OHS CONNECTICUT Office of Health Strategy

Healthcare Cabinet Meeting Minutes

November 13, 2018

Meeting Date	Meeting Time	Location
November 13, 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			
		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	Susan Adams	x		
Theodore Doolittle	x				
Valencia Bagsby-Young for Jordan Scheff	x				
Members Via Phone					
Margherita Giuliano	x	Dr. Raul Pino	x		

Others Present		
Allan Hackney (OHS)	Robert Blundo (AHCT)	Dr. Mario Garcia (DPH)
Kim Martone (OHS)	Michael Matthews CedarBridge	
Karen Roberts (HSP)	Mark Schaefer (SIM)	

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, November 13, 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 Minutes and 2019 Meeting Schedule**	**Victoria Veltri**
	The motion was made by James Michel and seconded by Pat Baker to approve the minutes of the Health Care Cabinet October 9, 2018 meeting. **Motion carried.** The motion was made by Pat Baker and seconded by Anne Foley to approve the 2019 Health Care Cabinet scheduled meetings. Motion Carried.	
4.	**Introductions:**	**Victoria Veltri**

5.	**Statewide Community Benefits Dashboards - Health Systems Planning Update**	**Karen Roberts**

Ms. Roberts' presentation on Statewide Trends in Hospital Community Benefits and Community Building using the information from the IRS Form 990, Schedule H, was generally focused on community benefits.

The Office of Health Strategy (OHS), the only state agency that is directed by statue to collect annually a copy of the 990 Form and Schedule H from the hospitals. It was noted that state owned hospitals are currently not required to file a 990 with the IRS.

OHS continues to monitor the impact of hospital acquisitions and consolidations on communities to ensure that required community benefits allocations are aligned with community health priorities.

Connecticut's privately owned, non-profits hospitals are required to file the 990 Form with the IRS along with Schedule H. Ms. Roberts gave a brief explanation of the IRS Form 990, Schedule H, along with an explanation of the terms used within the presentation. It was noted that the IRS definitions for these terms are very complex and very detailed. OHS uses the Schedule H for Certificate of Need (CON) purposes during reviews for hospital mergers and affiliation transactions.

The Dashboard of Statewide Trends in Hospital Community Benefits and Community Building using IRS Form 990 slide information was reviewed in various formats. Ms. Roberts noted that the amounts on the dashboard that OHS is concentrated on is NET not the total so it does not include the offsetting revenue, the amount shown after the direct revenue is applied.

In conclusion, the 990 Form has a large amount of information but what it does not reveal is how those dollars are being spent on social terms of health; state health improvement plans; their local Connecticut Hospital Association and implementation strategies.

Victoria Veltri clarified that an agreed settlement with a CON can completed by an order or by settlements, most cases are settlements with regards to mergers and acquisition. The CON applications that are before the OHS are being considered carefully concerning how these community benefit allocations are aligning along with the community health needs assessment. It is an OHS ongoing specific goal of the office.

The OHS has had discussions with other New England states as part of a "*Hospital Community Benefits Workgroup*", New England States Consortium Systems Organization which is supported by a Robert Wood Johnson Foundation initiative being coordinated by NASHP (National Academy for State Health Policy).

	Q &A's Mr. Doolittle thanked Ms. Roberts for the presentation. Mr. Doolittle asked if we knew about how the hospitals calculate the cost of the Medicaid care. Ms. Roberts responded that it is IRS instruction which are very complex and there is a worksheet. For this presentations' purposes, it was simplified just to be mostly the difference between the cost of the care and the actual reimbursement. Ms. Veltri commented that we do not see the worksheets. Ms. Baker asked if Ms. Roberts can share what has been learned at the NESCO workshop. Ms. Roberts responded that one of the issues the group discussed about was around the overwhelming Medicaid and financial assistant dollars that are reported on the 990 Form more so than social determinants of health and other documented community health needs. Massachusetts and New Hampshire have detailed guidance for hospitals in terms of community benefit dollars and reporting. The group would like to see more dollars going towards community health needs or we need to understand if they are already being in use but we are not seeing them on the forms. The group also noted that the dollars and the initiative are nice but we are not seeing the outcomes and tracking where the dollars are supposed to be going towards. Ms. Veltri noted that Massachusetts has created a council that oversee the Public Health and they have a fund that collects a special fee and they use the aggregated fund to identify particular places where they are going to fund community needs. Ms. Veltri thanked Ms. Roberts for the report. The handouts and presentation material for this presentation is located at: https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/11-13-18/Community-Benefit-Trends-Dashboard.pdf	
6.	**Consumer Information Website Update**	**Robert Blundo/Allan Hackney**
	The Consumer Cost Transparency Data presentation stated that Public Act 130-247 charged APCD to utilize healthcare information collected from Data Submitter to provide healthcare consumers in Connecticut with information concerning the cost and quality of healthcare services that allows such consumers to make more informed healthcare decisions. Goals: • Measure and report service price variation within Connecticut using APCD data • Present price transparency results in a manner that satisfies both consumers and subject matter experts • Produce information iteratively while providing opportunity for feedback • Maximize current and long-term value of information	

Work completed to date:

- Research on price transparency reporting options and methodologies completed
- Feedback collected from stakeholders and classification framework for reportable services finalized
- Services include 8 inpatient care, 21 outpatient procedures, and 22 outpatient diagnostic test pricing measures
- Reporting specifications and methodology shared and approved
- Final version of service price analysis using commercial claims data completed and delivered to OHS by Onpoint Health Data in 2018
- Planning on dissemination of findings in progress

Mr. Blundo reported on some Inpatient Care, Outpatient Surgery and Outpatient Diagnostic samples and methodology and presented a proposed plan.

