Connecticut Health Policy Project

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Comments on the Health Care Cabinet Strawman Proposal and Alternative Options

Connecticut's health system is under stress – rising costs, unacceptable quality, growing monopolies, and a disappointing economic outlook that is stretching resources to fix problems. Legislation passed last year directed the Health Care Cabinet to draft recommendations to the General Assembly for reforms to improve value and access while controlling costs. In June, Bailit consultants presented the Cabinet with a Strawman proposal for reform and asked for comments and alternatives. This response is from the CT Health Policy Project, a consumer advocacy nonprofit, working for seventeen years to improve access to quality, affordable health care for every state resident. The Strawman proposal pulls ideas from a number of leading states and expands on new economic theories beginning testing around the country. The following comments from the CT Health Policy Project are informed by that work together with an understanding of Connecticut's unique features and long experience of what works in our state.

General thoughts on the Strawman

First, do no harm. The Strawman suggestion that doing anything, even if we don't know if it will work, is better than nothing is understandable in concept, but risky to apply to Connecticut's health system. We've had considerable successes in Connecticut, and plenty of ideas that didn't work out. It would be foolish to ignore that important wisdom; we can't afford to move backward.

Downside risk for Medicaid is especially troubling. For over a decade, Connecticut's Medicaid program suffered from very poor access to care, providers fleeing the program, dismal quality, and poor patient satisfaction. Despite this the few insurers left in the program demanded outsized double-digit rate increases with no justification for the increases, but the state was not able to deny them. Consumers couldn't find providers willing to care for them; a secret shopper survey found that they could get appointments with only one in four of the few providers on the insurers' lists. Through substantial collaborative efforts things are far better now. The number of providers participating grew by 32% the first year after the transition to care coordination-based care, just as about 100,000 new enrollees joined the program. Since Connecticut moved away from capitated insurers in our program quality is up, patient satisfaction is up and total-cost-of-care is down, earning the state hundreds of millions in savings we can't afford to lose. It was a heavy lift, but we didn't have much choice. In Connecticut we know how much worse things can be, and no one wants to go back to that.

Unfortunately, downside risk would jeopardize all that hard work and progress. Connecticut recognizes that reality which is why **the administration gave their word not to implement downside risk in Medicaid**. The program has improved substantially but still pays less than other payers, and serves a fragile, difficult to treat population. The Strawman's proponents seem to miss the reality of Medicaid – providers are not required to participate and payment rates are lower than other payers. Nationally providers and Accountable Care Organizations (ACOs) are fleeing downside risk in Medicare, where payments rates are higher. Medicaid can't lose any providers – we simply can't.

What we are doing in Connecticut's Medicaid program now is working. Other states and national media are taking note, asking how we did it and how they can do the same thing.[1] Why would we jeopardize that?

Finances are tight. Connecticut's economic recovery has lagged significantly behind other states. State government, along with businesses and families, face very tight budgets. Experimenting is expensive and risky. We need to focus on better-developed, tested policy options that we can afford.

Successful payment reform can't happen in a vacuum. Delivery reform and quality improvement are just as important, and just as much a crisis in Connecticut, as is payment reform. Changing only how we pay for care, without fixing the quality of the care provided and how it is delivered, won't work. Shifting incentives in isolation can have serious unintended consequences.

Connecticut has trust issues. The consultants got this right – Connecticut's health reform (and probably all public policy) suffers from an anti-collaborative culture. The consultants posit that there is no table around which to have important conversations, with the corollary that we just don't know each other. But the table issue is a symptom, not the cause, of the problem. The good news is that it can change. Ten years ago, nothing could have been more contentious and dysfunctional than Connecticut's Medicaid program. More detail on how it happened will be forthcoming, but through collaboration, transparency, inclusiveness, good data, and a lot of hard work by all stakeholders, Medicaid members now enjoy high quality care, are very satisfied with their care and how they are treated, and taxpayers are benefitting from lower costs. It simply doesn't work to impose a top-down, infrastructure-driven "reform" on Connecticut. It really does take the entire village to make it work.

