OHS CONNECTICUT Office of Health Strategy

Healthcare Cabinet Meeting Minutes

October 09, 2018

Meeting Date	Meeting Time	Location
October 09, 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		
Dr. Raul Pino	x	Arlene Murphy	x		
David Whitehead	x	James Michel	x		
Ellen Andrews	x	Anne Foley	x		
Kate McEvoy for Roderick Bremby	x	Cassandra Murphy	x		
Mary Kate Mason for Miriam Delphin-Rittmon	x	Margherita Giuliano	x		
Theodore Doolittle	x	Nichelle Mullins	x		
Valencia Bagsby-Young for Jordan Scheff	x				
Members Via Phone					
Paul Lombardo for Katharine Wade	x	Hussam Saada	x		
Susan Adams	x				
Others Present					
Allan Hackney (OHS)		Ron Ciesones (HSP)		Robert Blundo (AHCT)	
Kim Martone (OHS)		David Fernandes (HSP)			
Karen Roberts (HSP)		Tillman Foster (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, October 09, 2018 at the Legislative Office Building Room 1D in Hartford, CT. The meeting convened at 9:00 a.m. Victoria Veltri presiding.	
2.	**Public Comment**	**Victoria Veltri**
	There was no public comment.	
3.	**Review and Approval of the Minutes**	**Victoria Veltri**
	The motion was made by Shelly Sweatt and seconded by James Michel to approve the minutes of the Health Care Cabinet September 18, 2018 meeting. Arlene Murphy and Nichelle Mullins abstained. **Motion carried.**	
4.	**Introductions:**	**Victoria Veltri**

	Ms. Veltri welcomed to the Health Care Cabinet Ms. Arlene Murphy, Co-Chair of the Consumer Advisory Board. Arlene was appointed to the Cabinet by Senator Looney. Margherita Giuliano introduced Nathan Tinker who is the new CEO of the Connecticut Pharmacist Association.	
5.	**Facility Fees Report – Health Systems Planning Update**	**Karen Roberts**

The OHS Health Systems Planning (HSP) 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.

Last month HSP presented a report on Facilities Fees which is a report that the hospitals prepare according to state statues. This a follow up based on a request made by the cabinet members for a report by location.

Ms. Veltri stated the Financial Stability Report will be presented along with the Facility Fees so we can bring the two pieces as whole to the cabinet to see a fuller picture of financial performance. In the future there will be a presentation on community benefits that will be also a part of the OHS reporting.

Karen Roberts reported that the handouts given are a follow up from the September meeting's overview of the Facility Fees. The conversations that occurred during the presentation, seemed to require the information in more detail. In order to bring more detail information, the following handouts contain the same information in CY 2017 but each are arranged differently.

- First one is sorted by the provider/system alphabetically by name; along with their address; number of visits and total net revenue which is an estimated. The last column CY 2017 average facility fee revenue per visit by location was created by the office. The averages do not tell the story in that some of these locations might have high volume which will change the average and some might have higher net revenue.
- The second spread sheet has the same information but it is sorted high to low in averages. On this spreadsheet the calculations on the last column, does not give you a full description due to the fact that some facilities are not reporting a high number of visits but the average net revenue is fairly high.
- The third spreadsheet it is categorized by location type. It shows all hospitals/systems grouped from information obtained by OHS only from the facility name and some internet research. From this spreadsheet you will note that:
    - most facilities do not offer the same departments and/or services;
    - the information does not show services, equipment, staffing;
    - you will notice which facility it is as they are evaluated, the difference appears in the net revenue;
    - most hospitals have multiple service locations;
    - the hospitals reports by location and not the services;

These are the three groupings that should give you more of an insight as to the overall statewide average, it is interesting but it does not give you a detail description of the type of facility and the type of services.

The handouts and presentation material for this presentation is located at:
https://portal.ct.gov/OHS/SIM-Work-Groups/Health-Care-Cabinet/Meeting-Agendas/October-9-2018

Q &A's

Ms. Veltri noted that the OHS receive reports on total visits by location divided total revenue by location but do not receive reports on service fees split out. Service fees can vary though the facilities, some higher than others.

Karen Roberts noted that it is filed by facility according to the statue wording.

