Nancy Wyman
LIEUTENANT GOVERNOR
STATE OF CONNECTICUT

Healthcare Cabinet Meeting Minutes
April 10, 2018

Meeting Date	Meeting Time	Location
April 10, 2018	9:00am-11:00am	Legislative Office Building, Hearing Room 1C 300 Capitol Avenue, Hartford

Participant Name and Attendance

Healthcare Cabinet Members					
Lt .Governor Nancy Wyman	x	Shan Jeffreys (AHCT)	x	Paul Lombardo (CID)	x
Pat Baker	x	Kate McEvoy (DSS)	x	Mark Root	x
Susan Adams	X	Robert Tessier	x		
Kurt Barwis	x	Joshua Wojcik (OSC)	x		
Roderick Bremby (DSS)	X		x		
Miriam Delphin-Rittmon (DMHAS) (Nancy Navarretta)	X				
Theodore Doolittle (OHA)	x				
Ann Foley (OPM)	x				
Margherita Giuliano	x				
Bonita Grubbs	x				
Members Via Phone					
Dr. Raul Pino (DPH)	x				
Others Present					
Allan Hackney (OHS)					
Kim Martone (OHCA)					

Meeting Information is located at:http://portal.ct.gov/Office-of-the-Lt-Governor/Healthcare-Cabinet/Healthcare-Cabinet

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	Agenda	Responsible Person
1.	**Welcome and Introductions**	**Lt. Governor Nancy Wyman**
	Call to Order The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, April 10, 2018 at the Legislative Office Building Room 1C in Hartford, CT. The meeting convened at 9:00 a.m. Lt. Governor Nancy Wyman presiding.	
2.	**Public Comment**	**Lt. Governor**
	There was no public comment.	
3.	**Review and Approval of the February 13, 2018 Minutes**	**Lt. Governor**
	The motion was made by Susan Adams and seconded by Bonita Grubbs to approve the minutes of the February 13, 2018 meeting @ 9:05 a.m. **Motion carried.**	
4.	**Access Health Connecticut Update**	**Lt. Governor**
	Lt. Governor Wyman introduced Shan Jeffreys, Chief Operating Officer, Access Health CT. Mr. Jeffreys reported the following: • Finalizing budgeting activities with approval at next Access Health CT Board of Directors Meeting. • Plan management is currently in the process; working with the carriers and CT Insurance Department on plan design. Anticipating solicitation to go out within a month and applications going out in May. Then it will go to the Board for review and approval of the plan designs for the next Board meeting or a special Board meeting. • Focus areas for the upcoming open enrollment looking at technological and operational enhancements. • Working with the carriers and State and Federal Legislators to look at state and federal landscape to be able to pivot change if needed and anticipate updated information available within the next two months to share with Committees and Cabinets. Victoria Veltri asked if there was any information on the Government's finalized rule on Essential Health Benefits as well as the Short Term Insurance Policy rule. Mr. Jeffreys stated that Access Health CT will be vetting that internally with Plan Management and will be providing a summary to the Board members as well as others on impact areas that are relevant to the Exchange and plan design. With regard to the Short Term Insurance plan, Mr. Jeffreys stated that Access Health CT is putting together some talking points and bullets around concerns, risks and also opportunities within those plans and following the current legislation. Paul Lombardo commented that the CT Insurance Department (CID) has not had an opportunity to review the Essential Health Benefits but their legal division will be reviewing it shortly. With regard to the Short Term plan, Mr. Lombardo stated that CID has not completed an analysis as to how that is going to impact, if short duration is less than 12 months, then there are some concerns on how that would impact pricing.	
5.	**Office of Health Strategy Update**	**Lt. Governor**
	Victoria Veltri, Executive Director, Office of Health Strategy (OHS) provided an update. • As of February 1st the office has formed.	

