Study of Cost Containment Models and Recommendations for Connecticut

Straw Model

Megan Burns & Marge Houy

July 12, 2016

bailit health

The Healthcare Cabinet Cost Containment Study is a Partnership

Funded by a grant from the Connecticut Health Foundation

Funded by a grant from the
Universal Health Care Foundation of Connecticut

Funded by The Patrick and Catherine Weldon Donaghue Medical Research Foundation

Funding for this project was provided in part by the Foundation for community Health, Inc. The Foundation for Community Health invests in people, programs and strategies that work to improve the health of the residents of the northern Litchfield Hills and the greater Harlem Valley.

Agenda

Context Setting	9:20 – 9:30
Bailit Health's Straw Model	9:30 – 10:20
Considerations and Challenges	10:20 – 10:25
Strategies vis à vis Cabinet's Charge	10:25 – 10:30
Discussion	10:30 – 11:50
Next Steps	11:50 – 12:00

Today's Meeting

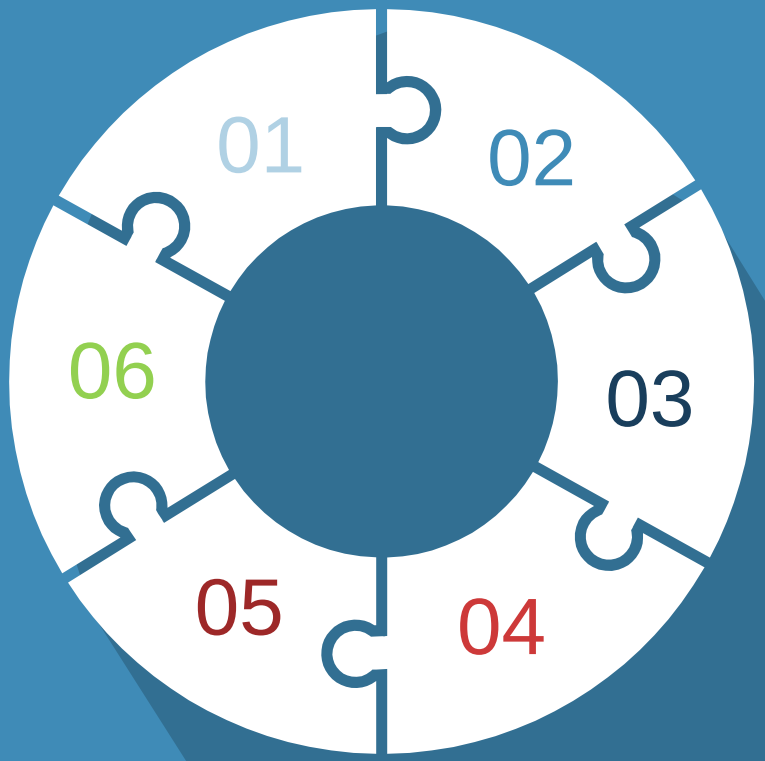
- Bailit Health is presenting a straw model for consideration.
  - Model is informed by our experience and research in the 6 states identified in the legislation, as well as others
  - Model is informed, to the extent possible, by evidence
  - Model is informed by opinions and feedback received through our first round of stakeholder engagement

- Our intention is that today will be the opening conversation and that discussion will continue through September.

- Our goal from here on is to facilitate the discussion and to help the Cabinet come to final recommendations.

What is a Straw Model?

"A straw model is **not expected to be the last word**; it is refined until a final model is obtained that **resolves all issues** concerning the scope and nature of the project."



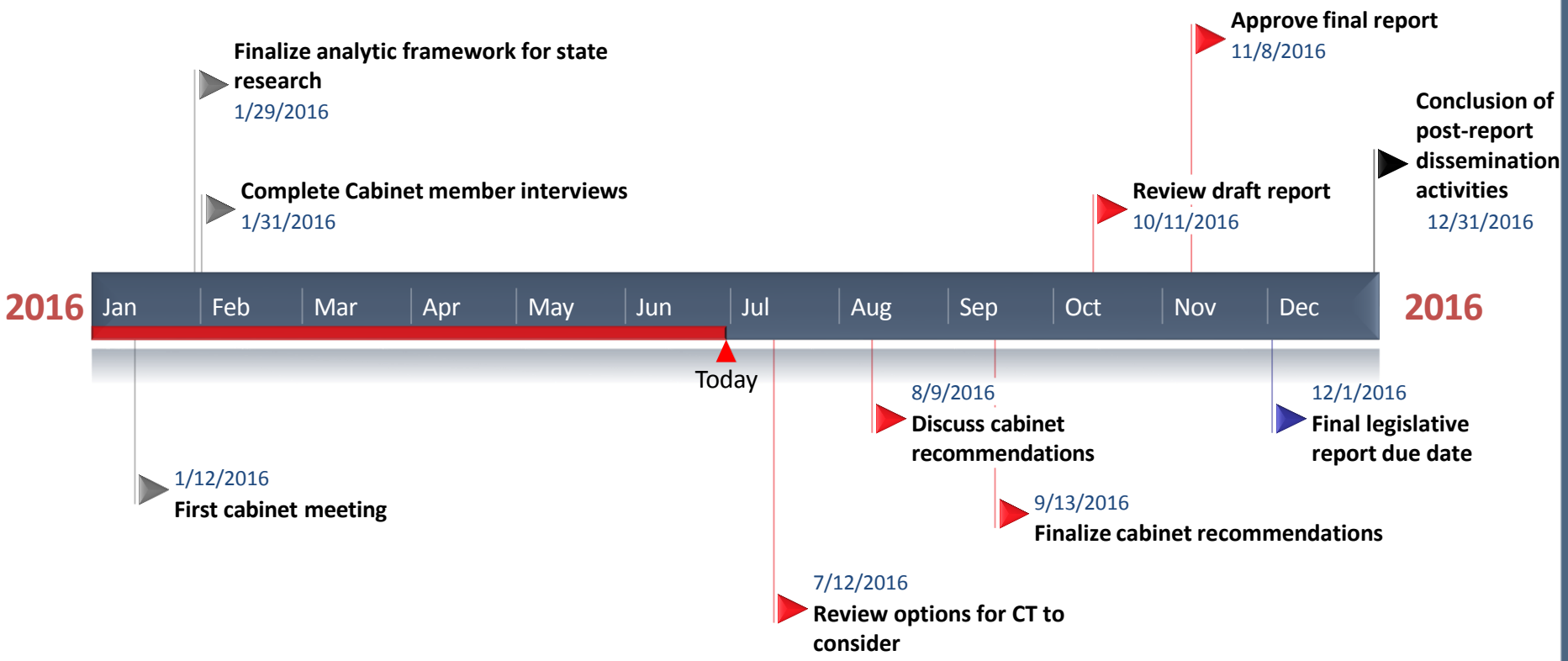
Process for Getting to Final Recommendations

- The process for getting to final recommendations will occur over the following three meetings.
  - We'll have over 7 hours of discussion time available.

- Bailit will facilitate discussion with the goal of getting to consensus-based recommendations.
  - Dissenting opinions can be discussed in the final report for any individual recommendation that is not consensus-driven.

- It is up to the Cabinet Members to engage in thoughtful dialogue while remaining focused on the charge.
  - It also up to the Cabinet Members to consider any public comment that may be provided in future meetings.

Study Timeline



Context for Today's Meeting

- For the past six months, we have been reviewing information about the cost containment models of MA, MD, RI, OR, VT, and WA
- Key themes have emerged from our review of these states, including:
  - Significant delivery system and payment system reform is happening
  - Trust is a critical success factor for successful reform
  - Data are a foundation support for many of the states
  - Aligning state strategies can drive broader change in the marketplace

CT State Agencies Have Implemented Cost Containment Strategies

- **Delivery System Reform**
  - Patient Centered Medical Homes
  - Behavioral Health Homes
  - Transforming Clinical Practice Initiative
  - State Innovation Model
- **Payment Reform**
  - Medicaid Shared Savings (MQISSP)
  - Potential use of episodes
- **Improving Population Health**
  - DPH work to reduce tobacco use, control high blood pressure and asthma, prevent health care associated infections, prevent unintended pregnancy, control / prevent diabetes
- **More Effective Use of Existing Services**
  - Reduce emergency department and inpatient hospital use through intensive care management
  - Community based long term care
  - Better use of youth foster homes
  - Pediatric psychiatric consultation
  - Value-based insurance design for state employees
- **Building Data Infrastructure**
  - Several agencies have robust databases
  - Building common eligibility platform
  - Hiring of health information technology coordinator

States Benefit From *Equifinality*

We believe that while each state has its own culture, marketplace, and state government structure, each state can achieve the "Quadruple Aim."

States Use Different Levers

- States use different “levers” to “move the needle” and improve their health care system.

