Recommended Health Care Cost Containment Strategies: Health Care Cabinet Report in Response to PA 15-146

January 5, 2017

Contents

Executive Summary 2
I. Introduction 8
II. Health Care Costs and Quality in Connecticut 10
III. Survey of Cost Containment Strategies of Maryland, Massachusetts, Oregon, Rhode Island, Vermont and Washington 19
IV. Connecticut's Current Cost Containment Activities 21
V. Health Care Cabinet Recommendations 24
VI. Stakeholder Input 51
VII. Next Steps 52
VIII. Conclusion 54
Appendix A. Health Care Cabinet Operating Principles 55
Appendix B. Survey of Cost Containment Strategies of Maryland, Massachusetts, Oregon, Rhode Island, Vermont and Washington 56
Appendix C. Key Model Features of PCMH+ and Recommended CCO Strategy 70
Appendix D. Existing Financial Support Programs Available to Providers in Connecticut 72
Appendix E. Summary Comments Received on Preliminary Recommendations 75
Appendix F. Potential Strategies to Control Pharmaceutical Costs for Further Cabinet Deliberation 87
Appendix G. Letter to the Cabinet from Commissioner Wade Regarding Opportunity to Further Consider Value-Based Benefit Design as a Cost Containment Strategy 95
Appendix H. Response and Alternative Recommendations by Cabinet Member Ellen Andrews 97
Appendix I. Suggested Alternative to CCO Proposal by Cabinet Member Frances Padilla 111

Executive Summary

Public Act Number 15-146, Section 17, enacted June 30, 2015, instructed the Connecticut Health Care Cabinet (the Cabinet) to make recommendations on health care cost containment strategies for Connecticut.

The legislation directed the Cabinet to study and report on the health care cost containment models in other states including, but not limited to, Massachusetts, Maryland, Oregon, Rhode Island, Washington and Vermont. Over the course of 11 months, the Cabinet learned about the cost containment efforts of these and other states for the purposes of (1) monitoring and controlling health care costs; (2) enhancing competition in the health care market; (3) promoting use of high-quality health care providers with low total medical expenses and prices; (4) improving health care cost and quality transparency; (5) increasing cost effectiveness in the health care market; and (6) improving the quality of care and health outcomes. The review of state activities revealed five key themes, including that:

a. significant delivery system and payment system reform is occurring across the U.S.;
b. health care cost and quality data are a necessary supporting foundation for informed state policy making;
c. aligning state strategies across state purchasing and regulatory agencies can drive broader change in the marketplace;
d. marketplace dynamics play an important role, and
e. trust has been a linchpin for many successfully developed and implemented state cost containment agendas.

The high and ever-rising costs of health care have been a serious problem for many nationally, including consumers, employers and states. This is true too in Connecticut where health care spending totals $29 billion.[1]

- **Impact on consumers**: While Connecticut has one of the lowest uninsured rates in the country[2], the costs of having that insurance is greatly affecting the pocketbooks of its residents. For example, in the individual market, recent survey data from Access Health CT, Connecticut's Health Insurance Exchange, showed that 22 percent of individuals who terminated coverage from the exchange did so because of its expense – both generally, and specifically for aspects of coverage like copays, deductibles, premiums

[1] Connecticut State Innovation Model. SIM at a Glance. May 2015. www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf Last accessed December 6, 2016.
[2] According to an analysis conducted by Access Health CT, Connecticut has a 3.8 percent uninsured rate in 2015. www.ct.gov/hix/lib/hix/Connecticuts_Remaining_Uninsured_Results_Revised_%5BRead-Only%5D.pdf Last accessed December 7, 2016.

and prescription drugs.[3] High health care cost growth syphons private funds from Connecticut's residents away from other urgent priorities of families and individuals.

- **Impact on employers**: Employers in the state list health care costs as one of their top concerns[4], particularly due to hospital and specialty pharmacy drug spending, lack of competition in certain market areas in the state and small group benefit mandates.[5] National data suggests that employees are spending a growing share of their income on health insurance costs, which is especially true in Connecticut,[6] which ranks highest in average annual employee premium contribution for single coverage among all states.[7]
- **Impact on taxpayers**: Health care spending takes a considerable amount of any state's budget and is nearly 20 percent of Connecticut's budget (12 percent Medicaid and 7.6 percent state employees and retirees).[8,9] Compared to the national average, Connecticut spends a greater percentage of its own-source revenue on Medicaid,[10] though the state share of Medicaid has decreased due to federal funding available through the Affordable Care Act for the expansion population.[11] Similar national comparison for state employee and retirees is not available.

Unless the overall trend is slowed, health care costs will continue to rise and prevent Connecticut's residents from allocating private and public resources to other priorities, including education, housing, social services, public safety, saving for retirement and public infrastructure. It also makes employers less competitive than other states in salary and benefit packages, which could leave them to locate or relocate elsewhere and thereby cause harm to the state economy.

---

[3] Access Health CT. Presentation made to the Board of Directors. July 22, 2015 www.ct.gov/hix/lib/hix/PRESENTATION07222015.pdf Last accessed December 6, 2016

[4] Herz, J. Testimony to the Health Care Cabinet. November 15, 2016. http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CBIA_comments_cost-containment-recommendations_11-15-16.pdf?la=en Last accessed December 6, 2016.

[5] Consultant interview with employers gathered by CBIA. April 20, 2016.

[6] Collins SR, et al. "The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch." The Commonwealth Fund, October 2016. www.commonwealthfund.org/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth Last accessed December 6, 2016.

[7] Ibid.

[8] OPM estimates for FY 2016.

[9] The federal government pays a substantial share of any state's Medicaid and CHIP program. In Connecticut, the federal government pays for 59 percent of the Medicaid expenditures and 88 percent of the CHIP expenditures. The state's share of spending on these two programs represents 12 percent of the state budget.

[10] Own-source revenue is defined as the U.S. Census Bureau's "general revenue" minus federal funds to states. It is reported as being broader than what most state budget officials define as "'general fund' revenue and includes all state sources except state-owned liquor stores, utilities and insurance trust funds." The Pew Charitable Trusts. Fiscal 50: State Trends and Analysis. www.pewtrusts.org/en/multimedia/data-visualizations/2014/fiscal-50?utm_campaign=2016-08-04+SPU&utm_medium=email&utm_source=Pew#ind7 Last accessed December 6, 2016

[11] Source: DSS

Currently, Connecticut state agencies are participating in a number of activities to improve health care system performance and contain costs, and Connecticut DSS has reported a decline in its per capita Medicaid costs.[12]

The Cabinet learned additional details about multiple strategies that the State Innovation Model Program Management Office (SIM PMO), the Office of the State Comptroller the Connecticut Insurance Department, and the Departments of Social Services, Mental Health and Addiction Services, Public Health, Children and Families, and Task Forces are pursuing to reduce the costs of health care. Presentations made to the Cabinet in June can be found here for further detailed information: http://portal.ct.gov/en/Office-of-the-Lt-Governor/Health-Care-Cabinet/Health-Care-Cabinet/Health-Care-Cabinet-Regular-Meetings-2016.

The work of the Cabinet was largely completed prior to the upcoming federal change in administration. Based on public statements of the new administration and Congressional leadership, there are some risks to Connecticut and other states in terms of future federal policy and financing. For example, much of Connecticut Medicaid's reform agenda was the result of the Affordable Care Act (ACA) and efforts to repeal it may impact these programs.[13] Regardless of actions the federal government may undertake, Connecticut's administration supports the policy and principles of the ACA. Connecticut and other states, however, will still need to work to reduce health care costs to manage their own budgets and respond to constituent concerns about the rising costs of health care. While some of the recommendations in this report may be impacted by actions taken under a new federal administration, others may not. The Legislature will need to take into account the changing federal landscape when considering these recommendations.

Recommendations

Over the course of five months, the Health Care Cabinet debated the merits of specific strategies that were designed to reduce health care costs by impacting a number of different causes and through using different state policy, regulatory and purchasing levers. There was robust discussion among the Cabinet members and stakeholders, and while the recommendations below represent the majority opinion (with the exception of one strategy for which there was a tie vote and is included for legislative review only), there were certain strategies where there was moderate to considerable disagreement. The recommended strategies upon which the Cabinet agreed are categorized and summarized as follows.

---

[12] McEvoy, K. Connecticut Husky Health: Cost Drivers, Reform Agenda, Outcomes and Future State. Presentation made to the Health Care Cabinet June 14, 2016. http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/HUSKY-Health---Health-Care-Cabinet-6-14-16.pptx?la=en

[13] For more information on potential risks as calculated in December 2016, see the presentation made to MAPOC on December 9, 2016. www.cga.ct.gov/med/council/2016/1209/20161209ATTACH_Inventory%20of%20Affordable%20Care%20Act%20Provisions.pdf Last accessed December 13, 2016.

1. **Transform the delivery and payment systems.** These strategies are designed to reduce costs in the health care system by promoting delivery system and payment reform through the adoption of models that: 1) engage and reward providers to provide needed services in a more coordinated, effective and efficient manner; 2) address issues of underuse, overuse, misuse and ineffective use; and 3) reduce the impacts of social determinants of health and health inequities. The chief strategy, after the period of the State Innovation Model Test Grant, is to implement independent, but aligned purchasing strategies to contract with Consumer Care Organizations (CCOs) – provider entities that are accountable for the cost of a comprehensive set of services for an attributed population. Under this approach, providers, on a voluntary basis, would be responsible for their quality performance on outcomes, patient access and efficiency using a risk-sharing model. A cap on CCO risk would be employed such that the amount of financial risk for which the CCO is responsible is meaningful and motivating, but not so much that CCOs are exposed to excessive risk. The Cabinet also recommends the State continue pursuing Medicaid's existing reform agenda, aspects of which lay the groundwork for the CCO model.

   A minority of Cabinet members and some stakeholders expressed concern regarding the use of shared risk in provider reimbursement methodologies. There were concerns about recommending the implementation of shared risk prior to evaluating the Medicaid PCMH+ shared savings program, and concerns about what unintended consequences may arise for providers and consumers under shared risk contracting. For more information on the concerns that were expressed see the Summary Comments on Preliminary Recommendations in Appendix E. Additionally, please see specific suggestions by Cabinet member Frances Padilla in Appendix I.

2. **Directly reduce cost growth**. There are two strategies in this topic area. The first is a cost growth target to focus the attention of the public, policymakers, providers and payers on containing cost growth, necessarily considering both service prices and utilization of services. The second promotes adoption of alternative payment methodologies that reward value and efficiency, rather than service volume, by setting adoption targets for insurers. An equal number of Cabinet members voted in support of and opposition to recommending adoption of alternative payment methodologies. That strategy is therefore included in this report for Legislative review only.

3. **Coordinate and align state strategies.** The Cabinet recommends assignment of dedicated personnel to coordinate and align state strategies across state agencies and with the private sector through the creation of an Office of Health Strategy that would report to the Governor.

4. **Support market competition**. Recognizing that the health care marketplace does not operate as a traditional free market, the Cabinet unanimously recommends, expanding the Attorney General's powers to monitor health care market trends to shine light on market practices and enable policymakers to create data-informed policies, provided funding is available.

5. **Support provider transformation**. The Cabinet supports consideration of strategies to offer Medicaid providers financial, infrastructure and technical support needed to change their care delivery models. The chief strategy is to consider seeking additional funding through a CMS Section 1115 waiver[14] and Delivery System Reform Incentive Payment (DSRIP) funds.[15]

6. **Support policymakers with data**. This strategy recognizes current efforts to build the claims data and clinical information infrastructure necessary to support delivery system and payment reform by assuring that the new Office of Health Strategy has access to information necessary to perform its functions.

7. **Incorporate use of evidence-based research into state policy making**. The Cabinet recommends that Connecticut adopt a strategy of incorporating the use of comparative effectiveness evidence research into policymaking decisions in order to reduce overuse and misuse of health care services.

Next Steps

There are several key areas of activity that the Cabinet intends to pursue subsequent to the submission of this report, including:

1. state strategies to address the rising prescription drug costs, for which the Cabinet has begun an examination;
2. value-based benefit design strategies that can be employed by payers to help slow the rising costs of health care;
3. strategies aimed at reducing costs through improved care for individuals with substance use disorder and better integrated behavioral health services;

[14] Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to approve experimental, pilot, or demonstration projects that give states additional flexibility to design and improve their Medicaid program and Children's Health Insurance Program (CHIP) such as using innovative service delivery systems that improve care, increase efficiency, and reduce costs. States that pursue Section 1115 Waivers must meet several requirements, including that demonstrations must be budget neutral to the federal government. (www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html) Currently 29 states and the District of Columbia have approved Section 1115 Waivers. www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html

[15] The continued availability of DSRIP funds under a new federal administration is unknown.

4. specific strategies to address individuals with high health care needs and intensive resource utilization;
5. developing a detailed cost growth target methodology; and
6. working to build trust among all stakeholders to more effectively create future health care reform strategies in a collaborative environment.

In response to PA 15-146, the Health Care Cabinet spent 11 months engaged in a process to develop a comprehensive set of cost containment strategies to constrain the growth in health care costs for all Connecticut residents, informed by the work of other states. If the recommendations in this report are implemented, Connecticut would take a significant step forward to reduce the costs and improve the quality of health care for all residents.

I. Introduction

Public Act Number 15-146, Section 17, enacted June 30, 2015, instructed the Connecticut Health Care Cabinet (the Cabinet) to make recommendations on health care cost containment strategies for Connecticut. The legislation directed the Cabinet to study and report on the health care cost containment models in other states including, but not limited to, Massachusetts, Maryland, Oregon, Rhode Island, Washington and Vermont, to identify successful practices and programs that may be implemented in the state for the purposes of:

(1) monitoring and controlling health care costs,
(2) enhancing competition in the health care market,
(3) promoting the use of high-quality health care providers with low total medical expenses and prices,
(4) improving health care cost and quality transparency,
(5) increasing cost effectiveness in the health care market, and
(6) improving the quality of care and health outcomes.