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	• State Innovation Model (SIM) and Health Information Technology (HIT) teams within OHS and the Office of Health Care Access (OHCA), which will be referred to as the Health Systems Planning unit of the Office of Health Strategy to more fit the function they are serving. • Website is up and running. • Currently in the process of sending out information and public comment due on April 21st on Primary Care Initiative that OHS is looking at, or at least starting an engagement process on. • Ms. Veltri stated that the Cabinet was asked by the legislature last year to start working on how to monitor statewide spending and trends. That is the next big task of this Cabinet. • At the next Board meeting, Mark Schaeffer will provide updates on SIM activities. • Waiting for a piece of legislation that would move OHCA into OHS as soon as possible. There is also an implementer bill which is running alongside that for the OHS.	
6.	**Health Information Technology Update**	**Lt. Governor**
	Allan Hackney, Information Technology Officer provided an update on the Health IT activities. Mr. Hackney presented on the following: • Electronic Clinical Quality Measures (eCQM's) – SIM Team • Health Information Exchange (HIE) • All Payers Claims Database (APCD) • Trust Exchange Framework and Common Agreement (TEFCA) The presentation is posted on the Healthcare Cabinet website http://portal.ct.gov/Office-of-the-Lt-Governor/Healthcare-Cabinet/Healthcare-Cabinet-Meetings/Healthcare-Cabinet-Regular-Meetings-2018 Pat Baker asked about sustainability and key elements and components? Mr. Hackney replied that an extensive review was conducted across the country and the belief is that a public/private partnership are prospering and surviving. The other observation is that the payers play a big role in any model of sustainability. Ms. Baker asked about immunization records and if in the future would there be a capability for someone to query the database to obtain a copy of an immunization record and would that be accessible? Mr. Hackney stated that is the long term objective. Ms. Veltri relayed a message from Commissioner Pino, who was participating via phone, regarding the Immunizations. The Department of Public Health (DPH) is training nurses and giving them access to the existing registry while they wait for the new registry. Ms. Baker asked if the funding of IAPD would be submitted next month. Mr. Hackney stated that he will be working with DSS on some issues and submit that application as soon as possible with a plan of having funding in July.	

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Ms. Veltri asked if we know the number of lives in the APCD given that self-insured population is not in. Mr. Hackney responded that it is about half.

Ms. Veltri stated that the Medicare population is in some ways similar to some of the other populations in Connecticut but in some ways very different. In order to take under major reforms, we need to know about the Medicare claims as well as looking forward to using the APCD to begin helping with the work on statewide spending and trends. Ms. Baker commented that there are 680,000 lives covered under Medicare in CT and 750,000 lives in Medicaid, and half of the commercial population which should be enough for analytics and trends; that is a powerful data tool to mine and help determine reforms.

Mr. Lombardo added that the self-funded plans are about 65% of the market and that trends in the large employers is continuing to move toward self-funded arrangements; in the smaller market there is movement into stop loss arrangements. Mr. Lombardo also added that getting to the ERISA plans due to exemptions could prove difficult. Ms. Veltri stated that there is more work to convince those employers to voluntarily submit.

Robert Tessier commented that this has been discussed in the past and wanted to point out, no longer speaking on behalf of CT Coalition of Taft-Hartley Health Funds, since retiring, but after doing that for the last 10 years and having advocated and supported the importance that all of CT's health data be in one place. Mr. Tessier continued that since the Supreme Court decision, the notion that ERISA plans can voluntarily give their data to a state sponsored APCD is not universally accepted or agreed. ERISA Counsel to the CT Coalition of Taft-Hartley Health Funds believe it is not a permitted exception under HIPAA today. Prior to the Vermont Supreme Court decision, which tried to mandate an ERISA plan of under 200 employees to submit their data, a lot of self-insured plans did give their data. But in light of that Supreme Court decision it has become more contested. All it would take is one participant to file suit against an employer or a Board of Trustees. It's a lot more complicated short of amending HIPAA.

Ms. Veltri supplemented Mr. Tessier's statement adding that there has been a lot of activity at the U.S. Department of Labor with States that were impacted by the *Gobeille v. Liberty Mutual* decision, and believes there is still work going on with the U.S. Department of Labor around the issuance of regulations or potential issuance of guidance or regulations which would hopefully address that issue.

Commissioner Bremby said he would be remiss if he didn't say that CT should be proud of the work that has been produced as well as the work that will be produced in the days, weeks and months to come. Commissioner Bremby referenced back to Commissioner Pino's comments. DPH has been working extremely hard over the past couple of years to upgrade the immunization registry. To clarify the point he was making is that they have already gone out and secured an immunization registry using CDC grant funds.