State Levers to Control Costs with Examples

1. Purchasing power: use Medicaid and state employee plans to implement payment reform and evidence-based coverage decisions
2. Regulation of commercial insurers: to promote payment reform and to require cost caps in contracts
3. Provider rate setting: to promote payment equity and contain cost growth
4. Data sharing: to identify cost drivers and direct policy decisions
5. Bully pulpit: to set and then address cost targets
6. Legislation: to create new delivery models and control cost increases

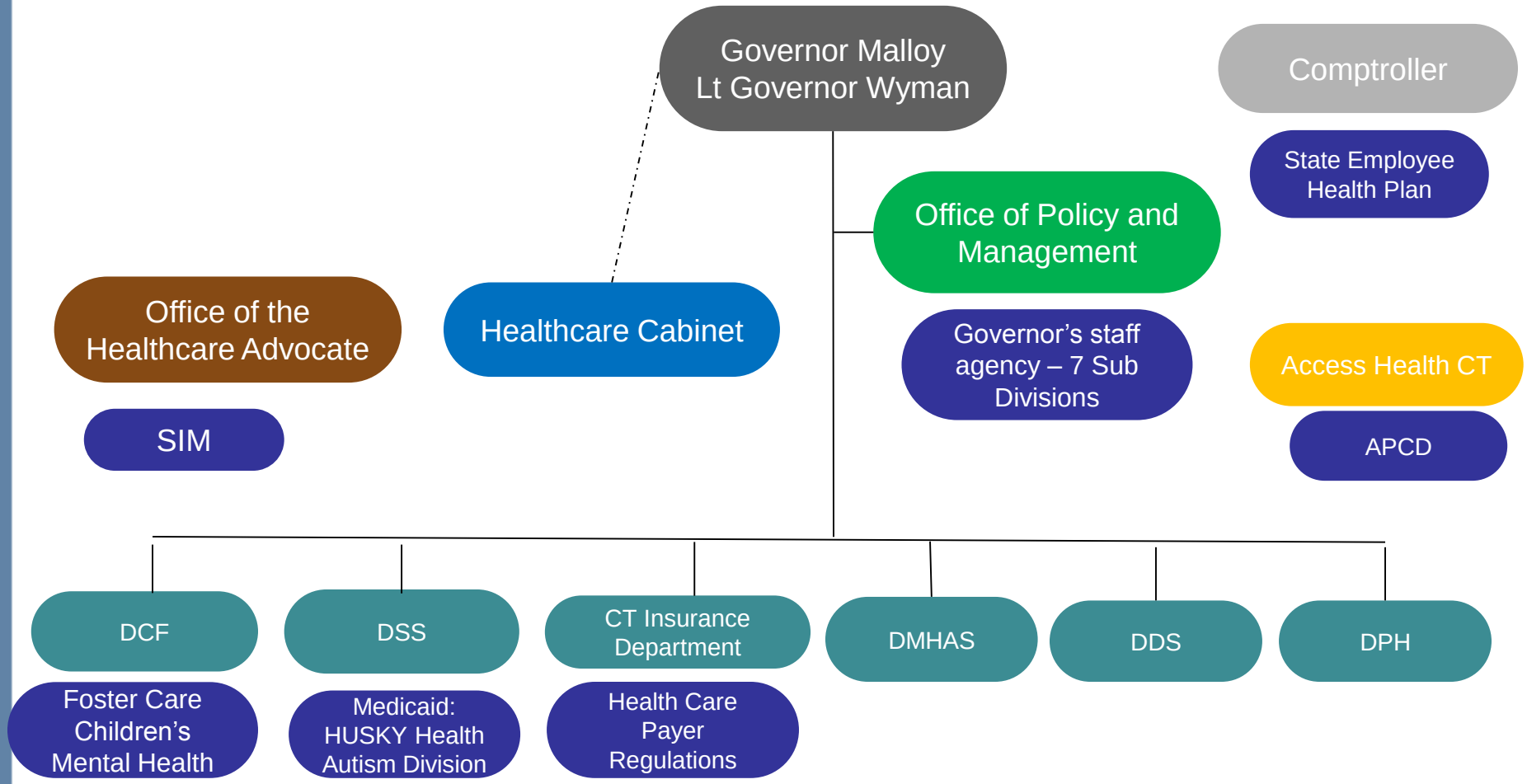
Building a State Cost Containment Strategy

- As we have seen, each state's strategy builds on the state's culture, historical activities and current public and private marketplace trends
- In June, we heard from Connecticut state staff describing the broad and varied cost containment strategies currently in place or proposed for the future

Observations about Current CT Initiatives

- Focus is on improving delivery models through enhanced services
  - PCMH, Health Home, Intensive Case Management
  - Seeing successes in cost containment and quality measures, particularly for targeted populations
- Public health initiatives are starting to align with payment and delivery system reform
- DMHAS is pursuing an integrated delivery system model
- Public and private payment is still predominantly FFS, and payment streams are likely siloed, but financial mapping to confidently state that has yet to occur.
- Many state agencies are making health care decisions

CT Government Oversight of Health Reform



Position of Agencies / Bodies are not meant to represent a hierarchy.

Note: This chart was created based on our assessment of Connecticut's organizational structure; it is not an official representation from the state.

Cost Drivers (Unit Price + Utilization)

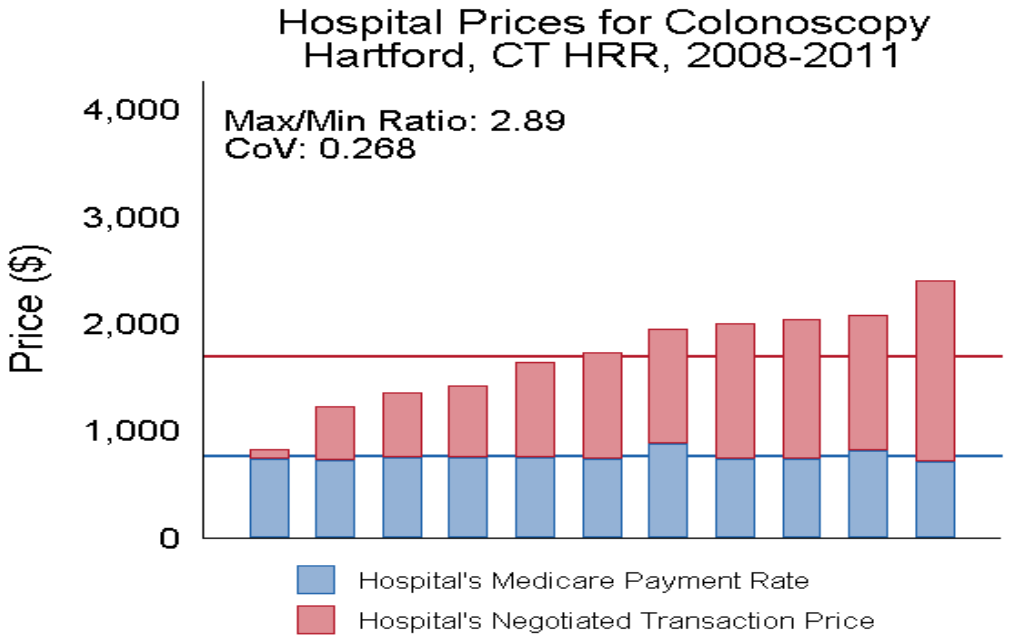
- Price
  - CT's non-profit hospital adjusted expenses per inpatient day is 4th highest the NE and exceeds NY and national averages

Location	Non-Profit Hospitals
1. Massachusetts	$2,862
2. Rhode Island	$2,725
3. New Hampshire	$2,535
4. Connecticut	$2,394
5. Maine	$2,371
United States	**$2,346**
6. New York	$2,324
7. Vermont	$2,033

Source: Kaiser Family Foundation, State Health Facts, 2014

Price Variation

- There are substantial price variation within key markets for key services



Unnecessary Utilization

Measure	Connecticut Rate	US Rate	Selected Regional Comparisons
Potentially avoidable ED visits (Medicare/1000 beneficiaries)	189	181	NY: 165 RI: 116 VT: 178
Medicare 30-day hospital readmissions/ 1000 beneficiaries	34	30	NY: 31 RI: 27 VT: 27
Summary Ranking: Avoidable Use and Cost	28	N/A	NY: 26 RI: 22 VT: 13

Source: The Commonwealth Fund: Scorecard on State Health System Performance, 2015