The legislation further directed that the report include recommendations for administrative, regulatory and policy changes that will provide for:

(1) a framework for
- *(A) the monitoring of and responding to health care cost growth on a health care provider and 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,*

(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,*

(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, and
(5) the implementation of other policies to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care.[16]

[16] An Act Concerning Hospitals, Insurers and Health Care Consumers 2015. CT SB 811, PA 15-146, Section 17.

To meet the requirements of the legislation, the Cabinet studied the cost containment models of the six states to understand what strategies each state was employing, the known effectiveness of the strategies, and the political, market and environmental context in which each state implemented its strategies. The Cabinet then considered an initial series of cost containment strategies that were informed by this research, broad stakeholder input and the known political, market and environmental context of Connecticut. The initial series of strategies also took into account the set of principles adopted by the Cabinet to guide its recommendations (see Appendix A.) The Cabinet spent four months considering and modifying the initial series of cost containment strategies, informed by ongoing Cabinet member and stakeholder input. These deliberations resulted in the recommendations detailed in this report.

The remainder of this report is organized into the following sections. Section II highlights the Connecticut landscape in terms of health care costs and quality, utilizing the most recent publicly available data. Section III describes findings from the study of the six states. Section IV describes the key current cost containment activities in Connecticut, as described by state leadership. Section V provides the detailed recommendations adopted by the Cabinet. Section VI provides a summary of stakeholder feedback. Section VII outlines several action items for the Cabinet to consider as it continues its work in 2017, and finally, the report concludes in Section VIII. There are several appendices in this report, including a response to these strategies and alternative strategies drafted by Cabinet member Ellen Andrews in Appendix H, and an alternative strategy drafted by Cabinet member Frances Padilla in Appendix I.

The work of the Cabinet was largely completed prior to the upcoming federal change in administration and based on public statements of the new administration and Congressional leadership, there are some risks to Connecticut and other states in terms of implications of future federal policy and financing. At the time this report was written there is some uncertainty about key programs that the federal government provides considerable support to Connecticut. For example, much of Connecticut Medicaid's reform agenda was the result of the Affordable Care Act (ACA) and efforts to repeal it may impact these programs.[17]Regardless of actions the federal government may undertake, Connecticut's administration supports the policy and principles of the ACA. Connecticut and other states, however, will still need to work to reduce health care costs to manage their own budgets and respond to constituent concerns about the rising costs of health care. While some of the recommendations in this report may be impacted by actions taken under a new federal administration, others may not. Likewise, current federal programs or other state programs may change in ways not yet foreseen. The Legislature must take into account the current federal landscape when considering these recommendations.

[17] For more information on potential risks as calculated in December 2016, see the presentation made to MAPOC on December 9, 2016. (Insert link after presentation is made).

For each strategy that may be affected by changes in federal policy, we note areas in which significant federal funding and policy under the ACA may affect this policy.

II. Health Care Costs and Quality in Connecticut

The high and ever-rising costs of health care have been a serious problem for many nationally, including consumers, employers and states. This is true too in Connecticut where health care spending totals $29 billion.[18]

- **Impact on consumers**: While Connecticut has one of the lowest uninsured rates in the country[19], the costs of having that insurance is greatly affecting the pocketbooks of its residents. For example, in the individual market, recent survey data from Access Health CT, Connecticut's Health Insurance Exchange, showed that 22 percent of individuals who terminated coverage from the exchange did so because of its expense – both generally, and specifically for aspects of coverage like copays, deductibles, premiums and prescription drugs.[20] High health care cost growth syphons private funds from Connecticut's residents away from other urgent priorities of families and individuals.
- **Impact on employers**: Employers in the state list health care costs as one of their top concerns[21], particularly due to hospital and specialty pharmacy drug spending, lack of competition in certain market areas in the state and small group benefit mandates. [22] National data suggests that employees are spending a growing share of their income on health insurance costs, which is especially true in Connecticut,[23] which ranks highest in average annual employee premium contribution for single coverage among all states.[24]
- **Impact on taxpayers**: Health care spending takes a considerable amount of any state's budget and is nearly 20 percent of Connecticut's budget (12 percent Medicaid and 7.6 percent state employees and retirees).[25,26] Compared to the national average,

---

[18] Connecticut State Innovation Model. SIM at a Glance. May 2015. www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf Last accessed December 6, 2016.
[19] According to an analysis conducted by Access Health CT, Connecticut has a 3.8 percent uninsured rate in 2015. www.ct.gov/hix/lib/hix/Connecticuts_Remaining_Uninsured_Results_Revised_%5BRead-Only%5D.pdf Last accessed December 7, 2016.
[20] Access Health CT. Presentation made to the Board of Directors. July 22, 2015 www.ct.gov/hix/lib/hix/PRESENTATION07222015.pdf Last accessed December 6, 2016
[21] Herz, J. Testimony to the Health Care Cabinet. November 15, 2016. http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CBIA_comments_cost-containment-recommendations_11-15-16.pdf?la=en Last accessed December 6, 2016.
[22] Consultant interview with employers gathered by CBIA. April 20, 2016.
[23] Collins SR, et al. "The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch." The Commonwealth Fund, October 2016. www.commonwealthfund.org/publications/issue-briefs/2016/oct/slowdown-in-employer-insurance-cost-growth Last accessed December 6, 2016.
[24] Ibid.
[25] OPM estimates for FY 2016.
[26] The federal government pays a substantial share of any state's Medicaid and CHIP program. In Connecticut, the federal government pays for 59 percent of the Medicaid expenditures and 88 percent of the CHIP expenditures. The state's share of spending on these two programs represents 12 percent of the state budget.

Connecticut spends a greater percentage of its own-source revenue on Medicaid,[27] though the state share of Medicaid has decreased due to federal funding available through the Affordable Care Act for the expansion population.[28] Similar national comparison for state employee and retiree is not available.

Unless the overall trend is slowed, health care costs will continue to rise and prevent Connecticut's residents from allocating private and public resources to other priorities, including education, housing, social services, public safety, saving for retirement and public infrastructure. It also makes employers less competitive than other states in salary and benefit packages, which could leave them to locate or relocate elsewhere and thereby cause harm to the state economy.

This report section provides additional detail on health care spending and quality compared to the New England and bordering states region. What drives those costs is also important to review. Therefore, this section examines the challenges of price variation in the state, and utilization of health care services. Finally, this section outlines key measures of quality to help assess whether Connecticut residents benefit in improved health care as a result of the higher costs they incur.

1. Per Capita Health Care Spending

When comparing Connecticut to other states, it is helpful to look at costs on a per-person basis, to account for the wide variation in population size of states. This allows for an assessment of how Connecticut fares compared to states across the country, and to states within the New England and bordering states region. Using the most recent data available,[29] Connecticut's per capita health care spending, which includes spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.), is the fourth highest in the country, the second highest in New England and exceeds the national average by more than 25 percent. Table 1 details the per capita health care spending for the six New England states and New York.

[27] Own-source revenue is defined as the U.S. Census Bureau's "general revenue" minus federal funds to states. It is reported as being broader than what most state budget officials define as "'general fund' revenue and includes all state sources except state-owned liquor stores, utilities and insurance trust funds." The Pew Charitable Trusts. Fiscal 50: State Trends and Analysis. www.pewtrusts.org/en/multimedia/data-visualizations/2014/fiscal-50?utm_campaign=2016-08-04+SPU&utm_medium=email&utm_source=Pew#ind7 Last accessed December 6, 2016

[28] Source: DSS

[29] The most recently available data from the Centers for Medicare & Medicaid Services is 2009.

Table 1. Per Capita Health Care Spending: New England and Bordering States

State	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 Average	$6,815

Source 1: Health Care Expenditures per Capita by State of Residence. Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, December 2011 using 2009 data.

When looking solely at per-beneficiary Medicare spending, Connecticut is ninth highest in the country, third highest among New England and bordering states and exceeds the national average by seven percent. Table 2 details the per-beneficiary spending in Medicare for the six New England states and New York.

Table 2. Per Beneficiary Medicare Spending: New England States

State	Health Spending Per Capita
1. New York	$11,604
2. Massachusetts	$11,277
3. Connecticut	$11,086
United States Average	$10,365
4. Rhode Island	$10,121
5. Maine	$8,821
6. New Hampshire	$8,763
7. Vermont	$8,719

Source 2: Health Care Expenditures per Capita by State of Residence. Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, December 2011 using 2009 data.

When looking at Medicaid per enrollee costs (for individuals receiving full or partial benefits), using more recent data, Connecticut is the tenth highest in the country, fourth highest among

New England and bordering states, and exceeds the national average by 22 percent. It is important to note that the data presented in this table are from 2011, which was prior to Connecticut's transition from Medicaid managed care to a self-insured ASO model and implementation of intensive care management and the PCMH program. It is the most recently available data publicly reported for all states, however. After the transition from MCOs, the Department of Social Services has reported a decrease in the PMPM spending in Medicaid.[30] While Connecticut has experienced a decline in its per capita Medicaid spending, the time period reported for Connecticut cannot be compared to the time period publicly reported by other states, and therefore is not presented in this table.

Table 3. Per Enrollee Medicaid Spending (Full or Partial Benefits): New England States

State	Health Spending Per Capita
1. Rhode Island	$9,247
2. New York	$8,901
3. Massachusetts	$8,717
4. Connecticut	$7,465
5. New Hampshire	$7,254
6. Vermont	$6,291
7. Maine	$5,968
United States Average	$5,790

Source 3: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

Per capita health care costs directly result from the combination of health care prices and health care service utilization. Growth in one or both contributes to health care cost inflation. The Cabinet considered data regarding price and utilization.

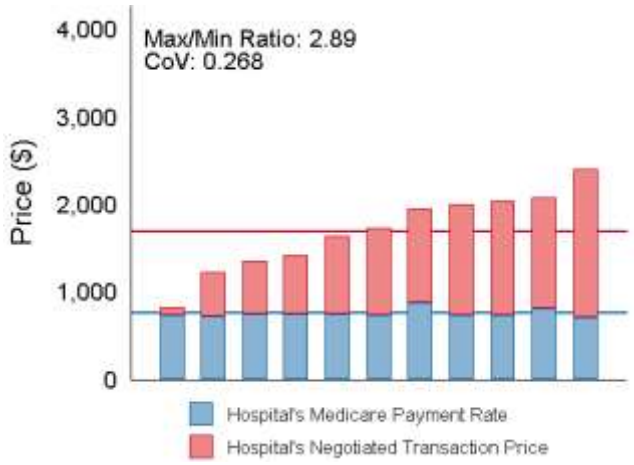
2. Health Care Prices

We define "health care prices" as the negotiated amounts that providers receive for delivering services. Providers are only able to negotiate prices with commercial payers as both Medicare and Medicaid use standard, statewide (or region-specific) fee schedules for most services. The Cabinet did not assess the extent to which Connecticut prices vary from those in other states. However, the Cabinet did examine price variation, i.e., the different prices commercial insurers pay for the same services, typically with no regard for any differentiation in quality of care. Recent studies have demonstrated the correlation between provider consolidation and higher prices obtained from the consolidated provider organizations, with no improved quality and

[30] McEvoy, K. Connecticut Husky Health: Cost Drivers, Reform Agenda, Outcomes and Future State. Presentation made to the Health Care Cabinet June 14, 2016. http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/HUSKY-Health---Health-Care-Cabinet-6-14-16.pptx?la=en

while holding patient illness levels constant.[31] With differential market negotiating leverage between the consolidated and independent providers, Connecticut payers are seeing significant price variation within key markets, principally metropolitan Hartford and metropolitan New Haven. Figure 1 provides an example of different reimbursement levels paid to Hartford-area providers by commercial payers for a colonoscopy, and Figure 2 provides an example of different reimbursement levels paid to New Haven-area providers for vaginal delivery.[32]

Figure 1. Hospital Prices for Colonoscopy, Hartford, 2008-2011

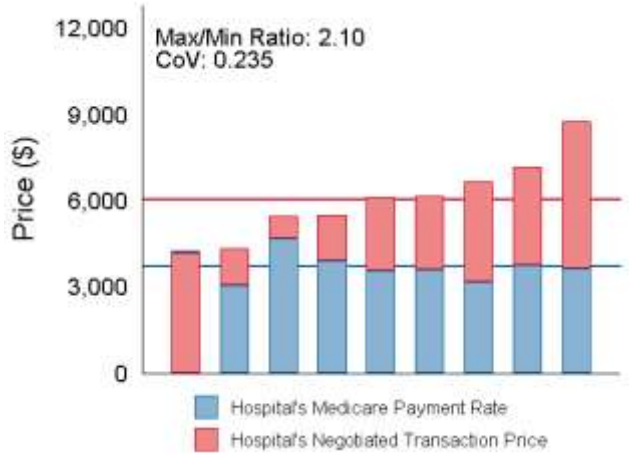


Note: Each bar represents one hospital. Source: Cooper, Z et al. Health Care Pricing Project

[31] Ginsburg. P. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." *Center for Studying Health System Change*: Research Brief, No 16. November 2010; Mutter RL, Romano PS Wong HS. "The Effects of US Hospital Consolidation on Hospital Quality." *International Journal of the Economics of Business*. Vol. 18, 2011, Issue 1; Cooper Z, Craig S, Gaynor M, Van Reenen J. "Paper 1: The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." The Healthcare Pricing Project. May 2015.

[32] Cooper, Z, Craig, S, Gaynor, M and Van Reenen, J. Health Care Pricing Project. Note: each column captures a hospital's negotiated transaction price and Medicare reimbursement. Prices are averaged from 2008-2011 and presented in 2011 dollars. CoV captures the coefficient of variation of hospital negotiated transaction prices within the HRR. Max/Min captures the maximum ratio of hospitals negotiated transaction prices within the HRR. Horizontal line indicates average rates and prices within the region.

