Study of Cost Containment Models and Recommendations for Connecticut

Discussion of Recommendations

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September 13, 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

Welcome and Housekeeping	9:00am – 9:10am
Public Comment	9:10am – 9:25am
Discussion of Straw Proposal	9:25am – 11:45am
Next Steps	11:45am – 12:00pm

Today's Meeting

- The objective of today's meeting is to have a productive discussion among Cabinet members about the health care cost control strategies presented on July 12th.
- The Cabinet will:
  - discuss the goals guiding the strategy development
  - discuss each strategy one by one, following a brief recap of the strategy
  - review the benefits and concerns previously identified through Cabinet member and stakeholder feedback
  - identify any recommended modifications to the strategy or goal
  - identify any proposed alternatives to the strategy or goal
- We will facilitate discussion, ensuring all voices are heard, and begin to identify emerging consensus themes.
- We will also be using a Parking Lot to capture new ideas for further discussion during the 9/28 meeting.

Why the Legislature Asked the Cabinet to Consider Cost Containment

- The Legislature was concerned about a number of trends and events:
  - Consolidation of providers, resulting in large facility fees
  - Increased physician prices due to hospital ownership
  - Increased costs not related to quality
  - State budget shortfalls
- It wanted to draw upon the experiences of other states actively engaged in cost containment measures.
- The goals of the legislation: a “blueprint” for policy making and a regulatory framework to achieve greater transparency, accountability, quality and budget savings.

Reminder: Your Legislative Directive

1. According to the legislation, the Cabinet is 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: Your Legislative Directive

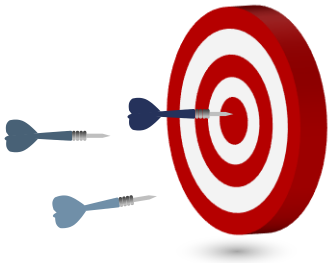
2. Provide recommendations regarding mechanisms to **identify and mitigate factors that contribute to health care cost growth as well as price disparity** between health care providers of similar services, including, but not limited to:

   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.

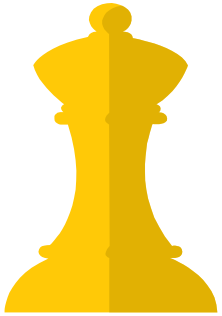
Reminder: Your Legislative Directive

3. Provide recommendations regarding the authority to **implement and monitor delivery system reforms** designed to promote value-based care and improved health outcomes.
4. Provide recommendations regarding 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. Provide recommendations regarding the **implementation of other policies** to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care.

1. Provide More Coordinated, Effective and Efficient Care



Goal: Reduce costs by **engaging providers** (both professionals and institutions) to provide services in a more **coordinated, effective and efficient manner** (addressing issues of under use, overuse, misuse and ineffective use, health inequities and social determinants of health) through implementation of **delivery system and payment reform models**.



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.

Strategy #1 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

- Benefits
  - Consumers are central to the governance and operations of the CCOs
  - Proposal pushes risk down to the providers

- Concerns
  - SDOH and Rx costs are not directly addressed
  - Penalizing providers for not participating through denying future rate increases is not feasible
  - Lacking trust required to implement
  - PCMH+ is too new to say it needs to be expanded and built upon.
  - Voluntary with incentives based on rate increases
  - Administratively burdensome for providers

Strategy #1 Modifications Suggested by Stakeholders

- Explicitly expand the responsibilities of the CCOs to include addressing SDOH and to create better linkages between clinical and social service providers
- Specifically include measures that address population health and prevention
- Include in QI measures, behavioral health measures that are meaningful to the consumers and which don't create incentives to deny nonmedical services
- Allow existing ACOs to be deemed CCOs
- Embed community health workers to address social determinants of health

Strategy #1 Modifications Suggested by Stakeholders, cont'd.

- Include pharmacists as a set of community-based providers that CCOs would be expected to incorporate into their care teams
- Require CCOs to implement Comprehensive Medication Management standards, consistent with the CT SIM
- Ensure meaningful integration of medical, behavioral and disability services as a CCO responsibility
- The CCO payment model should be aligned across all payers
- Build this model into a long-term plan that has flexibility based on experiences with PCMH+ and other active initiatives.