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	It is without question the best registry available on the market and is phenomenal in terms of its capabilities. DPH has been training nurses and physicians across the state to give them access to this system which will improve immeasurably the ability to track immunizations not only for children but also seniors as they look for immunizations later in life. A portion of the request that was submitted to CMS is dedicated to further enhance the registry and includes the interoperability with the Health Information Exchange. Commissioner Bremby continued that DSS will be securing funding and is hopeful that will happen within 60 days. He would like to offer support and congratulations to the teams who have been working hard over the last year to up level the technological capabilities. Reverend Bonita Grubbs, coming at this from the standpoint of the consumer, was particularly interested in knowing about the process that the OnPoint vendor is going to be doing to obtain consumer input into the final specifications and, what the process will be to engage consumers, and asked Mr. Hackney to speak about that. Mr. Hackney responded that the consumer transparency tool and specifications were developed before he arrived through the APCD Advisory Council and a number of consumer advocates that were a party to that. What has been done since that time is a review of those specifications relative to the introduction of new statutes that have emerged? That will be the basis of what the foundational services will be. At that point there will be focus groups with consumers and will work directly with them and engage them on the usability of systems and ability to understand what the information is about. Mr. Hackney continued that they will ask for public comment and consumer to join specific focus groups to review and comment on the application before it is delivered.	
7.	**Office of Healthcare Access**	**Lt. Governor**
	Kim Martone, Director, Office of Health Care Access (OHCA) and Karen Roberts, of OHCA (which will be called the Health Systems Planning Unit of OHS) Ms. Veltri introduced Kim Martone and the transition team meetings that have occurred; there are many opportunities to blend the work of OHCA with that other work that is being completed to have a bigger impact especially on CLASS for the State of Connecticut. Kim Martone provided a presentation on the following: • General reporting requirements that OHCA is responsible for • Cost Market Impact Review (CMIR) • Statute that OHCA was responsible for a year ago and facility fee information. • Certificate of Need (CON) program, • Publishes statewide facility and inventory, hospital financial stability report and collects data from hospitals both utilization and financial and have three years of outpatient surgical facility data. The presentation is posted on the Healthcare Cabinet website http://portal.ct.gov/Office-of-the-Lt-Governor/Healthcare-Cabinet/Healthcare-Cabinet-Meetings/Healthcare-Cabinet-Regular-Meetings-2018	

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Regarding the CMIR, Mr. Tessier asked if these are annual increase caps and for how long? If the first years' caps are higher and would it be an expectation that caps going forward would not be this high. Ms. Martone replied they are annual increase caps for the first year and then for five years. Yes, safe assumption that the caps going forward would be this high. They were so below the threshold and this brings it up to other providers and should be less going forward. Ms. Martone reminded the Cabinet that this is a cap, just the upper limit. Further discussion ensued and Ted Doolittle asked about the facility fee data and if it was collected on an aggregate or claims basis? Ms. Martone stated that it is aggregate. Ms. Veltri asked if that aggregate data was further divided and sorted. Ms. Martone replied it is further divided by payer by the top ten procedures by volume.

Ms. Veltri commented that this was a Medicare adjustment which we have no control over. Lt. Governor asked if they are comparing this to Yale and the surrounding areas of Yale, and asked if they look at ability to pay. Ms. Martone responded that ability to pay is not a factor and believes that it is distance related. The Lt. Governor asked if it's the distance from one hospital to another or distance to something else. Ms. Martone explained that it's a catchment area and region that they look at in terms of distance. Ms. Veltri interjected and stated that If the assignment is to that area, your wage index must reflect the wages and everything else; it's a federal assignment. Ms. Martone stated, no. There was a need to create a market and the market in this case is all of eastern Connecticut. They are bringing Yale in line with the market which is Eastern CT and not the New Haven area. Going forward it will be compared to the market in Eastern CT. Ms. Martone continued that she believes William Backus hospital is under the same situation utilizing the comparison to Nassau County. This also includes Lawrence and Memorial Hospital. The consultants informed them that Backus Hospital itself could also go up 9% because of that wage index.

The Lt. Governor commented that Connecticut cannot be the first State that is shocked by this and that something hasn't happened at the federal level at some point to change this. It doesn't make a lot of sense to balance it that way. Mr. Tessier agreed with the Lt. Governor and would like to understand it better and asked if additional information can be provided. Mr. Tessier asked why Nassau County was used as opposed to Western Rhode Island or Central MA or other parts of Connecticut, all of which would most closely reflect conditions in Eastern CT.

Ted Doolittle thanked Ms. Martone stating it is important information about the CMIR's. Mr. Doolittle had a question related to last summer's contract outage between Anthem and Hartford Healthcare which created a dead zone for health consumers in the northeast corner in the State. Is there any way in future CMIR's to examine the impact on contract outages between large hospital systems and large payers to predict if there is going to be an impact in the future in the event of a contract outage? Ms. Martone stated that the criteria is general in nature. If at that point if there is an issue to access, that can be looked at. However, if it is about specific contracts that is something that is not typically look at. The focus would be on access in the area to make sure that the population had access to needed services.

Mr. Doolittle asked if OHCA would examine Anthem in the northeast corner which has a large percentage of the population covered; wouldn't you take that into account when looking at the access, the fact that a large

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percentage of population is covered by that carrier that an outage might be devastating for the community. Ms. Martone stated no, not carrier specific. It would be more or less the access in the area.

With regard to Facility Fees, Vicki Veltri asked if the data is aggregated data, even though it's top ten procedures, isn't it split out by urgent care vs. regular outpatient and would be difficult to determine if it's an urgent care vs. regular outpatient.

Karen Roberts replied that the data OHCA collects is on two tables. The first table is the top ten by utilization and the top ten by revenue collected and that's just the procedures. Second table a list of all other information by service location. As an example, Ms. Roberts pointed out that from Milford Hospital all the revenue collected specific to an urgent care center would be reported out if that's how they titled the data. Ms. Veltri commented that makes sense because we are seeing a lot more urgent care centers around the state and across the country. It would be good to see what the impact is of those fees.