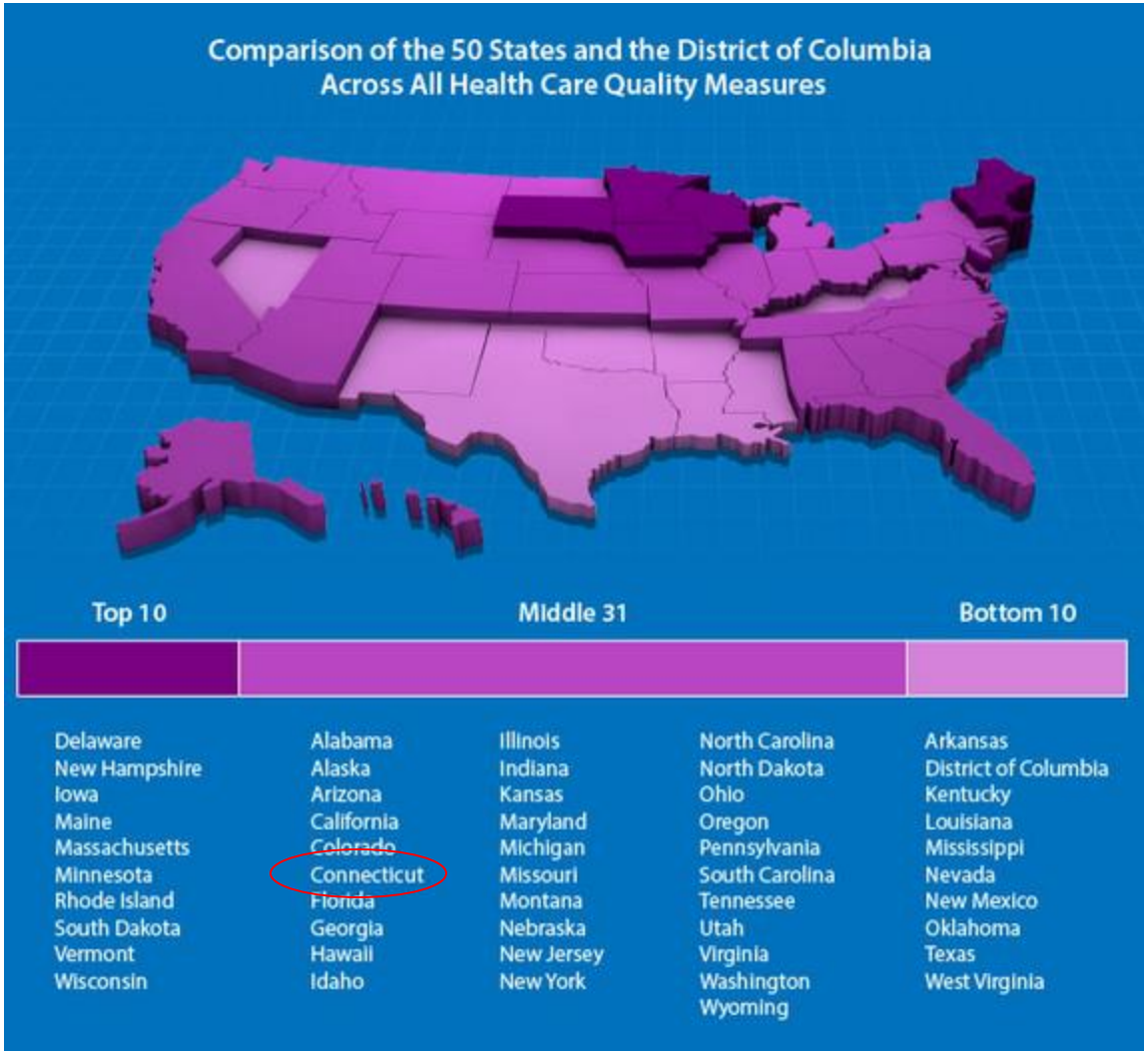
CT's Per Capita Spending: Price + Utilization

- CT's per capita spending is second highest in the NE and exceeds NY average and the US average
- It's also the 4th highest in the country

Location	Health Spending per Capita
1. Massachusetts	$9,278
2. Connecticut	$8,654
3. Maine	$8,521
4. New York	$8,341
5. Rhode Island	$8,309
6. New Hampshire	$7,839
7. Vermont	$7,635
United States	**$6,815**

Source: Kaiser Family Foundation, State Health Facts, 2009

Connecticut Ranks in the Middle on Quality of Care



Source: AHRQ State Snapshot

Some Key Facilitators for Connecticut

1. Active legislature that is willing to make policy decisions
2. Engaged stakeholders
   - Healthcare Cabinet
   - Robust SIM process
   - SIM Medicaid Consumer Advisory Board
3. State agency leaders that deeply care about clients' well-being
4. Budget challenges to motivate consideration of new approaches – "burning platform"
5. Strong foundation support for effective state government

Challenges Connecticut Needs to Address

1. Lack of trust among key stakeholders
2. No table at which to have meaningful policy conversations among all stakeholders
3. Cultural inclination to resist change – “land of steady habits”
4. No unified cost containment strategy among key state agencies
5. Preponderance of publicly-traded commercial health plans with difficulties in customizing programs for CT
6. Key health care systems slow to embrace value-based payment and delivery models

Reminder: What Are Our Recommendations Supposed To Accomplish?

1. According to the legislation, we are to develop a framework for:
   A. the monitoring of and responding to health care cost growth on a health care provider and a state-wide basis that may include establishing state-wide or health care provider or service-specific benchmarks or limits on health care cost growth,

   B. the identification of health care providers that exceed such benchmarks or limits, and

   C. the provision of assistance for such health care providers to meet such benchmarks or to hold them accountable to such limits.

Reminder: What Are Our Recommendations Supposed To Accomplish?

2. Mechanisms to **identify and mitigate factors that contribute to health care cost growth as well as price disparity** between health care providers of similar services, including, but not limited to:

   A. consolidation among health care providers of similar services,
   B. vertical integration of health care providers of different services,
   C. affiliations among health care providers that impact referral and utilization practices,
   D. insurance contracting and reimbursement policies, and
   E. government reimbursement policies and regulatory practices.

Reminder: What Are Our Recommendations Supposed To Accomplish?

3. The authority to **implement and monitor delivery system reforms** designed to promote value-based care and improved health outcomes.

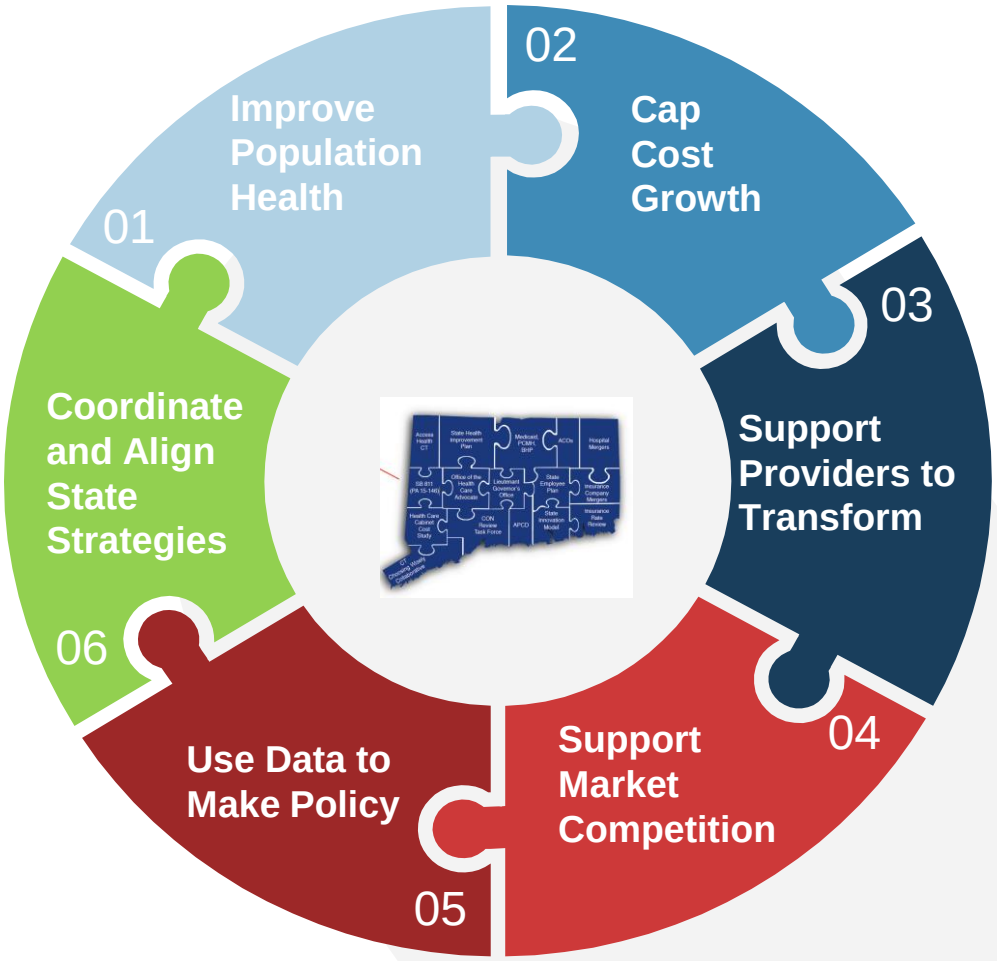
4. The **development and promotion of insurance contracting standards and products** that reward value-based care and promote the utilization of low-cost, high-quality health care providers.

5. The **implementation of other policies** to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care.

Agenda

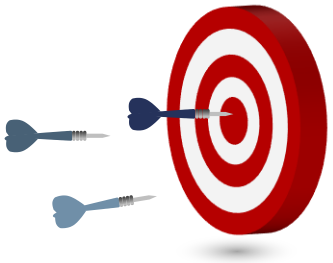
Context Setting	9:20 – 9:30
Bailit Health's Straw Model	**9:30 – 10:20**
Considerations and Challenges	10:20 – 10:25
Strategies vis à vis Cabinet's Charge	10:25 – 10:30
Discussion	10:30 – 11:50
Next Steps	11:50 – 12:00

Bailit Health's Straw Model

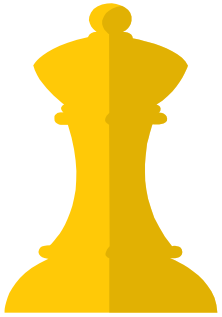


1. Improve Population Health

01 Improve Population Health



Goal: Implement delivery system reforms designed to promote value-based care and improved population health outcomes.



Strategy: Implement risk-based contracts with Consumer Care Organizations using aligned contracting and purchasing strategies for Husky Health and State of Connecticut Employee Health to promote efficient use of services and improve quality.

What are Consumer Care Organizations?

- Consumer Care Organizations (CCOs) would be groups of providers that **voluntarily** come together to coordinate a comprehensive set of services for an attributed patient population.
- Consumers' interests would be addressed by requiring CCOs to:
  - have a governing body that is representative of the provider-types that make up the CCO, with the providers being Connecticut-based
  - include consumer representation on the governing body across its lines of business
  - establish a separate consumer advisory board with a direct advisory relationship to the CCO governing body

What are Consumer Care Organizations?

