

Study of Cost Containment Models and Recommendations for Connecticut

Review of Washington and Stakeholder Feedback

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health

The Healthcare Cabinet Cost Containment Study is a Partnership



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Agenda

1. Review of Washington's Cost Containment Strategies
(9:05 – 10:00)
2. Analysis of Stakeholder Feedback (10:00 – 10:30)
3. Review of Principles (10:30 – 10:55)
4. Next Steps (10:55 – 11:00)

Reminder

- As we discuss Washington's strategies, please stay open to new possibilities



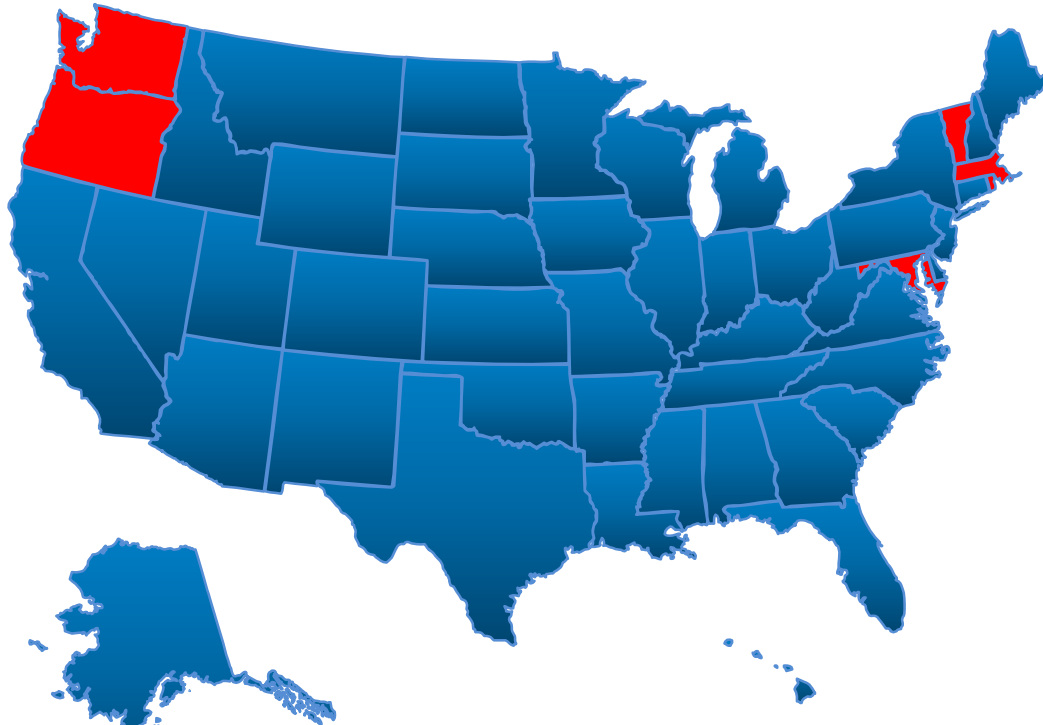
- Ask yourself, if Connecticut were to adopt some or all of the strategies discussed, what are –
 - Some of the facilitators?
 - Some of the barriers?

Before We Get Started: Acronym Cheat Sheet

- **ACP:** Accountable Care Programs
- **ACH:** Accountable Communities of Health
- **Apple Health:** WA Medicaid program
- **HCA:** Health Care Authority
- **HTA:** Health Technology Assessment
- **PEBB:** Public Employees Benefit Board
- **The Alliance:** Washington Health Alliance
- **UMP:** Uniform Medical Plan (PPO for PEBB)



State Cost Containment Models



Six States of Inquiry



Washington

Key Statistics



Washington

Population	7,170,351
Sources of health coverage, 2014	Employer: 48%
	Medicaid: 22%
	Medicare: 12%
	Uninsured: 9%



Connecticut

Population	3,596,677
Sources of health coverage, 2014	Employer: 58%
	Medicaid: 20%*
	Medicare: 12%
	Uninsured: 3.8%**

*Source: MAPOC website as of 1/2016:
https://www.cga.ct.gov/med/council/2016/0222/20160222ATTACH_DSS%20Presentation.pdf

**Access Health CT (4/5/16).

All other information from the Kaiser Family Foundation, 2014 data.

Health Care Market Profile: Hospitals



Washington: 90 hospitals

- Hospitals cluster in the Seattle, Spokane and Tacoma areas
 - Seattle: 12 hospitals in an increasingly competitive environment

Connecticut: 28 hospitals

- Most are domestic, but some are operated by larger health systems
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by increasing consolidation

Health Care Market Profile: Primary Care



Washington: ~5,100 individual PCPs

- 1,307:1 ratio of population to PCPs
- Smaller, independent practices in urban settings are merging into larger systems
- Shortage of PCPs to serve newly insured
- 25 FQHCs

Connecticut: ~ 3000 individual PCPs

- 1,385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients*
- 16 FQHCs

Sources: Physician Perspectives on Care Delivery Reform: Results from a Survey of Connecticut Physicians. April 2015. UConn Health and Yale School of Public Health; the Robert Graham Center and WA SCHIP 2014.

Health Care Market Profile: Health Plans



Washington: 80% of the market is captured by three non-profit plans:

- Premera Blue Cross: 28%
- Regence Blue Shield: 26%
- Group Health Cooperative (now owned by Kaiser): 30%

Connecticut: Dominated by three publicly-traded plans:

