Healthcare Cabinet Meeting Minutes
August 11, 2020

Meeting Date	Meeting Time	Location
August 11, 2020	9:00 a.m. - 11:00 a.m.	Webinar and Conference Call

Participant Name and Attendance

Healthcare Cabinet Member					
Victoria Veltri	X	Nancy Navarretta	X	Jill Zorn	X
Patricia Baker	X	Ellen Andrews	X	David Whitehead	X
Anne Foley	X	Heather Aaron	X	William Handelman	X
Valencia Bagsby-Young	X	Nicole Taylor	X	Alan Kaye	X
Paul Lombardo	X	Rev. Robyn Anderson	X	Miriam Delphin-Rittmon	X
James Michel	X	Sean King	X	Frances Padilla	X
Theodore Doolittle	X	Deidre Gifford	X		
Shelly Sweatt	X	Nichelle Mullins	X		
Susan Adams	X	Cassandra Murphy	X		
Others Present					
Michael Bailit		Amy Porter			
Michelle Gilman		Miriam Miller			
Kimberly Martone					
Members Absent					

	Agenda	Responsible Person(s)
1.	**Call to order and Introductions**	**Victoria Veltri**
	The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, August 11, 2020 via Zoom. The meeting convened at 9:01 a.m. Victoria Veltri presiding. Introductions were omitted.	
2.	**Public Comment**	**Victoria Veltri**
	There was no public comment.	
3.	**Cost Growth & Quality Benchmarks & Primary Care Target Program**	**Michael Bailit, Bailit Health**
	Michael Bailit, from Bailit Health, presented on the Cost Growth & Quality Benchmarks & Primary Care Target Program. • Mr. Bailit outlined Governor Lamont's charge regarding Executive Order #5 that sets forth the activities that have been undertaken over the last few months. He provided contextual information about healthcare cost, affordability, and disparities in Connecticut. Mr. Bailit also provided a description of the activities related to the cost growth benchmark, primary care target, and quality benchmarks. It was noted that Connecticut spends more than almost any state on healthcare. It was mentioned that worker contributions are growing faster than personal income. Mr. Bailit reported that Connecticut has higher income inequality than most other states. All of this leads to	

the rationale for a cost growth benchmark, a strategy to create some constraint on per capita healthcare cost growth.

- Ms. Veltri opened the floor for discussion and questions.
  There was a question about whether there is data available on the actual fees for individual services such as pharmacy, hospital, and physician fees negotiated for commercial payers. There was also a question regarding how the data compares with other states, GDP, immediate healthcare, and overall cost of health care. It was mentioned that information is available in terms of what commercial fees look like in Connecticut, but not on how they compare to commercial fees in other states. It was noted that other states that have implemented cost growth benchmark strategies have expressed some interest, with time, in sharing data with one another. There may be an opportunity to perform some cross-state analysis on many different levels.
- It was mentioned that Connecticut is part of the Rand 3.0 study. It is a repricing analysis of claims from the APCD based on Medicare prices. There will an indication of the relationship with the pricing of claims as a percentage of Medicare among providers in Connecticut, but it will not be available until next month. The Rand 3.0 study will also include other states.
- There was a question about how Connecticut will compare nationally with the growth and cost of care. It was mentioned that the Technical Team and the Stakeholder Advisory Board share data on where other states have set their targets. It was stated that the groups felt that setting the benchmarks relative to pertinent indicators was more meaningful than setting them relative to other states. There was a suggestion that it could be beneficial to have an awareness of what is going on elsewhere. It was commented that the aggressiveness of the approach to having our own benchmarks is good, but they should look at what other states are doing as well.
- There was concern expressed about unintentional consequences and potential harm. It was suggested they look at some of the things that Massachusetts is doing to reduce cost. Concern was expressed that the caps are aggressive and that an aggregate cap could be applied to Medicaid however it will not address the problem of rising cost. There was a question regarding how they would monitor for harm. It was noted that measuring for potential adverse consequences will be part of the data use strategy that will be developed. The Technical Team and the Stakeholder Advisory Board have expressed an interest in there being a measurement strategy to detect any unintended adverse consequences.
- There was a question regarding the Bill that was put on hold because of the pandemic and whether there would be a mechanism to enforce this. It was mentioned that the Bill put forth by the Governor included performance improvement plans like Massachusetts has done. The idea is that if an entity exceeds the benchmark, for a reason that does not appear to be obvious, the state could request that the entity to provide a plan to improve its performance. It was mentioned that currently the status of the Bill is unknown. It was stated that there may be time to develop an enforcement process before the first reporting year.