Connecticut's health system is about far more than state government. While government plays an important role, it is no more important than other stakeholders. Consumers, advocates, businesses, individual and institutional providers, taxpayers, and countless others are all essential to getting health care right.

In defense of non-alignment. Diversity is an equally important goal including diversity of opinion, of perspectives and of priorities. Alignment limits innovation while flexibility is adaptive. The Strawman's proposal to align all state health initiatives with the State Innovation Model (SIM) is concerning on many levels. SIM represents only the

[1] A brief on that will be coming soon.

administration's perspective and supporters, is closely tied to federal goals, which don't always reflect Connecticut priorities, and has been plagued by controversies including ethics, freedom of information compliance, secret meetings and dogmatic philosophical biases. SIM has not been constructive in establishing **trust** in Connecticut's health care environment. In fact, both Medicaid and Health Information Technology have had to be carved out of the SIM process to make any progress.

Strawman proposal comments

Merging state agencies has been tried in Connecticut without success. There is a myth that state agencies aren't communicating – they are talking more now than in the past. Having different agencies with distinct roles and perspectives benefits the state in many ways. We should be fostering more diversity rather than homogenizing government. In fact, at the federal level, different parts of the largest health agency often are unaware of what is happening in another section, even in the same region. Given state budget constraints and layoffs, a massive restructuring of state government would be a costly distraction from the real work of health reform. Agency structure is not the answer. However better communication with the public and stakeholders about what state agencies are working on, and better listening to communities is a worthy and feasible goal (see Alternatives below).

Aligning Medicaid and the state employee health plan has also been tried several times in the past with no success. In fact, opposition to the SustiNet plan was fierce, definitely not **trust-**building. Joint administration is difficult when one plan is collectively bargained while the other is protected by a federal entitlement. The most recent frustrated attempt, joint prescription drug purchasing, was described by the Department of Social Services (DSS) in their presentation to the Cabinet in June. The consultants' brief with options for California focused mainly on opportunities for health plan purchasing, but both Connecticut's Medicaid and state employee plans are self-insured, with great benefit to both programs.

Beyond the coincidence that they are both run by the state, the two plans share very little in common. They serve very different populations with different health and social needs. Despite a healthier population, the state employee plan is far better resourced costing over four times more per person than Medicaid. There is little overlap in participating providers, offering few opportunities for common levers to change individual providers' behavior.

Accelerating the movement of care delivery into ACOs with homogeneous standards is a risky proposal on several levels with little evidence to support it. There is a shift in Connecticut toward larger health systems, through both horizontal and vertical mergers, but forays into shared risk have been tentative and slow. Our recent survey of Connecticut ACO leaders found significant uncertainty about their ability to achieve the ambitious goals.

Many concerns have been raised about the consolidation of care into very large ACO health systems including monopoly pricing increases and less regulatory control to improve quality, patient experience of care, access to care, or consumer choice. There is currently no regulation, state or federal, and no national certification of these large

systems. (NCQA has suspended and is redesigning their program.) Often after corporate consolidation, large systems are still plagued with legacy barriers to care coordination and maximizing resources. **Coordination of care within health systems is often no easier or more difficult than between systems.**

Connecticut Medicaid spent years collaboratively developing an ACO model of health neighborhoods for dual eligibles with stakeholders engaged in all phases of the project. Unfortunately it was halted just before implementation due to budget constraints, despite acknowledgement that it held great potential to both improve health and control costs for the highest need, highest cost members. (See lack of **trust issues** above).

Shared/downside risk has had poor results, both nationally and in Connecticut, and is likely to intensify underservice incentives. Medicare ACOs are fleeing downside risk arrangements. Medicare's Pioneer ACO program began in 2012 with 32 first-adopters of downside risk; there are now only nine. Savings to Medicare from the Pioneer ACOs fell from a very disappointing high of $119 million to only $37 million last year. As the consultants pointed out in their recent memo, the larger, upside risk Medicare ACO program has generated very modest savings. (Quality improvement has also been disappointing.) Capitation through insurers also failed spectacularly in Connecticut, both for Medicaid and private plans. The reasons for that failure have not changed.

We have largely moved on from that model and Connecticut is better for it. So it is puzzling why the Strawman recommends doubling down to intensify those incentives by introducing downside risk.