- Anthem: 44%
- Cigna: 20%
- Aetna: 18%

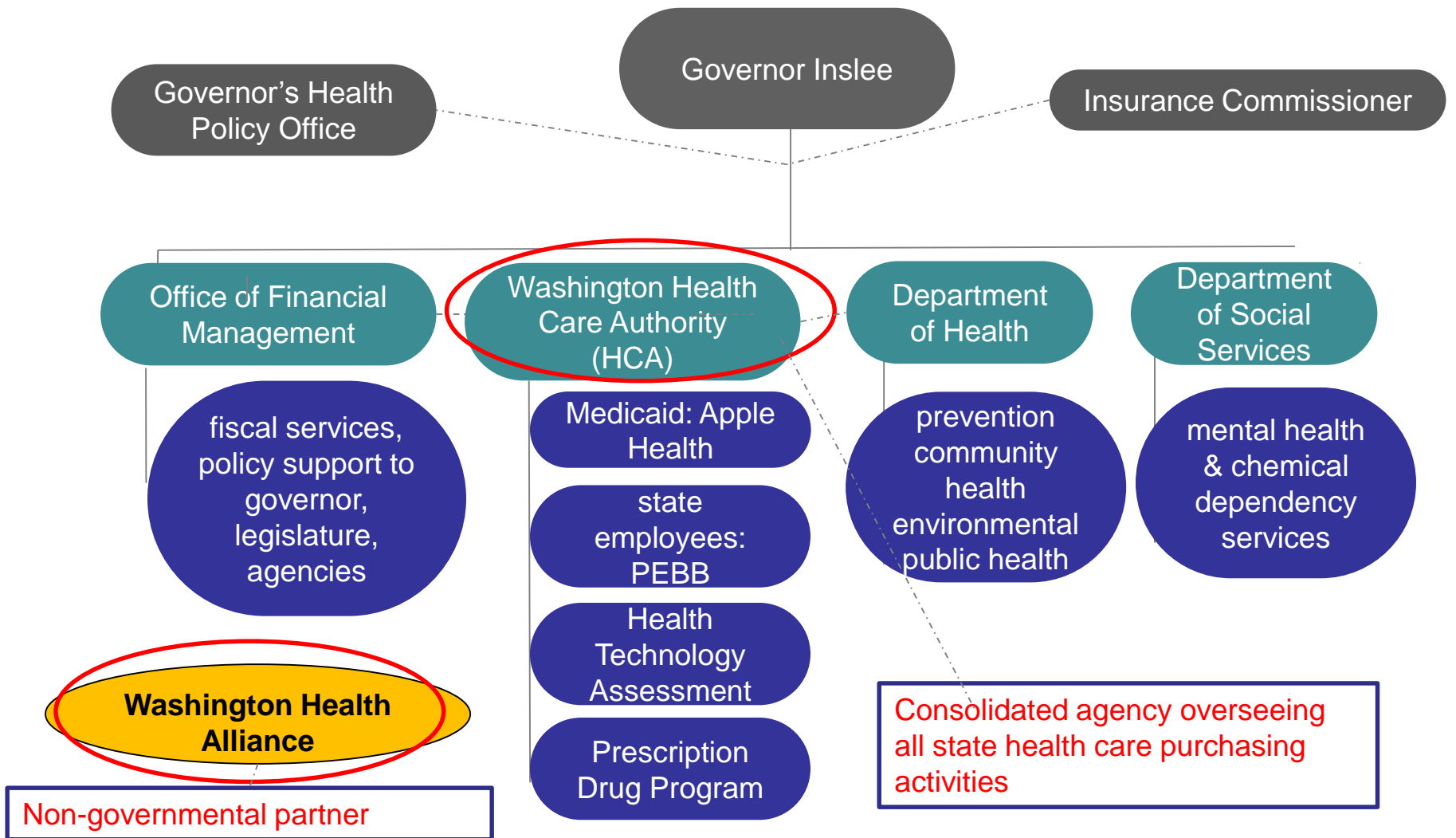
WA State Legislature's Role in Health Reform

- In 2014, HB 2572, required HCA to increase value-based contracting and other payment incentives
 - Authorized funding to develop two *Accountable Communities of Health* demonstrations, each received \$150k planning grants
 - Directed HCA to develop statewide core measure set and establish mandatory APCD
- In 2014, SB 6312 mandated full integration of behavioral & physical health services for Medicaid enrollees by 2020
 - Provided early entrant opportunity for 'innovator' regions
- In 2011, ESHB 1311 established the Bree Collaborative
 - "...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington..."

Federal Support for Washington State Health Reform Initiatives

- CMS awarded a 6-month \$1 million SIM Pre-Testing Grant, and a \$64.9 million Round 2 Model Test Grant in 2015
- WA is negotiating a Medicaid Transformation (1115) Waiver
 - Promises to hold Medicaid per capita cost growth 2 percentage points below national trend by:
 - Reducing avoidable use of intensive services and settings
 - Accelerating transition to value-based payment and improving population health
 - Waiver proposes that HCA contracts with Accountable Communities of Health (ACHs) to coordinate Medicaid transformation projects within their regions
 - ACHs = regional multi-stakeholder collaboratives (*more later*)
 - Agreement on programmatic approach; negotiations focused on finance issues, including budget neutrality

WA Government Oversight of Health Reform



Washington Health Care Authority (HCA)

- Established in early 1990s in response to major cost increases within state employee program
 - Prior to establishment of HCA, contracting for state employees done through a state board
 - In 2010, Medicaid came under HCA umbrella
- Today it's a **1,200 person agency**, that runs **8 programs** covering **~2.2 million residents**
 - Medicaid
 - Public Employee Benefits Board (PEBB)
 - Uniform Medical Plan (UMP), PPO
 - Accountable Care Plans (ACPs), narrower, at risk-networks in Puget Sound area
- **\$10 billion / year in costs**

Washington Health Care Authority (cont'd)

- **Vision:** A healthier Washington
- **Mission:** Provide high quality health care through innovative health policies and purchasing strategies
- **HCA values:**
 - being a national leader in health care transformation
 - working to achieve the Triple Aim
 - access to quality care
 - effective leadership and alignment
 - customer experience

