Testimony to the Health Care Cabinet

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Date: November 15, 2016

Regarding: Comments in support of the Connecticut Health Care Cabinet's recommendations.

Hello, I am Dr. Tim Elwell, President and CEO of Qualidigm, a not-for-profit, mission-driven, healthcare consulting organization with headquarters in Wethersfield, CT and offices in Rhode Island, Vermont, and New Hampshire. I represent a regional Quality Improvement Organization whose focus has been on supporting the interest of Medicare beneficiaries for 35 years. We have created a brand based on trust that has established many successful collaborations at the community as well as at the organizational level throughout Connecticut. Qualidigm is also the state's technical assistance consultant and practice transformation content expert who has led over 600 PCMH NCQA certifications in the state, more than any other organization, in support of the State Innovation Model's Advanced Practice Model.

First, I congratulate the Health Cabinet for its leadership and courage in setting forth a number of bold agenda items. Second, I come to you today to speak in support of strategy 1A, 1B, 1C, 2A, 3B, 5A, 6 and 7. In particular, I am supporting the Cabinet's desire to shift from volume to value and its desire to move to risk-based contracting, in accordance with the rest of the United States and the direction set by the Secretary of Health and Human Services. I believe, which I will submit as part an addendum to my testimony, the presumption that our fee-for-service payment construct for our Medicaid program is efficient and has saved money may be overstated when compared with our New England neighbors. I also believe the longer that we delay in moving aggressively toward value-based payments, we, as a state, will fall further behind the rest of the healthcare market, which will create an undesirable payment environment for our providers. If we continue on our present trajectory, the result of these delays will lead to the continued loss of providers, which will have negative consequences on access to care for our citizens. Furthermore, I strongly support the need to implement integration strategies that will improve transparency, including the implementation of the All Payer Claims Database, and the installation of a working health information exchange (HIE) for the state that will assist us in the evaluation of provider performance and align cost and outcomes so that patients may make informed decisions. Also, I support the need for improved accountability so that state programs are evaluated regularly for effectiveness and competition is introduced so that innovation is encouraged. Lastly, I applaud the Cabinet's support for improved collaboration across departments with the hope that valuable social determinants of health information may be made

available and combined with both medical and behavioral provider-held clinical information, with a focus on health equity, so that the best outcomes for our citizens, regardless of socio-economic or racial status, may be achieved. Qualidigm and our partners stand ready to support these initiatives. Thank you.

Addendum

Support for Testimony

Why are things different now?

Accountable care organizations (ACOs) under the Medicare Shares Savings Plan (MSSP) represent a recycled attempt to rebuild the integrated delivery systems of the 1990s (Mulvany, 2010). Previous integrated delivery systems sought to encourage collaboration between various stakeholders but failed to achieve their desired outcomes of lowered costs and improved patient healthcare outcomes. Unlike previous healthcare delivery models, the government's MSSP initiative provides legislated funding to improve the likelihood for success. Other attempts to rein in costs included the institution of health maintenance organizations through the Health Maintenance Act of 1973, pay-for-performance, and preferred provider organizations in the 1990s in which capitated arrangements with providers were established and episodic payments were based on historical fee-for-service data (Numerof, 2011). Unlike earlier managed care efforts that limited one's choice of providers, the ACO is not designed to constrain which provider the beneficiary chooses to visit (Berwick, 2011). However, ACO opponents fear that the construct has introduced an untested new organizational structure that will advantage larger provider organizations and reduce competition, which may be counter-productive to its goal of cost effectiveness and improved quality (Numerof, 2011). The question that the Cabinet needs to address is whether this fear is warranted.

Providers are already accepting risk!

Some might argue that providers are not yet accepting risk. In fact, as of April 2015, 99% of the ACOs participating in the Medicare Shared Savings Program (MSSP) participated in the one-sided payment plan (CMS, 2015). However, in a review of what ACOs under the MSSP must do, Moore and Coddington (2011) identified that to meet the CMS requirement of managing the health of a defined population and to manage risk adequately for their populations and drive anticipated savings, ACOs needed to make major investments. For instance, in two hospital-based examples, Moore and Coddington indicated that ACO organizers needed to: develop networks of appropriate providers; create a supporting infrastructure including technology investment such as electronic health records, connectivity, data analysis, and quality reporting; invest in management; and create a culture that was motivated to meet the financial incentives that the shared savings plan outlined. The authors also indicated that the ACO needed to work as a unified, coordinated organization. In their two prototype organizational examples, Prototype A was a 200-bed hospital system-based ACO with 80 primary care providers and 150 specialists; Prototype B represented a 1,200-bed, five-hospital system with 250 primary care providers and 500 specialists (Moore & Coddington, 2011). The anticipated first year costs for Prototype A included a start-up estimate of $5,315,000 with ongoing annual costs of $6,300,000. Prototype B start-up costs were anticipated at $12,000,000 with ongoing annual costs of $14,090,000. In both