Loss aversion is a very strong incentive in economic theory. The risk of unintended consequences is very high when experimenting. Concentrating both financial incentives to cut costs with control over treatment authorization (and even informing consumers about their options) courts, or even invites, inappropriate denials of necessary care – underservice or "stinting" on care. As provider incentives to save become stronger and more coercive, the risk of underservice, intended or not, grows. What will the state try next to incentivize providers when downside risk fails? Both the Centers for Medicare and Medicaid Services and Connecticut's final SIM plan have acknowledged the potential that downside risk will amplify underservice. As only 55% of American adults receive recommended care now, likely higher in the Medicaid program, underservice is a serious concern. **The Strawman proposal ignores of the dangers of underservice** and includes no policies to monitor or mitigate its impact.

Reliance on untested economic theory is very dangerous, especially extrapolating between fields. Health care in the United States is complex and economically unique in many ways. Theories can help suggest tactics, but should never be adhered to blindly and comprehensively but with caution, especially when initial evidence is not supportive.

Moving Medicaid into downside risk would **violate a promise** by the administration to 750,000 Medicaid members. It is important to note that a previous promise by this administration not to move Medicaid members into upside shared savings until it was well established in the rest of the market has already been broken. **(See lack of trust**

above). Despite this, and against our better judgment, advocates and other stakeholders participated constructively in a lengthy, difficult process with DSS in developing the PCMH+ program. Currently DSS is choosing among applicants to participate in that program; it is far from a stable success that is ready to be expanded into a more risky model. Another broken promise will jeopardize Connecticut Medicaid's hard won progress and the new culture of collaboration.

Connecticut's improved Medicaid program, with no provider risk or incentives to deny necessary care, is achieving better savings and quality metrics than the states highlighted by the consultants. Our results are the product of hard work and incentives to help practices improve quality and efficiency, not penalties. Our more supportive approach is a national model of successful quality improvement and improved access to care. Connecticut is of doing more for people with less; we should build on rather than jeopardize that success.

Limiting provider monopoly power is critical but the Strawman proposal to expand the Attorney General's subpoena power is wholly inadequate and possibly irrelevant given legal requirements passed last year in SB 811. If Connecticut's market continues to consolidate, the state's ability to affect any change or limit harm will be severely compromised. The Governor's Certificate of Need Taskforce (CON) is working on a solution. It makes sense to see what they develop.

But one suggestion is to regulate ACOs and develop "stress tests" for large health systems and ACOs that occupy a monopoly in Connecticut's market and are too-big-to-fail. (See Alternatives below)

The assertion on p. 61 of the slides that consumers use price information poorly assuming that high prices equate with high quality is objectionable. Consumers rarely have any reliable quality information to make choices. In any case, the solution is better consumer information, not that "experts" should make decisions for us.

An 1115 waiver is premature as is Strawman proposal to access DSRIP flexibility. An 1115 waiver exempts the state from important consumer and taxpayer protections in federal law and regulation. The best use of a very powerful instrument like an 1115 waiver is to first decide on the goals, explore less risky options, and only then to consider an application. The Strawman's goals for a waiver are either already happening in Connecticut or could be accomplished without a risky waiver of protections. Waivers require state matching funds Connecticut does not have, and require eventual budget neutrality, which will be enforced by a different federal administration.

While 1115 waivers are used in some cases for Medicaid purposes we might support, they are also being requested in other states for:

- Premium assistance/vouchers
- Eliminating benefits – i.e. non-emergency transportation
- To waiver retroactive eligibility
- Premiums and copayments for near-poor and poor
- Lock outs for nonpayment of premiums
- Work requirements
- Time limits on coverage

    - No wrap around benefits for children
    - Family planning restrictions

Given political transitions at the federal level, and possibly the state level, an 1115 waiver authorization would be unwise at this point.

Asking for an exemption from protections that have worked well for decades is serious and should be a last resort. As the Strawman has not made a convincing case for a wholesale shift to shared/downside risk, a waiver of important protections only to support that questionable goal is a very risky strategy.

