting on the Hospital Financial Stability report since 1996. It is a systems generated report. The information was gathered from hospitals, parent corporation's utilization data, audited financial statements. In 2017 a new system was created so hospitals will be able to do their own reporting through a web base application via a portal. This portal is accessible to hospitals and consumers year round. Trends are consistent to the past years. It shows hospitals who had done well in the past continue to do well and those who have not done so continue to not do so well. There are 6 hospitals on the Hospital Total Margin Trends handout that are not doing well. In the State Wide Total Discharge chart is a break out of who the payers are. Vicki Veltri thanked Karen and Ron for the preview and stated that Karen and Ron will be providing a full presentation of the Financial Stability Report at the October Health Care Cabinet meeting.	
7.	**Baseline Reports on Current Health Care Costs in Connecticut**	**Kelly Sinko**
	Presented to the cabinet the baseline reports on current health care costs in CT. Two years ago a charge was added to the Health Care Cabinet to advise the Governor on statewide health care spending and the methods to collect, analyze and report health care spending. An explanation of State Health Expenditure Accounts was utilized. Derived from the National Health Expenditure Accounts data and Kaiser Family Foundation "State Health Facts". The analysis of the data shows	

	that national health spending will grow at an average rate of 5.5% per year by 2026 it will reach $5.7 trillion. • Per the data acquired in 2014, Per Capita Personal Health Care spending shows that Connecticut is above the national average. Connecticut is on the lower of the range of the National Average in Growth. • In 2014, a comparison between New England states on total personal healthcare spending. Connecticut was 3rd below Massachusetts and Vermont. New England as a whole was well above the National amount. • A 2010-2014 comparison per capita personal health care expenditures the total of the 5 year average growth Connecticut came in 6th out of 8 states. Nationally, Connecticut was a below the national average. • A study for All Payers Personal Health Care Expenditures Annual Growth rate from 1992 until 2014. Connecticut grew from 6.3% peaking in 2004 at 8.6% and down to 2014 to 3.5%. **Q & A** Pat Baker asked about "hospital care" data, does that include inpatient, outpatient or ambulatory? Kelly replied that she believes it is by industry classification code and not by ownership but will obtain that information. Ted Doolittle asked where does the data come from, whose administrative cost are excluded is that hospital, carriers or both? Kelly Sinko stated that it is not the hospitals. The administrative costs are on the payer side. The way they define the net costs is interesting. All the premiums minus the benefit incurred and premium tax separated out. Very lengthy description. She will review and send out. Vicki Veltri asked when it comes to private pay does the CMS data include only the fully insured calculation? Kelly Sinko responded that it's her understanding that it includes all of it by industry code including census and IRS data. Ellen Andrews commented that Medicare/Medicaid is now $14 million in 2014 and private insurance was $12 million. Kate McEvoy thanked Kelly for her presentation. A lot has continued to happen since 2014 and that MAPOC presentation "Story of Medicaid Documents" showing 10 key facts and cross trends, 3.4% PMPM decrease; in 2017 1.1% increase compared to gross national expenditure trend of over 6%. Coordinating services and supports and preventive care has aided in these numbers. The presentation is posted on the MAPOC website. Welcome comments on those documents. Ellen Andrews commented that Medicaid total state dollars in 2017 were lower than 2014 despite enrollment being almost 1 million people.	
8.	**Report on Cabinet Member Calls on Addressing Health Care Costs**	**Michael Matthews**
	Vicki Veltri asked for volunteers form the cabinet to convene via phone to discuss on the scope of work on statewide spending and where the Cabinet can go.	

This is an approach to deciding on where you want to go. Presenting perspectives on data availability and insights that might help you tease through areas that you would like to pursue.

Background on the sub-group phone calls:

- Group members, meetings, framework, approach, data availability and feasibility.
- An explanation of HCC Data Group Process and Approach
- Identifying Top-tier Measures of Cost by Category
- Areas of Concern
- Accessibility of Data
- Analysis of APCD Data wish list and areas of concern

There are various ways of looking sat the data. Also realizing the dilemma that the data is easily accessible but not exactly what is needed.

The Cabinet members need to make clear the following:

1. What is the purpose and expectations of this Cabinet?
2. How do we use the power of the data?
3. Identify 2-4 areas that we will work on.

Pat Baker commented that as we enter into this task and work, think about what data is needed for what need and purpose. What is the purpose and expectations of the Cabinet in this work? Then to think about focus- what are the two or three things to start with and then build over time. How do we use the power of that data to do something?

Ellen Andrews stated that she would like more than two or three items to focus on. Utilization of services; over and underutilization; what is useful, learned from.

Shelly Sweatt's overall thought don't let our priorities be driven by what data is available. Set our priorities thereafter.

Vicki Veltri wants to bring everyone back to the statute; on advising the Governor on total statewide healthcare spending including methods to collect, analyze and report spending data. The discussion should be in this frame, we can go outside the frame as well. We need to talk to the Insurance Department, Access Health CT, private payers, etc. Vicki also thanked Allan Hackney who helped Michael with this process.

Pat Baker appreciates Vicki Veltri sharing the charge. To have the data points to do something with and Kelly Sinko gave us stark data on rising healthcare costs. Consumers bearing a greater brunt. We have to meet our charge.

Vicki Veltri also commented that we have to develop a way to start to contain healthcare costs, we need to get to that.

	Ellen Andrews stated that an early win with 5 -10 initiatives. One thing done in other settings, is to complete a Survey Monkey to rank the priorities. It is not the final endpoint, but gives people time to reflect. Pat Baker asked that if others had ideas around criteria it might help the workgroup. Reminder that we have principles and that this work is addressing those principles. James Michel offered looking at social determinants that impact costs and access to healthcare as one of the criteria. Also, looking at disparities across economics, reaching out to insurance companies to see what they are doing. They may have items in their buckets that we might be able to leverage. Shelly Sweatt stated that we should not be looking at reinventing the wheel but what's already begin done and the principles is a good idea and build upon those. Ted Doolittle stated the he is excited about APCD and shared a situation at OHA asked about a study on potentially minor issue, when a person's preventative colonoscopy and office visit; some are charged as preventative and others not preventative, may be a cost to consumer, wanted to find out how frequently that would happen. Went to APCD, the cost would be $10,000 for that study so there may be constraints are real here and overall wish list. Victoria Veltri stated we may need support to help with this work and OHS will look at that. Frances Padilla – Harking back to Kelly's presentation about our costs in Connecticut being lower than the national average and lower than the other New England states we still have to work on costs in Connecticut. I would prioritize our work on a category around price variation and understanding the differences behind the variations are and why and it could inform policymaking. Vicki Veltri agreed that is on her wish list as well and should be able to get that from the APCD and is critical and need to see differences across the state. Pat Baker stated that there is no surprise that health disparities in this work and looking at the list becomes a challenge because of data, but we do have race and ethnicity on Medicaid and Medicare data. Margi Giuliano very important that when we define costs we have a clear definition. Hard to do comparison, are we including matches, rebates, etc. Be careful on costs and comparing and on the space page and definitions. It would help getting auditing in that. Vicki Veltri commented that PA 18-41 passed will frame the work on pricing in the pharmaceutical space, we are going to work on that.	
9.	**Next Steps – Cabinet Discussion**	**Victoria Veltri**
	• Group members, meetings, framework, approach, data availability and feasibility. • An explanation of HCC Data Group Process and Approach • Any volunteers to be on this discussion group, please let Vicki Veltri know	
10.	Adjourn	Meeting adjourned at 10:59 am

	James Michel motioned to adjourn and Ted Doolittle seconded; **Motion carried.**