Figure 2. Hospital Prices for Vaginal Delivery, New Haven, 2008- 2011



Note: Each bar represents one hospital. Source: Cooper, Z. et al. Health Care Pricing Project

3. Utilization

The Centers for Disease Control and Prevention (CDC) identified a number of factors that increase health care service utilization, including but not limited to supply of providers, a growing elderly population and an increase in health insurance coverage. All of these factors affect Connecticut. For example, among the other fifty states, Connecticut ranks fifth for the number of active physicians and fourth for the number of residents and fellows in certified programs per 100,000 residents.[33] Connecticut's median resident age ranks it fifth oldest in the country.[34] Finally, the state has a 6 percent uninsured rate, which is below national averages.

Utilization can also contribute to health care spending when medically inappropriate or potentially avoidable utilization creates unnecessary costs. National estimates indicate that as much as 30 percent of all services provided are not needed or have no beneficial impact on the patient's condition.[35] Inappropriate and potentially avoidable utilization can be an indication of poor quality of care. For example, Table 4 shows Connecticut's Medicare potentially avoidable emergency department (ED) visit rate and Table 5 shows the state's Medicare 30-day hospital readmission, both for Medicare beneficiaries.

[33] Connecticut Physician Workforce Profile. 2015 State Physician Work Force Data Book. Association of American Medical Colleges, 2015.
[34] U.S. Census Bureau's American Community Survey, 2014.
[35] "Reducing Waste in Health Care." *Health Affairs*: Policy Brief, December 13, 2012. www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82

Table 4. Potentially Avoidable ED Visits Among Medicare Beneficiaries: New England and Bordering States, 2013

State	Potentially Avoidable ED visits among Medicare beneficiaries, per 1,000 beneficiary
1. Maine	217
2. Rhode Island	196
3. Massachusetts	197
4. Connecticut	189
United States Average	181
5. Vermont	178
6. New Hampshire	175
7. New York	165

Source: McCarthy D, Radley DC, and Hayes SL. "Aiming Higher: Results from a Scorecard on State Health System Performance." The Commonwealth Fund, December 2015.

Table 5. Medicare 30-day Hospital Readmissions: New England and Bordering States, 2013

State	Hospital readmissions among Medicare beneficiaries, per 1,000 beneficiary
1. Massachusetts	36
2. Connecticut	34
3. New Hampshire	32
4. New York	31
United States Average	30
5. Maine	28
6. Vermont	27
7. Rhode Island	25

Source: McCarthy D, Radley DC, and Hayes SL. "Aiming Higher: Results from a Scorecard on State Health System Performance." The Commonwealth Fund, December 2015.

4. Quality

Higher spending on health care is not universally associated with better outcomes.[36] Among published quality reports, there is variation in how Connecticut ranks, but it generally does better than most states. Variation in quality rankings in published reports and scorecards varies because of different measures used for assessment, different time periods used across reporting organizations, and different populations examined. For example, the Commonwealth Fund produced the *Scorecard on State Health System Performance*, which evaluated 42 key indicators of performance during 2013 and 2014 across the following five domains: (1) access and affordability; (2) prevention and treatment; (3) potentially avoidable hospital use and cost; (4) healthy lives; and (5) equity. This report indicates that Connecticut is one of the top performing states nationwide.[37] Other scorecards, however, indicate differently. Findings from an Agency for Healthcare Research and Quality 2014 report on health care quality, which assesses performance on 250 quality measures that span a wider range of domains than the Commonwealth Fund report,[38] indicate that Connecticut ranks in the middle of all states, and is the only New England state not in the top 10.[39]

The Commonwealth Fund's *Low-Income Population Scorecard* ranks Connecticut in the top 10 highest performing states for measures of access and affordability, and healthy lives, but is 27th for potentially avoidable hospital use.[40] Accordingly, the Commonwealth Fund estimates that if Connecticut were to improve its potentially avoidable hospital use ranking to the highest performing state, it would have nearly 2,000 fewer hospitalizations for potentially preventable conditions.[41]

More specifically related to Medicare, nearly 60 percent of hospitals in Connecticut received three out of five stars for Overall Hospital Quality in the Medicare Star Rating program, which measures hospital performance on mortality, safety, readmission rates, effectiveness and timeliness of care, efficient use of medical imaging and patient experience. Nationally 48

---

[36] Hussey PS, Wertheimer S, and Mehrotra A. "The Association Between Health Care Quality and Cost." *Annals of Internal Medicine* v. 158, no. 1, January 2013.
[37] McCarthy D, Radley DC and Hayes SL. "Aiming Higher: Results from a Scorecard on State Health System Performance." The Commonwealth Fund, December 2015. www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/2015_scorecard_v4.pdf?la=en
[38] Domains for the AHRQ report include: (1) national quality strategy priorities (care affordability, care coordination, etc.); (2) access to care; (3) diseases and conditions (cancer, mental health and substance use, etc.); (4) health insurance; (5) priority populations (children, low income, Black, Hispanic, etc.); (6) settings of care; and (7) types of care (safety, preventive, acute and chronic).
[39] 2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy. Agency for Healthcare Research and Quality, Rockville, MD. www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html
[40] Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013. http://datacenter.commonwealthfund.org/scorecard/low-income/8/connecticut/
[41] Ibid.

percent of hospitals received three stars. Only one hospital in Connecticut received four stars, and none received five.[42]

With respect to Medicaid, Connecticut performs well on most measures compared to other states. The Affordable Care Act requires the Secretary of HHS to identify and publish performance on a "core set" of health care quality measures for adult Medicaid enrollees. Table 6 shows Connecticut's performance on the Adult Core Set of measures compared to the median rate of most other states.[43]

Table 6. Connecticut Performance on Medicaid Adult Core Measures, Federal Fiscal Year 2014

Measure Name	Number of States Reporting	CT Rate	All-State Median Rate
Percentage of Adults Ages 18 to 74 Who Had an Outpatient Visit and Documentation of Their Body Mass Index (BMI)*	26	67.20%	69.30%
Percentage of Adults Age 18 and Older With a Diagnosis of Major Depression Who Were Treated With and Remained on an Antidepressant Medication - Acute Phase Treatment*	31	61.80%	47.20%
Percentage of Adults Age 18 and Older With a Diagnosis of Major Depression Who Were Treated With and Remained on an Antidepressant Medication - Continuation Phase Treatment*	31	46.80%	31.20%
Percentage of Women Ages 50 to 74 Who Received a Mammogram to Screen for Breast Cancer*	31	61.80%	52.50%
Percentage of Women Ages 21 to 64 Who Were Screened for Cervical Cancer	33	66.90%	57.70%

[42] Lee M. "Medicare Releases New Ratings System for Hospitals." *Hartford Courant*. July 27, 2016.
[43] The median rate was used for comparison as opposed to the mean, because the mean was an unweighted average that is not consistently based on 50 dates (due to which states reported) and there was significant variability in reporting between states in terms of population (e.g., populations in enrolled in managed care organizations vs. those who are not), thereby potentially skewing the results of the mean.

Percentage of Sexually Active Women Ages 21 to 24 Receiving at Least One Test for Chlamydia*	32	70.50%	59.30%
Percentage of Adults Age 21 and Older Hospitalized for Treatment of Mental Illness Receiving a Follow-Up Visit Within 7 Days of Discharge*	30	38.20%	37.00%
Percentage of Adults Age 21 and Older Hospitalized for Treatment of Mental Illness Receiving a Follow-Up Visit Within 30 Days of Discharge*	30	56.90%	57.30%
Percentage of Adults Ages 18 to 75 with Diabetes (Type 1 or Type 2) Who Had a Hemoglobin A1c Test*	34	79.70%	79.50%
Percentage of Adults Ages 18 to 75 with Diabetes (Type 1 or Type 2) Who Had a LDL-C Screening Test*	34	68.40%	67.60%
Percentage of Adults Who Received at Least 180 Days of Medication Therapy and an Annual Monitoring Visit*	27	85.60%	84.90%
Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery	34	42.50%	58.20%

*All states did not report rates for the same age population.

Source: Centers for Medicare and Medicaid Services. Performance on Adult Core Measure Set, FFY 2014. **www.medicaid.gov/medicaid/quality-of-care/downloads/performance-on-the-adult-core-set-measures-ffy-2014.zip**

While taking into account these sometimes conflicting quality reports, generally speaking, Connecticut enjoys high quality health care. Cabinet members did raise concerns, however, about quality care being accessible to all populations, especially low-income and diverse populations.

III. Survey of Cost Containment Strategies of Maryland, Massachusetts, Oregon, Rhode Island, Vermont and Washington

PA 15-146 directed the Cabinet to identify successful practices and programs that were implemented in Maryland, Massachusetts, Oregon, Rhode Island, Vermont, and Washington for the purposes of (1) monitoring and controlling health care costs; (2) enhancing competition in the health care market; (3) promoting use of high-quality health care providers with low total medical expenses and prices; (4) improving health care cost and quality transparency; (5) increasing cost effectiveness in the health care market; and (6) improving the quality of care and health outcomes. The review of state activities revealed five key themes, including that:

1. *Significant delivery system and payment system reform is occurring across the U.S.* Most of the states studied have implemented a version of a patient-centered medical home (PCMH) model that enhances the role of the primary care practice in proactively

promoting preventive services and managing chronic conditions through supplemental payment that financially supports practices for added functions it performs. In addition, most of the states studied have already or are expanding their delivery system reform strategy beyond primary care to incorporate broader systems of care that include institutional providers, such as hospitals and skilled nursing facilities, and specialist providers, including behavioral health providers into accountable care organizations (ACOs) or "advanced networks." These new models of care are typically supported with population-based payment where providers have a per-member-per-month budget for providing care needed and the opportunity to share in savings if the costs at the end of the year are below budget.

2. *Health care cost and quality data are a necessary supporting foundation for informed state policy making*. Delivery system redesign and payment reform are built on a foundation of data. Most of the six states included in the study have developed very strong data collection, analytic and reporting capabilities. Some states have developed the capability within state government, while others partner with external organizations.
3. *Aligning state strategies across state purchasing and regulatory agencies can drive broader change in the marketplace.* Five of the six states included in this study created specific organizational infrastructures to align state strategies across state government and/or across all payers in the state (Rhode Island has not). This alignment, and in some cases purchasing power, gives states significant leverage to drive delivery system and health care payment reform. The purchasing power is enhanced by state actions to align both public and private payer initiatives, which states have found more challenging, but valuable to do.
4. *Marketplace dynamics play an important role*. Health care is truly local, and the marketplace dynamics within any given state can play an important role in the type of cost containment models the state is able to employ. State policy can be influenced by the number of dominant provider systems, the mix of "domestic-based" and national commercial carriers, as well as, the participation of large and small employers in health care value-based purchasing efforts.
5. *Trust has been a linchpin for many successfully developed and implemented state cost containment agendas.* A common theme across all of the six states is a general sense of trust among key public and private stakeholders, which was articulated through a series of interviews conducted by the Cabinet's consultants, and with the experience the consultants had in working in some of the states.

Each of these five themes is discussed in further detail in Appendix B. In addition to that detail, there is a repository of state research available on the Health Care Cabinet's website at http://portal.ct.gov/hcc/.

IV. Connecticut's Current Cost Containment Activities

At the June 2016 Health Care Cabinet meeting, each state agency participating on the Cabinet provided an overview of the agency's cost containment initiatives. The following is a summary of their presentations.

Department of Public Health (DPH). Acting Commissioner Pino identified the burden of chronic disease as the key cost driver that his department is addressing. He identified six key activities his department is undertaking to reduce chronic disease burden (reducing tobacco use, controlling high blood pressure, preventing health care-associated infections, controlling asthma, preventing unintended pregnancy and controlling/preventing diabetes) and 18 evidence-based interventions that are recommended by the CDC. In addition to the CDC recommendations, DPH will be focusing on HIV prevention and increasing the use of the HPV vaccine. He noted the adverse impact of socioeconomic factors, such as housing and transportation, on the health of minority residents of Connecticut.

Medicaid Program. Director McEvoy identified the key cost drivers of Medicaid to be "high need, high cost" individuals with complex needs and individuals who receive long-term services and supports (LTSS). She identified the following five strategies that her program is implementing to address these cost drivers:

- streamlining and optimizing administration of Medicaid through its self-insured, managed fee-for-service model and ASO structure;
- improving access to primary, preventive care through the PCMH program;
- coordinating and integrating care through the Intensive Case Management program;
- predictive modeling and risk stratification to better identify individuals with high costs and high needs, and develop programs to support them;
- rebalancing LTSS services, and
- moving towards value-based payment approaches.

Specifically, she reported that through intensive care management and behavioral health community care teams, and in cooperation with the Connecticut Hospital Association, ED visits have been reduced by 4.70 percent for HUSKY A and B, 2.16 percent for HUSKY C, and 23.51 percent for HUSKY D. Generally, through the work of the Medicaid program, the state has seen a decrease in admissions and other hospital outpatient services. The Medicaid program has also seen a reduction in per member per month costs over the last several years.

The Medicaid program, in conjunction with the State Innovation Model initiative launched PCMH+, a comprehensive primary care shared savings program with Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g., accountable care organizations, integrated practices).[44]

[44] For more information, see recommendation 1A.

The Medicaid program, in partnership with the Partnership for Strong Communities, is participating in CMS' Innovation Accelerator Program on Housing Partnerships to implement a housing-support initiative that identifies homeless beneficiaries through a data match between Medicaid and Homeless Management Information System databases and then links high-cost, high-need beneficiaries with multidisciplinary health care and supportive housing services.

Ms. McEvoy indicated that her department is exploring group purchasing options and saw potential there for cost savings.

Department of Mental Health and Addiction Services (DMHAS). Commissioner Delphin-Rittmon identified the following three cost drivers that her department is addressing through specific initiatives:

- ED and inpatient utilization;
- skilled nursing facility care for mental health clients; and
- intersection of homelessness and behavioral health.

