SustiNet Board of Directors
Meeting of September 16, 2009
Meeting Minutes

Board Attendees (Appointing Authorities in parentheses): *Nancy Wyman, Comptroller, co-chair; Kevin Lembo, Healthcare Advocate, co-chair; Paul Grady, Mercer (Rep. Lawrence Cafero); (Sen. Donald Williams); Norma Gyle, DPH (Governor M. Jodi Rell); Jeffrey Kramer, UConn School of Business (Rep. Denise Merrill); Joseph McDonagh, Self-Employed (Sen. Martin Looney); Jaime Mooney, Norwalk Hospital (Sen. John McKinney); Robert Galvin, DPH Commissioner, ex-officio; Rob Zavoski for Michael Starkowski, DSS Commissioner, ex-officio; Thomas Sullivan, Insurance Commissioner, ex-officio; Christine Vogel, Office of Health Care Access Commissioner, ex-officio.*

Absent: *Bruce Gould, AHEC (Sen. Donald Williams); Sal Luciano, Council 4 AFSCME (Rep. Christopher Donovan)*

Legislative Attendees: Rep. Betsy Ritter and Sen. Jonathan Harris, co-chairs of the legislature's public health committee

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SustiNet Board of Directors co-chairs, members and legislators introduced themselves. Kevin Lembo thanked staff from the public health committee and from the offices of the Comptroller and Healthcare Advocate for their work in moving the work of the board forward.

Kevin then introduced Stan Dorn from the Urban Institute to make a presentation on the history of SustiNet's development. Stan's presentation is available by clicking here. Stan offered continued assistance to the board as the board begins its work.

After Stan's presentation, there was a Q & A period.

Q. Kevin asked how SustiNet fits with what's going on with Washington, D.C.

A. Stan said that if legislation passes that's roughly along the line under discussion now, SustiNet could become an option available in the health insurance exchange. Increased federal reimbursement is promising in terms of making SustiNet fiscally doable without painful revenue increases. He's concerned about subsidies for people above Medicaid–eligible incomes. Maybe there will be a federal waiver option that allows for subsidies for folks –low-income families should not lose ground on reform.

Q. Nancy asked whether there were any major discussions on pharmacy in the SustiNet development. Would there be a separate benefit or would it be part of the regular health insurance coverage?

A. Stan said the answer would be left to the discretion of the public authority or other entity. It's worth looking at joint purchasing, but it may be the best option to prescribe all details in statute of how pharmacy would be parceled out.

Q. Paul asked, in Stan's opinion, what are the top three issues the board will have to grapple with?

A. Stan: The issues of how to pay for SustiNet and what incentives will be established to ensure evidence based care.

Q. Paul then asked if there are models around the country to integrate HUSKY benefits into the state employee plan.

A. Stan: There isn't a plan to integrate the HUSKY population into the state employee plan, only to allow everyone to have same opportunities of appropriate care. Other states often combine purchasing like DME, pharmacy. No one has precisely gone down this road before.

Q. Joe asked whether medical home idea gets around resistance to the notion that PCP should be responsible for deciding whether someone needs to go to a cardiologist.

A. Stan: SustiNet is not a gatekeeper model. In other states where there is a medical home model, issues re referrals have not presented themselves. Need to convince people that they will get more, not less, under this plan. The model can't be rolled out immediately, and it may make sense to start with enrollees that have chronic illnesses.

Q. Jaime asked what is different about Connecticut that prevents physicians from forming into groups, as is needed for medical home model.

A. Stan says he is not sure and doesn't necessarily agree that there need to be groups of physicians set up together for it to work. The North Carolina example is a good one.

Jaime commented that HIT can foster some coordination between individual practices, but that going forward it is going to be difficult to connect providers to HIT if they are functioning as their own practice.

Stan responded that quality measures for providers (peer reviews, etc.) had a positive reception among providers and can make the plan function more like an

integrated system of care, along with virtual HIT connections between individual providers.

Q. Rob said that he attended a meeting with providers who, even though they know there's an incentive for Medicare HIT, physicians think that it will be cheaper to pay the fine rather than go to HIT. The medical home change would also require reimbursement changes.