Strategy #1 Alternatives Suggested by Stakeholders

- The following *alternatives* were suggested:
  - Continue with the current SIM agenda on use of shared savings program, and use of common quality measures across payers
  - Examine experience with PCMH+ and a range of available Medicaid authorities (1115, State Plan Amendment) to plan carefully for implementation of “regional health neighborhoods”
  - Continue to increase the percentage of Medicaid payments tied to meeting quality goals
  - Pilot bundled payment models
  - Develop targeted Medicaid programs for high-cost, high-need patients

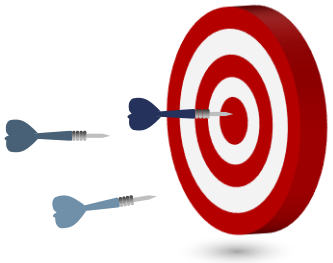
Cabinet Discussion

Goal: Reduce costs by **engaging providers** (both professionals and institutions) to provide services in a more **coordinated, effective and efficient manner** (addressing issues of under use, overuse, misuse and ineffective use, health inequities and social determinants of health) through implementation of **delivery system and payment reform models**.

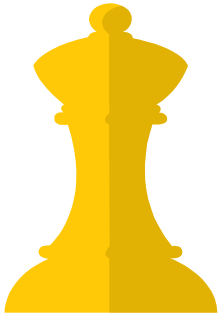
Strategy #1: Implement risk-based contracts with Consumer Care Organizations using aligned contracting and purchasing strategies for Husky Health and State of Connecticut Employee Health to promote efficient use of services and improve quality.

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

2. Directly Reduce Cost Growth



Goal: Reduce cost growth by setting a limit on annual increases and developing mechanisms to 1) track actual costs against a target, 2) identify key cost drivers, and 3) make data transparent to the public.



Strategy:

(1) Cap advanced network cost growth
(2) set targets for APM adoption, and
(3) create the Office of Health Reform to implement, and act as an independent body of experts

Strategy #2 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

- Benefits
  - Having a single locus of responsibility through OHR will improve coordination and alignment across agencies
  - Setting growth caps will focus necessary attention on containing costs

- Concerns
  - New office will create confusion, skepticism and could interrupt current health care programs and services, cost resources
  - Setting cost growth caps might limit services to those who require expensive services
  - Setting a growth cap does not adequately address CT's problem with increasing prices and hospital consolidation
  - Not clear how a cap would be set
  - Cost caps don't reflect the current "underfunding" of Medicaid
  - Does not apply to self-insured

Strategy #2 Modifications and Alternatives Suggested by Stakeholders

- The Office of Health Reform should have the Certificate of Need authority to ensure Advanced Networks can be formed.

- The following *alternatives* were suggested:
  - Establishing a cost growth cap without the Office of Health Reform, and base the cost growth cap on Medicare's growth rate
  - Expand CID authority to require plans to meet a cost growth cap
  - Leave the monitoring of risk arrangements under the jurisdiction of the CID
  - Regulate ACOs for financial soundness and appropriate delivery of care
  - Better control Rx costs by such programs as value-based benchmark pricing, indication-specific pricing, P4P contracts with manufacturers, medication therapy management, drug price transparency legislation

Cabinet Discussion

Goal: Reduce cost growth by setting a limit on annual increases and developing mechanisms to 1) track actual costs against a target, 2) identify key cost drivers, and 3) make data transparent to the public.

Strategy #2:

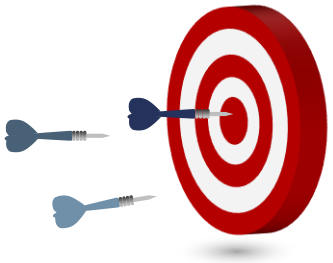
(1) Cap Advanced Network cost growth;

(2) set targets for APM adoption, and

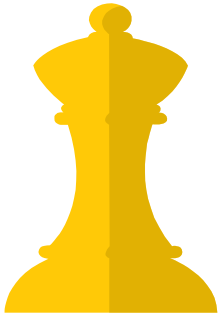
(3) create the regulatory authority and new structure to monitor target achievement (Office of Health Reform)

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

3. Support Provider Transformation



Goal: In recognition that implementing delivery system reform in a manner that improves health care and reduces costs is very difficult for providers, provide them with financial, infrastructure and technical support needed to change their care delivery models.