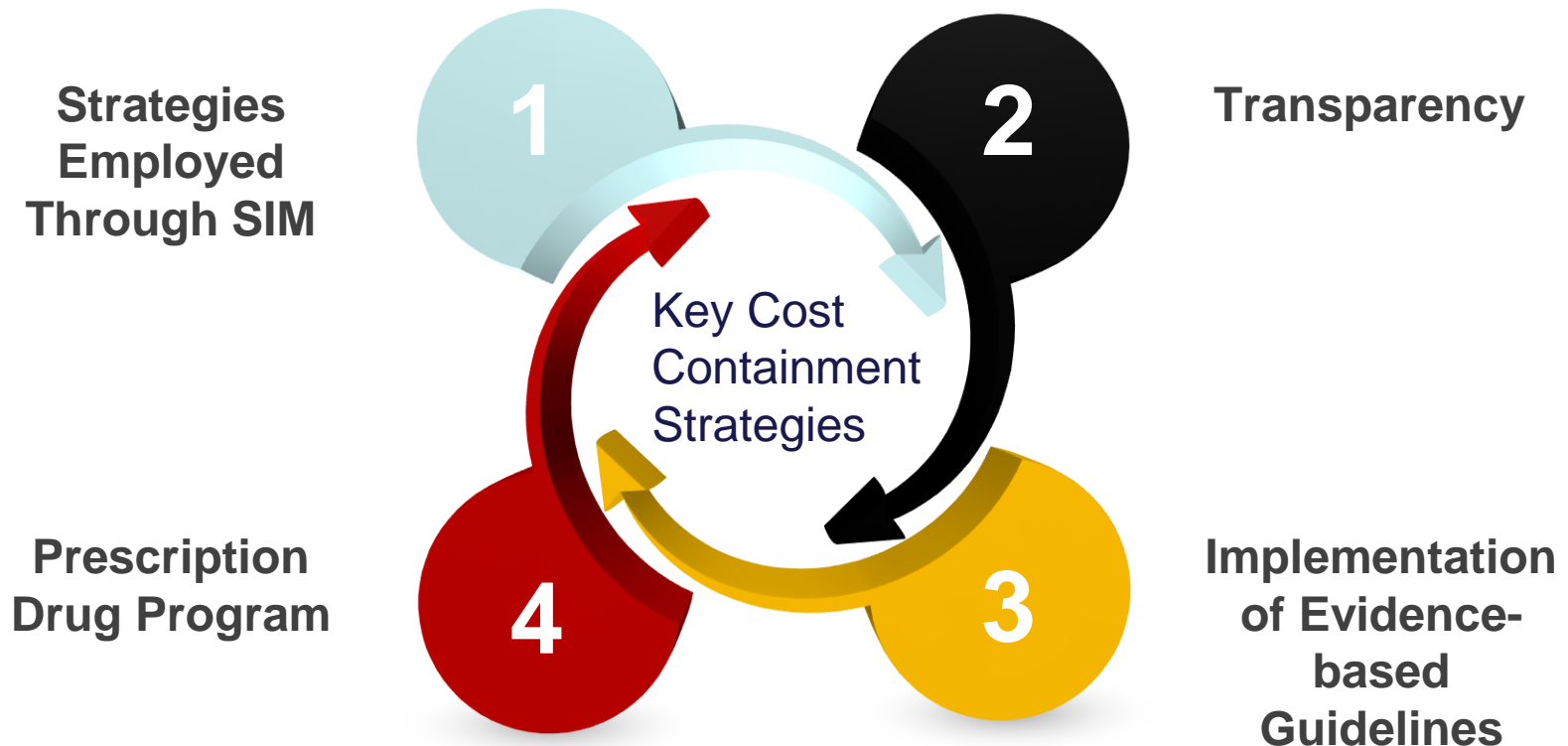
HCA: Collegial, Collaborative Culture

- Staff describe an informal, collegial management style that cuts across agency silos
 - SIM grant led by three agencies, helps break down silos
 - HCA, DOH, DSHS
 - Tone set by Governor
 - Weekly meetings with Governor's policy staff and budget agency to avoid disconnects
 - Historical relationships helped
 - "We all work in service of the Governor"
- Close working relationships with legislative committees
- This collaborative style also extends to external partners, like the Washington Health Alliance (*more on this later*)

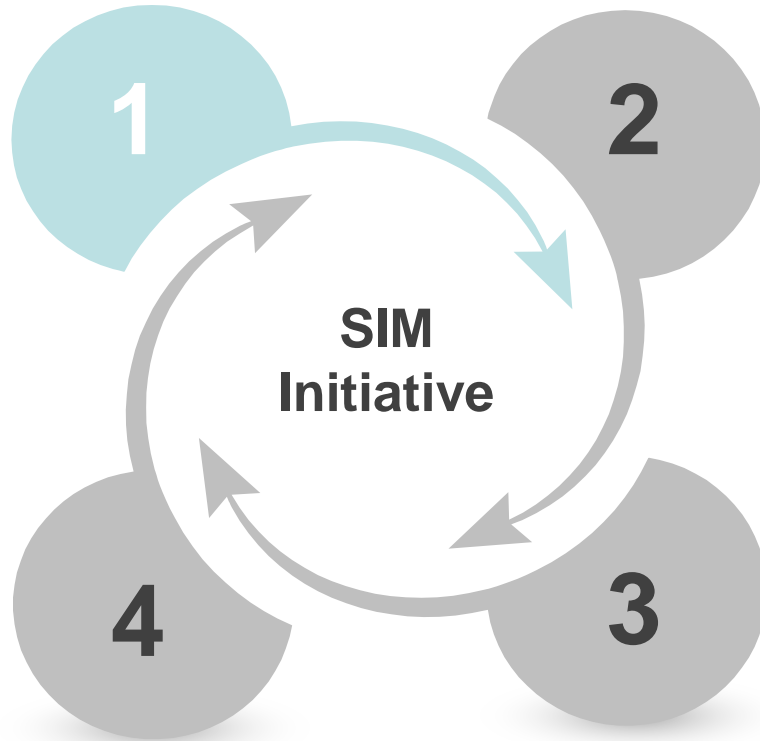
HCA: A Purchaser Mindset

“We have \$10 billion a year to support our various delivery systems – that is a huge lever. We use regulatory mandates only as a last ditch approach.”

Four Key Cost Containment Strategies



Strategy 1: Strategies Employed Through SIM



Spotlight on Two SIM Initiatives

A. Paying-for-Value Strategies

- Testing value-based reimbursement in PEBB via two pilot Accountable Care Programs (ACPs)

B. Accountable Communities of Health

- Building block for regional transformation

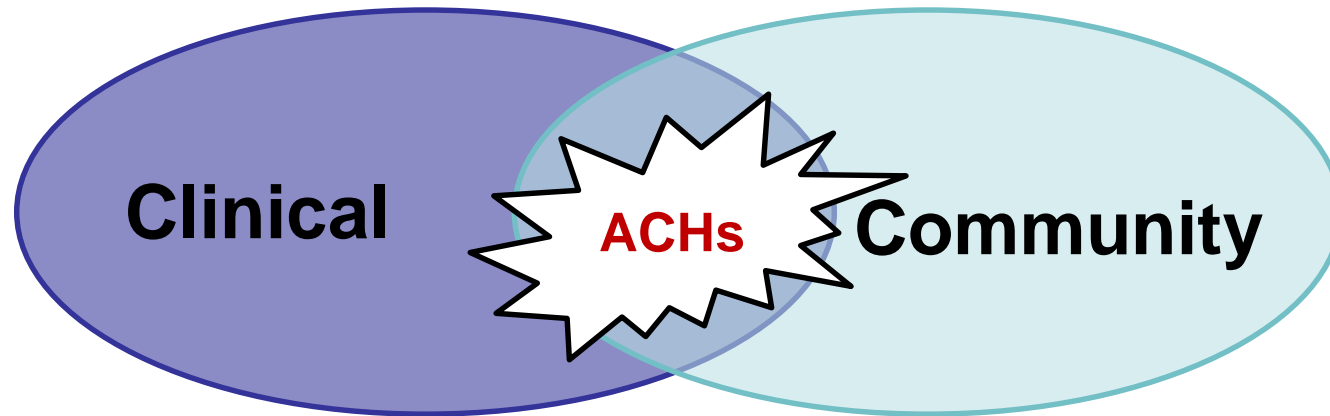
Strategy 1A: PEBB's Integrated, Risk Sharing Accountable Care Programs (ACPs)

- In 2016, PEBB launched two ACPs for state workers in five Puget Sound counties
 - ACPs = ACO-like networks of providers that deliver integrated physical health, mental health and substance abuse services
 - PEBB launched ACPs in an area where Boeing had established similar, direct ACO contracts
 - HCA contracts directly with ACP networks
 - Networks are responsible for the total cost of care for an attributed population and share in savings (or deficits)
 - Based on performance against a negotiated medical trend target, quality/patient experience data

Accountable Care Programs (cont'd)