The Commissioner reviewed programs designed to address each cost driver, including ED diversion programs, establishing behavioral health homes, alternatives to hospitalization, and working to address homelessness for those who have been in the corrections system. She also emphasized that the department is focusing on mining data to better understand what programs are impacting these cost drivers.

Department of Children & Families (DCF). Kristina Stevens, Administrator, Clinical and Community Consultation / Support Teams, identified two high cost populations:

- high utilizers of ED and inpatient services, and
- youth who remain in congregate facilities beyond their treatment needs.

Her department is implementing the following strategies to address these areas of concern:

- standard practices to strengthen families;
- implementing differential responses regarding removal of children;
- adopting a policy of using congregate care for treatment, and not placement;
- increasing support for children at home and in communities;
- enhancing support for schools to work with traumatized children; and
- improving primary care provider access to mental health consultation.

Insurance Department (CID). Paul Lombardo, Actuary**,** spoke about the Department's transparent rate review process. He noted that CID is seeing some market innovations to address costs, including use of provider tiers, value-based insurance designs, and use of primary care providers to coordinate care. He also explained that CID will now be doing pharmacy formulary reviews along with network adequacy reviews.

State Innovation Model Program Management Office (SIM PMO). Mark Schaefer, Director of Healthcare Innovation within the SIM PMO, identified wasteful spending, including practice variation and misuse, overuse and underuse of services as key cost drivers. He noted that Connecticut has health care spending that is the fourth highest per capita level of all states. He also noted that quality is uneven and that health disparities remain a major concern, which point to the need to more effectively address social determinants of health.

Dr. Schaefer described the four initiatives that the State Innovation Model is pursuing to achieve the triple aim:

- improving population health through health enhancement communities, prevention service centers, community health measures;
- implementing payment reform through Medicare and commercial shared savings programs, the Medicaid Quality Improvement & Shared Savings Plan (QISSP, now renamed PCMH+), and quality measure alignment;
- transforming care delivery through community and clinical integration program, advanced medical homes, and community health workers initiative; and
- empowering consumers through value-based insurance design, public quality scorecard and consumer outreach.

State Office of the Comptroller. Marge Houy, Senior Consultant with Bailit Health, presented OSC material in lieu of OSC staff presence at the meeting. She noted that the Comptroller's Office implemented a value-based insurance design for employees and dependents in 2012 which focuses on encouraging enrollees, through reduced member costs and other incentives, to obtain suggested screenings and other prevention care, and for those with chronic conditions to better manage them.

A recent assessment of the first two years of the initiative found that the rate of preventive services increased; utilization of the ED decreased, while office visits increased, and overall medical costs decreased 3.2 percent.[45] There were also increases in screenings and testing for chronic disease, but improved clinical outcomes were not evident.

During the course of the presentations, several commissioners provided examples of cross-agency collaboration on specific programs. For example, DPH and DMHAS work together on the opiate crisis, and DPH and DCF on fetal alcohol syndrome. A project management office meets regularly to discuss cross agency information technology issues, which may result in some cost savings. The State is onboarding a Health Information Technology Officer (HITO) that co-chairs a Statewide Health Information Technology Advisory Council that advises the HITO on the coordination of statewide health information technology efforts. However, currently there is no regular meeting of all the commissioners with health-related programs and

[45] Lembo, Kevin. "Connecticut's Health Enhancement Program (HEP)" Presented at the June 14, 2016 Health Care Cabinet Meeting.

there is no aligned strategy to address rising health care costs. Most commissioners noted that they did not have the data to effectively evaluate their initiatives to determine the level of impact on costs.

V. Health Care Cabinet Recommendations

Over the course of five months, the Health Care Cabinet debated the merits of specific strategies designed to reduce health care costs through using different state policy, regulatory and purchasing levers. The recommended strategies upon which the Cabinet agreed can be categorized and summarized as follows:

1. **Transform the delivery and payment systems.** These strategies are designed to reduce costs in the health care system by promoting delivery system and payment reform through the adoption of models that: 1) engage and reward providers to provide needed services in a more coordinated, effective and efficient manner; 2) address issues of underuse, overuse, misuse and ineffective use; and 3) reduce the impacts of social determinants of health and health inequities. The chief strategy, after the period of the State Innovation Model Test Grant, is to implement independent, but aligned purchasing strategies to contract with Consumer Care Organizations (CCOs) – provider entities that are accountable for the cost of a comprehensive set of services for an attributed population. Under this approach, providers, on a voluntary basis, would be responsible for their quality performance on outcomes, patient access and efficiency using a risk-sharing model. A cap on CCO risk would be employed such that the amount of financial risk for which the CCO is responsible is meaningful and motivating, but not so much that CCOs are exposed to excessive risk. The Cabinet also recommends the State continue pursuing Medicaid's existing reform agenda, aspects of which lay the groundwork for the CCO model.
2. **Directly reduce cost growth**. There are two strategies in this topic area. The first is a cost growth target to focus the attention of the public, policymakers, providers and payers on containing cost growth, necessarily considering both service prices and utilization of services. The second promotes adoption of alternative payment methodologies that reward value and efficiency, rather than service volume, by setting adoption targets for insurers.
3. **Coordinate and align state strategies.** The Cabinet recommends infrastructure to coordinate and align state strategies across state agencies and with the private sector through the creation of an Office of Health Strategy that would report to the Governor.
4. **Support market competition**. Recognizing that the health care marketplace does not operate as a traditional free market, the Cabinet recommends, provided funding is available, expanding the Attorney General's powers to monitor health care market trends to shine light on market practices and enable policymakers to create data-informed policies.

5. **Support provider transformation**. The Cabinet supports strategies to offer Medicaid providers financial, infrastructure and technical support needed to change their care delivery models. The chief strategy is to consider seeking additional funding through pursuing a CMS Section 1115 waiver[46] and Delivery System Reform Incentive Payment (DSRIP) funds.[47]
6. **Support policymakers with data**. This strategy recognizes current efforts to build the claims data and clinical information infrastructure necessary to support delivery system and payment reform by assuring that the new Office of Health Strategy has access to information necessary to perform its functions.
7. **Incorporate use of evidence-based research into state policy making**. The Cabinet recommends that Connecticut adopt a strategy of incorporating the use of comparative effectiveness evidence research into policymaking decisions in order to reduce overuse and misuse of health care services.

Details regarding each specific strategy grouped within the seven categories are presented below.

1. Delivery System and Payment System Transformation Strategies

The Cabinet recommends three strategies to promote cost savings through delivery system and payment system transformation:

A. Build on the SIM Agenda and Current Success in the Medicaid Program
B. Provide More Coordinated, Effective and Efficient Care Through Consumer Care Organizations
C. Create Community Health Teams to Address Complex Health Care Needs

A. Build on the SIM Agenda and Current Success in the Medicaid Program

The Cabinet recognizes the value of current State Innovation Model (SIM) initiatives and the current Medicaid programs to control growing costs, and supports their continuation.

Recommendation: Continue with the following current strategies:

[46] Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services to approve experimental, pilot, or demonstration projects that give states additional flexibility to design and improve their Medicaid program and Children's Health Insurance Program (CHIP) such as using innovative service delivery systems that improve care, increase efficiency, and reduce costs. States that pursue Section 1115 Waivers must meet several requirements, including that demonstrations must be budget neutral to the federal government. (www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html) Currently 29 states and the District of Columbia have approved Section 1115 Waivers. www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html

[47] The continued availability of DSRIP funds under a new federal administration is unknown.

(1) Continue with the SIM agenda in its focus on care delivery reforms, development of a common quality framework, and cross-payer alignment around use of Medicare ACO SSP shared savings arrangements, as those features contribute to cost containment.

(2) Continue to optimize the current Medicaid care delivery reform initiatives including ASO-based intensive care management, person-centered medical homes, behavioral health homes, and the long-term services and supports re-balancing plan; and implement targeted new interventions that address and improve outcomes for high need, high cost Medicaid members.

Rationale: The SIM agenda has set important strategic aims for multi-payer alignment on care delivery and payment reform strategies that require time to be implemented, to mature, and to be properly evaluated.

Connecticut Medicaid's program has proven success in improving:

- **member access to services** through increased participation of primary care providers, behavioral health providers, and dentists;
- **health outcomes**, including sustained reductions in emergency department visit rates, overall admissions, and utilization of emergent medical visits, as well as improvements in results on many health measures related to chronic conditions;
- **care experience**, as evidenced by results on CAHPS and use of mystery shopper reviews; and
- **per member per month costs**, which have decreased by 1.9 percent from SFY 2012 through SFY 2016.

Further, the program is actively engaged in launching, and developing additional, new health care delivery and payment innovations.

Continue with the SIM Agenda

The Connecticut State Innovation Model (SIM) is a multi-payer approach to promote improved health care delivery. It is a four year, $45 million grant awarded to Connecticut from the Centers for Medicare & Medicaid Innovation (CMMI). SIM was established as a means to ensure that health care reform initiatives are informed by the diversity and expertise that exists within Connecticut's stakeholder community – consumers, consumer advocates, employers, health plans, providers, and state agencies. SIM promotes alignment on methods and requirements where alignment makes sense, while also promoting flexibility and innovation. If the new federal administration and Congressional leadership make changes to future funding of the state's SIM program, the State will have to reassess its ability to continue to advance these initiatives.

There are four major strands of SIM work that have bearing on Medicaid. These include:

- **Advanced Medical Home (AMH).** Connecticut's SIM initiative emphasizes the importance of investing in primary care transformation. Through the AMH program, SIM will fund approximately $3.6 million in technical assistance to support the advancement of 300 primary care practices statewide to achieve NCQA PCMH recognition, while emphasizing health equity and patient-centered care. NCQA PCMH recognition allows practices to meet the current eligibility requirements to participate in the PCMH+ program. The AMH program is expected to conclude in 2019.

- **PCMH+.** Nearly $9 million in SIM grant funds is dedicated to support the planning and implementation of DSS's shared savings program payment reform known as PCMH+. DSS' goal with PCMH+ is to continue to improve health and satisfaction outcomes for Medicaid beneficiaries currently served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g., Accountable Care Organizations, integrated practices), which have been competitively selected by the Department via a request for proposals. Both FQHCs and certain ACOs are currently providing a significant amount of primary care to Medicaid beneficiaries.

  PCMH+ represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home initiative, and Intensive Care Management (ICM) initiatives. As of October, 2016, 108 practices (affiliated with 435 sites and 1,518 providers) were participating in PCMH, serving 328,169 beneficiaries (over 43 percent of Medicaid members). The Medicaid PCMH model is a strong base from which to build in that PCMH practices have demonstrated year-over-year improvement on a range of quality measures (e.g., adolescent well care, ambulatory ED visits, asthma ED visits, LDL screening, readmissions, well child visits) and also have received high scores on such elements as overall member satisfaction, access to care, and courtesy and respect. Connecticut Medicaid's ICM initiatives have also demonstrated exciting initial results.

  While PCMH will remain the foundation of care delivery transformation, PCMH+ will build on current efforts by incorporating additional requirements for care coordination, focusing upon integration of behavioral and physical health care, children with special health care needs, health equity, and competency in care for individuals with disabilities, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits.

- **Clinical and Community Integration Program (CCIP).** As part of the SIM grant, approximately $3 million dollars has been devoted to providing technical assistance, peer learning support and financial awards to providers that are participating in the PCMH+ initiative to help them achieve best practice standards in improving care for individuals with complex health needs, introduce new care processes to reduce health equity gaps, and to improve access to and integration of behavioral health services.

Technical assistance will also be provided on e-consults, comprehensive medication management, and oral health integration. The standards emphasize social determinants of health, integrating community health workers into primary care teams, community linkages, and a range of capabilities intended to improve the effectiveness of FQHCs and Advanced Networks that are accountable for quality and cost of care. In addition, a pool of $5.5 million has been established to support awards of up to $500,000 for CCIP participating entities that are not participating in the Practice Transformation Network (PTN) initiative. Funds will help support the costs associated with working toward achievement of the standards. SIM funding for this initiative concludes in 2019.

- **Population Health Planning.** The Population Health Planning activities are led by the Department of Health and focus on two major sub-initiatives targeting, community health improvement objectives (i.e., primary and secondary prevention). Nearly $6 million in SIM grant funding is allocated for planning; however, there is not yet a solution for financing the implementation of these initiatives nor for sustaining them over time:
    - Health Enhancement Communities (HEC): Accountable Health Community models are coming to the forefront as a promising strategy to improve health outcomes and meet health-related needs, such as food insecurity or unstable housing. These models differ from state to state, but often include the linkage of clinical and community services, strategies to address both health and social needs, an accountability structure, and a financing strategy. HECs in combination with PSCs will be the Connecticut-specific model of an ACH. HECs will administer targeted resources and facilitate both local coordination and accountability among providers, local public health departments, municipalities, nonprofits, schools, housing authorities and others through innovative financing strategies (e.g., wellness trusts) and multi-sector governance solutions (e.g., local coalitions led by a fiduciary agent). Evidence-based policies and strategies will be linked to innovative reimbursements and to strategies that address social determinants of health and health equity (e.g., sustainable financing for healthy homes assessments and community health workers). These enhanced agency partnerships and capacity building, which relies on both traditional and nontraditional partners, will strengthen the ability of the community to address social determinants of health. The resulting alignment between health care and public health will additionally reframe conventional strategies and broaden targeted groups.
    - Prevention Service Centers (PSCs). PSCs are community-placed organizations or consortiums that would meet criteria for the provision of evidence-informed, culturally and linguistically appropriate community prevention services. PSCs may be new or existing local organizations, health care providers (e.g., PCMH, FQHCs), non-profit agencies or local health departments. These centers will be

an integral part of the community interagency consortiums seeking designation as an HEC. The State anticipates that the PSCs will initially focus on environmental quality issues in homes and promoting positive health behavior (e.g., asthma home environmental assessments, diabetes prevention programs, and hypertension screening and control). PSCs will also foster alignment and collaboration between primary care providers, community-based services and State health agencies. Their workforce will include existing workers providing similar services (e.g., local health department staff, Area Agencies on Aging, FQHC staff) and the emerging cadre of community health workers envisioned as part of the SIM health care workforce development strategy.