Using data to make policy decisions is an exceptional idea. Credible, useable data has been one of the keys to our Medicaid program improvements. Too many health care and other decisions in Connecticut are made based on relationships and conflicted interests. Use of Comparative Effectiveness Research in policymaking is our best hope to improve the value of spending. However creating a new committee or agency in Connecticut is repetitive and invites the usual conflicted interests to apply their powerful influence. There are numerous independent, credible sources for this information that are not dependent on Connecticut's political winds.

Unfortunately development of Connecticut's All Payer Claims Database (APCD)* and its policies have been disappointing for a number of reasons common to Connecticut policymaking. Attempts to create a Health Information Exchange (HIE) in Connecticut have failed, largely due to conflicted interests chasing funds and control. However we have a great deal of data available for decision-making now. The main challenge has been having the courage to follow it faithfully, regardless of whether it supports powerful interests or preconceived biases. We should also pursue innovative alternatives, like Hugo, that are feasible, independent, consumer-controlled and far less costly.

Alternatives to the Strawman proposal

Some alternatives to the Strawman proposals to achieve the same goals, and other options to achieve goals that were missed.

Building trust is critical. Effective reform requires all stakeholders at the table, working together in good faith, to see others' perspectives, working to find solutions that work for everyone, and, most importantly, honor the agreements. Without this, nothing else will work. Perceptions matter. It will take time and patience to build a culture of collaboration and inclusion, and listening to develop feasible solutions that aren't imposed by one group. Connecticut needs to build these muscles.

- *Start small* – We need some easy wins, some pilot programs to build trust among Connecticut stakeholders. We also need pilots to test ideas – no one knows what is going to work. Possibilities include joint purchasing (when possible), sharing data and analytics, public health and social determinants project support/ engagement, high cost high need people projects, social service connections/ support, literacy and language support resources, using comparative effectiveness and best practices, and learning collaboratives.
- *Public transparency and accountability*

    - Meetings should be held at the Legislative Office Building and prominently noticed in the Bulletin, no secret meetings
    - Data transparency – show the math, let everyone crunch your numbers, crowdsourcing is powerful, and others may find something you missed
    - Everyone needs to be working from the same information -- respond fully to all FOI requests, including those that are inconvenient or do not support the agenda
- *Strong conflict of interest protections* -- Unfortunately Connecticut has a very poor history in this area that causes pervasive harm to policymaking in our state. Outsiders have no reason to perform or take risks that could improve care, as they are unlikely to be rewarded with grants or favorable policy changes. Conversely, insiders have little incentive to make the effort to perform well as they know they will get the next opportunity as well, either way.
    - Fix the loophole in the law reflected in SB-361 from this year's session that would apply Connecticut's Code of Ethics for Public Officials to all appointees to policymaking councils, taskforces and committees
    - Avoid even the perception of conflicted interests; perceptions are powerful inhibitors of performance
    - Hire and appoint based on competence and independence
    - It is very easy to get input from interests without giving them a vote on decisions that affect their bottom line. There are lots of models, in Connecticut and elsewhere that work extremely well.
- *Everyone must honor commitments.* -- Once decisions are made, shifting priorities or cutting funds when people have invested time and resources not only undercuts the specific project but also whittles away at the interest to engage next time. Inconsistent policymaking and budget commitments are a strong disincentive to future participation or any interest in making changes.

Effective communications are the foundation of good policymaking and **trust** building. There is enormous opportunity to improve two-way communication between government and the rest of the health system.

- It's critical to create a formal function for this, preferably outside government. Centralizing health communications would give the public one place for information and to provide input. This doesn't have to cost a lot or require a new agency; it could be included in the scope of an existing entity. The formal function would benefit from an advisory group of state and non-state health stakeholders. Just the act of reaching out to other stakeholders and asking for input would help build **trust.**
- The state must emphasize two-way communication. Most of health care happens outside state government, e.g. free clinics, nonprofits, community coalitions, faith-based, academic, nonprofit advocates.
- This communications function could also connect with other states collecting independent information and report back to policymakers and stakeholders. It is critical that this entity be seen as independent, not advocating one agenda, but an impartial source of trusted information.
- More information about ongoing projects and proposals should be online and accessible. People shouldn't have to attend dozens of meetings to find out what is happening. The state needs to pursue technology options like webinars and online meetings to expand participation and understanding.

