OHS CONNECTICUT Office of Health Strategy

Consumer Advisory Council
Meeting Minutes
November 10th, 2020

Meeting Date	Meeting Time	Location
November 10th, 2020	3:00 – 5:00 p.m.	Zoom Meeting

Participant Name and Attendance

Jeffrey G. Beadle		Christiane Pimentel	X	Adrienne Benjamin	X
Alan Coker	X	SB Chatterjee	X	Peggy Lampkin	
Robert Krzys	X	Soneprasith Phrommavanh	X	Andre L. McGuire	X
Velandy Manohar		Taylor Edelmann	X	Daniel C. Ogbonna	
Terry Nowakowski	X	Ann R. Smith			
Others Present					
Dashni Sathasivam (HES)		Adrian Texidor (OHS)			
Terry Gerratana (OHS)		Leslie Greer (OHS)			
Ormand Clarke (OHS)		Tekisha Everette (HES)			

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Consumer-Advisory-Board

	Agenda	Responsible Person(s)
1.	Welcome	Terry Nowakowski
	Call to Order The scheduled meeting of the Consumer Advisory Council (CAC) was held on Tuesday, November 10th via zoom. The meeting convened at 3:03 p.m. Terry Nowakowski chaired the meeting.	
2.	Public Comment	Terry Nowakowski
	There was no public comment.	
3.	Tabled October 13th, 2020 Meeting Summary	Terry Nowakowski
	The approval the minutes of the Consumer Advisory Council meeting of October 13th, 2020 was tabled to the next CAC meeting on January 12th, 2021.	
4.	Update on All-Payer's Claims Database	Adrian Texidor
	• Adrian Texidor presented on the All-Payer's Claims Database (APCD), which is currently housed under the Office of Health Strategy via legislative mandate in 2019. Previously the APCD was housed under Access CT. The APCD contains Medicaid, Medicare and commercial data each of which have different data use agreements determining how that data can be used and shared. • Onpoint is the vendor responsible for collecting and cleaning the data and creating a HIPPA compliant data set. Via HIPPA laws, a data release of a limited data set (LDS) requires that 18 specific identifiers are removed. Covered entities, Date of birth, and zip code (though granularity may be suppressed for instances where geographic units contain 20,000 or fewer people) are the only identifiers able to be seen in an LDS. Data release APCD data sets include a safe harbor limited data set which include randomized dates. This is a CT modified standard. Access to these	

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sets are limited to those recipients who have been approved by the APCD data release committee.

- The APCD advisory Council is responsible for governance and discussing various changes to the APCD (such as including and integrating dental data) while the APCD Data Release Committee functions like an Institutional Review Board (IRB) committee. OHS is the APCD administrator and holds all responsibility for the APCD. Data submission from commercial, Medicaid, and Medicaid are delivered to OHS on a quarterly basis. OHS has different periods of available claims data depending on the payer.
- SB Chatterjee asked: what is the breakdown (percentage) of commercial data compared to Medicare/Medicaid (public program) data?
- Adrian Texidor commented that commercial is the largest number of claims (500K) that are delivered. Medicaid data is not disclosable. Medicare is around 285 million claims.
- Bob Krzys asked if the current state of CT self-insured data inside the APCD?
- Adrian Texidor affirmed that they the APCD includes this data and this also includes the data of CT State employee retirees. There are 53 payers submitting data to the APCD not including public payers.
- OHS and DSS data use agreements are an annual agreement and allows for the receipt of Medicaid data to the APCD. Medicare (CMS) has given OHS broad authority to use Medicare data for current inflight projects and undefined future projects that align with OHS's mission and values.
- Adrian Texidor discussed the Rand Hospital Price Transparency 3.0 study which intended to measure and publicly report prices paid for hospital care at hospital and service-line level. Patterns observed in price data showed that among all outpatient and inpatient services, there is a significant range in price. Some prices were 2 – 3x more than the Medicare price. A range in prices were also seen among Emergency Department services. Stamford hospital was found to be the hospital charging the highest commercial prices relative to Medicare service prices.
- Adrian Texidor discussed the Healthcare Affordability Standard, a project aiming to develop metrics that can be used to gauge the minimums necessary to afford basic needs and health care coverage in CT. Phase one was focused on defining the real costs to consumers. Phase two will build and test a CT Healthcare Affordability standard calculator.
- SB Chatterjee mentioned the stratification of risk and discussed his concerns with methodologies.
- Terry Gerratana provided background on the project and mentioned that the Healthcare Affordability Index was recently developed with UCONN AIMS and the University of Washington. She mentioned that that should be released in January. This work is building upon the CT self-sufficiency standard. A report was released at the end of 2019.
- Adrian Texidor discussed the APCD Cost Estimator a web tool that utilizes ACPD data or healthcare claims information collected from payers to provide consumers in CT with cost information to enable consumers to make more informed healthcare decisions.
- Adrian Texidor provided a demonstration of healthscorect.com which includes the Quality Scorecard, the Cost Estimator tool and a Researcher's tab for an overview of OHS's data release process.