- State aims to enroll 50,000 PEBB employees in the new ACP programs (roughly 25%)
 - achieved 10 percent shift of eligible enrollees into ACPs in Year 1 (n = 12,000)
 - state is satisfied with first year enrollment take-up
- Premium is 30 percent less for enrollees shifting into ACPs than for those in traditional UMP plan, and effectively \$0 if the enrollee fulfills its wellness requirements
- PEBB will expand ACP program statewide in 2017

Strategy 1B: Accountable Communities of Health (ACHs)



Accountable Community of Health:

A regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of participants in order to achieve healthy communities and populations

Strategy 1B: Accountable Communities of Health

- The state views ACHs as an effective and efficient way to transform the health care system
- ACHs are administered and self-governed at regional level - with expectations set by HCA
- ACHs are made up of leaders from a variety of sectors in a given geographic area
 - Providers, insurers, local health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services, tribes and philanthropic organizations
 - Share common interest in improving health and health equity
 - Identify and implement health-related projects and advise state agencies on tackling local health issues

Strategy 1B: Accountable Communities of Health (cont'd)

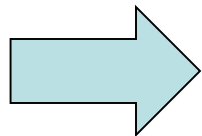
- Many ACHs built on long-standing community coalitions that have received sporadic state support in the past
 - Reinvigorated by WA's 2013 SIM grant
 - Legislature funded two ACH pilots in 2014
 - Primary support (grants and technical assistance) comes from HCA
 - Secondary support from in-kind contributions and local grants
 - 2015 SIM award brought additional funding
 - SIM funds enable each ACH to hire part-time staff, build infrastructure for regional collaboration
- Nine ACHs cover entire state of Washington
 - Geographic boundaries aligned with state's Medicaid Regional Service Areas

Strategy 1B: Nine Accountable Communities of Health



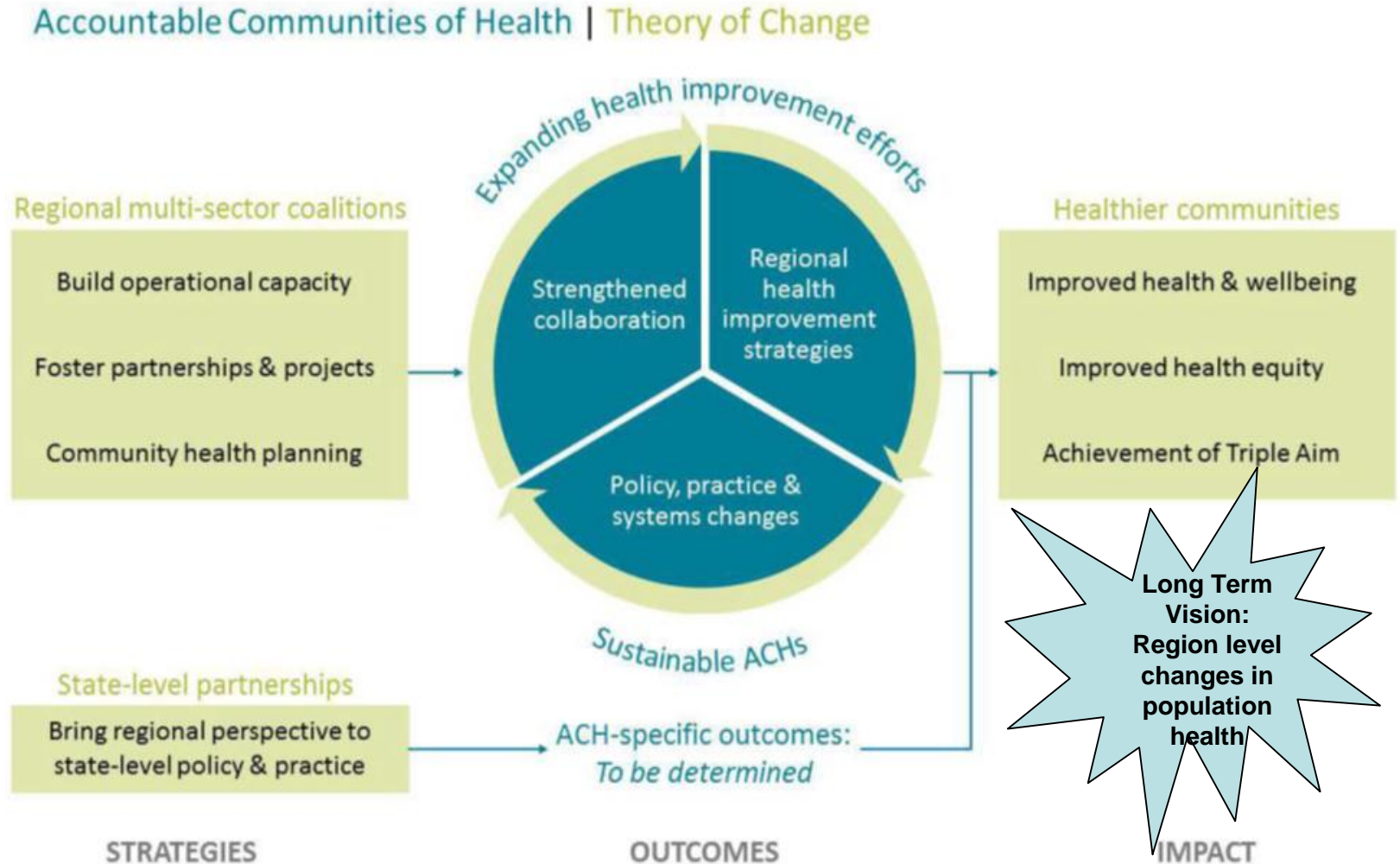
Strategy 1B: ACHs Bring Focus on Regional Planning, Multi-Stakeholder Collaboration

- To obtain designation, ACHs are required to develop a Regional Health Needs Inventory
- ACHs are expected to implement at least one regional project designed to create measurable goals
 - Expectation of a continuous cycle of improvement projects
- Each ACH must select measures from state's Common Measure Set to track progress toward goals
(http://www.hca.wa.gov/hw/pages/performance_measures.aspx)
- Many ACHs focus on social determinants of health, and use non-traditional providers to meet goals



State envisions central role for ACHs in accomplishing Medicaid Transformation Waiver