- This group could connect with public and provider education efforts around value. Options include consumer information on over and under treatment, comparative effectiveness for providers and consumers, or a provider value-based purchasing education campaign similar to New York's.

Trusted sources of health policy information are critical but the Strawman proposal to create a new quasi-public agency is expensive and unworkable.

- Connecticut should build on the diversity of resources that already exist here including nonprofits, academics, state agencies, consultants, and legislative research staff. These sources are already trusted and diversity of opinions and different perspectives lead to better solutions.
- Crowd source all data (protecting patient privacy) and let the diversity of opinion lead to consensus and new learning.

Payment reform has to support delivery reform. Expecting incentives alone to drive change has failed repeatedly in Connecticut and elsewhere, with grave results. Financial incentives are only one of many drivers for human behavior. Overreliance on financial incentives can backfire. Savings should be shared with the providers who generate them, but that can't be the starting point. Connecticut's Medicaid program is an excellent model for overcoming huge challenges with limited resources.

- **Build on what we have and, over time, move larger percentages of compensation from volume to quality.**
- **Connecticut's Medicaid program has had great success by using quality incentives that also save money**, e.g. lowering ED visits, and paying directly for things we know save money, e.g. care coordination. We measure everything to be sure it is working and adjust when necessary.
- **This can't be rushed and one-size-does-not-fit-all**. Different programs, providers and populations are unique and are at different places.
- **Start slow, pilot everything, evaluate and adjust.** Don't be overly committed to one model or dogma – flexibility is far more likely to succeed. We have a better chance of getting it right if we try many things, and learn from experience.
- The Strawman authors are right that **shared savings has not met expectations**. But it would be a great mistake to double down into more extreme downside risk without evaluating what isn't working.
- **Support pilots with proven records of success such as bundles.**
- Employ **real efforts to lower premiums** and ensure value in insurance plans across payers.
    - Negotiate rates
    - Monitor access to care, network capacity, quality, etc. with meaningful penalties, and then be willing pull the trigger
    - Risk adjustment, reinsurance, risk corridors
    - Encourage and assist rather than discouraging new, non-profit insurers
    - Reward insurer efficiency and meaningful, effective quality improvement efforts
- **Set up and support data systems** to help providers to deliver better care, such as an HIE or, even better, the consumer-centered Hugo project, provider portals with usable patient utilization and clinical information, analytics to see how practice patterns compare with best practices and with their peers.

- Payment reform doesn't happen in isolation. It cannot be designed to benefit payers at the expense of already underserved state residents. **It is critical to monitor for unintended consequences including underservice and adverse selection, both inside and outside the health system placed at risk.** Monitor for impact on the safety net and other social services, access to care for the un- and under-insured, high need or complex patients. When underservice problems are identified, there must be robust corrective plans with resources and enforcement when necessary.
    - SIM's Equity & Access Council developed a detailed plan with policies for monitoring plans that connect with the rest of Connecticut's complex health system.
- Any reforms should be designed to correct historic imbalances between primary and specialty care reimbursement.

Regulate ACOs and large health systems With growing market concentration and monopolies in Connecticut's health care landscape, preventive regulation is essential. As ACOs assume financial risk, combined with provider authority to order treatments, the risks to consumers are amplified. The usual regulate-after-there's-a-problem response will be too late to avoid, or unravel, massive market failure.