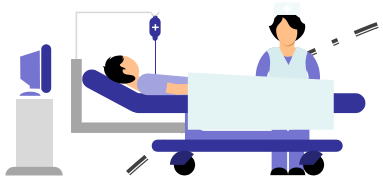
- Medicaid and the Comptroller's Office should issue RFPs:
  - that invite providers to form CCOs to deliver coordinated, efficient care
  - that require contracts with certified CCOs
  - that require the majority of payments to providers that make up the CCO be value-based, as defined by the state
    - Migration to value-based payment would occur over time
    - Common parameters will reduce administrative cost incurred by the state's ASOs, and allow the state to continue further alignment of quality measures and payment models

How are Consumer Care Organizations Different than Accountable Care Organizations?

- The key distinguishing feature of our recommended Consumer Care Organization is:

The Consumer

Consumer Care Organizations



Long-Term Care Providers

Home and Community-Based Providers

Consumers

Primary Care Providers

Specialists

Behavioral Health Providers

Hospitals

What Health Care Services Should Consumer Care Organizations Provide?

- Structure services and payments using the principles of:
  - PCMHs for primary care
  - Paying for outcomes and improved health status
  - Measuring performance and shared accountability
  - Coordinated and integrated care across the continuum of care and over time
  - Sustainable rate of growth in total cost of care
- Initially, the CCO must provide integrated medical and mental health and substance use services
- Medicaid CCOs must develop the capacity to provide dental care within 3 years.
- LTSS services should be integrated within 3 years.

How Should Consumer Care Organizations be Paid?

- Use a population-based payment that includes a consolidated stream of funds for the medical, behavioral health, LTSS and oral health needs of the population
  - Implement a shared risk model that recognizes the CCO's level of readiness to assume risk
- Withhold 2-5% of the payment to be earned based on the performance of the CCO on standard quality measures that include patient experience measures, and clinical process and outcome measures
- Administer the population-based payment model through the existing Medicaid ASOs.
  - Consolidating the four Medicaid ASOs should be a consideration
- Encourage participation by limiting rate increases for non-participating providers

Consumer Care Organizations Are Not….

- …Medicaid Managed Care Organizations
  - They will not be taking insurance risk, paying claims, credentialing providers
- …just for large hospital systems
  - They could be started and operated by entities other than hospitals
  - They must include providers across the continuum of care
  - They must develop infrastructure to manage high-risk patients
- …Oregon's CCOs (which pay claims, take on full risk)
  - These are really quasi-managed care organizations

Consumer Care Organizations Are…

- …able to build upon the Patient- Centered Medical Home model to include other key health care providers (e.g., hospitals, SNFs, etc.)
  - PCMH providers create an important foundation in any CCO and allow them to continue to grow and evolve
- …capable of being formed by any willing provider
  - E.g., Coalitions of independent practices
- …designed to accept shared risk with the state and move beyond MQISSP
  - MQISSP is an important step to prepare organizations to become CCOs
- …able to accommodate Husky Health episodes
  - If the Medicaid program develops an episode-based payment model, those episodes can be the model by which the CCO providers are paid

Why Do We Think This Will Work?

- There is evidence that ACO programs in Medicaid are saving money, while also improving quality.
- Costs:
  - **Colorado**: $29-33 million in net savings over three years.
  - **Oregon**:
    - PMPM inpatient care spending down 14.8%;
    - PMPM outpatient spending down 2.4%;
    - spending on primary care **up** 19.2%.
  - **Minnesota**: $14.8 million in 2013 and $61.5 million in 2014 compared to expected costs

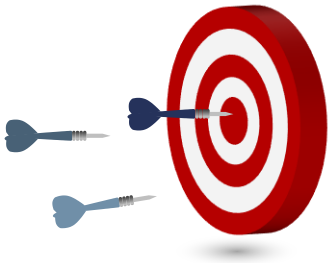
Why Do We Think This Will Work?

- Quality:
  - **Colorado**:
    - ED visits that did not result in an admission decreased
    - Well-child visits increased
    - Post-partum care increased
  - **Oregon**:
    - Significant improvements in adolescent well care visits, SBIRT screening, dental sealants for kids, assessments for kids in DHS custody, number of people without poorly controlled diabetes, etc.
  - **Minnesota**:
    - In 2013, all IHPs met their quality goals.

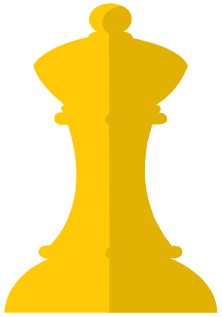
Bailit Health's Straw Model

2. Impose a Cap on Cost Growth and Promote Payment Reform

02
Cap
Cost
Growth



Goal: Control costs and offset the price effects of provider market consolidation



Strategy: Set requirements and limitations on the increase in health care costs, set targets for APM adoption, and create the regulatory authority and new structure to monitor target achievement

Time for a Pause to Discuss Terminology

- **CCOs** – term used to refer to integrated Medicaid provider organizations, as previously defined.

- **Advanced Networks** – term used by SIM to refer to integrated delivery systems, large medical groups, clinically integrated networks that are moving toward or have achieved medical home recognition – in both commercial and Medicaid markets.

- We will use Commercial Advanced Networks (CANs) and Medicaid Advanced Networks (MANs), which include CCOs, when differentiation between commercial and Medicaid markets is necessary.

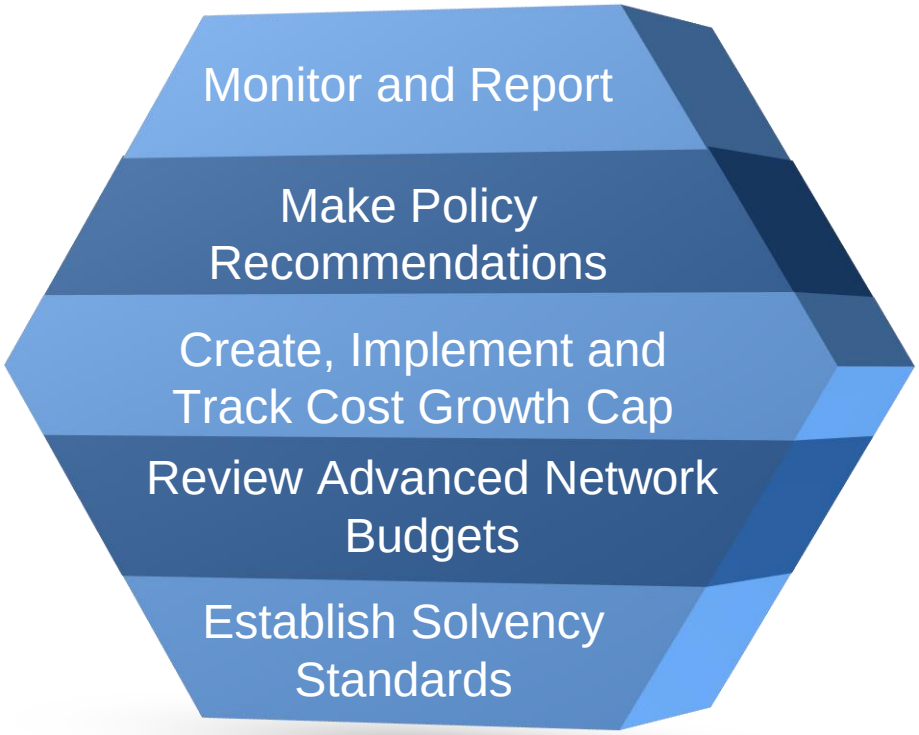
Impose a Per Capita Cost Growth Cap

- The cap on per capita cost growth would apply to providers who care for fully insured, commercial members and Medicaid beneficiaries (CANs and MANs).
  - The state does not have regulatory authority over self-insured employers.

- Two sub-strategies are necessary in order to adequately establish a cap on cost growth:
  1. Restructure existing state agencies to form a small quasi-independent agency that is responsible for developing and enforcing the cap on cost growth, and monitoring and reporting cost trends. **"Office of Health Reform"**
  2. Support growth cap through aligned MAN and CAN Advanced Network contracting requirements and standards between Medicaid, Comptroller and CID

1. Connecticut Office of Health Reform

- Setting cost growth limits on per capita cost increases and monitoring those limits **requires a quasi independent agency to:**



Connecticut Office of Health Reform (OHR)