Ms. Veltri asked if these are visits versus services. Would there be services bundled into the visit? Karen Roberts response was yes but we are unable to tell. It is important to know that some facilities have many services that are not reported. The sites that are defined as primary care is important to know because the way the law is written, E/M Codes do not allow facility fees.

Mr. Whitehead noted that these reports show the inconsistencies in the hospital/systems reporting. Since it is all payer net revenue you need to be aware that there is also payer contracting services. It is very broad reporting that the law requires. Mr. Whitehead asked, what is the value of the current type of reporting and what type of reporting OHS would like to receive in order to have a better understanding of what particular services and what areas are those facility fees being charged?

Ms. Veltri noted that is one of the concerns, a net revenue report versus specific reimbursement by the carrier. Also, contracting from site to site, who has what contract with which payers by what rate; which is evident by the ranges that is listed on the charts. We are not getting the kind of value from the report that we should be getting. You have to see a service fee and the charge versus the reimbursement of the services in order to have some insight.

Ellen Andrews commented that we need to think about the value of the facility fee and how important is it for the financial sustainability of the hospital and why is that?

Ms. Veltri noted that the visit numbers that are subject to the fees, a pattern can be seen where they are applied, that will be also reviewed. Services fee have varied in different visits/services.

Kurt Barwis noted that it is almost impossible to recruit the specialist with the rates that they are receiving from Medicaid and to get them covered. Part of the problem is the relationship between why we are charging these facility fees and the actual community need, where they are being charged, how can that support and help to promote the physicians that need to take care of the

	community. Facility fees can be extremely helpful in creating access in the community that cannot actually otherwise afford to have a specialist take care of patients. Ms. Veltri noted that is why we need a deeper look at what we are seeing in terms of numbers of location and access. We are going to be looking at community health need assessment tied to the community benefit. We need to link the Facility Fees, Hospital Systems Financial Stability Report and the community benefits as a whole. It needs to be reviewed that way so we can see the whole picture. At OHS, we have not gotten to that point yet. Ms. Veltri noted that it is critical moving forward. Ms. McEvoy's response to Mr. Barwis' comment regarding the level of Medicaid reimbursement for specialty providers is that It is matter about priority around public policy and appropriation. Some sources give us a relational idea of where we are situated in the ratio of Medicare and Medicaid payment. Often looked at as a bellwether of sufficiency of the rates. Comparatively CT is pretty well situated when compared to other states. This administration and legislature has made significant investments in primary care that have been greatly beneficial in many incentives. Ms. Veltri wanted the Committee to be aware of some hospital numbers that were corrected since the last meeting which were emailed to the cabinet and posted on line. This is part of a picture that relates to costs for consumer, where and how they access care and it needs to be reviewed further. If the data is not as meaningful as it needs to be then the data is not helpful in making policies decisions for the state and for the broader community. There are areas within this reporting that can be improved. Ms. Veltri is looking forward to working with everyone to try to improve the reporting to make it more accurate and meaningful. We need to know where those costs are coming from with more accuracy to make better decisions. Vicki thanked Karen for her report.	
6.	**Hospitals & Hospital Systems Financial Stability Report – Health Systems Planning**	**Ron Ciesones/David Fernandes**
	Introduction of Ron Ciesones and David Fernandes, The Financial Stability Report has very valuable information. If you would like to review the report please see the link below also has been posted on the OHS website. https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/10-9-2018/Financial-Stability-Report_2017.pdf and https://portal.ct.gov/OHS/Lists/Hospital-Financial-Data In the OHS, 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. This presentation will highlight some key aspects of the report. A strong healthcare system is an important economic sector in Connecticut that attracts a talented workforce; drives modernization efforts; provides high quality healthcare to our citizens. It is	

profitability that helps the hospitals operate efficiently, stability, funding to invest in day-to-day operations; debt servicing; cash reserves and facility upgrades.

One ration used looked at financial stability is operating margin. Profits that hospitals make from operating a hospital and providing a core health care services.