Strategy 1B: Long Term Vision for ACHs to Achieve Region Level Changes



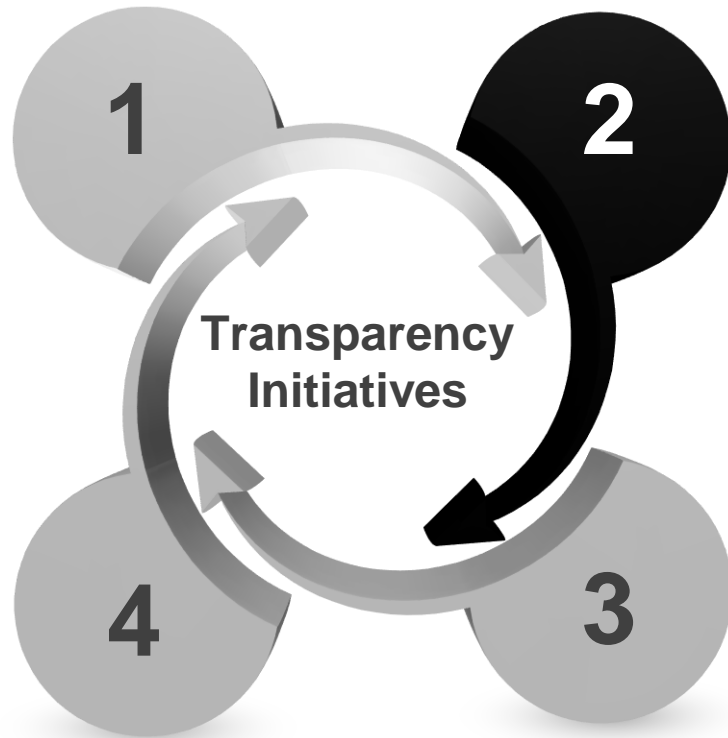
Strategy 1B: Example of King County ACH

- Governance: single county ACH, received state ACH designation 11-15, 23-member Leadership Council
- Regional priorities:
 - Physical/behavioral health integration
 - Care coordination for complex needs
 - Health equity, housing-health intersections
 - Prevention – chronic disease and social determinants of health
- First project: build regional IT infrastructure to support integration of housing and health data
 - Successful in securing grant to support project
- Selected to represent ACHs in discussions with state on broader measurement initiatives

Strategy 1B: ACHs Year 1 Evaluation Shows Steady Progress Toward State's Goals

- Early wins: developing regional projects
 - Cascade Pacific Action Alliance launched pilot to identify children with behavioral health challenges early and connect them to community-based interventions
 - Southwest WA Regional Health Alliance established 'early warning system' to monitor state's implementation of fully-integrated Medicaid managed care in region
- Potential challenges with ACH approach
 - ACHs have SIM funding through 2019 and all are working on sustainability planning
 - State needs to better define ACH role in broader Healthier Washington initiative
 - Need to reach clarity on where there is flexibility to implement state's ACH requirements

Strategy 2: Transparency Initiatives



Transparency Initiatives

Providing transparency through a Common Measure Set, and in collaboration with the Washington Health Alliance

Strategy 2: The Key Role of Washington Health Alliance In Transparency Efforts

- Independent, *trusted*, non-profit multi-stakeholder collaborative with 150 employer members
 - Long history, founded by King County executive
 - Formerly Puget Sound Health Alliance; statewide since 2013
 - Engaged, senior executive board member participation
- HCA serves on Board and participates in all four major Alliance stakeholder work groups
- Alliance maintains voluntary APCD with claims level insurance data on 4 million Washingtonians
 - Worked with HCA to develop technical specifications for mandatory APCD procurement

Strategy 2: Washington Health Alliance's Strong Online Reporting Capability

- Alliance's signature report = Community Checkup
 - Web-based, 9th annual report recently released
 - Quality data: performance scores by provider/clinic for asthma, COPD, depression, diabetes, heart disease
 - Cost data: health care spending growth, Medicaid and PEBB spending per enrollee
- Alliance publishes statewide patient experience survey, reports on price and care utilization variations
- Development of Common Measure Set spearheaded by the Alliance, under contract to HCA
- Alliance is pursuing Choosing Wisely initiatives with state hospital and medical associations

Alliance's Community Checkup Report – Now Incorporates State's Common Measure Set



Comparison of Commercial Health Insurance Plans

Measure Name	Aetna	Asuris Northwest Health	Cigna	Group Health Cooperative	Group Health Options	LifeWise Health Plan	Premera Blue Cross	Regence Blue Shield	United Healthcare
Access to Care									
Child and adolescent access to primary care - ages 12-24 months	▼ WORSE	■ AVERAGE	■ AVERAGE	■ AVERAGE	■ AVERAGE	N/R	N/R	▼ WORSE	▼ WORSE
Child and adolescent access to primary care - ages 2-6 years	▼ WORSE	▼ WORSE	▼ WORSE	▼ WORSE	▼ WORSE	N/R	N/R	▼ WORSE	▼ WORSE
Child and adolescent access to primary care - ages 7-11 years	▼ WORSE	▼ WORSE	▼ WORSE	▼ WORSE	▼ WORSE	N/R	N/R	▼ WORSE	▼ WORSE
Child and adolescent access to primary care - ages 12-19 years	■ AVERAGE	▼ WORSE	■ AVERAGE	■ AVERAGE	▼ WORSE	N/R	N/R	■ AVERAGE	▼ WORSE
Adult access to preventive/ambulatory care - ages 20-44	■ AVERAGE	▼ WORSE	▼ WORSE	■ AVERAGE	■ AVERAGE	N/R	N/R	■ AVERAGE	▼ WORSE
Adult access to preventive/ambulatory care - ages 45-64	■ AVERAGE	■ AVERAGE	▼ WORSE	■ AVERAGE	■ AVERAGE	N/R	N/R	■ AVERAGE	▼ WORSE
Adult access to preventive/ambulatory care - ages 65+	■ AVERAGE	■ AVERAGE	■ AVERAGE	■ AVERAGE	■ AVERAGE	N/R	N/R	■ AVERAGE	■ AVERAGE
Asthma and COPD									
Use of appropriate medication	■ AVERAGE	■ AVERAGE	■ AVERAGE	▼ WORSE	▼ WORSE	■ AVERAGE	■ AVERAGE	■ AVERAGE	▼ WORSE

Community Checkup report:
www.WACommunityCheckup.org

More about the Alliance:
www.WAHealthAlliance.org

More about Healthier Washington:
www.hca.wa.gov/hw

Strategy 2: Alliance Helping Achieve HCA's Statewide VBP Goal

- HCA is partnering with the Alliance to achieve SIM goals
 - 80 percent of state-financed health care and 50 percent of commercial health care from 'volume to value' by 2019
- But driving down health care costs is not 'front burner' issue for Puget Sound area employers
- Large employers like Microsoft and Starbucks more concerned with workforce recruitment, retention
- Boeing – a trailblazer – manages health care like any other supply chain product

"...Alliance is an absolutely crucial partner for us. I don't know how we would be doing what we are doing without them." – HCA staff

Strategy 3: Implementation of Evidence-Based Guidelines



Implementation of Evidence-based Guidelines

- A. Health Technology Assessment (HTA) Program
- B. Bree Collaborative

Strategy 3A: The Washington Health Technology Assessment Program (HTA)

- Ensures that medical treatments and services paid for with state dollars are safe, effective and cost effective.
- About 6-10 health technologies are reviewed per year
 - Medical and surgical devices
 - Procedures
 - Medical equipment
 - Diagnostic tests
- Serves as resource for HCA, DSHS, Dept. of Corrections and Dept. of Veterans Affairs
- State conducted evaluation and assessment of stakeholder perceptions to improve the program
- **Goal**: State agencies using the same, evidence-based reports – to make informed and consistent coverage decisions.