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

Strategy #3 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

- Benefits
  - Enables implementation of the CCO strategy and funding of provider transformation
- Concerns
  - The state is currently implementing many cost containment strategies without the 1115 waiver
  - A 1115 waiver is not consistent with Connecticut's values
  - 1115 waiver might take away resources from SIM
  - DSRIP proposal is too conceptual

Strategy #3 Modifications and Alternatives Suggested by Stakeholders

- Current provider taxes could be used as funds to offer for federal matching
- The following *alternatives* were suggested:
  - Continue to optimize present Medicaid care delivery reform programs (PCMH, behavioral health homes, LTSS rebalancing agenda) and launch Medicaid programs in active development (optimizing care for justice-involved individuals, health home for children with complex trauma, etc.)

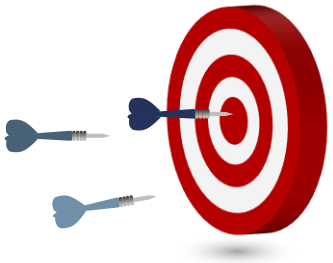
Cabinet Discussion

Goal: In recognition that implementing delivery system reform in a manner that improves health care and reduces costs is very difficult for providers, provide them with financial, infrastructure and technical support needed to change their care delivery models.

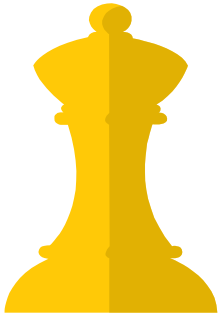
Strategy #3: Pursue a Section 1115 Medicaid Waiver, and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

4. Address Variation in Provider Payment



Goal: Address variation in provider payments by developing a better understanding of provider (particularly hospital) practices.



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

Strategy #4 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

- Benefits
  - Enables the state to understand provider pricing in a manner that allows informed policy decision-making
- Concerns
  - Insufficient to address price increases and hospital consolidations
  - New resources required to fulfill the requirements.
  - Not clear what would trigger an AG investigation or review.

Strategy #4 Modifications Suggested by Stakeholders

- Increase the AG's role to also improve transparency of prescription drug costs
- Increase regulatory role over increase in health care prices, specifically regarding mergers and acquisitions

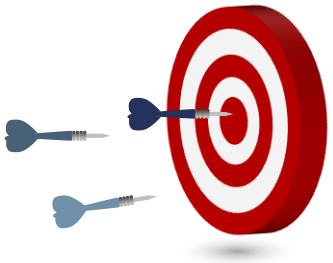
Cabinet Discussion

Goal: Address variation in provider payments by developing a better understanding of provider (particularly hospital) practices.

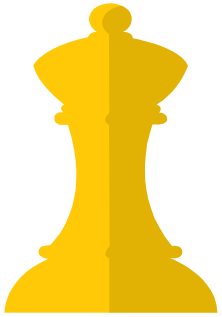
Strategy #4: Give the Attorney General additional subpoena powers to collect confidential information from plans and providers to examine and report on trends in costs to improve transparency and promote competition

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

5. Support Providers and Policy Makers with Data



Goal: Build the data and clinical information infrastructure necessary to support delivery system and payment reform at the provider level and to inform good state policy-making.



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.

Strategy #5 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

Strategy #5-1: Ensure a robust APCD and HIE

- Benefits
  - This is essential to drive improvements and to inform policy making
  - An effective HIE is needed to implement CCOs and the state does not have one
- Concerns
  - HIE is expensive and provider organizations have developed other means of sharing information
  - *Gobeille vs. Liberty Mutual*

Strategy #5 Modifications Suggested by Stakeholders

Strategy #5-1: Ensure a robust APCD and HIE

- Give the new HITO the resources to build a robust data infrastructure
- Develop a universal Memorandum of Understanding (MOU) between state agencies to allow for data sharing which will increase efficiency and guide policy decisions
- Ensure providers and stakeholders have the ability to provide significant input into the building of an APCD or HIE

The following *alternative* was suggested:

- Coordinate the use of existing resources and data across agencies
- Continue crowd-sourcing data
- Use independent researchers to build trust in data, develop conflict of interest protections

Strategy #5 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

Strategy #5-2: Incorporate Comparative Effectiveness Evidence in Coverage Decisions

- Benefits
  - This approach addresses the underuse of services
- Concerns
  - Not all evidence is “strong”
  - Not all studies include a diverse population, thus possibly leading to inappropriate generalities
  - Many studies don’t focus on non-traditional treatments
  - Medicaid already covers everything that is medically necessary

Strategy #5 Modifications and Alternatives Suggested by Stakeholders

Strategy #5-2: Incorporate Comparative Effectiveness Evidence in Coverage Decisions

- Include non-traditional treatments in analysis of effectiveness for possible coverage
- Apply recommendations made by the state for Medicaid and state employees to commercial plans
- Draw upon the UConn School of Pharmacy for its expertise in comparative effectiveness research
- Ensure that this recommendation would not supplant a physician's medical judgement or limit the care needed by a patient.
- Any established guidelines must include medical malpractice safe harbors

The following *alternatives* were suggested:

- Optimize pharmacy purchasing across state employees, DOC and VA, and if possible, DSS.

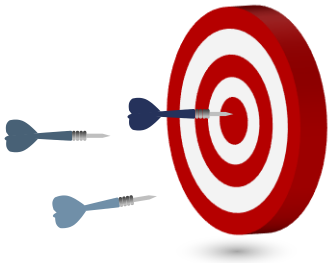
Cabinet Discussion

- **Goal**: Build the data and clinical information infrastructure necessary to support delivery system and payment reform at the provider level and to inform good state policy-making.

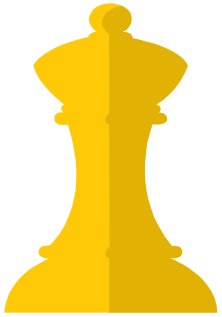
- **Strategy #5:** (1) Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange. (2) Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services.

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

6. Coordinate and Align State Strategies



Goal: Set a cohesive vision for health care in the state, improve planning and coordination of health care strategies, create alignment in the public health care sector, and effectively deploy resources



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

Strategy #6 Benefits and Concerns Identified by Cabinet Members and Other Stakeholders

- Benefits
  - Increases opportunity for a unified vision on state health care policy
  - A unified structure is essential to assure implementation of reform in Connecticut
  - Promotes increased state agency coordination
  - Creates a foundation for creating common goals and accountability

- Concerns
  - Creates a huge bureaucracy without benefits
  - Consumer voices will be diminished
  - Consolidation has been tried in the past and was not successful
  - Funding for behavioral health services might be reduced if consolidated into the Medicaid program
  - There are no state funds available to implement any of the upfront costs of any of the recommendation

Strategy #6 Modifications and Alternatives Suggested by Stakeholders

- The following *alternatives* were suggested:
  - Use existing bi-weekly intra-agency meeting (or develop a new task force) to analyze health care cost, quality and outcomes across shared populations
  - Improve cross-agency coordination by creating a steering committee under the LG's Office of Health Reform
  - Consider integrating oversight bodies related to health care reform (i.e., Health Care Cabinet, the SIM Steering Committee, CON Task Force, HIT Council, MAPOC, Behavioral Health Program Oversight Council)
  - Create a formal function outside of state government to improve two-way communications between government and the rest of the health care system
  - Coordination of purchasing strategies between the Office of the Comptroller, DOC, and DSS could be explored for potential cost savings.

Cabinet Discussion

Goal: Set a cohesive vision for health care in the state, improve planning and coordination of health care strategies, create alignment in the public health care sector, and effectively deploy resources

Strategy #6: 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

1. Does the strategy achieve the intended goal?
2. How might the strategy be modified?

Next Steps

- On **September 28th**, we will discuss:

1. Any remaining strategies not addressed today, and identified follow-up items from today's discussion.
2. The authority needed to implement the strategies the Cabinet is favoring
3. Whether the strategies the Cabinet is favoring meet the principles adopted June 14, 2016
4. Any alternative strategy recommendations Cabinet members wish to discuss