Monitor and Report

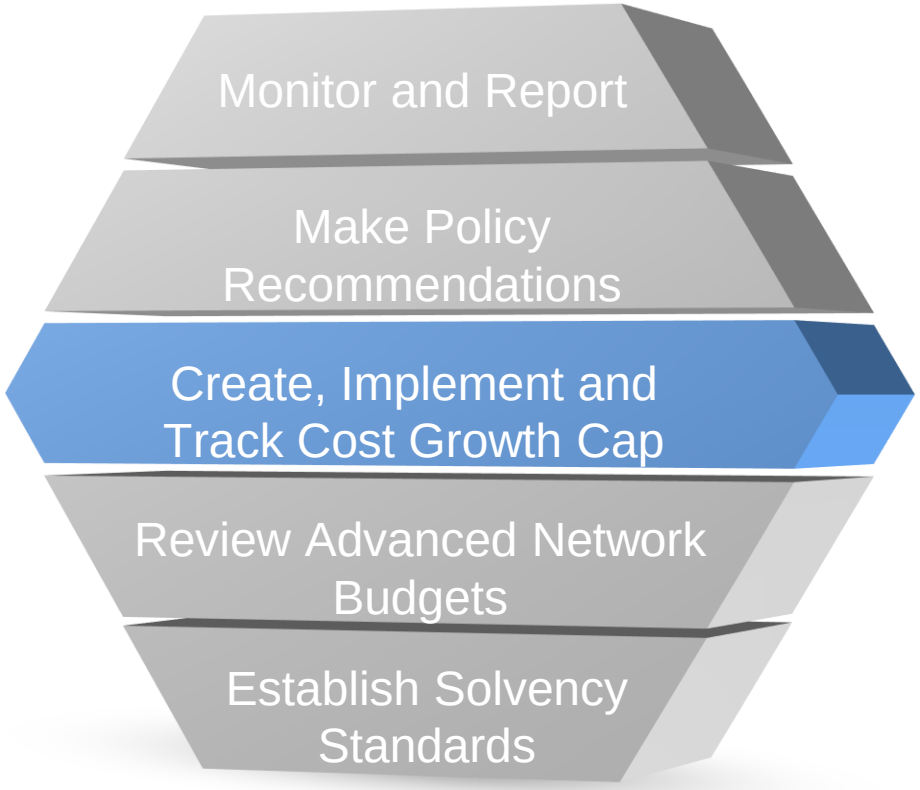
Monitor and report on cost trends using data obtained through new data resources (see Recommendation #5) and in concert with the AG's new authority (see Recommendation #4)

Connecticut Office of Health Reform

Make Policy Recommendations

- Analyze major cost drivers
- Make policy recommendations on strategies to continue to reduce cost growth
- Set APM targets, including down-side risk assumption and non-FFS model adoption

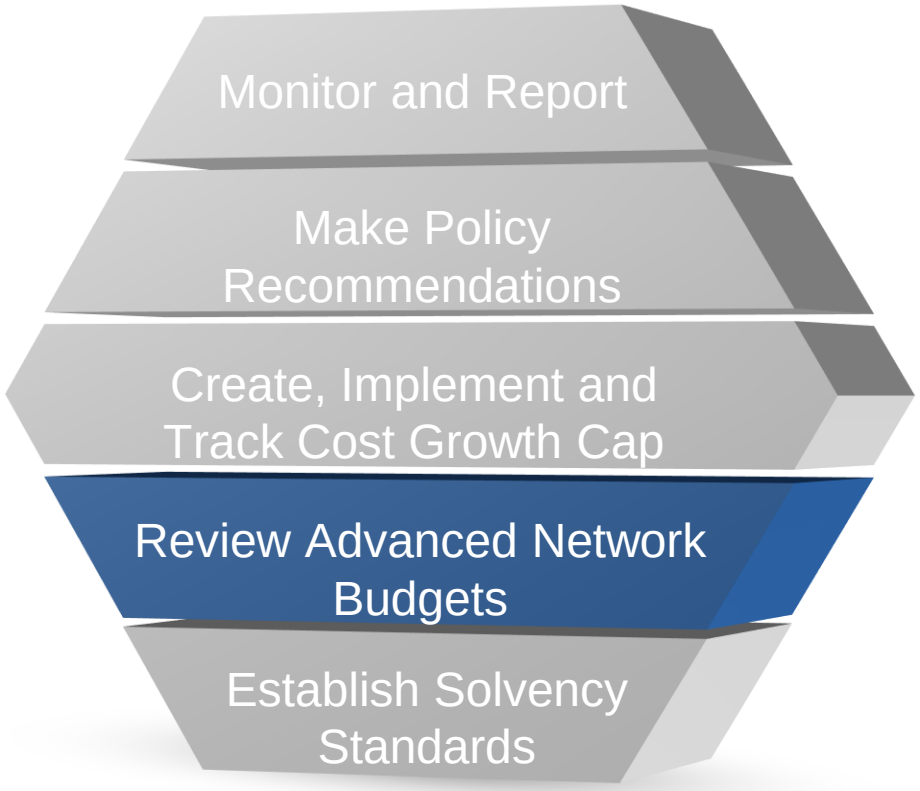
Connecticut Office of Health Reform



Create, Implement and Track Per Capita Cost Growth Caps

Create, implement and track per capita cost growth caps for the state. In setting the growth cap, the OHR would consider all information available, including APCD, external economic indices (e.g., CPI, GSP), and Medicaid's MAN cost experience and goals.

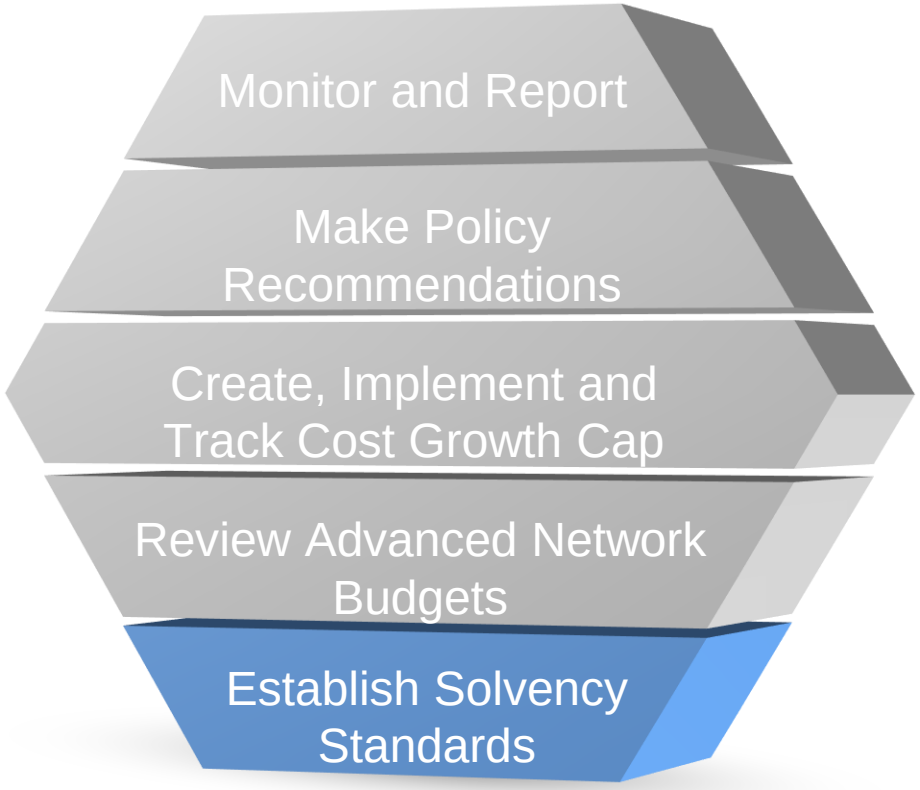
Connecticut Office of Health Reform



Review Advanced Network Budgets

To ensure compliance with cost growth caps, the OHR would review and approve CAN budgets annually for all commercial services. OHR would have the authority to adjust ACO budgets to address current price inequities. OHR would also receive MAN cost information from DSS.

Connecticut Office of Health Reform



Establish Solvency Standards

Establish certification standards with which CANs and MANs would be required to comply in order to assume downside risk.

2. Regulatory Authority Expansion Required

- The legislature should give the CID expanded authority to require plans to meet the standards set forth by the Office of Health Reform

- And for providers that cannot come to agreement with CANs or with hospitals on payment rate increases that support the state-defined cost growth cap, to use the state-defined cost growth cap as a default growth rate

Regulatory Authority Expansion Required

- During annual rate reviews, the CID confirms that plans are meeting hospital and Commercial Advanced Network rate increase limits
- The CID must annually collect information from health plans about VBP model adoption
- Plans that do not comply with these regulations shall be subject to the regulatory sanctions currently available to the CID, including but not limited to fines and denied rate filings