Strategy 3A: The Washington Health Technology Assessment Program (cont'd)

- How does the HTA program work?
 - Public nominates and agency recommends potential health technologies for review.
 - HTA contracts for impartial, scientific, evidence-based reports about whether certain medical devices, procedures, and tests are safe and work as promoted
 - An independent clinical committee of health care practitioners then uses the reports to determine if state programs should pay for the medical device, procedure, or test
- The HTA program has robust public involvement
 - All meetings are public, and comments are welcome
 - Public comment available after draft evidence reviews are produced (for 30 days)
 - Public can provide input into which technologies to review

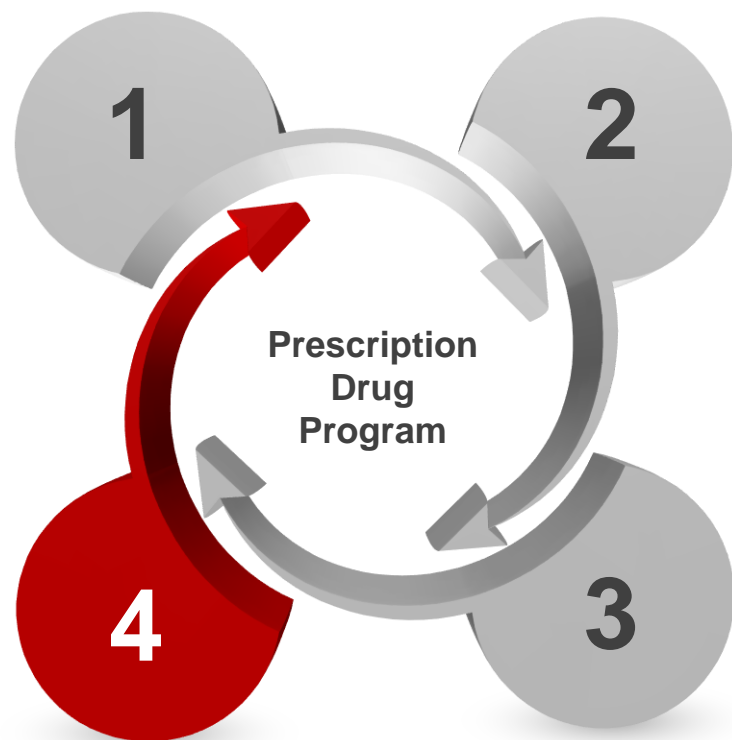
Strategy 3B: Bree Collaborative

- Consortium of public and private agencies – employers, union trusts, health plans, providers, hospitals created by the legislature in 2011.
 - Governor has the authority to appoint the Collaborative members.
- Charged with identifying specific ways to improve health care quality, outcomes and affordability in the state.
 - Each year the members identify up to three health care services with significant variation in care delivery to develop evidence-based recommendations to reduce variation.
- HCA using work of Bree Collaborative to push transformation
 - ACP networks are required to implement several of the Bree Collaborative's recommendations
 - HCA also plans to build similar requirements into Medicaid contracts

Strategy 3B: Bree Collaborative (cont'd)

- The Bree Collaborative has developed guidelines on:
 - Addiction and dependence treatment
 - Bariatric surgical bundle and warranty
 - End-of-life care
 - Use of opioids for pain
 - Hospital readmissions
- It has also developed methodologies for accountable payment models
 - Bundled payment for CABG, lumbar fusion and joint replacement
- HCA has allocated SIM funding to improve dissemination of Bree's recommendations

Strategy 4: Prescription Drug Program



Prescription Drug Program

- A. Joint purchasing
- B. Discount card

Strategy 4: WA Prescription Drug Program (WPDP)

- The WPDP's goal is to lower the price of prescription drugs for underinsured residents, state purchasers and private employers throughout the state.
 - WPDP is administered by HCA.
- It consists of a network of over 1,150 contracted retail pharmacies and one mail order pharmacy that give the same negotiated discount to the state, its employers, and individuals who are underinsured and uninsured.
 - Savings are also extended to institutional facility purchasers (e.g., hospitals, prisons).
- Through a free discount card, any Washingtonian may join and receive the same discount off the regular price that large employers get.
 - Uninsured get the greatest benefit from the program
 - Insured get some benefit, especially when their plan doesn't cover the drug

Strategy 4: WA Prescription Drug Program (cont'd)

- Average savings is about \$43 per prescription (63%).
- Over the seven-year history, discount card members have spent \$40 million and saved \$41 million.

WPDP Rx Discount Card Savings: 2007-2013	
Rx Discount Card Enrollee Age Group	Percent of Total Rx Discount Card Savings
<18	1%
18-64	72%
65+	27%

Strategy 4: WA Prescription Drug Program (cont'd)

- In 2006, WPDP joined forces with Oregon to consolidate two states' drug purchasing power to garner even bigger savings.
 - Combines non-Medicaid prescription drug programs.
- \$600 million in annual drug spending extending savings to 900,000 people - evenly split between WA and OR.
- In 2015, Connecticut entered a similar program (TOP\$) with LA, MD, DE, ID, NE, PA and WI for its Medicaid purchasing.

What Else is Washington Working On?

- The state has several other strategies that are directly, or in part, related to cost containment:
 - **Integrating Medical and Behavioral Health Services** through Medicaid Managed Care Organizations (MCOs)
 - **Moving Foster Kids to MCOs**
 - **Integrated Social Services Databases:** an often envied data base that links data from multiple agencies for purposes of supporting cost-benefit and cost offset analyses, program evaluations, program decisions, etc.
 - **Health Home Demonstration** that targets high risk Medicare & Medicaid eligible adults with chronic illnesses.
 - **Emergency department improvement initiatives** that seek to reduce inappropriate utilization.

What Else is Washington Working On? (cont'd)

- The state has several other strategies that are directly, or in part, related to cost containment:
 - **Link4Health Clinical Data Repository** (HIE) in which Medicaid providers must participate no later than 2/17
 - **Washington Healthcare Improvement Network**: a state-based technical assistance center / learning collaborative for practices transforming into medical / health homes.
 - **Center of Excellence** for joint replacement in PEBB program
 - **Health literacy and wellness program** for PEBB members

Summary of Key Cost Containment Strategies

1. **Strategies Employed Through SIM**
 - A. Accountable Care Program with PEBB members
 - B. Accountable Communities of Health
2. **Transparency**
 - A. Partnering with the WA Health Alliance to provide transparency on core quality and cost measures
3. **Implementation of Evidence-Based Guidelines**
 - A. WA Health Technology Assessment
 - B. Bree Collaborative
4. **Prescription Drug Program**
 - A. Joint purchasing and discount card

Challenges on Road to a Cohesive Cost Containment Strategy

1. **Coordination is reliant upon strong leadership**
 - Change in leadership could bring change in commitment to cross-program coordination
2. **Some large employers are not fully committed to VBP**
 - They don't have a “burning platform”
3. **Mandatory state-based APCD – a key element of the transparency strategy – is not yet functional**
 - Procurement has hit roadblocks but staff committed to successful launch
4. **State legislature is under pressure to increase education funding**
 - Which might result in cuts to the Medicaid program

Keys to Success in Washington

1. Combined purchasing power of Medicaid and PEBB under HCA
 - And further coordinated purchasing power across state lines
2. Strong culture of collaboration
 - Both within state government and external to state government
3. Strong regional involvement to accomplish population health aims
 - ACH model built on long history of innovation and collaboration at local level
4. Partnership with Washington Health Alliance
 - Alliance viewed as credible, neutral, trusted and influential
 - Trailblazing employers (e.g. Boeing) paved way for state to engage in direct, risk-bearing contracts

“We are lucky here because collaboration is in the water.”