Continue to Optimize Existing Care Delivery Reform Initiatives and Refine Proposed Initiatives

In addition to the above referenced PCMH+ initiative, Connecticut HUSKY Health (Medicaid) has an established and successful reform agenda that centers around the elements summarized in the table below.

Connecticut HUSKY Health Reform Agenda	
Streamlining and optimizing administration of Medicaid through . . .	• a self-insured, managed fee-for-service structure that contracts with Administrative Services Organizations • unique, cross-departmental collaborations including administration of the Connecticut Behavioral Health Partnership (DSS, DCF, DMHAS), LTSS rebalancing plan (DSS, DMHAS, DDS, DOH) and the new ID Partnership (DDS and DSS)
Improving access to primary, preventative care through . . .	• extensive new investments in primary care (PCMH payments, primary care rate bump, Electronic Health Record payments) • comprehensive coverage of preventative behavioral health and dental benefits
Coordinating and integrating care through . . .	• ASO-based Intensive Care Management (ICM) • Cross-ASO collaboration • PCMH practice transformation • DMHAS-led behavioral health homes • Money Follows the Person "housing + supports" approach and Innovation Accelerator Program • PCMH+ shared savings initiative
Re-balancing long-term services and supports (LTSS) through . . .	A multi-faceted Governor-led re-balancing plan that includes: • Extensive collaboration by DSS, DMHAS, DDS, DOH • State Balancing Incentive Program (BIP) activities • LTSS waivers (DSS, DMHAS, DDS) • Nursing home "right sizing" • Workforce initiatives • My Place consumer portal
Moving toward Value-Based Payment approaches through . . .	• Hospital payment modernization • Pay-for-performance (PCMH, OB) • PCMH+ shared savings initiative • Exploration of use of episodes

Medicaid should also continue to use Connecticut Medicaid claims data to design and implement targeted new care delivery and payment initiatives focusing on high cost, high need Medicaid members, including initiatives to:

- optimize Medicaid claiming and care access /continuity for justice-involved individuals re-entering communities;
- develop a health home for children with complex trauma;
- develop a 1915(i) state plan amendment to cover transition and tenancy-sustaining supports under Medicaid, to address and support the need for housing stability as it contributes to improved health outcomes;

- address the care coordination needs of children with complex medical needs (e.g., with sickle cell) who present to the hospital;
- increase the use of standards-based telemedicine;
- launch "Safe to Wait" consumer intervention around self-triage and use of the ED;
- address, with hospitals, the needs of individuals presenting to ED because of pain; and
- develop bundled payments (e.g., for maternity care).

Eighteen members of the Cabinet approved this strategy and one member abstained.

B. Provide More Coordinated, Effective and Efficient Care through Consumer Care Organizations

Recognizing the need to aggressively engage all providers in delivery system transformation, the Cabinet is recommending the following strategy that builds on the current SIM and Medicaid PCMH strategies and provides an implementation pathway to developing delivery and payment models that promote integration across the full spectrum of care, and across all payers.

Recommendation: The Cabinet recommends that the Medicaid program and the Office of the State Comptroller (OSC) to pursue a Consumer Care Organization (CCO) strategy that includes the use of independent but aligned purchasing strategies, including contract language, with entities that are each accountable for the cost of a comprehensive set of services (e.g., "total cost of care") for an attributed population using an approach that holds providers accountable for their quality performance on outcomes, patient access and efficiency. The Cabinet recommends that this strategy be coupled with support from the Office of Health Strategy (see recommendation #3) to pursue CCO development and contracting as an all-payer strategy.

Rationale: This recommendation builds upon the shared savings programs being launched by Medicaid (PCMH+) and the OSC (ACO-type) by requiring providers to organize themselves in such a way that would allow better care coordination across the continuum of multiple providers and increase accountability among all providers, and in particular, among the highest cost providers (e.g., hospitals and specialists). This recommendation introduces financial shared risk over time to give providers greater incentives to change the way they deliver care – a stronger incentive than shared savings programs offer – and to emphasize care coordination for those most in need. Since this recommendation affects all state-purchased health care, it sends a clear and coordinated message to the provider community, making it easier for providers to adapt to this change. Furthermore, the Cabinet recommends that the Office of Health Strategy initiate efforts to develop an aligned approach to delivery system and payment reform model and quality measurement to assist CCOs in achieving common goals across all Connecticut payers, and to over time reduce competing or sometimes conflicting incentives. Importantly, this recommendation keeps consumers at the center of the health care delivery system and provides strong protections for their active participation in the business decisions of the health care system.

The strategy to utilize shared risk arrangements is in keeping with national trends among states that contract directly with providers for Medicaid. Of the 11 states with active ACO programs in Medicaid, eight utilize shared risk or intend to use shared or full risk.[48]

To be successful under a total cost of care model, the CCOs must: 1) identify and better manage high-cost, high-need patients who will benefit from intensive care management services; 2) better manage transitions of care between inpatient and community-based organizations; 3) quickly identify and better manage ambulatory patients with poorly managed chronic diseases or conditions that could lead to the use of high-cost services; and 4) address social determinants of health through forging close service connections with community-based organizations.

Finally, a total cost of care model that includes providers along the continuum of care is the model being aggressively pursued by Medicare and by private insurers in other states. Connecticut's top insurers have also publicly stated their desire to move to value-based contracts, including risk-based contracts with willing providers.[49] By participating in the CCO model, providers would benefit directly by having opportunities to earn savings and to potentially exempt them from the Medicare MIPS reporting and performance requirements, which would make providers eligible for Medicare rate increases.[50]

Additional Model Detail

What are Consumer Care Organizations? Consumer Care Organizations (CCOs) would be a collection of providers that voluntarily come together to coordinate a comprehensive set of services for an attributed population. An ACO, or Advanced Network, could be a CCO if it meets the requirements stated below. The Cabinet recommends that Consumer Care Organizations be regulated by the State for financial solvency and operational capacity, and if qualified, comply with Preferred Provider Network regulations enforced by the CID.

Aligned Requirements: The Cabinet recommends that the Medicaid program and the Office of the Comptroller each include in their contracts requirements that:

- CCOs have a governing body that is representative of the provider-types that make up the CCO, with the providers being Connecticut-based;
- consumers are meaningfully represented on the governing body across its lines of business;

---

[48] Medicaid Accountable Care Organizations: State Update. Center for Health Care Strategies, September 2016.
[49] Anthem: www.beckershospitalreview.com/payer-issues/anthem-makes-nearly-40b-shift-from-fee-for-service-medicine-to-value-based-pay.html; Aetna: www.strategy-business.com/blog/Aetna-Frugal-Healthcare-Strategy?gko=432ba
[50] Under MACRA, providers that participate in a "qualifying" value-based payment model will be eligible for a 5 percent increase in rates, and will be exempt from participating in the MIPS quality program, which has the potential of a 9 percent rate increase, and a 9 percent rate reduction over a four-year period. The CCO model, as described in this proposal, could be a "qualifying" value-based payment model in the "Other APM" category starting in 2019. See footnote 55 for incidences in which the CCO model would not be considered a "qualifying APM." The PCMH+ model is not a qualified model under the final MACRA rule.

- a separate consumer advisory board be formed with a direct advisory relationship to the CCO governing body;
- CCOs meaningfully participate in Community Health Collaboratives;
- in order to address health inequities and social determinants of health, CCOs meet the Community and Clinical Integration Program (CCIP) standards set forth in the SIM program; and[51,52]
- CCOs meet minimum requirements and undergo a readiness review, as defined by the State, to participate in the shared risk model. Such requirements could include substantive progress made toward acquiring and utilizing new health analytics technology, and making operational connections with social service and community-based organizations.

Nonaligned Requirements: The Medicaid program and the Office of the Comptroller may have additional requirements that are not aligned, including, for example:

- the number of attributed lives that a CCO must have before assuming risk;
- provider types that are required to be part of a CCO;
- social service agencies that are required to be part of a CCO; and
- the suite of health care services for which the CCO is responsible (so long as it is a comprehensive set of services).[53]

The Office of the Comptroller will also have to consider the provisions of the State's collective bargaining agreements in pursuing the CCO strategy.

Requirements Specific to Medicaid: The Cabinet recommends that Medicaid require its providers to develop the capacity to assume clinical and financial responsibility for dental and long-term support and services within three years of the start of the contract.

How CCOs are Paid: In keeping with the goals of the SIM program, and aligned with the goals of the Cabinet to move hospitals, specialists and other providers to value-based payment models (see recommendation #2B), Consumer Care Organizations should be paid using a value-based payment model. For the Medicaid program, the model should include accountability for medical and behavioral health services, and within three years include dental and long-term services and supports. For the Office of the Comptroller, it should include all covered medical and behavioral health care services.

Generally, the payment model should adhere to the following principles, with the design and operational details to be fleshed out by the Department of Social Services and the Office of the

[51] For more information on the CCIP program standards, see: www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_report_4-13-16_draft_5_14.pdf Last accessed December 1, 2016.
[52] CCIP standards are intended to apply to all payers/populations.
[53] For example, the Medicaid program may wish to include dental providers as a required provider for CCOs, but the Office of the Comptroller may not.

Comptroller, under the leadership of the Office of Health Strategy. The payment model should be consistent, to the extent possible, with the MAPOC Care Management Committee and SIM Equity and Access Council recommendations.

Principles of the Payment Model:

Total Cost of Care

- CCOs will be held accountable for a total cost of care (TCOC) target that includes the broadest range of services possible.
- A TCOC target should be based on historical analysis of the TCOC for the patients of the primary care providers (and subspecialists functioning as PCPs for patients with certain conditions, such as cancer or complex diabetes) that make up the CCO with a trend rate that is no greater than the cost growth target set by the state (see Recommendation #2).
- In order to provide incentives for providers to care for individuals with illnesses that result in high costs, the TCOC target will be risk-adjusted, and high-cost outlier cases will be truncated at a predetermined threshold.[54]

Risk Model

- All CCOs, unless otherwise willing and capable of demonstrating readiness, should begin in a shared-savings model. The opportunity to share in savings should be greater than what is being offered at the time in the PCMH+ program to encourage provider participation in the CCO model.
- Within 3 years, CCOs should be expected to move into shared-risk models where providers share in savings and in risk with the state. The shared savings portion of this opportunity will be greater in this model than in the shared savings-only model to encourage providers to adopt shared risk. Risk caps should be employed such that the risk is meaningful, but CCOs are not exposed to catastrophic risk. Risk caps should be set no lower than 1 percent and no higher than 5 percent of the total cost of care on a per member per month basis.[55] Higher risk caps and higher potential savings percentages, similar to the Medicare Next Gen model, could be considered for qualified CCOs.
- The risk cap may vary between the Medicaid program and the state employee health program.

[54]Currently, risk adjusters do not adequately account for social determinant risk factors. When and if there is a risk adjuster that takes into account social determinant risk factors, it should be considered for inclusion in this program.
[55] Under the final regulations for MACRA, to be exempt from MIPS, providers must participate in a "qualifying APM' which includes accepting at least 3% risk for total expenditures which the provider is responsible for within the model. If a risk cap is set lower than 3%, as this strategy allows, it will not be a qualifying APM.

Quality Model

- CCOs should be focused upon improving the health status of the Connecticut population, with special attention to reducing health disparities based on race, ethnicity, gender, and sexual orientation, reducing the impact of negative social determinants of health, and reducing barriers to care for those most vulnerable. The State should specifically incorporate quality performance measures addressing these desired outcomes.

- Performance on quality process and outcome measures should affect the portion of shared savings for which a CCO is eligible, and the amount of risk for which a CCO is responsible, with the levels being determined by the State.

- Quality measures to which CCOs are held accountable should be consistent with the core measurement set recommended by the SIM Quality Council. In accordance with the recommendations of the Council, the scorecard should include measures of health equity gaps in order to ensure that CCOs drive reduction in such gaps. Measures should target opportunities for performance improvement, as well as ensure that there is no diminishment in access to services. Additional quality measures will be necessary to measure the performance of non-primary care providers, and to adequately measure outcomes as previously described. Any additional quality measures that the state Medicaid program or Office of the Comptroller wish to include should be decided with input from CCOs, providers that make up CCOs, and consumers, and in coordination with the Office of Health Strategy, which will lead efforts to align quality measures with other payers.

- To address the risk of potential underservice, the State should consider utilizing "secret shoppers" and consumer experience of care surveys as part of its quality measurement system.

Primary Care Bundles

- Primary care payment should be modified to support primary care practices' ability to diversify the care team and to deliver care using currently non-reimbursable modalities, including through the use of upfront payment. Care team diversification may include but would not be limited to patient navigators and community health workers. New care modalities may include telephone, e-visits and video visits, as well as remote monitoring.

Timeline for Implementation of CCOs: The work of the Medicaid program has fastidiously laid the groundwork for the development of CCOs through its focus on primary care transformation, high-risk and high-need population-based programs, and the PCMH+ shared savings program. Some of the providers that may wish to become a CCO have been gaining experience in value-

based payment models, including in enhanced medical home and pay-for-performance models, and as of January 1, 2017 will through the PCMH+ shared savings model. Other providers will have had experience in shared savings and shared risk models offered by Medicare[56] and commercial payers, while some providers will have had no experience.

When considering the timeline for implementing the CCO model, it must be recognized that Medicaid must work with stakeholders to develop program detail, including but not limited to CCO performance standards, expectations regarding how to address social determinants of health, and details regarding the payment methodology. It will therefore important to ensure the availability of additional Medicaid and OSC staff and contracting resources to perform this work, and the following timelines could be adjusted accordingly.