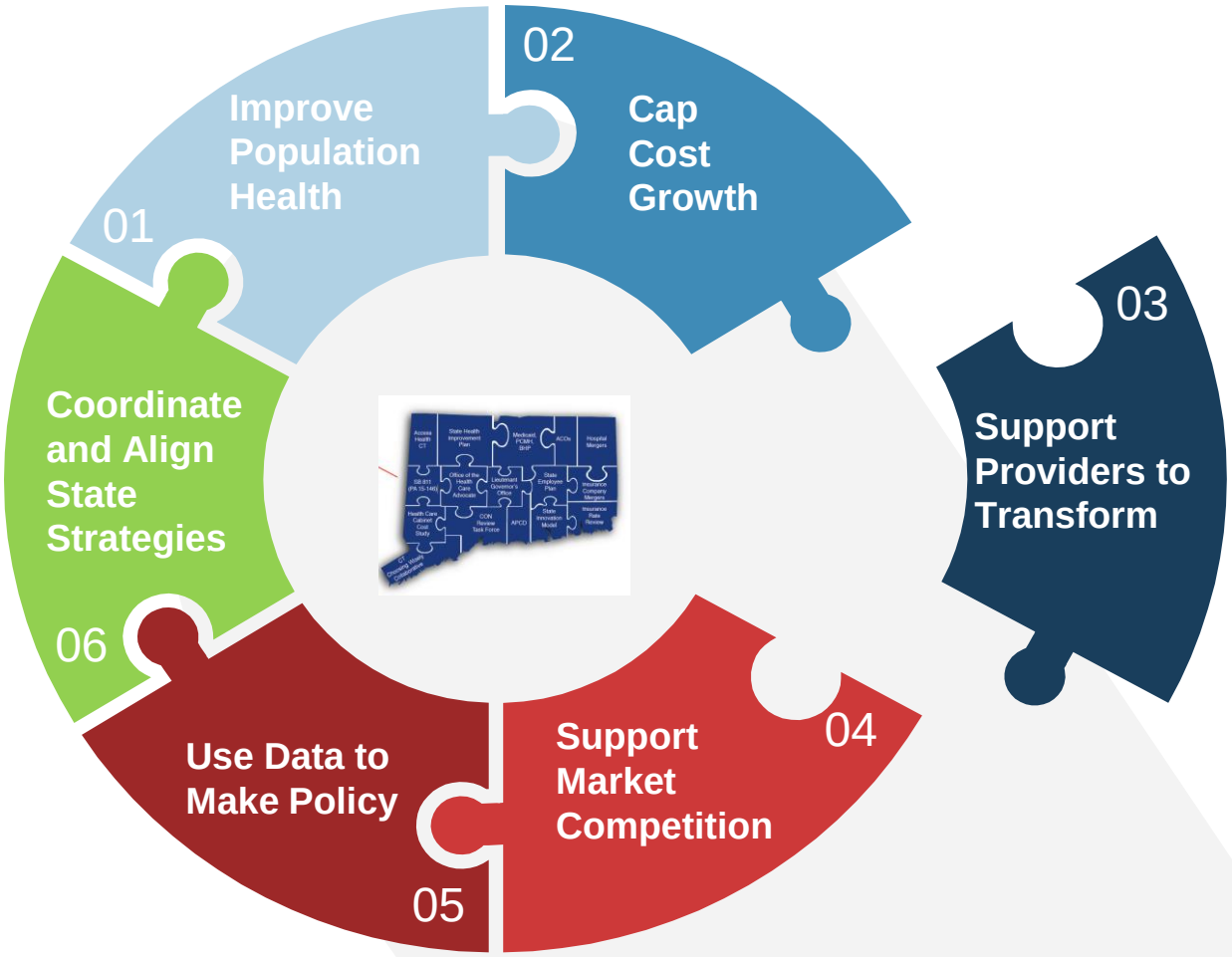
Why is Expanded Regulatory Authority Required?

- Market consolidation, a side-effect of Advanced Network contracting, is rapidly occurring in CT today and can lead to higher prices and unjustified price variation because of negotiation imbalances.

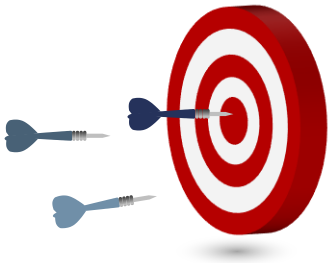
- Regulating the use of VBP and cost growth caps will help to mitigate the ill effects of market consolidation.

- Regulations are an effective lever that Connecticut can use to impact cost increases in the public sector

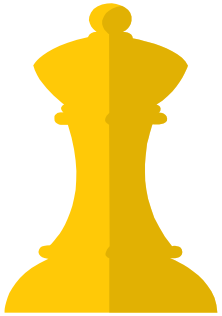
Bailit Health's Straw Model



3. Support Provider Transformation by Pursuing a Medicaid 1115 Waiver



Goal: Obtain state flexibility in Medicaid program design to support aligned cost containment strategies and sustain the work achieved through the SIM grant



Strategy: Pursue a Section 1115 Medicaid Waiver, and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment

Why is an 1115 Waiver Necessary?

- Section 1115 of the Social Security Act gives HHS the authority to approve experimental, pilot or demonstration projects to promote the objectives of the Medicaid and CHIP programs
- It gives states the flexibility to design and improve their programs
- The reimbursement structure for the CCOs would require an 1115 Waiver
- An 1115 Waiver is required to access Delivery System Reform Incentive Payment (DSRIP) funds

What is DSRIP?

- Delivery System Reform Incentive Payments are part of 1115 Waivers and provide states with significant funds to support providers in delivery system transformation. Must be budget neutral for federal government.
  - Current DSRIP states use Designated State Health Programs funds, intergovernmental transfers, state funding of safety-net providers, provider taxes or state general funds for matching.
  - More work needs to occur to identify appropriate funding opportunities for Connecticut
- DSRIP funds can be awarded to providers for key activities (or projects) that support improvements in the delivery system and prepare providers for accepting risk-based payment

Summary of State DSRIP Program Funding

State	DSRIP Time Period	Total Funding
California	2010-2015	$6.5 billion
Texas	2011-2016	$11.4 billion
Massachusetts	2014-2017	$1.35 billion
New Mexico	2015-2018	$29.4 million
New Jersey	2014-2017	$555.4 million
Kansas	2014-2017	$99.8 million
Oregon	2014-2017	$1.9 billion
New York	2016-2020	$6.42 billion
New Hampshire	2017-2020	$150 million
Arizona	Not yet approved	TBD
Washington	Not yet approved	Applied for $3 Billion

How Are DSRIP Funds Being Used by States?

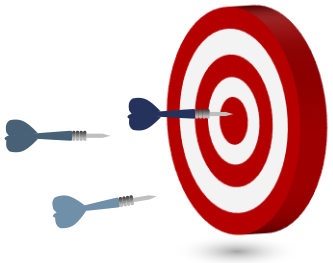
- The state has the flexibility to design the DSRIP in whatever ways are the most supportive of its providers. Examples of how DSRIP funds have been used (or proposed) include:
  - To support **care redesign**, like the integration of primary care with mental health and substance use services, improving care transitions, and reducing utilization of intensive services (e.g., ED and hospitals)
  - To support **infrastructure development**, like building new clinics (e.g., clinics integrated with probation / parole offices), hiring new staff (e.g., care managers), workforce development, disease registry development

How Might DSRIP Funds Support Connecticut?

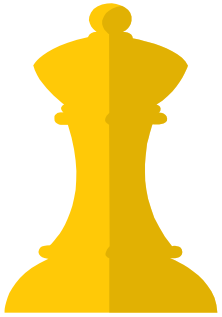
- Some ways in which DSRIP funds could support Connecticut. DSRIP funds could assist providers:
  - with the infrastructure development and necessary training to get connected to the state's developing HIE
  - in developing Consumer Care Organizations, especially independent practices, FQHCs or health care facilities that may wish to anchor a CCO
  - in PCMH transformation for practices that have not participated in the Medicaid PCMH program
  - to expand access to underserved communities and underserved population
  - in engaging in Health Enhancement Communities

Bailit Health's Straw Model

4. Support Market Competition by Increasing AG Subpoena Power



Goal: Monitor cost growth and price disparity between health care providers of similar services



Strategy: Give the Attorney General additional subpoena powers to collect confidential information from plans and providers to examine and report on trends in costs to improve transparency and promote competition

Why Increase AG Subpoena Power?

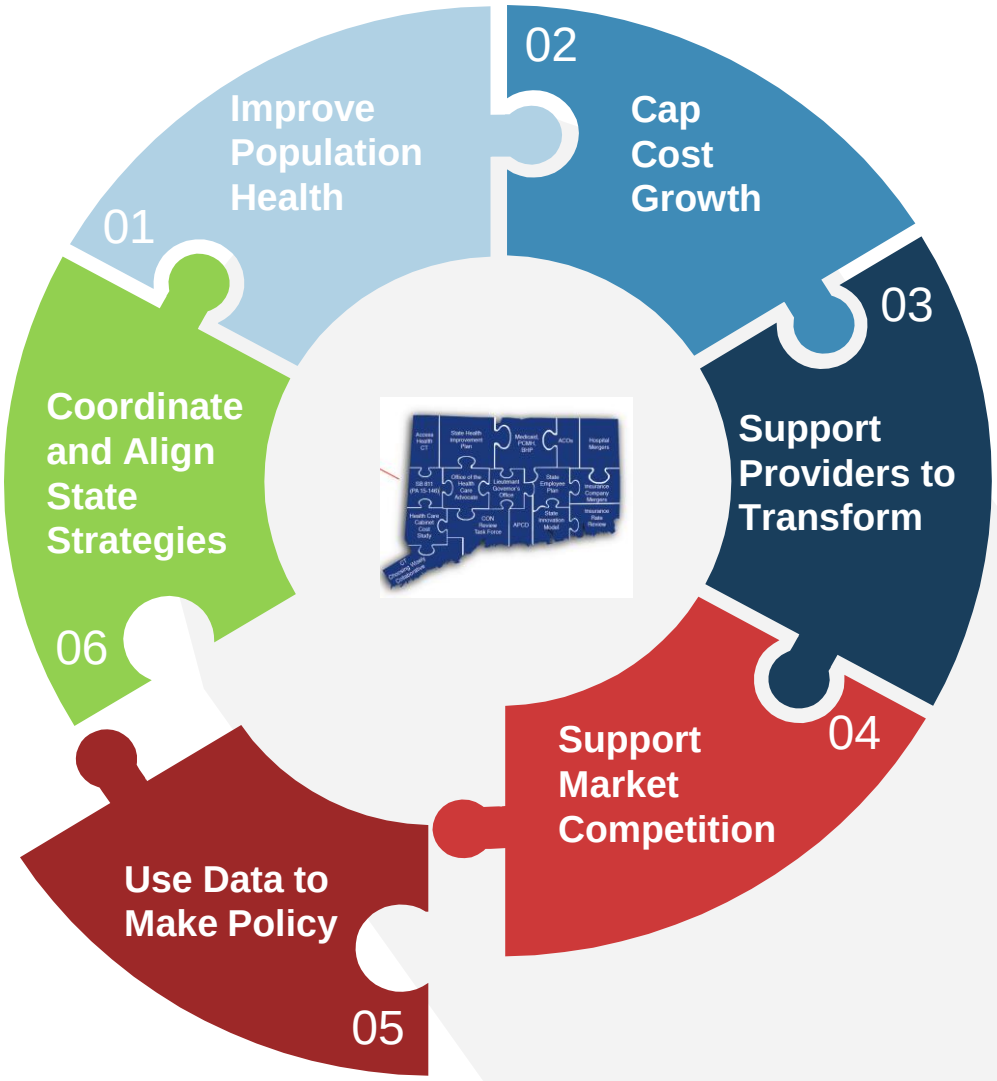
- Health care is not operating in a free market
- Widespread cost-shifting has been proven to be a myth; rather, relative market power of plans and providers dictate prices
- Consumers are shielded from prices with insurance coverage and when they have pricing information, they often incorrectly equate high cost with high quality

➢ For these reasons the AG needs the authority to investigate and report on root causes of cost growth and price variation by accessing data not otherwise available

What is Needed to Increase the AG's Subpoena Power?