Questions and Discussion



If Connecticut were to adopt some or all of these strategies, what are –

- Some of the facilitators?
- Some of the barriers?

Stakeholder Feedback



Background

- Between January and the end of April, Bailit consultants interviewed:
 - 21 out of 24 Cabinet members
 - Health plan representatives organized by the CTAHP
 - Hospital CEOs organized by the CHA
 - Pharmaceutical representative
 - Home and community-based providers organized by the Healthcare at Home Association
 - Employers organized by CBIA
 - Union representatives
 - Consumer advocates
 - State government leaders not on the Cabinet
- To promote candor, we conducted interviews with the understanding that there would be no attribution

Background (cont'd)

- Today we are presenting a synthesis of the themes and key takeaways from those interviews
- This information is meant to help inform our discussions of strategies that will occur during the June - September meetings
 - A similar “listening tour” will be done in the Fall to inform the Cabinet on feedback specific to strategies under consideration.
 - Some specific points of stakeholder feedback on key strategies will be shared with the Cabinet throughout the summer

“How serious is the issue of increasing health care costs in Connecticut?”

- Cabinet members saw increasing health care costs as a serious problem for everyone
 - Negative impact on low-income residents
 - Expensive state for providers to do business in
 - Health care costs are squeezing out other spending at the governmental, employer and individual level
- Cabinet members clearly recognize that change must happen because the status quo is not viable
- Other stakeholders generally agreed, however, some were more focused on increases in the cost of doing business with the state

“Can you identify any cost containment strategies currently in place in CT that are working?”

- Strategies mentioned included:
 - Medicaid PCMH Initiative
 - State employee health plan’s VBID strategy
 - Medicaid rebalancing initiative
- Generally Cabinet members had the impression that there was not much cost saving activity going on, but thought that SIM had the potential to unify disparate initiatives and drive cost savings initiatives
 - Some of this might be due to members not seeing all state activity. We will share CT information in the June meeting.
- Plans, providers, and employers discussed their own strategies

“What are the top 2 to 3 cost drivers in CT?”

Stakeholders reported four primary contributors:

1. High unit costs due to --

- Reduced competition due to hospital consolidation and insurer consolidation
- Technology race
- Surplus of specialists
- Cost of doing business (equipment, salaries, etc.)
- Pharmacy costs, particularly specialty drugs

“What are the top 2 to 3 cost drivers in CT?” (cont’d)

2. Inefficient delivery of care due to –
 - Lack of financial incentives to improve efficiency and effectiveness, and no industry accountability
 - Lack of coordinated care across the continuum of care, leading to avoidable inpatient and ED utilization, longer stays, and unnecessary services
 - Lack of infrastructure to share information (e.g., EHR interoperability) resulting in duplicate/uncoordinated services
 - Too many small hospitals
 - Lack of statewide health systems planning

Cost Drivers (cont'd)

3. Population health risk

- Poor health of Connecticut residents, increasing prevalence of chronic conditions, and an aging population
- Lack of patient engagement in managing their own health
- Lack of culturally competent providers able to engage patients

4. Lack of price transparency

- Consumers “haven’t a clue” regarding cost of care
- No competitive pressures among peer groups of providers
- No comprehensive data for policy development
- No way to consistently measure cost or quality performance

Additional Stakeholder-identified Cost Drivers

- Legislatively mandated benefits
- State and federal plan assessments which are reported to represent 10% of premium costs
- State Exchange regulations that are reported to limit innovation
- Large number of small physician practices, which makes transformation more difficult
- High compensation of health care executives

Additional Stakeholder-Identified Cost Drivers (cont'd)

- Lack of cost sensitivity by consumers with insurance coverage
- Lack of emphasis on preventive care
- Cost shifting to commercial plans
- High cost of long-term care for Medicaid (which is out of scope for this study)
- Cost of doing business (e.g., labor, supplies)
- Overutilization of certain high cost providers (e.g., SNF and post-acute)

“What are the top 2 or 3 cost containment strategies that you would like to see adopted?”

1. Control high unit costs

- Eliminate unnecessary and costly regulations
- Empower the CON process to look at systems of care when making CON determinations, rather than just looking at addition of specific service or piece of equipment
- Develop a state-wide hospital capacity plan

Top Cost Containment Strategies (cont'd)

2. Promote more efficiency and effectiveness of health care delivery models
 - Expand PCMHs into “health neighborhoods” and create specialty-based PCMHs for patients with complex needs
 - Promote provider accountability through total cost of care contracting and bundled payments, using state purchasing power
 - Promote the Choosing Wisely campaign to change culture that more is not necessarily better
 - Adopt VBID plan designs to create consumer incentives to use system more effectively; engage consumers and hold them accountable
 - Create a program enabling providers to access state bonds to build necessary infrastructure to better manage care

More Efficient/Effective Delivery System (cont'd)

3. Promote care coordination by –

- Investing in technology infrastructure to share information among providers (e.g., a functioning HIE)
- Bringing PharmD's, Community Health Workers, Peer Specialists into the care team
- Create community structure to share care team resources
- Provide intensive case management for high-risk/high need patients
- Better coordinate services funded/managed by different state agencies

Top Cost Containment Strategies (cont'd)

4. Promote improved population health

- Create a unified state agency to align incentives among and across state programs
- Empower the Connecticut Insurance Department to develop “affordability standards” for commercial plans that promote improved population health
- Address social determinants of health on a community-wide basis by establishing community-wide accountability
- Promote more behavioral health integration, including trauma-informed care across a lifespan

Top Cost Containment Strategies (cont'd)

5. Promote price transparency

- Develop a small set of core cost and quality measures to be used by all payers and providers; collect and share data
- Create a vehicle for collecting and sharing costs of care with consumers
- Develop data collection and reporting capacity at the state level
- Create a consolidated state agency that would have a single shared information system among state programs

Additional Stakeholder-Identified Cost Containment Strategies

- Create community-based, multi-disciplinary care teams
 - Focus on coordinating and integrating care based on patient needs
- Better management of end-of-life care
- Enhance consumer accountability
- Allow narrower networks
- Closer alignment of Medicaid and commercial plan payer strategies

Additional Stakeholder-Identified Cost Containment Strategies (cont'd)

- Hospitals work to drive out costs of delivery services (e.g., LEAN)
- Better management of post-acute care (SNFs and home care)
- Mandatory generic substitution bill
- Reduce state coverage mandates
- Tort reform
- Form an independent health care commission

“What role do consumers have in containing health care costs?”