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	• Concern was expressed that there are ways to increase primary care spending that are not good and do not improve quality. It was mentioned that there is a primary care group that is being reformed to discuss ways to improve primary care. • There was a suggestion that quality should be focused on first before tackling the cost issue, or at least during the same time. Regarding quality, it was stated that the Quality Council is continuing its work on core quality alignment and quality measures. The Quality Council will start work on the quality benchmark in the fall. It is anticipated that quality reporting will be done alongside the quality benchmarks as recommended by the Technical Team and Stakeholder Advisory Board. • The Council continued to discuss the cost growth, quality benchmarks, and the primary care target program. There was a discussion about how the impact of COVID will being factored into the development of the benchmark. It is expected that spending patterns will be unusual for the next two years. It was mentioned that the cost growth benchmark strategy will be treated as a long-term strategy to persist well after the pandemic is over with the understanding that spending patterns may be unusual for 2021 and possibly beyond. There was a suggestion to look at this as a long-term project. There was also a suggestion that it would be important to monitor the implication and understand the impact on patients and the health system. • Ms. Veltri thanked everyone for their participation in the discussion. She noted the work is ongoing and will continue. The goal is to have some recommendations in October and to have a public comment period before the next calendar year.	
4.	**Legislative Update**	**Anne Foley, Office of Policy & Management**
	Anne Foley, from the Office of Policy and Management, presented on the Legislative update. She spoke about the July special session of the Connecticut General Assembly. • The provisions of two health related Bills were provided. One on Telehealth and the other on Diabetes. ➡ Telehealth Bill Public Act 20-2 of the June special session. ➡ Diabetes Bill Public Act 20-4 of the July special session. • Materials regarding the Legislative update will be shared with the Health Care Cabinet.	
5.	**COVID – High Risk Test Strategy, Contact Tracing, Quarantine & Isolation (Q&I) Supports**	**Michelle Gilman, OTG Laurie Wagner, DSS Kristen Soto, DPH Amy Porter, ADS**
	Michelle Gilman, Deputy Chief Operating Officer of the Office of the Governor (OTG), presented on the high-risk testing strategy. Laurie Ann Wagner from the Department of Social Services (DSS) and Kristen Soto from the Department of Public Health (DPH) presented on some of the work that is happening with contact tracing. Contact tracing is being used to monitor the spread of COVID-19. Commissioner Amy Porter of the Department of Aging and Disability Services (ADS) spoke about quarantine and isolation supports.	

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	• There was a question about turn around time for testing in nursing homes and other long-term facilities and how frequently. There was also a question on whether the terms for turnaround times are being specified in the contracts with community testing partners. An answer was provided that the terms are included in the contracts between DPH and the testing partners for nursing homes, DSS and the health centers. It was mentioned that there are strict terms regarding the turnaround time (TAT) for labs especially for health care requirements such as nursing homes. It was noted that the testing turnaround time is being monitored very closely. • Concern was expressed that the 48-hour testing turnaround time is too long. There was a suggestion to strive for better than 48 hours. Miriam Miller, from the Office of the State Comptroller and lab liaison, reported that many labs report results within a 24-hour time for nursing homes and 48 hours is the max. The Cabinet continued to discuss the contact tracing process. • It was noted that state partners are in discussion about contact tracing. The Connecticut Health Foundation is providing significant funding and partnering with 4CT to assist the local health departments with community health workers in the contact tracing process. For more information on the presentation please see the link below: https://portal.ct.gov/OHS/Content/Health-Care-Cabinet/Meeting-Agendas	
6.	**Next Steps**	**Victoria Veltri**
	• The next Health Care Cabinet meeting will be on September 22, 2020.	
7.	**Adjourn**	**Victoria Veltri**
	The motion to adjourn the meeting was made by Anne Foley and seconded by Ted Doolittle. The motion passed. The meeting adjourned at 11:00 a.m.	