Ms. Baker asked for help me in understanding facility fees. She state that she participates in the Yale system and when she goes to one of the facilities she receives a document that she signs regarding facility fees which can range from $50 to $1000; and they don't seem to be able to tell her what the difference is or what the fee might actually be. Ms. Baker asked why a facility might have that kind of range. Ms. Roberts replied that it will be based on the range of the services there, the lower level to the higher level of care. Ms. Veltri stated that as far as she knew, there is no formula that states if the service is $100 then a facility fee is 10%, as an example, that it would be hard to determine. Ms. Roberts replied that there is no formula and it would be hard to determine.

Mr. Tessier asked how long has OHCA had been collecting this data. Ms. Roberts replied since 2015 and will be collecting 2017 by July 1st which will give them a three year trend.

Mr. Tessier commented that the dollars are so much greater than anything he has seen. Ms. Martone pointed out that this is just for the physician visit and there other services that are more profitable that a facility fee can be charged for. Ms. Roberts illustrated that one of Hartford Healthcare's top generate facility fee is for cataract surgery, by way of example.

Lt. Governor asked if OHCA collects data on the number of facilities outside of the main hospital. Karen Roberts stated that each facility owned and operated by a system or hospital that falls under this law submits specific data such as how many patient visits for which they charged a facility fee, their net revenue, the range by different kinds of payers.

Mr. Barwis stated that Bristol Hospital was one of the few hospitals that did not charge facility fees and made a conscious decision to not do that, but unfortunately with the impact of the net provider tax, there is no way Bristol Hospital can survive without charging facility fees we are now being implemented.

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	Mr. Tessier thanked Mr. Barwis for his statement and asked if it was fair to say that it's just another way to get revenue and the charge was all of a sudden then called facility fees and in many cases even payers couldn't see it and didn't know it was there. There are data analytics and looked at coalitions' data and could not identify discrete charges for facilities fees but they are somehow lumped in there. It sounds like it's just a way to generate revenue which has nothing to do with the cost of healthcare. Is that fair? Ms. Burwis responded that it's complicated. Hospitals are very expensive enterprises and technology and all the things we have to do to deliver high quality care. It's tough and I do think the insurance companies now clearly see them and know it and negotiate them as part of the contract negotiations. We couldn't make it without doing that. It is nominal and we are on the right side of that sheet. It's a balancing act. We stopped charging them because patients react to them and we received complaints, it's confusing and our board made a decision to do that. I wish today that we hadn't made that decision because I have a lot of infrastructure needs that I cannot tend to because of the loss in revenue related to the net impact of the hospital provider tax. It's difficult and there is no easy answer to your question. Ms. Baker interjected that the CT Health Foundation is hosting an event April 25th and Elizabeth Rosenthal who wrote the book *"American Sickness"* is the luncheon speaker. She will talk a great deal about costs and how they have added up over different points and facility fees is one section of her book. Ms. Veltri stated that OHCA is providing data and the question from the APCD is, given what Mr. Tessier said, whether there is a breakout on the claim. If there is it would obviate the gap you have at OHCA. Maybe that's something we need to check. If we are seeing it in the APCD that will allow us to look at the variations by procedure and it won't be just the top ten, it would be every procedure that is essentially reported. That is one positive that we can take out of that. Mr. Wojcik stated that in terms of claims data, they are separate charges. There is CPT code that facilities charge as opposed to a professional fee and they are very hard to match up. Kate McEvoy asked a question on a different topic; Does OHCA have any role in receiving information or reporting around the statutory obligation hospitals have to inform people that they are in observation status in the Emergency Department? This was legislated because there were implications especially for Medicare folks to meet the three day requirement for the Skilled Nursing Facility coverage for Medicare enrollees and a spill over affect to Medicaid. Ms. Martone replied that they do understand and realized that that is a problem and they look at the number of beds and discharges, but do not have the observation status. Ms. Veltri replied to Ms. McEvoy's question and thought that the Office of the Healthcare Advocate (OHA) under statute that gave OHA some reporting information on observation status. Ted Doolittle replied that he don't think so but it could be. Ms. McEvoy will review the statute and noted that would be useful to collectively obtain some information on that.	
	Wrap Up and Next Steps	**Lt. Governor**

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	The next meeting is scheduled to take place on Tuesday, May 8, 2018, however, that meeting will most likely be changed as it is the next to the last day of the session. The motion was made by Ms. Baker and seconded by Robert Tessier to adjourn the meeting. **Motion carried.**	
9.	**Adjourn**	Meeting adjourned at 10:50 a.m.