- **As large health systems become too-big-to-fail, stress tests** must be a part of prudent regulation and consumer protection. Some options for stress tests include
    - Ensure financial reserves to absorb serious losses
    - Evaluate quality incentives, analytics capacity
    - Model a bad flu season, public health disaster, or a hurricane like Katrina and impact on ACO capacity and finances
    - Primary care shortage or nursing grows, labor costs rise and workforce stress leads to high turnover
    - Health Information Technology (HIT) breakdown, or privacy hack such as has happened when hospital records are held for ransom
    - Sudden loss of critical personnel – HIT, clinical leadership
    - Long strike by workers
    - Substantial increase in uninsured patients with economic recession
    - Loss of access to capital
    - State regulatory changes – i.e. a mandate to cover expansive community health worker services; limits on family planning
- ACOs should be regulated and certified, ideally by an independent, credible outside entity, such as NCQA.
- Certified ACOs should include only primary care practices that have reached the highest level of Patient-Centered Medical Home certification. It is imperative to have a solid foundation of capacity to provide coordinated care within each practice before moving to wider, more difficult care coordination challenges.
- A robust underservice monitoring system should be required for any entity accepting financial risk.
- The state should prioritize creating multiple ACO choices in each community to maximize consumer choice. This is more important than getting to state-wideness. In other states, this competition for enrollment has been an important driver of quality improvement, consumer responsiveness, and cost control.

- Remove/prohibit any incentives or rewards for underservice – either to providers, ACOs, health systems or insurers. See recommendations from SIM's Equity and Access Council.
- Monitor the financial health of ACOs and their ability to continue providing services with sustained losses, just as the state does for insurers.
- Monitor anti-competitive impact on markets, safety net, small independent providers and other critical community resources.
- Monitor access to care, quality, and referral patterns to ensure consumer choice and independent second opinions.
- Monitor the efficiency of ACO spending, i.e. limit executive salaries (like nursing homes) and administrative overhead/profit (like insurers)
- Ensure connections to these services as a minimum:
    - Housing, utility bill assistance
    - Nutrition, food security
    - Employment assistance
    - Education, child care
    - Transportation as a barrier to care
    - Language and literacy training, resources
    - Peer support services and networks
    - Criminal justice system
    - Elder support services
    - Other state, local social service programs
    - Local health departments

Multipayer high-cost, high-need patient analysis and intervention offers our best chance of both improving quality and controlling costs. It must be multipayer as many people with complex problems have more than one source of coverage. Exciting new models and best practices are being developed in other states.

- Design and pilot interventions, customized for each circumstance, e.g. different interventions for homeless populations than for people with severe disabilities or those in institutional care or seniors taking dozens of medications.
- Robust, meaningful, specific, detailed care plans that begin with consumer goals are critical.
    - Require approval by the consumer. People can't be compliant with a plan they've never seen, and it won't work if it doesn't track with their goals.
    - Include both services and self-management goals
    - Update regularly
    - Ensure that care plans are available to every provider who touches the patient, regardless of whether they are in the same health system or not.
    - Monitor and evaluate. Look for both problems and best practices
    - Care plans could be an important source of quality and underservice information.

Limiting monopoly power is crucial to controlling prices, consumer choice and effective regulation. The state must make preserving and supporting competitive markets a priority.

- There must be no CON approvals for more market mergers. We need to evaluate and unravel those that have already gone wrong such as for Windham Hospital.

- As both a deterrent and monitor, Connecticut needs to develop a structure and policy of robust anti-trust regulation and enforcement.
- Do not confuse coordination of care with corporate mergers; in practice they are entirely independent. There are many cases of corporate mergers, horizontal and vertical, where care coordination still happens the way it always did – with phone calls and FAXes. There are also many instances of effective care coordination between providers in different corporate entities. In fact this will always be necessary, no matter what happens to Connecticut's shrinking market.
- The Governor's CON Taskforce is working on it. We should see if they come up with something better.

Drug costs are a significant and growing driver of health spending increases. As Congressional action is unlikely in the near future, states and other payers are stepping up and new, private tools for policymakers are emerging. Any option must be implemented with the overarching **principle of safeguarding high quality care and consumer access to necessary medications.**