cases, although both ACOs were not engaged in downside risk associated with payments, they were both at financial risk relative to offsetting their IT investment. Already, we have heard from Kurt Barwis, one CT-based CEO, and a member of the Healthcare Cabinet, who remarked in your meeting on November 1, 2016 that in actuality, his hospital is engaged in risk-based arrangements because of the high investment costs that they must recoup. Accepting this assumption that many in CT are engaged in risk-based models, a case may be posited that providers are currently engaged in risk and the fears of moving to a risk-based model are unwarranted.

Foot in two canoes!

The frequent analogy used to describe today's healthcare reimbursement model pictures a provider with one foot in a "*fee-for-service*" canoe and another foot in a "*value-based*" canoe. The problem with this picture is that the provider will ultimately get wet, which is the direction that Connecticut is headed by refusing to move toward value-based contracting. While some initiatives, such as the Advanced Medical Home (AMH) model and the Community and Clinical Integration Program (CCIP) which fall under the State Innovation Model (SIM) program, are assisting providers to accept risk by helping them to align quality and outcomes with payments, there are some dissenting consumer advocate voices who are attempting to manage the process using fear and uncertainty and cautioning the state that the only answer is a fee-for-service model. Fee-for-service represents a broken model that provides incentives for volume over value. In fact, at a time that HHS Secretary Burwell has set aggressive goals for the Medicare program to move to 50% value-based payments by 2018, CT continues to be only one of three states in the United States that has not accepted a managed care construct and continues to pay providers 100% on a fee-for-service basis (the others being Alaska and Wyoming – Kaiser Commission, 2015). Of course, advocates point to the value of our fee-for-service practices as reining in costs. This conclusion is curious to us because with 771,512 CT citizens (healthinsurance.org) covered under the Medicaid program as of June 2016 and a budget of $7.85 billion [Urban Institute estimates based on data from CMS (Form 64), as of Sept. 2016 as cited by the Kaiser Family Foundation, 2015], the average cost per beneficiary is $10,179 (up 36.4% over the last five years compared against the Kaiser Report). Additionally, CT's cost per beneficiary is at least 7% higher than the next highest New England state (Maine) and 7.3% higher than Massachusetts. Based on our current spend, 7% translates into nearly $550 million in excess spending! At a time when the HHS secretary is setting aggressive targets at moving to value-based payments, we do not feel that it is in CT's best interest to row in the opposite direction. CT is working hard to help prepare providers for value-based reimbursement, which will require accepting risk. Options such as consumer surveys, secret shoppers, and closely monitoring quality and outcome measures are the way to ensure that all beneficiaries are being served appropriately. Additionally, periodic external evaluations of our programs by third-party, unbiased groups with excellent reputations are needed to determine if progress is being made. Departmental reports, while helpful, need to be supported.

MACRA is coming…

While CT continues to be slow in adopting or accepting risk-based contracts, MACRA reform is underway. Benchmarking has begun in long term care and home healthcare. In January 2017, baseline measurements for physician practice will begin, and in our experience, we believe many of the providers are not prepared. Unless the state helps providers to prepare for the MACRA change, which will be based on upside and downside risk, our providers will be penalized. As our providers fall further and further behind, the CT market will become less attractive and we will see a further exodus of skilled providers as they move to more supportive markets. With nearly 30% of our providers 60 years or older (AMA Physician Masterfile, 2012), Connecticut can ill afford to create a provider environment that cannot support practices. When beneficiaries lack sufficient access to adequate providers, regardless of insurance type, the healthcare system in Connecticut will be disadvantaged. We can no longer ignore these trends. In fact, we believe the Bailit Health report has begun to create a healthy dialog around this very issue.