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- Adrienne Benjamin asked if there is a chart that includes both costs and quality together as people care about both of these factors.
- Adrian Texidor said that at this time there is not chart or graphic that combines the two. He provided a brief overview of the Quality Scorecard and highlighted measures related to patient utilization and compliance
- Terry Nowakowski clarified that the APCD does not include quality measures such as readmission rates.
- Adrienne Benjamin also noted that quality measures may be important to look at going forward reflecting the patient experience, inclusive of, but not limited to patient satisfaction surveys.
- SB Chatterjee mentioned that there are some technical features via Tableau allowing for data to be extracted and sliced and diced by a technical audience.
- Adrian Texidor presented on the COVID-19 hospitalization susceptibility study. The aim of this study was to anticipate and respond to the needs of CT residents in response to the pandemic and help increase hospital surge bed capacity. Population susceptibility was based on the CDC and World Health Organization, the study identified at-risk populations. Results were mapped by zip code based on APCD data. This allowed for the identification of areas of concern as well as supported monitoring and surveillance of COVID-19.
- Terry Nowakowski asked if this was broken up by race and ethnicity
- Adrian affirmed that it was not as race and ethnicity does not have high completeness in the APCD. He also referred to the HEDA team report that was released on the OHS website
- Dashni Sathasivam recommended that those interested look at the report appendix for APCD race and ethnicity completeness in commercial data. There is no uniform race and ethnicity and primary language data collection standards.
- Andre L. McGuire stated to his surprise that race and ethnicity were not included as factors contributing to at-risk populations or areas of susceptibility. Considering that racial disparities are known particularly doing COVID-19, this is needed to effectively address the issues. In the HIV field, there is extensive race and ethnicity data collected. He was wondering why that couldn't happen in this context.
- SB Chatterjee added that in addition to the lag in REL data, also frontline workers impacted by COVID-19, there race and ethnicity was not well captured. To get a handle on COVID-19, we need to look at the demographics of workers
- Terry Nowakowski added that the APCD is being collected is from HCFA1500 outpatient billing forms. Race and ethnicity data are not being collected on the HCFA 1500 forms and is not tied to payment. We need to look at better ways to collect race and ethnicity data to gain a better understanding of race equity and disparities. However, unless it is tied to payment, this may be a challenge. As we move forward, knowing this data will be critically important.
- Terry Gerratana brought up the State Innovation Model (SIM) CCIP project which worked with various health care providers and found out the providers are recording race and ethnicity and language data; however, the problem is that it is not standardized. Examining the information from CCIP would be valuable. Also, REL data is a policy question and would need legislation so that everyone is mandated to collect the data in the same way.