- Report 1 – Introduction, methodology and exclusions published.
- Report 2 – Report 1 plus 51 reported services, prices published for each facility names remain anonymous, additional content added to promote literacy
- Report 3 - Report 2 with facility names published.

The report information is currently in-house and intended as an educational component for the consumers.

The Appendix presented named the procedure included in the reporting.

Q & A

Ms. Baker asked if Mr. Blundo could show how this data can be understood in both a qualitative and quantitative way. Mr. Blundo responded that at this time, it has not been determined yet. Currently the work ahead is to focus on the design of the report and how to present the cost information. The quality data has not been determined where to source it from yet. The data will not be derived from a claims database it would have to come from a third party. Ms. Baker stated that we will have the cost data but it will be while before we can compare it to quality data.

Ms. Arlene Murphy thanked Mr. Blundo for the presentation. There is considerable work being done on public a score card on quality measure and it seems like a parallel effort. How would your work connect on a score card on quality? Mr. Hackney responded that there were two parts to that question; 1) is the website where the data will be available to consumer there will also be where the score card will be set up. Those are not linked in any kind of way; 2) is that it is our objective to bring in quality measures from external source that would be directly connected. But the first priority is to release the data and then to set up the SIM score card. Arlene also mentioned that we are talking about the consumer cost transparency data and we are aware that you are in the process of designing a website that consumers can navigate to obtain information to make good decisions. Would you be able

	to tell me what consumer process, what engagement has been taken? Mr. Blundo noted that the APCD was managed by different organization but up until last November it was managed by Access Health. Early in the days of development Access Health started putting together focus groups to start to translate the information into a health literate manner for consumers. A report was created and will be available to OHS to use. Mr. Hackney reported that there is a 3 step process to prepare for the website. Starting with a small group of consumers to give us feedback, adjust the approach, and bring in the providers. Ms. Veltri noted that after the APCD Council group met and they felt strongly that there is work to do on the website. Ms. Delphin-Ritmon asked if there will be any data related to demographics. Mr. Blundo responded that due to the claims data, there is no collection of ethnicity data. We have several programs on the way to capture that data. Ms. Baker noted the Medicaid and Medicare data is available and it has half of Connecticut's' population information on ethnicity. Ms. Veltri noted that we are definitely going to incorporate any data available. Ms. Veltri thanked Mr. Blundo and Mr. Hackney for their report. The handouts and presentation material for this presentation is located at: https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/11-13-18/Consumer--Cost-Transparency-Data.pdf	
8.	**Healthcare Cabinet Cost Containment Workgroup**	**Michael Matthews**

	Michael Matthews provided a brief update of the Cost Containment Workgroup meetings:
	
	Discussion Overview:
	• Overview of Process and Approach current progress, Recap of meetings, Approved operating principles,
	• Outcome of Prioritization Exercise – Top 4 Items:
	  o Track price and utilization variations;
	  o Over-utilization, waste, and under-utilization;
	  o Preventable hospitalizations and ED visits – costs and predictors;
	  o Out-of-pocket cost burden – trend over time.
	Next Steps:
	• Finalize top 4 items from prioritization activities, create semantic alignment, and define scope
	• Conduct in-depth evaluation of data availability and feasibility to support prioritized items
	• Identify policy and program implications and opportunities	

	Ms.Veltri thanked Mr. Matthew for the report. For more information on this presentation please visit: https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/11-13-18/Healthcare-Cabinet-Cost-Containment-Workgroup.pdf	
9.	**Health Enhancement Community**	**Mark Schaefer**

Health Enhancement Community Framework (HEC)

- HECs will be multi-sector collaborative with formal governance structures operating in defined geographic areas that will improve community health, prevention, and health equity and reduce cost and cost trends for select health priorities.
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable, including financing that rewards communities for prevention, health improvement, and the economic value they produce.

HEC Proposed Health Priorities:

- HEC Child Well-Being Goal: Assuring safe, stable, nurturing relationships and environments*
- **Healthy Weight and Physical Fitness Goal**

HEC Geographies:
Proposed Elements and Process

- HECs will have defined geographies for which they are accountable.

Stakeholder and Community Input

- Proposed HEC framework is based on stakeholder and community input

Proposed HEC Financing Approach

- Will require a mix of:
  - **Near-term**, upfront funding in the first 5 years of implementation
  - Sustainable **long-term** sources of funds beyond 5 years
  - Assumption that near-term financing options will serve as a bridge to longer-term financing
  - Long-term financing will rely upon ongoing collaboration with health care purchasers such as Medicare, Medicaid, and potentially other payers.
- Pursuing multiple strategies
  - Multi-payer demonstration
  - Social finance options

Longer-Term Financing

- A critical component of securing long-term financing for HECs is developing prevention-oriented shared savings arrangements with Medicare, Medicaid, and potentially other payers

	Due to time restraint the Health Care Cabinet will invite Dr. Schaefer to attend December's meeting for the Q & A's portion of the presentation. Ms. Veltri thanked Dr. Schaefer for the report. For more information on this presentation please visit:**https://portal.ct.gov/-/media/OHS/Healthcare-Cabinet/2018-Meetings/11-13-18/HCC-HEC-Presentation.pdf**	
10.	**Next Steps – Cabinet Discussion**	**Victoria Veltri**
11.	**Adjourn**	**Meeting adjourned at 11:05 am**
	Pat Baker motioned to adjourn and Arlene Murphy seconded; **Motion carried.**	