- Legislative action to increase the subpoena power of the AG to specifically review and analyze reasons for health care cost growth and price variation
  - Precedent set in Massachusetts in 2008, which resulted in revelations on reasons for and ill effects of price variation in the state
- Adequate appropriations are necessary to allow the AG to fulfill new requirements

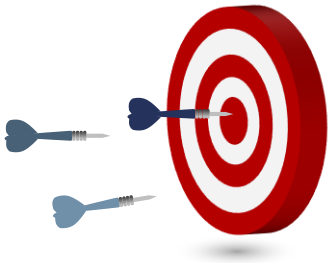
Bailit Health's Straw Model



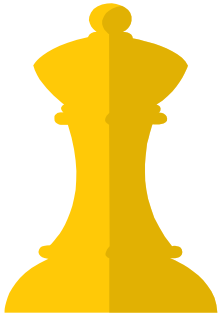
5. Use Data to Make Policy by Building a Robust Data Infrastructure

Use Data to Make Policy

05



Goal: Enable the state to monitor cost growth, use data to inform policy making, and make coverage decisions based on comparative effectiveness data



Strategy: (1) Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange. (2) Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services.

Why Should CT Invest in Data Infrastructure?

- Connecticut needs the ability to **objectively** study the state's health care system and its value (both cost and quality)
  - Medicaid currently has a robust database
  - CT needs similar information across all health care sectors
- Objective data should help drive policy making through the Office of Health Reform, across state agencies and through the Legislature

Resources Newly Available to Connecticut

- P.A. 16-77, passed May 2, 2016, modifies coordination of HIT related policy and activities for health reform initiatives in the state.
- It allows the state to build upon existing assets acquired and developed by DSS.
- It created a Health Information Technology Officer (HITO) that will report to Lt. Governor Wyman
- HITO will coordinate all state HIT initiatives, and lead efforts to create a fully functioning HIE.
- Will also coordinate Medicaid data, SIM HIT, the APCD, DPH's population health work, and other HIT related projects.

1. Use of APCD and HIE

- The HITO should be required to work with the Office of Health Reform to ensure that OHR has the data necessary to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Support the Build of a Statewide HIE

- DSS and the Comptroller should use their purchasing powers to promote provider engagement in the HIE
  - Hospitals and other providers that do not participate in the HIE should not be eligible to participate in the Medicaid and state-employee health CCO strategy
    - The requirement should be phased in, beginning with hospitals and then expanding to PCPs, physician specialists, nursing facilities and behavioral health providers
  - Hospitals and other providers should receive financial support for infrastructure development for HIE participation through the DSRIP program, including
    - Funding support to connect to the HIE
    - Resources to develop reporting capabilities

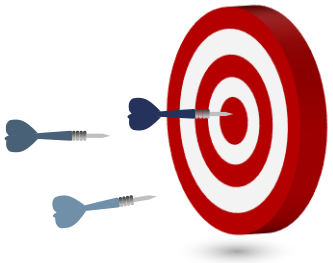
2. Adopt an Evidence-based Coverage Strategy

- The Legislature should enact legislation mandating that the best available scientific evidence should guide coverage decisions for every agency of the state government that purchases health care
- Approximately 30% of all health care spending may produce no benefit to the patient – and some of it produces clear harm
  - Unexplained variation in the use and intensity of the end-of-life care, CABG surgery and angioplasty alone is estimated to cost the health care system $600 billion (New England Healthcare Institute, 2008).
  - $1.1 billion is spent just on unnecessary antibiotics for respiratory infections (O'Connor, 2013)
- Adopting evidence-based coverage decision-making can reap savings. For example Washington has seen:
  - 94% reduction in spending on bariatric surgery
  - a $10 million savings from reducing tube feeding spending
  - 3:1 ROI in ADD spending for children by using second opinions

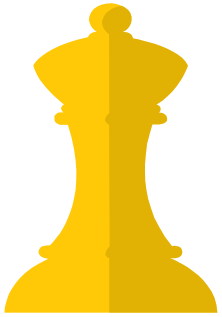
To Enact This Strategy, Relevant State Agencies Should…

- Implement a transparent process that allows for public input into determining medical necessity of medical, behavioral health and dental services
- Establish a state health technology assessment committee to determine safety and effectiveness of medical devices, procedures and tests
- Expand the scope of the current Medicaid P&T Committee to cover all pharmacy benefits offered under all state-purchased health care services

6. Coordinate and Align State Strategies

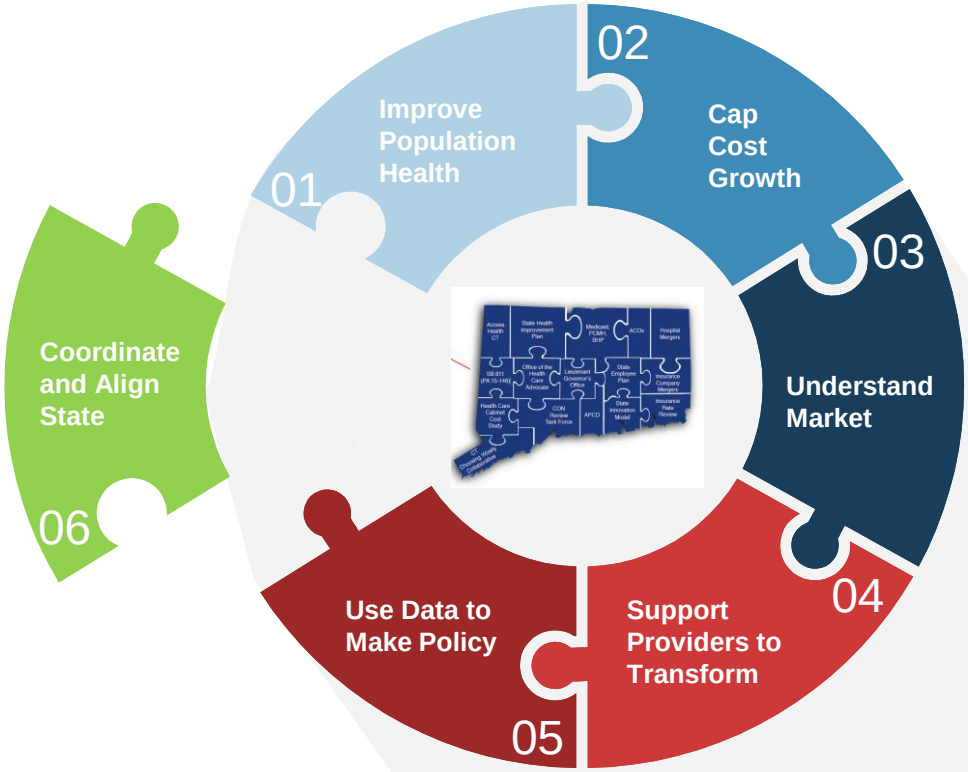


Goal: Align existing SIM initiative and other state health care strategies to maximize impact of the State's purchasing and policy levers



Strategy: Restructure existing agencies into a single state entity composed of all health-related state agencies to be responsible for aligning all state health policy and purchasing activities

Why Create a Single State Authority?



Why Create a Single State Authority?

Because the pieces of the puzzle need to fit together…

…and be governed with a unified, trusted voice.

What Functions Would the Connecticut Health Authority (CTHA) Have?