- Use value-based benchmark pricing in negotiations or as hard stop. ICER and other independent nonprofits offer states and other payers critical tools for value-based purchasing.
- Use indication-specific pricing. A drug that is found effective and approved for one indication may warrant a high price. However the price needs to be different for off-label use of the same drug to treat other problems without justification of the value.
- Drug price transparency legislation – see Vermont's new law
- Expand use of medication therapy management. Too many people are taking too many drugs that aren't helping them. This has enormous potential to both reduce costs and improve health and patient safety.
- Risk-based contracting with drug manufacturers holds great promise. Something like a money-back guarantee, the concept is to withhold or clawback funds from drug companies if their products don't improve health and lower costs as promised. Cigna has implemented these contracts for a costly new class of cholesterol medications.
- State litigation for price gouging is an important tool to prohibit unfair trade practices. New York's Attorney General is investigating anticompetitive contracts with schools by the maker of EpiPen.
- Align with other payers and states on the best treatment protocols and guidelines for high cost drugs. Use evidence-based guidelines regarding when it's best to use lower cost, more effective medications. Be careful to ensure guidelines are independent of conflicts of interest.
- Use emerging best evidence to improve medication adherence. Drugs that aren't taken can't be effective and waste money.
- Prohibit all drug company payments and gifts to providers (individuals, institutions, health systems, schools, trainings, meals, trips, Continuing Medical Education, etc.)
- Prohibit use of consumer coupons for cost sharing. Any short term easing of costs for some consumers is more than out-weighed by increased costs to all consumers.

Workforce capacity issues are foundational. Heath care is not like other markets, providers can create their own demand and the costs of entry into the field are extremely high. Excess capacity can drive demand for their services, driving up costs without a link to improved quality or value. Alternatively, shortages of critical professionals drives up labor costs and can lead to burnout, accelerating the problem. Unlike other fields, many health professional credentials are costly and time consuming to achieve without support. There are fine studies of Connecticut's current and future health workforce needs, with thoughtful planning to get us there. The problem has always been devoting the attention and resources needed. Any reform plan needs to address this critical foundation to our troubled heath system.

Protect consumer choice in all policies. Not only is it the right thing to do, it also allows market forces to build value.

- Crowds of consumers often have wisdom that we aren't capturing. Things we don't know to look for now can show up in consumers' choices.
- Educate consumers yes, but also listen – really listen.
- Do not be afraid of informing consumers of their rights, and enforcing them – they are important clues to what isn't working.
    - Often consumers are harmed by inefficiencies in the system and other things that shouldn't be happening.
    - Fix both the proximate problem and the system flaw that allowed it.
- Lower extra out-of-network costs. They are an important indicator of poor quality or low access to care that may not show up in current measures.
- Give consumers real, usable information on the quality of care.
    - Now consumers' best indicator of quality is price – but we are flying blind.

Data, HIT and evaluation capacity are critical to any effective reforms. Unfortunately this has been an ongoing challenge for Connecticut, largely because of conflicted interests and turf battles. If we hope to improve, we must move toward success and away from failures, and trust the data to lead us there.

- This area especially needs very strong conflict of interest protections and clearly stated expectations that grants and control of information systems will be shared.
- Robust evaluation by independent researchers, with no interest in the outcome, should be a minimum for all pilots and programs. Equally important is the commitment to follow the evaluation's findings and adjust or abandon what isn't working. We can't be emotionally or philosophically attached to any policy option. At best, this delays improvement and sends good money after bad. At worst, Connecticut could entrench a bad system. (Note prior Medicaid managed care program).
- Thoughtfully expand on what is working. Devote resources and attention to smart program expansion.
- Hire smart, nonconflicted, independent, qualified people as both leaders and staff.
- Create strong boundaries around conflicted interest or other meddling.
- Use nationally respected, independent, national sources of comparative effectiveness information. Creating a new Connecticut entity to oversee this powerful function is duplicative, invites conflicts of interest and would undermine **trust** and credibility.

- Public full transparency in all policy and grantmaking is critical (see communications option).
- We need to require solid science to back up all policymaking decisions. No post-hoc analyses when policymakers don't like the result. Proponents must release all data, and detail their methodology.

Quality improvement is key and Connecticut has a lot of room for growth in this area. Quality is half the value equation and just as important as cost control.