The presentation included:

- **Statewide Operating Margin totals for FY 2017**
- **Statewide Average Total Margins FY 2017**
- **FY 2017 Hospital Total Margins**
- **5 year Hospital Performance**

Ms. Veltri asked Mr. Ciesones if he would explain what operating income is in terms a lay person would understand. Mr. Ciesones' response was that the operating income would be the gain or loss from providing all the healthcare services operations, parking, cafeteria, imaging operations and radiology derived from strictly healthcare services. Another ration to access profitability is the Hospitals Total Margin. It takes into considerations all of the above operating margins. It also adds in the non-operating revenue from investments stocks bond subsidiary income and joint venture income. Transitioning to Health Systems include the hospital which is the bulk of the revenue but it also includes imaging centers, insurance companies, medical groups entities such as rehab.

Ms. Veltri asked where in the footnote does the UCONN's $332 million show up on this chart? It shows in the non-operating? Mr. Ciesones' response was yes, it includes the $322 million in state and capital appropriations for UConn and $27 million that showed in Vassar Health Connecticut a new parent of Sharon Hospital who was purchased by Health Quest out of NY. Ms. Veltri added if you subtract the $322 million of the $832 million you can actually see the real numbers. UConn typically reports a large operating loss but it reports a large operating gain.

James Michel asked if the $322 million in addition to regular support they get from the state? Is that all they get from the State? Mr. Ciesones' stated he did not have that information but would obtain that and respond.

Ann Foley stated that this number represents the appropriation that was beyond the Medicaid reimbursement. There would be Medicaid reimbursement for the hospital for services for Medicaid beneficiaries, this was an additional appropriation on top of the Medicaid reimbursement.

Ms. Veltri also noted that the number represents their commercial reimbursement from commercial payers. Ms. Foley also mentioned that it also include some bonding as well.

Kurt Barwis noted that they are excluded from the hospital tax as well.

David Whitehead commented that one of the key components we should consider is reporting on hospitals vs reporting on the systems, which are various hospitals put together. The health systems are the total system of care. The systems are not performing at an industry standard that is really allowing the CT system of care to continue to thrive at the level we all would like to see it thrive at.

	It is good that the hospitals from an operating margin are at a 3% that is still below the industry standard of 4%. But the health system component where you are seeing negative margins and actually declining margins is the investment is in that total systems of care that goes beyond hospitals services. Ms. Foley clarified that it is to characterize it as a negative position even when you subtract out the $322 million it is still over $250 million excess revenue over expenses. I would characterize that as a negative position. Mr. Whitehead's responded that he was talking about operating margin not total margin, which is primarily at the performance of the investment market. We look at the operating margin because that is what it takes to operate our system of care on a day to day basis. Mr. Barwis noted that Mr. Ciesones' report was very good. We just had a full facility assessment. We have $100M in deferred facility costs that we are unable to make good on. We should be looking at our average age of our plant. We need to make our facility current and make investment on our labor force. One item not in this report is the subsidy we paid as hospitals throughout the state to physician's practices which is $241 million statewide. The cost of coverage also needs to be added that hospitals pay the practices. So, whether you look at the operating margin which is negative or you look at the total margin at about 2% taking out UConn subsidy; that is not an adequate amount of money by any metric to sustain our system in the State of CT. We have enormous deferred costs. Another is the deferred costs associated with of our pension plans. A discussion between Ted Doolittle and Kurt Barwis occurred regarding the model being used in Maryland. Mr. Barwis stated that the system is currently evolved and changing into a different waiver. Even though they do have rate setting, the costs and the charges that the hospitals in Maryland has is relationship with which has not been seen anywhere else. Ms. Veltri noted that we do have reporting on the practices that the hospital and health systems have acquired. We currently do not acquire the age of the plants. We need to talk about how to get that information from the facilities. Ms. Barwis noted that there is an accounting ratio where you can get the average age of the plant information from your balance sheet. Ms. Veltri wanted to make sure that everyone understood that slide 13 is just hospitals reporting of acute inpatient data not systems the data and that data sometimes raises questions, but these types of data are reported in silo and we need to put them together to get the bigger picture to see what is really going on. Ms. Barwis would like to look at some measures on how are we are doing and how the acute care hospitals are impacting the overall cost of care of CT. Ms. Veltri would welcome any suggestion on how to better monitor costs overall, not just the state to consumer, payer, and employer.