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	• Terry Nowakowski added that unless data is tied to payment, it is difficult to capture it. If tied to payment, the data would be collected. • Adrian Texidor agreed. He also clarified that it is not that the data is not being collected or submitted, but REL data is not being received from all payers equally. He mentioned the HIE is one way to improve the capacity to collect and analyze REL data. • SB Chatterjee mentioned that health care analytics, stratification and algorithms brings up a new level of complexity and a need to rethink how we capture data. To have this innovation, good quality data is needed to ensure or mitigate bias. He is interested in this topic for the upcoming legislative session. • Terry Gerratana mentioned her history of supporting the collection race, ethnicity and language data and health equity during her time in the legislature. She is not certain if REL data is included in the package of legislation that OHS is supporting. • Adrian Texidor continued to present results and graphs. This helped OHS issue waivers to allow hospitals to quickly increase their COVID-19 bed capacity.	
5.	Update on CHESS program	Terry Nowakowski
	• Terry Nowakowski presented a summary of the Connecticut Housing Engagemnet and Support Services (CHESS) program. In 2016, CT was one of eight states selected by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Housing Innovation Accelerator Program (IAP). At that time, it did not appear that there was the political will to expand the Medicaid benefit in this state to include housing. In the last year, DSS decided to move forward with this program and has hit the ground running. Gov. Lamont proposed that the legislature include the supportive housing benefit in the biennial budget. The budget was passed and approved by the General Assembly. A policy recommendation was made to proceed to include supportive housing benefit under CT Medicaid. CHESS is funded through the DSS budget to cover the state match for Medicaid supportive housing services for up to 850 individuals. The Department of Housing will cover 345 housing vouchers and will offer additional housing for 505 people through housing subsidies. • A State Plan Amendment was created and the State of CT is currently is in negotiations with CMS to have them expand the 1915 Waiver through a State Plan Amendment (SPA). The CHESS program is designed for Medicaid eligible who spend $40,000 on recurrent medical costs (in and out of emergency departments) in one year. There is a large body of evidence showing that supportive housing works, so this was another way to address the unmet needs of this population and bring this under a Medicaid benefit. Beacon Health Option will be the administrator responsible for eligibility. • CHESS Partners include DSS, DMHAS, CT Housing and Finance Authority, OPM, CT Coalition to End Homelessness, Corporation for Supportive Housing, The Partnership for Strong Communities, and stakeholders with lived experience and providers. These partners have been collaborating on the CHESS model design. The co-morbidity index scores used as the basis of the model design were carefully reviewed to ensure equity in contrast to other models that use claims data, which has been shown to be inherently biased. The goal was to ensure that the data reflected the population in need.	

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	• The DMHAS supportive housing providers will be most likely participating in this program. Smaller housing providers may have to become DSS providers and do billing. • Critical to this program is the outreach component to ensure that people are getting the services that they need and will heavily rely on DMHAS providers. Components of the CHESS plan include a person-centered recovery plan, pre-tenancy (steps needed to take to get someone into an apartment, looking for an apartment and negotiating lease) providing ongoing support, and transportation services to medical services or landlord appointments. Housing subsidies will be covered by DOH. CHESS operates on a bundled payment model. • The projected live date is February 1st 2021. Covered services in addition to supportive housing will include case management, peer support, employment support, social and family living support, access to substance use and management etc. • Adrienne Benjamin expressed her enthusiasm and support for the CHESS program. • Terry Nowakowski mentioned that because CHESS has been constructed as a Medicaid benefit there is hope for expansion after looking at outcomes data over time. Related to previous discussion about long-term care facilities and how many individuals prefer to live in community settings. She mentioned that program structures and benefits like CHESS can support people in moving or staying in the community.	
6.	Standing Committee Reports	Taylor Edelmann, Alan Coker & Bob Krzys
	• Taylor Edelmann provided an update on the LGBTQ event. While one panelist recently dropped, there are now 4 confirmed panelists. There are two dates that are being considered in February 10th or 11th. Ideally, he would like to have another youth voice on the panel and someone who can speak to housing and he has reached back out to True Colors. There is a focus on housing, mental health and medical care. He is working on objectives and ensuring that there are tangible outcomes. He also mentioned the planning group's desire that stakeholders and policy makers are in the room. The goal is to move beyond just highlighting the gaps and providing recommendations from this event that can help to move this work forward. The group will also have to discuss how to follow up on this effort to ensure that the work does not stop after the event and there is a sustainable path forward. There will be 2 meetings with the panelists prior to the February event. He is excited that there is wide range in representation on the panel so that the people on the panel are represented in populations of LGBTQ youth most impacted by homelessness, mental health and lack of access to medical care. • Terry Gerratana reminded everyone that the Standing Consumer Outreach and Engagement committee will be meeting from 4 – 5pm on Tuesday, Nov. 17th. In addition to the LGBTQ event, Alan Coker and Robert Krzys will discuss the happenings at the executive and legislative branches related to COVID-19 and long-term care facilities. • Alan Coker voiced his appreciation for the LGBTQ event and all the work and planning that has happened so far.	
7.	New Business/Announcements	Terry Nowakowski
	• Terry Gerratana reminded the group that the next meeting of the full CAC will happen in January as the CAC does not meet in December.	

8.	Adjournment	
	Terry Nowakowski moved to adjourn the meeting. SB Chatterjee seconded. Motion carried. The meeting adjourned at 4:57 PM.	

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