To account for the variation in experience in value-based payment in the state and the administrative capacity of the Medicaid Department, the Cabinet recommends the following timeline for implementation of CCOs, unless the Office of Health Strategy adjusts the timeline to better align existing and ongoing initiatives, including consideration for changes in federal policy or financing that may affect precursors to the CCO model (e.g., PCMH+):

- Begin contracting with CCOs on January 1, 2019.
- All CCOs start in a shared savings model, which could be nearly identical to the PCMH+ model, with the exception that CCOs would be provided the opportunity to share in additional savings, from January 1, 2019 to December 31, 2019. CCOs that are comprised of a substantial number of providers that are participating in PCMH+, or that have participated in any Medicare or commercial shared savings model, move into a shared risk arrangement on January 1, 2020. This is in keeping with the State's commitment to not require Medicaid providers to move risk-based contracts under the PCMH+ program during the SIM initiative.
- CCOs that did not exist in any form prior to January 1, 2019 or did not have prior experience with shared savings, move into shared risk on January 1, 2021.

Technical Assistance: To be successful in population management and assuming risk, providers will need to build the necessary infrastructure to collect and analyze both claims and clinical data. Moreover, CCOs will need to develop delivery system processes, including a strong care management system that supports population management models. Infrastructure development will necessarily occur at practice, facility and CCO levels. To facilitate the development of needed infrastructure, the Cabinet recommends the State provide opportunities for providers to participate in learning collaboratives that will enable participants to learn from the experiences of providers who have successfully developed needed infrastructure and to

[56] There are currently five Connecticut-based ACOs participating in the Medicare Shared Savings Program. Another six New York-based ACOs count some Connecticut counties as part of their service area. See https://data.cms.gov/ACO/2016-Medicare-Shared-Savings-Program-Organizations/5kdu-cnmy.

participate in peer learning on aspects of CCO performance that are critical to success. This technical assistance can be provided in concert with a Delivery System Reform Incentive Payment (DSRIP) program (see Recommendation #5), if the State applies for one to CMS.

For more information on how the proposed CCO model differs from the current PCMH+ program see Appendix C.

Eleven members of the Cabinet voted for this strategy, while eight voted against this strategy. The major concerns that were expressed by Cabinet members and stakeholders related to the use of shared risk in provider reimbursement methodologies. There were concerns about recommending the implementation of shared risk prior to evaluating the PCMH+ shared savings program, and concerns about what unintended consequences may arise for providers and consumers under shared risk contracting. For more information on the concerns that were expressed see the Summary Comments on Preliminary Recommendations in Appendix E. Additionally, please see specific suggestions by Cabinet member Frances Padilla in Appendix I.

C. Create Community Health Teams to Address Complex Health Care Needs

The Cabinet recognizes that many primary care providers in Connecticut are in small, independent practices and may not join CCOs, but need more support to provide more coordinated and integrated care, particularly for their high-cost, high-risk patients. The Cabinet recommends the following strategy to provide them with needed support.

Recommendation: Develop all-payer, multi-disciplinary community health teams composed of, at a minimum, a team manager, a nurse care manager, a behavioral health clinician, a social worker, a community health worker and a pharmacist. The community health team should serve primary care providers and patients within a specific geographic community by offering individual care coordination, health and wellness coaching, and behavioral health counseling. It should connect patients to social and economic support services and perform community outreach to support public health initiatives.

The community health teams should be designed to support PCPs who are participating in PCMH. The community health teams could also provide services to newly formed CCOs until they have built their own infrastructure to provide these services. This would enable a broad range of providers to participate in the CCO strategy.

Under this proposal, the key functions of the community health team include:

- Care managers follow up with patients who are overdue for appointments or tests, manage short-term care for patients with high needs, check that patients are filling prescriptions and taking their medications appropriately, and follow up with patients on their personal health management goals.
- Behavioral health providers help providers identify patients with untreated depression or substance abuse, and provide brief behavioral health interventions, when necessary.

- Community health workers help patients fill out insurance applications, follow treatment plans, manage stress, and work toward their personal wellness or disease-management goals, accompany patients to appointments and help them find transportation or child care.
- Pharmacists work with primary care physicians on medication management for patients taking multiple prescriptions and/or with chronic conditions that can be well managed with effective drug adherence, and assist with medication reconciliation when patients transition from inpatient to outpatient settings.
- Social workers help patients connect to social service agencies and to public health initiatives that are designed to address the negative impact of social determinants of health.
- Other service specialists, such dieticians, would be engaged as needed.

All team members would work with patients on improving self-management of their health and behavioral health conditions.

Funding sources to make this an all-payer initiative need to be identified, in concert with any changes to federal financing that may occur. Possible sources of funds could be legislative funding, insurer payments or through other sources identified by the legislature. The cost of each community health team would vary based on the region covered, the number of primary care practices served, and the composition of the team. The Cabinet recommends that the resources first be devoted to PCMH practices, and then if funding is available, to non-PCMH practices. It is estimated minimum support for a team would be $500,000 annually.

Rationale: This strategy is based on the success experienced in Vermont with its community health teams, which are an integral component of Vermont's Blueprint for Health. Vermont's Blueprint for Health, which is built on a model of PCMH and community health teams and data-sharing infrastructure, has demonstrated significant savings and improved quality.[57] By being an all-payer model, PCMH providers are able to meet the needs of all high-risk, high-cost patients using a single, coordinated model.

A community health team with its multi-disciplinary resources is able to support primary care practices that do not have the internal resources needed to become advanced patient-centered medical homes and could be implemented under the current Medicaid PCMH+ strategy. The community health team strategy is also consistent with the CCO strategy in two regards. First, community health teams could provide necessary care management services to a newly formed CCO until it is able to build its own infrastructure. Second, for providers who are not aligned with a CCO, the community health teams would provide needed delivery system support so that they can become mature PCMHs.

[57] Blueprint for Health 2015 Annual Report, published January 31, 2016

Sixteen members of the Cabinet voted for this strategy while three voted against this strategy. Those Cabinet members who opposed the strategy were concerned about the costs of the community health teams.

2. Directly Reduce Cost Growth

A. Create a Health Care Cabinet Working Group to Recommend How to Define and Best Implement a Health Care Cost Growth Target

The Cabinet concluded that more transparency regarding the rate of health care cost increases and key drivers of those increases is needed to start changing the state dialogue on how to control rising costs. To further this goal, the Cabinet recommends reducing cost growth by setting a statewide target on annual total cost of care, and assessing performance at the state, payer and large provider level.

Recommendation: The Cabinet should recommend how best to define and implement a statewide health care cost growth target.

The Cabinet should create a work group that includes stakeholders, at a minimum consisting of Advanced Networks, hospitals, post-acute providers, private providers, public and private health care purchasers and payers, consumers, an economist, and a health care policy expert.

When considering a cost growth target, the work group should:

- Study the methodology of Massachusetts and any other state that has adopted or implemented a state-level cost growth target, including their relative public and private reimbursement environment.
- Identify what data various Connecticut agencies have, and what data are needed to define baseline spending and assess state, payer and provider performance relative to the target.
- Recommend a state entity that should assume responsibility for computing state, payer and provider performance relative to the target.
- Define the minimum number of provider-attributed lives for a provider to have its performance assessed relative to the cost growth target.
- Identify what external economic indicator should be used to define the cost growth target, with consideration given to the Prospective Gross State Product and the Consumer Price Index for All Urban Consumers (CPI-U).
- Recommend an implementation timeline for the cost growth target that spans several years' time and defines the time period during which performance relative to the cost

growth target should be reported publicly without penalties or sanctions for meeting or exceeding the target. The recommendation should specify the timing for setting each year's cost growth target.

- Recommend how the results of the cost growth target are reported publicly, and what steps payers and providers must take to explain their performance if they exceeded the target.
- Recommend the frequency with which the cost growth target should be assessed for its effectiveness.

The work group should make its recommendations to the Cabinet in a timely manner to allow the Cabinet to make its final recommendations to the Governor and legislature by December 15, 2017.

Rationale: Setting a cost growth target will focus the attention of the public, policymakers, providers and payers on containing cost growth, and thereby necessarily consider both service prices and utilization of services. It will also spur action on prices and changes required in care delivery to contain cost growth. The goal is to establish a cost growth rate target that is affordable to consumers, employers and taxpayers. This is consistent with SIM's goal to "achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP)."

Sixteen members of the Cabinet voted for this strategy while one voted against it. The one Cabinet member who opposed this strategy did so for several reasons, including the cost to implement and execute this strategy.

B. Set Targets for and Adopt Value-based Payment Models

Recognizing the power of payment models and the need for the expanded use of alternative payment models that reward quality and efficiency, rather than volume, among all payers, the Cabinet concluded with a tied vote on the following strategy recommendation. The Cabinet, however, agreed to include the strategy in this report for legislative review only.

Recommendation: In support of the existing SIM goals for primary care providers and to further advance payment reform beyond primary care, the Office of Health Strategy should set payment reform adoption targets for all payers in the state, including primary care and non-primary care providers. Targets should be set by the Office of Health Strategy in coordination with its stakeholder advisory committee. Targets for payment reform adoption should be set with consideration for plan enrollment, geographic concentration of enrollment and current levels of adoption. Targets should be set using the "Alternative Payment Model" Framework established by the HCP-LAN (described below), and encourage more provider participation in Categories 3 and 4.

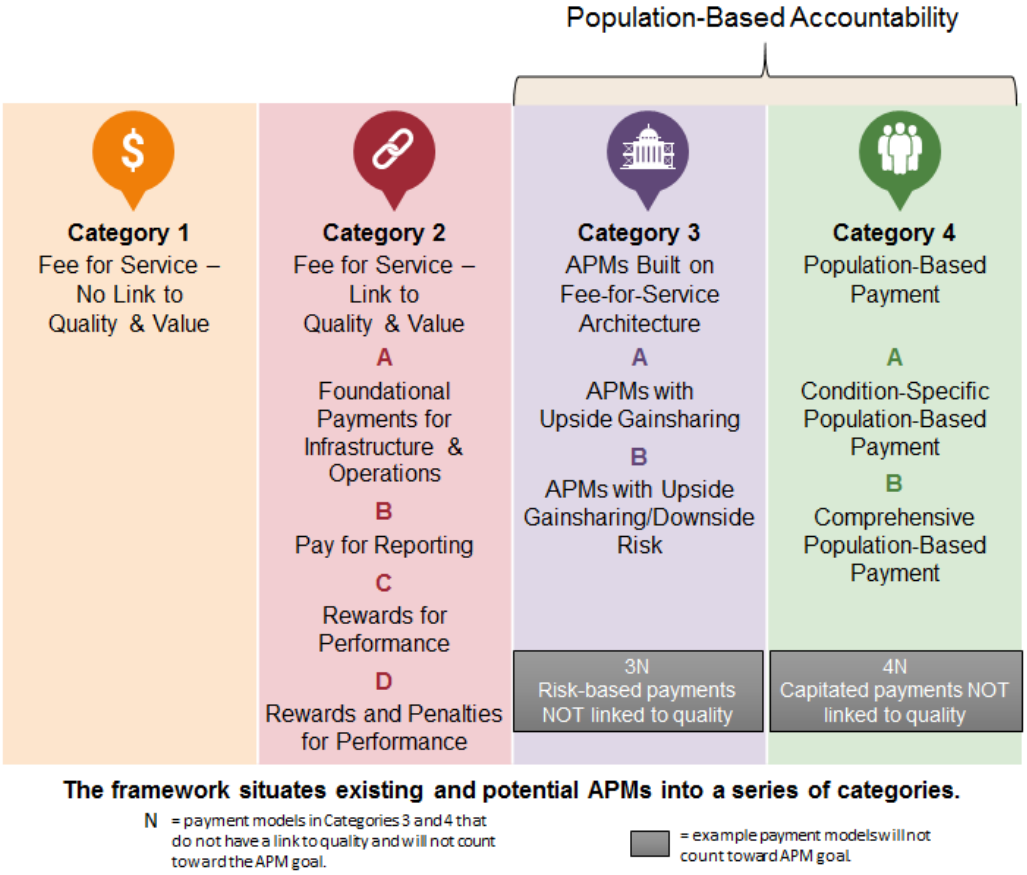
On an annual basis, commercial payers with a specified minimum number of covered lives and Medicaid should submit data to the Office of Health Strategy on their use of value-based payment models. The Office of Health Strategy should annually report on the progress each payer is making toward the value-based payment model targets. Any insurer that fails to meet the goal will be required to submit a public plan of correction to the Office of Health Strategy, identifying action steps being taken to come into full compliance with the targets. The diagram below outlines the HCP-LAN framework for categorizing alternative payment models.

Rationale: In 2015, the U.S. Department of Health and Human Services set a goal that 30 percent of U.S. health care payments would be in value-based payment models by 2016 and 50 percent in 2018. These standards were developed out of recognition that the fee-for-service health care payment system rewards volume over value of services, leading to overuse, misuse and the devaluing of lower-priced services like primary care and mental health. By changing the health care payment system to one that rewards the quality of care provided and the efficiency with which it is provided, it is expected that the health care system will save money, while at the same time, improving the quality of care provided. To track progress to the HHS goals, the Health Care Payment Learning Action Network (HCP-LAN), a national collaborative body, was created and was charged with creating a "framework for categorizing value-based payment models and establishing a standardized and national accepted method to measure progress in the adoption of [value-based payment] across the U.S. health care system."[58]

Similarly, one of the goals of Connecticut's SIM model is to promote payment models that reward improved quality, care experience, health equity and lower cost. The Connecticut SIM initiative has set a goal to have 89 percent of Medicaid beneficiaries in the PCMH+ program, and 88 percent of the Connecticut population going to a primary care provider responsible for the quality and cost of their care by 2020.

[58] Alternative Payment Model (APM) Framework. January 12, 2016. https://hcp-lan.org/groups/apm-fpt/apm-framework/

HCP-LAN Framework for APMs



Source: https://hcp-lan.org/groups/apm-fpt/apm-framework/

3. Coordinate and Align State Strategies by Creation of an Office of Health Strategy

Recognizing the value of having a more coordinated state strategy and identifying a locus of accountability, the Cabinet recommends the following strategy.