- Quality assessment must be independent, credible and above suspicion of conflicted interests. Use national measures and standards whenever possible.
- A tight list of quality performance metrics for contracting can be useful in focusing attention on problem areas. They should be identified through a clear process and data-driven. They should also be revised regularly as quality improves to ensure they remain meaningful and do not become easy-A's.
- However, no one should confuse quality metrics for payment purposes with protections from underservice. Most ACO programs have short lists of narrow quality standards so that, the joke is, only pregnant 3-year-olds with diabetes are protected from harm.
- Don't align measures across diverse populations. The need to have similar metric definitions is sensible, but that doesn't extend to using the same list for every population. Measures for adequate prenatal care are critical for Maternal and Child Health populations, but they are not relevant for the elderly in nursing homes. Aligned lists homogenize away meaning.
- Quality measurement should be constructive, not punitive for providers. Every report should come with resources to help improve. This is especially important in critical high-need shortage programs and populations such as Medicaid and primary care.
- Be patient and explore provider resistance to poor performance metrics – sometimes they are right. Quality measurement in health care is not an exact science. And if they aren't, they need to agree on the problem or nothing will be fixed.
- However, payers have to be willing to impose robust penalties when necessary for noncompliance with improvement plans.
- Both improvement and absolute performance should be rewarded. We need incentives across the spectrum of performance. Incentives should be tied to the level of improvement or performance, avoiding a cliff effect that reduces incentives to try.
- Be careful about "adjusting" for case mix. Never create even a perception that could result in avoidance of any population (either well or high need patients). New evidence suggests that adjusting for social determinants has had no impact on hospital Medicare readmission penalties.
- Oversample underserved populations. Good quality for the majority can mask a smaller number receiving unacceptable care.
- Don't worry about too many measures. Most are generated from claims data and there is no provider burden in the reporting. Effort is required to sort out concerns identified by the reports, but that is central to improving quality.

Social determinants of health are likely more important to good health than medical care. New evidence suggests that government spending on social services can reduce

medical costs. There is a great deal happening to address social determinants in Connecticut, but it is not well-supported by state government. In fact, one of the Strawman proposals, to create Clinical Care Teams already exist in several Connecticut communities and are reducing intensive care needs and costs. Unfortunately they are at risk due to budget cuts. The state should follow and support ongoing local efforts and proven interventions such as

- Affordable Care Act-mandated nonprofit hospital community health benefit plans formed across the state
- DPH's inclusive and thoughtful strategic plan
- Evidence-based home visiting services
- Fall prevention
- Health homes
- Healthy eating, weight control, safe housing and healthy lifestyle supports and resources
- Judicious deployment of Community Health Workers
    - Creating an entire, new health care workforce will increase costs if not carefully done, using best practices from non-conflicted, independent sources backed up with good science
    - Critical elements include effective supervision, training, evaluation/ monitoring and only for conditions and patient populations with evidence of effectiveness
- Proven opioid addiction treatment services
- ER diversion programs
- Full access to smoking cessation resources

Effectively integrate behavioral health with medical care. Unmet behavioral health need drives higher costs and historic separation between the two treatment systems inhibits care.

- Take advantage of emerging evidence on effective integration and best practices
- Design and pilot interventions to specific populations (see high cost high need policy option)
- This will require good data and analysis capacity that crosses traditional treatment boundaries.

Meaningful consumer engagement – Patient-centeredness cannot just be a label, but is a completely different way of operating. It will be difficult for many, but it's important not only because it's the right thing to do. Consumers have the most at stake (our lives and we are the ultimate payers through our premiums, out-of-pocket costs, lost wages, and taxes) and we have untapped wisdom that is undervalued and dismissed.

- One example – A study published in JAMA Oncology last year debunked the myth that patient demands are common, usually inappropriate and consequently are driving up health costs. The researchers found that cancer patients make clinical demands in a small number of encounters (8.7%) and that in the large majority of cases (71.8%) the requested treatment is clinically appropriate and should be granted.
- Relying on one or two consumer Board members to represent the needs of an entire population in a few meetings is unfair to both. Real consumer engagement must be far more meaningful. See the Medicaid Study Group recommendations

for proven ways for consumers to have real input. For example, other states have had success with Medicaid ACO consumer councils that are public, members are chosen by an independent process not appointed by officials, have a substantive role in decision-making and resources to ensure they can actively exercise that role. A separate council ensures that consumer voices are not drowned out by expert alphabet soup and that they have a comfortable forum where their input is respected.