STATE OF CONNECTICUT
LIEUTENANT GOVERNOR NANCY WYMAN

Health Care Cabinet:
Business Plan Development Work Group

Monday, April 16, 2012
Meeting Minutes

Business Plan Work Group Attendees (9): *Frances Padilla, Co-Chair; Nancy Yedlin, Co-Chair; Ellen Andrews; Phil Boyle; Demian Fontanella (for Vicki Veltri); David Guttchen; Alex Hutchinson; Linda St. Peter; Tom Woodruff*

Delivery System Innovation Attendees (1): *Mark Borton*

Office of the Healthcare Advocate (1): *Africka Hinds-Ayala*

Absent (2): *Bonita Grubbs; Jeannette DeJesús;*

Co-Chair Frances Padilla opened the meeting by welcoming members. Minutes from the April 16, 2012 meeting were approved with no changes by consensus.

There was proposed meeting dates and agenda items presented for consideration and approval as follows:
- April 30: Ken Lalime (Executive Director, CT State Medical Society IPA) | Co-Op Plan Application and ACO Activities
- April 30: Leslie Swiderski (Program Coordinator, Waterbury Access Program) | Waterbury Access Program-Care for Uninsured/Underserved
- May 7: Laurel Pickering | Northeast Business Group on Health-Value Purchasing
- May 16: Health Care Cabinet Meeting | Capitol District Physicians Health Plan Presentation

The HCC: Business Plan Work Group invited the Office of the State Comptroller (OSC) to share their cost effective measures for the State Employee Health Plan that have been put into place, as this plan will eventually include non-profits and small businesses. It was explained that the Business Plan Work Group is charged with identifying gaps in affordable health care coverage, as well as any gaps to access to quality healthcare, and the value (cost) of that care today and in 2014. Thomas Woodruff, PhD, the Office of the State Comptroller, presented the State Employee Health Plan (SEHP) as it exists today and how it got to its current state. The SEHP began its road in 2005 with looking at various ways to control costs without disrupting the existing coverage; in its development a competitive environment developed amongst the various carriers and adding one additional carrier – United Healthcare. Eventually the SEHP included national networks for all its plans. There was a review of management labor and legislation to improve the SEHP where possible with self-insured carve-out of pharmacy. In 2009, came a change in the prescription benefits to a three-tier structure, which allowed for deep discount on prescriptions, as well as a 28% federal reimbursement of covered drugs for those state retirees signed-up with a Medicare Part D Plan. All the significant pharmacy changes introduced several different cost-effective measures including EG-WIP (Employer Good Waiver Incentive Plan), which is a Medicare Part D plan paired with a WRAP plan to get State Retirees to join Medicare Part D. Eventually, the pharmacy benefit moved toward a simpler structure. The economic arrangements changed; therefore, a move from Medicare Part D current plan to something that is optional.

In 2011, the SEBAC negotiations changed some things around with the majority of State Employees to participate in the Health Enhancement Program (HEP). This was a significant change in the health benefit design for state employees. OSC has looked at different cost-effective measures: patient centered medical homes, increase primary care certification, behavioral economics, and plan design. With regard to the Behavioral Economic piece, it was negotiated and approved by both sides in the 2011 SEBAC agreement that state employees will be "fined" $100 monthly standard plan deduction and $350 annual deductible per covered person ($1,400 family maximum) if not in compliance with the HEP; this penalty alone generated 98% participation amongst state employees. What emerged from the SEBAC negotiations was a value based designed that lowered co-pays for maintenance drugs, increase of medical screenings, and inclusion of drugs that were considered non-formulary. The deadline for State Employees to report on their respective HEP is May 31, 2012, for the period of October 2011 through June 2012. For those state employees (and dependents) who have not complied by the May 31, 2012 deadline will receive a non-compliance letter. There will be some graces provided because it is the first year of the program with the first full year going to a calendar year beginning January 1, 2013.

Alex Hutchinson asked what input does small business report on having, as distance is more of a risk. Dr. Woodruff reported that second level of analysis takes place with the OSC having authority to give subset of municipality to come in. There are four dental plan options that share the common thread of cleanings and x-rays, which must be reported in the HEP. Anthem does not have a contract with XXX; use of United Healthcare network (99% match). Nancy Yedlin stated that large cities have a serious challenge because each plan is different. The municipalities do not represent the critical mass, but Milliman, Inc. does crunch the numbers with the Municipal Health Insurance Plan (MHIP). There is a duplication design issue.

Dr. Robert Zavoski (DSS Medical Director) and Staff provided a presentation to share with the work group: Person Centered Medical Home: *A Rebirth of Primary Care* . The presentation addressed health purchasing and practice challenges, a model PCMH, data on pre-natal care, and PCMH program rationale. The presentation was not limited to these topics, but provided a comprehensive review on how the state is moving forward and stepping closer to implementing the Patient-Centered Medical Home. With this model, there is no measurement outcome, but it is a team-based approach with the patient (person) in the center. Department of Social Services (DSS) is hopeful that long-term care is a way to improve the health environment. There is assignment of the people to the providers. PCMH = EMR. Although EMR reduces productivity and it is difficult to get back to 100%. EMR is not cost effective for practices or providers. The National Committee for Quality Assurance accredits the providers/practices participating in PCMH; and the Early Preventive Screening Detection Testing should be central to the PCMH. Under the PCMH Model, there are consumer protections in place. THE NCQA indicates a small practice will pay anywhere between $13-25K to be setup as a PCMH for approximately 18 months. It is imperative that measurements of outcomes and claims data be performed.

Nancy Yedlin asked how the independent practices are affected. The independent practices are not attached to a hospital or health center; they are solo groups that include APRNs, Pas, and some physicians; the services are paid for by code.

Dr. Zavoski ended the meeting by stating that people are "voting with their feet" and it can cause limitations when the rules are changed within the NCQA. There are providers who want to participate but are not paid accordingly. Currently Medicaid physicians are accepting payment of 57% of the 2007 approved rates of services.

Meeting was adjourned. **Next meeting will be April 30, 2012 at 3:00 pm at State Capitol – Room 410**

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