Recommendations: The Cabinet recommends the creation of an Office of Health Strategy that would effectively develop and implement key components of the state's cost containment strategy by having the authority to work with other state agencies and providing technical expertise and facilitation support for the State's strategic direction.

Rationale: The Office of Health Strategy would create the infrastructure necessary to implement key cost containment strategies, such as the cost growth target, and provide an entity to be accountable for developing and implementing a coordinated state cost containment strategy. By having clear accountability and authority, there is the opportunity to maximize state programs to drive cost saving initiatives within both the public and private sectors.

To effectively develop and implement key components of the state's cost control strategy, the Cabinet recommends creation of an Office of Health Strategy that reports to the Governor and has the appropriate authority to effectively implement the following seven key responsibilities:

1. Convene the appropriate Task Forces, Councils, Cabinets, including those supported through the SIM project, and consumers, for the purposes of developing a comprehensive and cohesive health care vision for the state.

2. Develop and implement the cost growth target, which will require close collaboration with CID, Medicaid, the Comptroller's Office and the agency implementing the CON and budget review processes.

3. Track and report on the progress all payers are making toward value-based payment, utilizing the HCP-LAN Alternative Payment Model framework as guidance.

4. Study and then, based on the results of the study, consider developing, as appropriate, other payment and delivery system reform models, including a global payment model that is based on the total cost of care paid by all payers. The Office of Health Strategy should study the feasibility of Connecticut implementing a rate-setting process based on a total cost of care model. In collaboration with the CID, it should also study whether and how consumer affordability can be incorporated into the CID rate review process.

5. Create forums within state government and with external stakeholders to discuss health care issues in a manner that develops trust and leads to the development of effective health care cost and quality strategies. The Health Care Cabinet should serve as an advisory board to the Office of Health Strategy. To assure effective stakeholder representation the Health Care Cabinet should be modified in statute to more accurately reflect the broad public and private health care stakeholders, for example, but not limited to including primary care physicians, integrated provider organizations, health plans, long-term care providers, consumers and liaisons to existing committees or Task Forces, like MAPOC and BHPOC. The Office of Health Strategy may also create or seek additional input from existing consumer input groups to obtain the views of health care consumers in the state, but specifically those insured through Medicaid, the state employee health benefit plan, and through commercial insurers. The goal is to create a coordinated process for hearing stakeholder input as aligned strategies are developed across the state.

6. Fulfill the requirements of Section 19 of PA 15-146 to study the rising health care costs. Annually publish a report that reports compliance (or non-compliance) patterns, cost drivers, and recommendations for meeting the cost growth target, if it is not achieved. Every two years, report on price variation among Connecticut providers, including variation by most frequent and most high-cost services, and report on any changes since the prior report.

7. Initiate efforts to improve multi-payer alignment regarding delivery system and payment reform models, quality measurement and any other payment or delivery system reform strategies that benefit from consistency across payers. The Office of Health Strategy should work closely with SIM to accomplish these goals.

Fifteen members of the Cabinet voted for this strategy while three voted against this strategy. Those Cabinet members who voted against this strategy did so for several reasons, including the cost of establishing the Office of Health Strategy and concerns that it could be duplicative of existing bodies.

4. Support Market Competition by Expanding the Attorney General's Powers to Monitor Health Care Market Trends

Recognizing the difficulty in obtaining accurate and reliable information about industry practices, the Cabinet sees the need for more systematic investigations of concerning practices by a state agency with appropriate experience and, therefore, recommends the following strategy.

Recommendation: The Cabinet recommends that the Attorney General have the necessary authority, if funds are available, monitor health care market trends by collecting information from any provider, provider organization, private health care payer or public health care payer through document production, answering interrogatories and providing testimony under oath with regard to health care costs and cost trends, the factors that contribute to cost growth within the state's health care system and the relationship between provider costs and payer premium rates.

The Attorney General, in collaboration with the Office of Health Strategy, should hold a public hearing no less than annually at which providers and representatives from provider organizations, private health care payers and public health care payers testify and answer questions regarding health care market trends, including but not limited to health care costs and cost trends, the factors that contribute to cost growth within the state's health care system and the relationship between provider costs and payer premium rates. Participants should also be expected to provide testimony regarding any specific topics identified in advance by the Attorney General or the Office of Health Strategy.

In anticipation of the annual public hearing, the Cabinet recommends that the Attorney General publish a report on key topics relevant to health care market trends, such as, but not limited to: price disparities for health care services, relationship between price and quality of services provided, effectiveness of payment reform to reduce costs and improve quality, health service disparities by race and ethnicity, the behavioral health care market, and pharmaceutical costs. The report should detail the market practices that impact costs without identifying providers unless the practice is publicly known to be followed by a specific market place participant. For

example, if a leading commercial payer was pursuing a total cost of care strategy with downside risk and publicly promoted this practice as a market differentiator, and the Attorney General chose to investigate the effectiveness of this contracting strategy on containing costs, the Attorney General could name the payer in its report, if it were important to the findings to do so.

The Attorney General, who currently has authority to challenge mergers and acquisitions under Connecticut's anti-trust laws, could use any of the information provided to pursue an anti-trust case, if illegalities were uncovered.

Rationale: The role of the Attorney General as investigator and reporter is key to assuring data and information transparency. While other state agencies have the authority to collect and report on health care market trends, the Attorney General, as an independent office, would have the ability to investigate and report on politically-sensitive marketplace issues independently. Working with the Office of Health Strategy on an annual public hearing, the Attorney General's Office would help make these issues more transparent.

Once a new issue is disclosed and better understood because of the Attorney General's work, other state agencies would be in a better position to maintain on-going oversight by collecting and reporting on data similar to that initially collected and reported on by the Attorney General and by implementing strategy initiatives to address concerning practices. In this role, the Attorney General would serve as the state's investigative probe.

By working collaboratively with the Office of Health Strategy and other state agencies, the Attorney General would be 1) furthering the State's understanding of the underlying causes of health care cost increases, 2) providing information and policy recommendations for an aligned state health care policy and 3) working with other state agencies to systematize oversight of and transparency regarding important health care market issues.

To assure that the Attorney General was collecting appropriate data and correctly interpreting it, the Attorney General should seek consulting services from people with strong familiarity with the Connecticut marketplace. Their expertise might include detailed understanding of network contracting, clinical quality measurement, financial analysis, actuarial analysis, health care economics, pharmaceutical pricing, data analysis, and behavioral health service delivery. The expertise needed might vary depending on the specific market practice or market segment under investigation.

By producing a report and by participating in public hearings at least annually, the Attorney General should be held accountable publicly, and unable to pursue "fishing expeditions." Moreover, the areas of inquiry should be guided by outside experts with in-depth knowledge of the Connecticut health care marketplace.

Cost: The Attorney General will need to determine what personnel resources its office requires to fulfill this requirement, and the Legislature would need to appropriate such funds. Based on the experience in Massachusetts the funding for additional consulting services is between $200,000 and $500,000, depending on the areas of investigation the office wishes to pursue.

This strategy passed with unanimous consent.

5. Support Provider Transformation by Augmenting Existing Funds and Programs to Support Provider Transformation through Applying for Federal DSRIP Funds

Recognizing the need to provide technical assistance and funding support for providers who are participating in delivery system transformation, the Cabinet recommends consideration of augmenting existing funds and programs to support provider transformation through a potential application for a federal Delivery System Reform Incentive Payment (DSRIP) Program. For more information on the existing financial support programs currently available to providers, see Appendix D.

Recommendation: Provide new capital and support to continue the acceleration of practices achieving improved health outcomes efficiently, while reducing the growth of health care spending. The Cabinet recommends that DSS study and consider pursuit of a five-year Delivery System Reform Incentive Payment (DSRIP) program that would allow the State to access new federal funds for Medicaid provider infrastructure development, system redesign, clinical outcome improvements and population-focused improvements, if the federal government continues the program under a new administration. If DSRIP is no longer available, the State should study and consider pursuing any program that allows for new federal funds for Medicaid provider transformation, if one exists. Under the current DSRIP program, funds to providers are tied to meeting state-defined milestones and metrics. These funds would augment the existing funds available through DSS's Person Centered-Medical Home Program, the Electronic Health Record Incentive Program, the Behavioral Health Homes, and the SIM program.

Rationale: The rapid transformation of the health care system from episodic care to a value-based payment system that is cost-effective requires providers to deliver health care in a new manner, utilize new technology (e.g., population health analytic tools and electronic medical records), and hire new staff (e.g., care managers, community health workers). Providers need financial and technical support to build required infrastructure.

CMS is providing states with significant funding through DSRIP programs to support Medicaid provider transformation. To date, individual states have received between $34 million and $6.5

billion in support.[59] Utilizing a Section 1115 waiver, states negotiate special terms and conditions that outline key design elements for DSRIP programs and provide a conceptual framework, including performance reporting and outcome requirements. All DSRIP programs intend to achieve the Triple Aim. Participating provider organizations earn DSRIP incentive payments by demonstrating implementation of projects or development of infrastructure that focus on management of health and wellness for a designated population. Each state's DSRIP program reflects its own Medicaid program and delivery system needs and a state-defined strategy.

Connecticut could use the funds to support provider engagement in any existing delivery system reform initiative, or Health Care Cabinet proposed initiative, including to assist providers in transforming into CCOs. It could also assist providers through programs that DSS is considering, including for community reintegration of justice-involved individuals, or health homes for children with complex trauma.

Operational Considerations: In order to pursue a DSRIP program, selected state staff would need to be dedicated to the operations of developing and applying for a Section 1115 waiver and developing a proposal for a DSRIP program, for which DSS would need to hire. This work should continue to be directly administered by DSS.

When developing a proposal for a Section 1115 waiver and DSRIP program, the State should be inclusive and transparent, allowing for stakeholder input in the design of the program and the source of the state matching funds. DSRIP programs require the State to identify funds that the federal government would match to make up the incentive payments that are distributed to providers. States have identified many different sources of matching funds, including state general revenue, designated state health programs, intergovernmental transfers from public entities, and provider taxes. Connecticut would first need to identify a source (or sources) of revenues to receive matching funds, and should build into the proposal, like many states have, that a portion of the DSRIP funds go to the state to administer the program.

Additional Operational Details

Designing a DSRIP Program: DSRIP programs across the country are focusing on issues that are most important to their Medicaid program, including behavioral health integration, electronic medical record adoption, workforce development, community integration of justice-involved individuals, improving care for foster children, and general infrastructure development for providers to participate in delivery and payment system reform, to name a few. DSS should consider building upon the SIM CCIP Transformation Awards to support activities, including social determinant assessments, care coordination, community support connections, health technology investment and data integration for population health analytics.

[59] Delivery System Reform Incentive Payment (DSRIP): State Program Tracking. Center for Health Care Strategies, Inc. October 2016. www.chcs.org/media/DSRIP-State-Program-Tracking-102016-FINAL.pdf

For example, Washington recently announced that it will receive $1.125 billion from the federal government for its DSRIP program focused on health systems capacity building (e.g., workforce development, system infrastructure technology and tools), care delivery redesign (e.g., integrated physical and behavioral health care services, recovery support), and prevention and health promotion.

Mitigating Risk of a Section 1115 Waiver: DSRIP funding can only be obtained through a Section 1115 waiver, which is a contract between the federal government and a state. Stakeholder concerns have been raised about how 1115 Waivers have been proposed in other states, and that waivers must be budget neutral to the federal government. To mitigate these concerns, if it develops a 1115 Waiver to request DSRIP program funds, the State should ensure the Waiver not reduce services, scope of the program or eligibility. Specifically, the 1115 Waiver should not institute premium assistance vouchers, eliminate benefits, waive retroactive eligibility, place premiums and copayments on the near-poor or poor, lock beneficiaries out for nonpayment of premiums, institute work requirements, place lifetime limits on coverage, eliminate wraparound benefits for children or restrict family planning care. DSS has raised concerns about their ability to not reduce services, scope of the program or eligibility if the federal government makes significant changes to the financing of the Medicaid program. These issues will have to be weighed carefully when pursuing an 1115 Waiver to request DSRIP program funds.

Regarding budget neutrality, over the course of the Waiver, federal Medicaid expenditures must not be greater than they would have been without the Waiver. Medicaid programs can accomplish this in one of two ways. First, budget neutrality can be achieved by reducing state costs, which Connecticut is actively pursuing, including via initiatives described in strategy 1B "Build on the SIM Agenda and Current Success in the Medicaid Program." In addition, the Health Care Cabinet is considering numerous other cost savings strategies. Second, states may reallocate funds. For example, Colorado, is proposing to utilize existing hospital provider fees and repurposing them for use in a DSRIP program, and thereby not need to offset new federal money with cost savings.

Fifteen members of the Cabinet voted for this strategy while three voted against this strategy. Those who voted against it were largely concerned about the implications of an 1115 Waiver and particularly, the requirement that it be budget neutral.

6. Support Policy Makers with Data

The Cabinet recognizes that for the Office of Health Strategy to be effective, it must have appropriate data. In support of that goal, the Cabinet offers the following strategy.

Recommendations: Ensure that the Health Information Technology Officer equips the Office of Health Strategy with data necessary to fulfill the requirements of section 19 of PA 15-146 to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Public Act 16-77 called for the development of a statewide HIE, and for the Lieutenant Governor to designate an individual to serve as the Health Information Technology Officer (HITO), responsible for coordinating all state health information technology initiatives, including overseeing the development and implementation of the statewide HIE, which would support providers with data. The HITO should be required to work with the Office of Health Strategy to ensure that the Office of Health Strategy has the data necessary from all state resources, including the APCD, to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Rationale: Data are essential for the State to make informed policy decisions, set strategy, and track progress toward goals of health care reform. Given the State is actively pursuing the completion of its APCD and the building of its HIE, this recommendation is focused on how those data can be used to inform the health care reform policy agenda, and is solely focused on ensuring the Office of Health Strategy can complete its recommended work.

Seventeen members of the Cabinet voted for this strategy and one member abstained.