Social Determinants, DSRIP, CBOs and Funding moving forward

Additionally, at a time when one's zip code has a higher predictive value on one's healthcare outcomes than the medical therapy or prescription one receives from a provider, we believe it is now time to invest in the integration of public health and healthcare. However, to invest in this integration, funding sources must be established and tapped. We believestrongly that the DSRIP through the 1115 waiver is a logical vehicle to create funding streams and a logical mechanism to support the creation of community-based organizations. Such an effort will require that DSS, DPH, OHA, DDS, DHMAS, and others, including knowledgeable partners, including the Qualidigm-led Connecticut Partners for Health to work together to make this integration possible. This combination of valuable data, combined with real-time clinical information and predictive analytics, will help to identify the most vulnerable in our communities. By doing so, safeguards may be placed in our healthcare delivery system, including improved behavioral health and social worker access, to improve outcomes. To achieve this goal, we recommend a pilot focused on the dual eligible population. We believe that accessing the DSRIP dollars through the 1115 waiver, as you have identified, is a logical vehicle to create funding streams in support of a pilot. Lessons learned from this pilot will help lay the foundation for the development of community-based organizations, similar to the Health Communities Model that was never funded.

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Referenced Connecticut Companies and Collaborations

With its corporate headquarters in Wethersfield, Conn. and offices in Dover, NH; Barre, VT; and Providence, RI, Qualidigm's mission is to improve the quality, safety, and cost-effectiveness of healthcare through transformational change. Qualidigm provides consulting services to public and private sector clients nationwide and is the State of Connecticut's advanced transformational practice consultant partner in support of the State Innovation Model. In addition to consulting in quality improvement, health information technology, patient safety, and utilization review, we also perform data analysis and primary research. Qualidigm is part of a team that is serving as the Medicare Quality Innovation Network Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare and Medicaid Services for New England. Finally, Qualidigm is a Patient Safety Organization (PSO) as designated by the State of Connecticut.

www.Qualidigm.org

Founded in 2013, CT Partners for Health is a working group of over 30 Connecticut healthcare stakeholders representing healthcare providers and trade associations, consumer organizations, health plans and payers, community-based organizations, academic institutions, government agencies, quasi-government agencies, voluntary health organizations, the Regional Extension Center, and the business community. Qualidigm convenes the group regularly to identify and develop strategies for managing healthcare-related issues that present challenges to the consumer and provider communities in Connecticut. The CT Partners for Health's vision is to achieve the triple aim of the National Quality Strategy: Better Care, Healthy People/Healthy Communities and Affordable Care. Its mission is to align healthcare quality improvement and patient safety initiatives in Connecticut to assure efficient, cost-effective and coordinated efforts among its healthcare providers and stakeholders. Qualidigm serves as the chair of CPH.

www.ctpartnersforhealth.org/

Founded in 2014, The Connecticut Partnership for Patient Safety (CPPS) offers a patient safety-focused forum that is free of self-interests and that promotes transparency, inclusion, and debate towards the creation of an informed, and trusted and trusting organization. The organization strives to promote non-punitive policies that improve the culture of patient safety across the state of Connecticut. The mission of CPPS is to create a culture of patient safety across the healthcare continuum through a statewide collaboration that provides education and consultation. Qualidigm serves as the Vice President on the Executive Board of Directors.

www.safehealthcarect.org

Founded in 2014, the Mission of the Connecticut Choosing Wisely Collaborative (CCWC) is to raise awareness among groups in Connecticut about Choosing Wisely™ by creating a community made up of patients & consumer groups, employers & payers, practitioners and health systems, state government officials and policy makers. The group aims to accelerate the adoption of Choosing Wisely by sponsoring programs, facilitate and advocate for specific initiatives that address misuse and overuse. Additionally, CCWC actively creates avenues for local programs to get access to national and CT-based CW resources. Qualidigm serves as Vice Chair of the Leadership Council.

www.choosingwisely.org/partners/connecticut-choosing-wisely-collaborative

Founded in 2006, eHealthConnecticut is a not-for-profit entity that represents a collaborative approach to meeting the challenges of health information technology adoption and interoperability for the entire State. A Board of Directors representing physicians, providers, consumers, purchasers, payers, academia, and quality organizations governs eHealthConnecticut. eHealthConnecticut operates in a transparent fashion with the necessary privacy and security protections in place to earn trust from all entities and the general public. Qualidigm serves as the organization's fiscal agent and serves on its board.

www.ehealthconnecticut.org