- The CTHA should be established to oversee state programs and initiatives that directly or indirectly purchase and / or regulate health care services or set state health care policy. It should work closely with the CT Office of Health Reform to develop a unified statewide strategy.
- The CTHA should produce one centralized budget for all of its component agencies
- It should direct the coordination of purchasing strategies with the Office of the Comptroller and Department of Corrections
- It needs to be supported with APCD and HIE data

CTHA Should be Mandated by Legislature to:

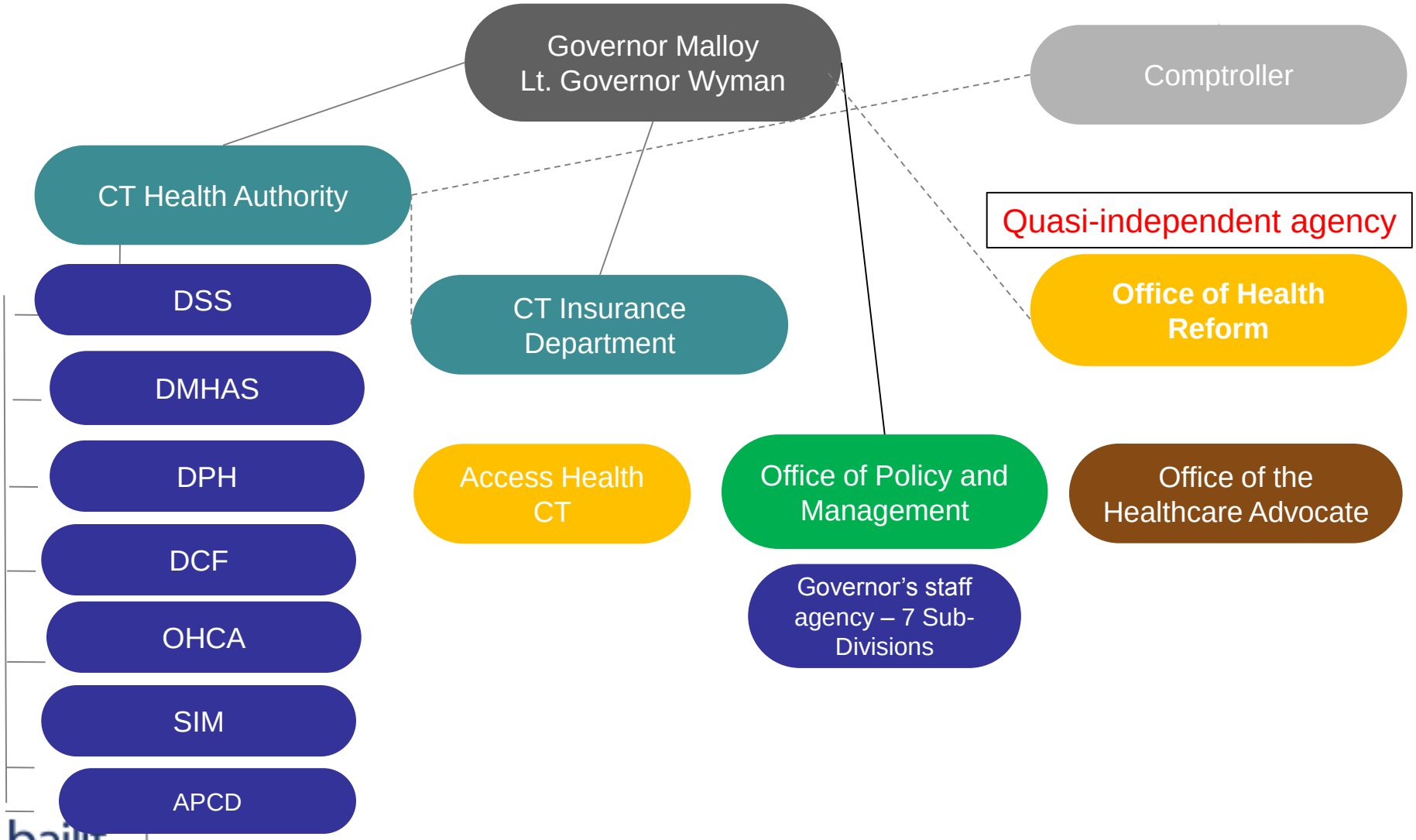
1. Set annual measurable targets around goals of:
   - Reducing cost increases
   - Improving population health
   - Promoting healthy children and families
   - Providing timely access
   - Promoting improved quality
   - Providing superior care experience
   - Reducing health status and health inequities
   - Reducing avoidable and wasteful spending

CTHA Should be Mandated by Legislature to:

2. Coordinate the state's health care initiatives, including these recommended strategies, and the SIM initiative.

3. Submit an annual report to the Legislature on its progress toward meeting the aforementioned goals.

Recommended Organizational Chart



What are the Benefits to a Single State Agency?

- While Connecticut state staff currently do some informal coordination across agencies, today, a single state agency would:
  - establish more formal coordination and allow for accountability in developing an aligned set of strategies
  - facilitate the ability of the State to identify and quantify funds available to use as state contributed matching funds, which could expand access to federal funding sources

Agenda

Context Setting	9:20 – 9:30
Bailit Health's Straw Model	9:30 – 10:20
Considerations and Challenges	**10:20 – 10:25**
Strategies vis à vis Cabinet's Charge	10:25 – 10:30
Discussion	10:30 – 11:50
Next Steps	11:50 – 12:00

Considerations

- Evidence of effectiveness of any one single programmatic component is difficult to obtain.
  - States implement programs without control groups and without plans to do robust evaluations.
  - Some states would rather be found trying something than to not try at all.

- “The secret of change is to focus all of your energy, not on fighting the old, but on building the new.” - Socrates

Challenges

- No recommendations will go without some challenges. We have identified the following challenges to implementing our straw recommendations:
  - Presidential election year
    - Uncertainty about DSRIP program for applicants beyond 2016 due to CMS / CMMI staff turnover and possibly priority shifting
  - High degree of change management required
    - Leadership is an essential ingredient to our strategies especially with internal state government changes
  - State fiscal crisis
    - Some creativity is necessary to identify and allocate resources for agency reorganization
  - Market reaction
    - We are calling for stronger regulation which might create tension by market stakeholders

Agenda

Context Setting	9:20 – 9:30
Bailit Health's Straw Model	9:30 – 10:20
Challenges	10:20 – 10:25
Strategies vis à vis Cabinet's Charge	**10:25 – 10:30**
Discussion	10:30 – 11:50
Next Steps	11:50 – 12:00

Summary of Strategies Relative to the Cabinet's Legislative Directive (1 of 4)

Legislative Requirement	Strategy
1. Monitoring and responding to cost growth, including use of benchmarks or limits.	a. Legislature: build data infrastructure b. Office of Health Reform: collect/report cost data, develop cost cap c. AG: collect and report health cost issues d. CID: set VBP model adoption targets and require plans to have hospital and Advanced Network contracts supportive of OHR's cap e. Health Authority - DSS: implement cost growth cap for MANs f. Office of Comptroller: implement cost growth cap for employee/retiree CANs

Summary of Strategies Against Legislative Requirements (2 of 4)

Legislative Requirement	Strategy
2. Identification of health care providers that exceed benchmarks or limits	a. CID: monitor payer contracts b. AG: investigations c. Office of Health Reform: data analysis and reporting
3. Provision of assistance for providers to meet benchmarks	a. Health Authority - DSS: DSRIP funds to support delivery system transformation

Summary of Strategies Against Legislative Requirements (3 of 4)

Legislative Requirement	Strategy
4. Identify and mitigate factors that contribute to cost growth and price disparity.	a. Office of Health Reform: collect/report cost data, develop cost cap; approve/modify Advanced Network budgets to meet cap and address price disparities b. AG: collect and report health cost issues c. Health Authority: align strategies d. Health Authority/Office of Comptroller: implement evidence-based coverage decision-making
5. Mitigate ill effects of consolidation, both horizontal and vertical.	a. Office of Health Reform: develop cost cap b. CID/Health Authority/Office of Comptroller: promote risk-based contracting c. CID: require plans to limit provider cost increases d. AG: improve competition

Summary of Strategies Against Legislative Requirements (4 of 4)

Legislative Requirement	Strategy
6. Authority to implement and monitor delivery system reforms	a. Health Authority: implement aligned strategies for delivery system reform b. Health Authority – DSS: seek Section 1115 waivers to allow for risk-based contracting
7. Development and promotion of insurance contracting standards and products that reward value-based care.	a. CID: establish VBP model adoption targets; set Plan-Advanced Network and hospital contracting standards b. Health Authority/Office of Comptroller: develop aligned contracting strategies for MANs and CANs; implement evidence-based coverage policies for health and pharmacy benefits c. Office of the Comptroller: continue to offer VBID plans

Agenda

Context Setting	9:20 – 9:30
Bailit Health's Straw Model	9:30 – 10:20
Considerations and Challenges	10:20 – 10:25
Strategies vis à vis Cabinet's Charge	10:25 – 10:30
Discussion	**10:30 – 11:50**
Next Steps	11:50 – 12:00

Discussion

What are your ideas to:

1. Monitor and respond to cost growth, including use of benchmarks or limits
2. Identify health care providers that exceed benchmarks or limits
3. Provide assistance for providers to meet benchmarks

Discussion

What are your ideas to:

4. Identify and mitigate factors that contribute to cost growth and price disparity
5. Mitigate ill effects of consolidation, both horizontal and vertical
6. Authority to implement and monitor delivery system reforms
7. Develop and promote insurance contracting standards and products that reward value-based care.

Agenda

Context Setting	9:20 – 9:30
Bailit Health's Straw Model	9:30 – 10:20
Considerations and Challenges	10:20 – 10:25
Strategies vis à vis Cabinet's Charge	10:25 – 10:30
Discussion	10:30 – 11:50
Next Steps	**11:50 – 12:00**

Next Steps

- Bailit Health will document today's discussion and identify themes that require further investigation or conversation
- The Cabinet will continue strategy / recommendation discussions in August

- **September**: Finalize recommendations
- **October**: Review draft report
- **November**: Finalize report
- **December 1**: Submit report to the legislature