A. Stan: One of the ways to make the plan affordable is to have CHEFA do a bond with subscriptions for providers—providers would get hardware and software paid over time, updates and replacement, technical support, training, etc. There would be substantial leverage if all providers were involved. We'd need to set up a platform for integrating data across multiple providers, build interfaces between offices—could be done by a statewide purchase. There would be varying financial incentives for providers who might still lose some money by coordinating all steps by converting to HIT.

Jaime commented that until we have a unique patient identifier, sharing of information will be difficult. She also stated that she hoped there would be a focus on one, two or three vendors to provide the HIT support/services. We also need to be careful with implementation of other HIT initiatives, including federal stimulus initiatives. We also want to ensure we don't replicate the HIT initiative that is already ongoing in Connecticut.

Sen. Harris suggested that we use the model proposed by Victor Villagra's proposal, in the Health First Authority Report, Exhibit #4, in which Dr. Villagra analogizes healthcare to a utility and develops a community health proposal based on that assumption. Insurance companies know about HIT—we should reach out and learn what platforms already exist in the state.

Q. Jeff asked how the issue of workforce shortages would be addressed in the SustiNet proposal.

A. Stan said the issue is exactly why a work force task force was created in the legislation. Additional demand will be created, but the state has to grapple with the issue now anyway because there is already a problem. He suggested that the task force or board has to adopt incentives to get providers to stay in Connecticut.

Q. Jeff also asked about previous efforts' failure as partly a function of financial issues. Would this suggest a need for standardization of offerings across companies?

A. Stan says he's not sure whether it is truly an issue of non-standard issues. Point re failures of previous efforts points to the need for an integrated financial system. SustiNet is the one entity that would control finances.

Q. Joe wondered why it was stated that adverse selection would not a problem in SustiNet. He also wondered whether plan would be age-based as well.

A. Stan: You need a level playing field. You can't have different rating rules in individual plans versus SustiNet. Set the rules for SustiNet and reform the individual market. Combine small group market and individual market rating rules, so there will be age-based rating across all products. Other rules could change. SustiNet could also penalize folks if they wait too long to enroll in the plan to encourage early enrollment.

Q. Paul says all comments made have touched on reimbursement in one way or another. He recommends a separate committee to address reimbursement reform. The medical home model won't work without payment reform. What are Stan's thoughts?

A. Lots of questions on how to pay – bundles? Whatever you do, it is critical to move forward with physicians and nurses, collaboratively. You should also remain open to new ideas and options. For medical home, need risk adjusted capitated payments, but you also need outlier payments.

Kevin asked that remaining questions be funneled through the co-chairs so they can be forwarded to Stan.

Advisory Committees

Kevin reported that dozens of additional names were collected so it seemed inappropriate to send the lists down to the board yet. Instead the board would address the liaisons to the committees and task forces and the co-chairs of the committees.

Liaisons were named: Norma Gyle for Prevention, Sal Luciano for Work Force Task Force, Bruce Gould and Joe McDonagh for Medical Home, Paul for Provider Advisory, Jeff Kramer and Jaime Mooney for HIT, Kevin and Nancy for Obesity and Smoking Cessation Task Forces.

Paul suggested a discussion on a reimbursement reform committee. Nancy suggested that reimbursement be a major subcommittee of the Provider Advisory Committee. The board agreed with this recommendation.

Kevin then suggested that the board move on to a discussion of electing co-chairs for each of the committees. Kevin and Nancy suggested Marie Smith and John Brady for HIT, Ellen Andrews and Tory Westbrook for Medical Home, Margaret Flinter and Robert McClean for Provider Advisory/Health Quality and Mike Critelli & Nancy Yedlin for the Preventive Health Care.

Voting was not completed on the co-chairs for the advisory committees. Jaime expressed a concern that the board does not have enough information to vote on the proposed co-chairs and proposed that the co-chairs provide information to the board before voting for the co-chairs. Kevin said that the co-chairs could push the bios down to the board so that there could be a vote on the co-chairs at the next meeting.

Nancy suggested that once co-chairs are established, the Board of Directors asked the committee co-chairs contact people on their advisory committee lists to determine who is ready and willing to participate because there will be a lot of hard work involved. After the advisory committees are contacted by the co-chairs, then there will be a vote to approve the actual committees, after discussion by the Board of Directors, to ensure that committees are complete.

The next meeting was scheduled for September 30, 2009 at 12:15 p.m. in LOB room 1D.