	James Michel said it would be good to have a big picture of what is the total amount of unfunded costs going forward with respect to deferred maintenance costs to unfunded pension costs. Ms. McEvoy wanted to revisit Mr. Burwis' comment which was very useful. The overall theme to looking relationally across the episode of care is a well taken point and also examining all contributing data sources. Ellen Andrews is interested in uncompensated care costs that have not gone down by much when we cut the number of uninsured by half. Ms. Andrew's would have expected it to be a lot lower. Ms. Foley was interested in the utilization figures. It was interesting that at the same time the ED visits, patient day discharges were reducing and the FTE's increased; wondering the profitability and total margins for the hospitals would have been greater if the employees had not increased that year. Is that correct? Is there any explanation that you see about the employee increases at the same time all of those things are going down? Why FTE's would increase at the same time ED visits, patient days and discharges were going down? Ms. Ciesones' mentioned that Stamford was in the process of establishing a new hospital so there could be some new employees due to that. It is a small percentage statewide. Ms. Veltri asked if we could have this information broken down in the Financial Stability Report. Mr. Ciesones' stated he could provide an excel spread sheet comparing this year to last year. Ms. Barwis stated that he has had to double his security team and presence. There is a lot of money spent on safety and security. Acuity of the patients that we receive at the hospital is increasing dramatically as everyone has made it more difficult to qualify for inpatient admission. If November 7th the Massachusetts ballot question passes, we are going to see nursing staffing ratios and a related dramatic increase in costs. Additional staff has been added to his Human Resources Department to start recruiting. This question is to address Ms. McEvoy's response on Medicaid, can DSS determine of the dollars spent on specialists in Medicaid, how many of those dollars spent are hospital employed specialists versus non-hospital employed specialists. Ms. Veltri stated that we will have to keep an eye on what happens in Massachusetts regarding the nursing ratio.	
8.	**Access Health CT Open Enrollment Update**	**Robert Blundo**
	Robert Blundo provided an updated to the 2019 open enrollment and provided the Cabinet members with a review of the new Access Health CT website. Updates were provided on: • Implementing technology • Educating Customers • Improving retention and acquisition rate • Continuously improving customer experience	

- Certification of brokers this month
- Staffing is complete
- Insurance Department completed rate plans
- Marketing conducted focus groups on new concepts
- Major Challenges:
    - The shortest open enrollment period
    - Staffing to accommodate the volume
    - Premium change
    - Wise plan selection
    - Consumer confusion
    - Website – new and improved and decision support suite

James Michel mentioned that in addition to what we do, we also enroll Medicaid applicants. Access Health CT is the only venue for Medicaid applicants.

Shelley Sweatt asked about the provider search, with the introduction of the tiered networks, is that shown on the provider search?

Mr. Blundo, responded in the event that the plan is tiered the screen will show tier one vs tier two.

Arlene Murphy asked how current is the information of the provider network? Are you encouraging applicants to check with their providers directly to make sure the information is accurate?

Mr. Blundo responded that the data is updated every day but they are promoting checking with the provider, it is not an easy challenge to overcome, they are reminding customers to make sure their provider is covered.

Ms. Murphy asked with the Tier one and Tier two providers, is there any warning in place to let the customer know that if they are outside of those tiers that there will be a significant expense related to their selection?

Mr. Blundo responded that at this time the plan consumers are choosing is forcing them to see the plan detail.

Ms. Sweatt asked if the consumer has the availability to find the facility Tiers? Mr. Blundo informed the cabinet that the provider tool will be able to be used for this type of search.

Mr. Michel stated that they are strongly encouraging customers to get clarity about some of the plans, because health care is very confusing.

For more information on this presentation please visit:

	https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/10-9-2018/AHCT_Health_cabinet_20181004.pdf Vicki Veltri thanked Mr. Blundo and Mr. Michel for their report.	
9.	**Next Steps – Cabinet Discussion**	**Victoria Veltri**
	• Cost issue group will be meeting and will have a report in November on the progress for consideration.	
10.	Adjourn	**Meeting adjourned at 10:59 am**
	James Michel motioned to adjourn and Ted Doolittle seconded; **Motion carried.**	