- Respondent views varied widely:
 - Some questioned what impact consumers could really have on costs
 - Others thought that consumers should be involved at every level of health care decision-making
 - Others thought that price transparency promotes cost and quality improvement through competition
 - Others believed that consumers must take more responsibility to improve their own health status

“What is the role of state government in containing costs?”

Most, but not all, respondents envisioned an activist state role, offering a full range of possibilities:

- Serve as convener to identify and spread best practices
- Promote transparency and provide data analytics
- Conduct centralized population health and health care systems planning based on demographic needs
- Establish a unified agency with strong leadership to align all state agency activities
- Use state purchasing power to drive change
- Create a stronger CON process
- Enforce anti-trust laws
- Consider rate setting

Role of state government (cont'd)

Others expressed more skepticism:

- Reduce regulations that create expense without any value-add (“nothing has happened” pursuant to a 2013 Executive Order intending to reduce antiquated or unnecessary regulations)
- Don’t micromanage the health care marketplace
- The state needs to deliver on its promises

“What are the key elements of a successful and sustainable cost containment strategy?”

- **‘Broad buy-in,’ ‘trust among stakeholders’** and a **‘need to coordinate across initiatives’** were the most common types of responses
- Other responses included:
 - Infrastructure to support delivery system redesign (e.g., HIE)
 - A strategy that starts with the highest cost individuals and skilled navigators to work with complex patients
- Several respondents recognized that the budget crisis could provide a motivating opportunity to make needed changes

“How important is data transparency?”

- Most respondents consider data transparency as absolutely essential and a top state priority for policy development and strategy implementation
 - Many thought health care provider performance measures were not effective for personal health care decision-making
 - Others thought that consumers would benefit from having cost and quality data

“Should the state address competition issues in the provider marketplace?”

Responses were very mixed and recognized the complexity of the issue.

- Many saw the benefits of provider consolidation for their financial stability, while expressing concern about the potential for increased rates
- Others were concerned about the impact of additional regulation on the cost of doing business
- Several said that there was a need to better understand hospital finances before the state took any action
- Others said that it was essential that consolidation be addressed, citing providers’ unwillingness to join the HIE

“What are the key barriers to implementing cost containment strategies?”

- The top barrier was **lack of trust** among stakeholders
- Top barriers identified within state government were --
 - Lack of strong state leadership that sees health care as a top priority
 - Siloed, balkanized government with no culture of cooperative decision-making
 - Lack of data to identify issues and drive policy decisions
 - Lack of a global health strategy for the state

Top Barriers (cont'd)

- Barriers extending beyond state government included –
 - “Community of nay-sayers” coupled with an unwillingness to make stakeholders unhappy
 - Opposition from stakeholders with financial interests at stake
 - Lack of political will because cost containment may cost jobs
 - People not willing to talk about the issues
 - Time and resources
 - Lack of infrastructure to support change
- Other observed barriers included:
 - Appetite for transformation varies, with hospitals more ready than clinicians, and consumers and payers ambivalent
 - Consumer expectations are unreasonable (e.g., no limits)

“What are possible solutions to overcome the identified barriers?”

- Several specific suggestions were made to build trust among stakeholders
 - Break down silos by holding forums where real listening occurs
 - Have a collaborative public-private team work on issues
 - Pursue incrementalism; small wins will develop a track record
- Structural and regulatory changes were suggested to overcome roadblocks
 - Create a state entity with authority to direct health care strategy, set and implement goals, possibly with rate-setting powers
 - Strengthen the Insurance Department’s authority to allow it to implement affordability standards

Possible Solutions (cont'd)

- Several programmatic initiatives were suggested
 - Create a state-wide strategy around hospital capacity
 - Find a for-profit solution to the HIE
 - Create reports showing cost and quality by provider
- Other stakeholders added:
 - Any solutions must be all-payer to be most impactful
 - Payment reform must be at the center of efforts to improve quality and reduce costs

“What do you want to come out of this study?”

- **Directional:** The report should result in a set of Connecticut-specific strategies to reduce costs that are based in best practices and address the cost drivers.
- **Uniting:** The report should be an important vehicle for educating stakeholders and uniting them around the importance of making needed changes.
- **Motivational:** The report should make a clear statement of the implications of doing nothing.
- **Integrative:** The report should establish a coordinated set of strategies that build on current cost containment initiatives.

Summary: Key Takeaways From Interviews

1. Change that results in reduced costs is essential.
 - Payment reform that moves away from FFS volume incentives and promotes provider and community-wide accountability is fundamental
 - Data collection, analysis and reporting must be a foundational strategy, including creating a functional HIE
2. Building stakeholder trust to drive change will be difficult, but must occur.
3. Most are looking for strong state leadership to lead the change initiatives within and beyond state government.
 - All-payer initiatives
 - Aligned and coordinated state policies, strategies and initiatives
 - Expanded AG and CID authority to address issues

Key Takeaways From Interviews (cont'd)

4. Delivery system redesign should include more care coordination, behavioral health integration and use of non-traditional clinical and non-clinical personnel.
5. Building the necessary infrastructure within the provider communities is expensive and time consuming, but necessary.
6. Market consolidation is a concern, but there is uncertainty on how to effectively address it without creating negative unintended consequences.
7. Removing regulations that generate cost but do not add benefit may yield substantial savings.

Bailit's Big Takeaways

- The time is absolutely ripe to take steps to move Connecticut health care delivery in a forward-focused direction away from a FFS, volume-driven approach.
- There is an absolute need to get key decision-makers in the same room to hammer out solutions.
 - People point to each other as being an impediment to change, which tells us that there is lack of shared understanding and consensus pathway
 - Need a real deadline to get decisions made

Discussion



Follow-up Discussion of Principles

Principles

- The Principles were discussed during our January meeting and a copy was circulated for review.
- We incorporated the (very few) edits received and shared a new draft in February, but deferred discussion due to time.
- It's time to review them one final time and vote on adopting them as Principles to guide our recommendations and report.
- Please refer to the handout.

Next Steps

- Next month we will present a straw model set of strategies as a starting point for discussion.
 - The straw model will be informed by the states we studied, prior work from Bailit Health, the extensive stakeholder input we obtained, and Cabinet discussions.
 - We expect the straw model to evolve based on your active participation and input in the discussion.
 - Our ultimate goal is having a set of strategies that are adopted by the Cabinet, and delivered to the Legislature on December 1st.
- The straw model will be presented in the context of Connecticut's governmental structure and current strategies for cost containment.