7. Incorporate Use of Evidence into State Policy Making

The Cabinet recognizes that increasingly data comparing the effectiveness of different procedures and services are available and can be incorporated into health care decision-making. To further an informed decision-making process, the Cabinet supports the following strategy.

Recommendations: The Cabinet recommends that DSS and OSC access outside resources through a new Health Technology Assessment Committee to review and incorporate comparative effectiveness research into policy making and coverage decisions in an effort to reduce unnecessary and costly services.

Rationale: Research indicates that overuse and misuse of health care services are costly problems deserving of attention for both quality of care and cost concerns. Experts estimate that perhaps one-third of all U.S. health care spending produces no benefit to the patient – and some of it produces clear harm.[60] For example, unexplained variation in the use and intensity of end-of-life care, CABG surgery and angioplasty may cost the health care system approximately $600 billion a year in avoidable costs.[61] Angioplasty is inappropriate in about 1 in 10 patients

[60] Wennberg JE, Fisher E and Skinner J. "Geography and the Debate over Medicare Reform." *Health Affairs,* February 2002 Web Exclusive. Berwick DM and Hackbarth AD. "Eliminating Waste in the US Health Care." *Journal of the American Medical Association,* 307(14):1513-1516, April 11, 2012.
[61] "Waste and inefficiency in the US health care system." New England Healthcare Institute. February 2008.

according to experts, and another third may be questionable.[62] Misuse of drugs and treatments may cost $52.2 billion and overuse of antibiotics for respiratory infections may cost $1.1 billion.[63] Use of double CT scans, a common practice in some hospitals, can unnecessarily expose patients to radiation equal to that of about 350 x-rays.[64]

Operational Considerations. A state Health Technology Assessment Committee should be formed within the Department of Public Health to determine the safety and effectiveness of medical devices, procedures and tests and make their recommendations to DSS and OSC.

Unless appropriated, the Health Technology Assessment Committee should not conduct de novo research, but instead leverage the work of well-established medical evidence review organizations, such as the federal Agency for Healthcare Research and Quality (AHRQ), England's National Institute for Health and Care Excellence and the Scottish Intercollegiate Guidelines Network. Two of the most long-standing, collaborative state efforts to reduce overuse and misuse include the Medicaid Evidence-based Decisions (MED) Project and the Drug Effectiveness Review Project (DERP), both operated out of the Oregon Health and Science University's Center for Evidence-Based Policy, for which participating states pay dues. These two multi-state efforts use comparative effectiveness research to answer policy-related research questions and inform benefit coverage considerations with a particular focus on state Medicaid programs. Currently, 19 states are participating in the MED program and 13 states participate in the DERP. Most, but not all, of the involved states participate in both. Connecticut is not participating in either.

The Health Technology Assessment Committee could review the guidelines and research from these external organizations, if they become members, and use that information to make a recommendation regarding under what circumstances and for what conditions the service would be a covered benefit for the respective beneficiaries, or whether a drug should be on the preferred drug list. Careful consideration, however, should be given to limitations of comparative effectiveness research, in particular when research does not adequately study the impact of a service or drug on specific subpopulations or if the analysis does not adequately cover alternative treatment options.

Stakeholder Input. The state Health Technology Assessment Committee should conduct these reviews in a public manner, with ample input from stakeholders, including consumers. Consumers and other stakeholders should be allowed to make suggestions on what services or drugs should be reviewed. In addition, consumers and stakeholder feedback on the impact on removing any covered benefits or prescription drugs from the preferred drug list should be considered before any final policy decision is made.

---

[62] O'Connor. "Heart stents still overused, expert says." *New York Times,* August 15, 2013.
[63] Ibid.
[64] Cheung-Larivee. "Hospitals are overusing double CT scans, risking patient harm, CMS finds." *Fierce Healthcare.* June 20, 2011.

Thirteen members of the Cabinet voted for this strategy while five voted against this strategy. The Cabinet members who voted against this strategy for several reasons including the concerns that similar work is already done by DSS and Medicare.

VI. Stakeholder Input

Stakeholder input was given in several ways throughout the process of the Cabinet's work to develop cost containment strategies for the state. As a first step, the Cabinet's consultants conducted interviews with key stakeholders to obtain feedback on what were the key cost drivers in Connecticut, what current state activities were in place to reduce costs, and what strategies might the State employ to rein in costs across public and privately funded health care. Interviews were conducted with 21 out of 24 of the Cabinet members, and representatives from across the health care spectrum including health plans, hospitals, physicians, the pharmaceutical industry, visiting nurses, employers, unions, consumer advocates and state government leaders who were not Cabinet members. To promote candor, the consultants conducted the interviews with the understanding that there would be no attribution, and that general themes would be shared with the Cabinet.

Second, each Cabinet meeting had a period of public comment that allowed any interested stakeholder to provide feedback to the Cabinet on the progress of its work. Some stakeholders utilized this time including, the Connecticut Hospital Association, individual hospitals, New Haven Legal Aid, independent physicians, and consumers.

The Cabinet utilized the information summarized by the consultants and received through the public comment process to inform their thinking about cost containment strategies that were presented and debated throughout the Cabinet's study.

Last, the Cabinet devoted the November 15, 2016 meeting to stakeholder input for the purposes of receiving feedback on a set of preliminary recommendations that were voted upon and adopted by the Cabinet on November 1, 2016. The Cabinet heard oral remarks from 15 different stakeholders, and an additional 26 stakeholders provided written comment. The most significant amount of feedback was received on three strategies: (a) provide more coordinated, effective and efficient care through CCOs (1B); (b) Create an Office of Health Strategy (3); and (c) Adopt a Statewide Health Care Cost Growth Target (2A). A brief summary of feedback is provided on these three strategies, below. For a full summary of all of the comments, plus links to each stakeholder's original comments see Appendix E.

a) Feedback on *Provide More Coordinated, Effective and Efficient Care through CCOs.* Twenty-nine stakeholders provided feedback on this strategy. Nearly half of the comments were neutral in nature, about a third of commenters were opposed to the strategy and slightly over a tenth were in support of the strategy, and another tenth had mixed viewpoints. Those expressing neutral feedback mostly asked the Cabinet to consider adding

specificity to the CCO model. For example, articulating a primary care patient attribution model with input from a multi-stakeholder group, and adding chiropractic services to the CCO model. Those who opposed the strategy were mostly concerned about CCOs taking on a portion of financial risk for the cost and quality outcomes of the care they provide, fearing this might lead to unintended consequences such as loss of patient access, or restriction on care. Those who supported the strategy noted that fear of shared-risk is unwarranted as it already exists in the marketplace, and that the CCO strategy would continue to build upon the state's SIM initiative and transform the delivery system in a positive way.

b) Feedback on *Create an Office of Health Strategy.* Twenty-one stakeholders provided feedback on this strategy. Nearly half were in support of the strategy, slightly more than a third were opposed to the strategy. Those who were in support stated that further coordination at the state level is important and an oversight entity could be helpful. Many also supported expanding the members of the Cabinet to provide balanced input to the Office of Health Strategy. Those who were opposed expressed concerns about the availability of resources to create this office and about redundant bureaucracy.

c) Feedback on *Adopt a Statewide Health Care Cost Growth Target.* Fourteen stakeholders provided feedback on this strategy. Nearly three quarters were opposed to the strategy, while a third were in favor. Those who were opposed were most aligned around the concerns that a cost growth target cannot be implemented by Medicaid without first addressing the "deficient reimbursement environment" for hospital and long-term care providers. Those in support of the concept thought it would create additional transparency of the health care market in the state.

The Cabinet appreciated the robust stakeholder input and utilized the feedback prior to approving the final set of recommendations that are included in this report.

VII. Next Steps

The Cabinet views the submission of this report to the Legislature as a first step in its mission to pursue effective cost containment strategies for Connecticut. As a result of this initiative, the Cabinet intends to pursue the following areas of activity.

Prescription Drug Strategies. Prescription drug costs for both generic and brand drugs is an important driver of heath care costs. To start discussion of this issue, the Cabinet solicited input from several volunteers from the Cabinet to raise a set of potential issue areas for further discussion. Those potential issue areas are attached as Appendix F. Because the Cabinet in full did not have sufficient time to fully explore these issue areas, hear from multiple stakeholders and experts on these issue areas or prescription drug costs generally, or to discuss, select, debate or vote upon strategies designed to address the issue areas in time to include them in

this report, the Cabinet intends in 2017 to address the issue areas and will submit an addendum to this report on Prescription Drug Strategies.

Flexible Benefit Design. The Insurance Commissioner raised concerns that the Cabinet did not fully study how flexible benefit and value-based benefit design strategies might be able to slow the rising costs of health care. The Cabinet agreed that it would like to look at design options in benefit and network design both on and off the exchange, as well as state mandates that may be affecting health care premium costs in 2017. Comments provided by the Insurance Commissioner are included as Appendix G.

Substance Use and Mental Health Forces Impacting Health Care Costs. Stakeholders raised concerns that the work of the Cabinet did not address two key drivers of health care costs: (1) the opioid epidemic; and (2) the need for more and better integrated behavioral health services. The Cabinet considers these to be very important topics and will be taking steps to understand what the needs are and what best practices could be introduced or more widely adopted in Connecticut.

High Emergency Department Utilization. High emergency department utilization is symptomatic of problems in the delivery of health care, including lack of access to primary care providers, ineffective management of chronic conditions that can be controlled, and lack of understanding of how to effectively use the health care system. Since high emergency department utilization is a cost driver in Connecticut, the Cabinet will investigate the causes for and possible solutions to the high use of emergency services. DSS has already performed extensive analysis on high need, high cost individuals under the NGA High Need, High Cost Policy Academy and will use this information to inform the Cabinet's work. The Cabinet believes, however, that its recommendations regarding Delivery System and Payment Reform (see Section I, above) will help address this issue.

Cost Growth Target. If the Legislature charges the Cabinet with the responsibility of developing a cost growth target methodology, the Cabinet will begin its work as soon as possible by developing a strong understanding of possible methodologies, discussing issues and concerns with stakeholders and developing a recommended methodology and implementation plan, including a timeline, for moving forward with this strategy. This will be a significant undertaking because of the methodological complexities and the need for the adopted methodology to be fair to all those impacted.

Trust. The need for a more trusting culture was a theme that came up throughout the work of the Cabinet. All stakeholders feel a need to build more trust and believe that more trust will enable Connecticut to implement needed strategies to contain costs. The Cabinet believes that if its suggestions for broadening the representation of the Cabinet are implemented, it can play an important role in providing a safe forum to start building that trust. The co-chairs of the Cabinet will focus on incorporating processes during Cabinet meetings to specifically address trust. One possible approach is to hold facilitated discussions of "third rail" topics among

stakeholders with the goal of understanding and addressing underlying concerns. Building trust will require long-term commitment and strong leadership, which the Cabinet is prepared to provide.

VIII. Conclusion

In response to PA 15-146, the Health Care Cabinet spent 11 months engaged in a process to develop a comprehensive set of cost containment strategies aimed at affecting health care costs for all Connecticut residents and informed by the work of other states. If the recommendations in this report are implemented, Connecticut would take a significant step forward to reduce the cost and improve the quality of health care for all residents.

Appendix A
Health Care Cabinet Operating Principles

(Approved June 14, 2016)

1. Commitment to Impact: Contribute to the improved physical, behavioral, and oral health of all Connecticut residents as seen in the following:

a. The number of individuals and/or constituencies affected
b. The depth and/or intensity of the problem
c. Reduction of barriers and burdens for those most vulnerable
d. The time frame in which change can occur
e. The cost effectiveness of health and health care purchasing that promotes value and optimal health outcomes.
f. A health insurance marketplace that provides consumers a competitive choice of affordable and quality options**.**

2. Equity in health care delivery and access: Recommendations incorporate the goal of reducing disparities based on race, ethnicity, gender, and sexual orientation.

3. Leverage: Recommendations must:

a. Make the best use of past and current knowledge and expertise.
b. Maximize the opportunities provided through initiatives from the public and private sector.
c. Be informed by data and evidence-based practice and research.
d. Be sustainable.

4. Accountability and Transparency: Be fully accountable to the public in a transparent process that meets the objectives of Public Act 11-58.

a. Identify and measure outcomes that demonstrate meaningful results
b. Maintain consumer-driven goals throughout the process

5. Inclusion: Ensure that there are meaningful opportunities to obtain a broad cross-section of views from all stakeholders, including consumers, communities, small business, payers, providers and government.

6. Action: All recommendations must take into account implementation and position of Connecticut to seize opportunities.

Appendix B
Survey of Cost Containment Strategies of Maryland, Massachusetts, Oregon, Rhode Island, Vermont and Washington

PA 15-146 directed the Cabinet to identify successful practices and programs that were implemented in Maryland, Massachusetts, Oregon, Rhode Island, Vermont, and Washington for the purposes of (1) monitoring and controlling health care costs; (2) enhancing competition in the health care market; (3) promoting use of high-quality health care providers with low total medical expenses and prices; (4) improving health care cost and quality transparency; (5) increasing cost effectiveness in the health care market; and (6) improving the quality of care and health outcomes. The review of state activities revealed five key themes, including that:

a. significant delivery system and payment system reform is occurring across the U.S.;
b. health care cost and quality data are a necessary supporting foundation for informed state policy making;
c. aligning state strategies across state purchasing and regulatory agencies can drive broader change in the marketplace;
d. marketplace dynamics play an important role, and
e. trust has been a linchpin for many successfully developed and implemented state cost containment agendas.

Each of these five themes is discussed below.

1. Delivery System and Payment System Reform

Each of the states studied is in the process of promoting alternative delivery models that aim to lower health care costs. Most have implemented a version of a patient-centered medical home (PCMH) model that enhances the role of the primary care practice in proactively promoting preventive services and managing chronic conditions. It is a practice model characterized by provider-based care management of high-cost patients, team-based care, and reliance on evidence-based care protocols to provide high quality care. The model includes services that are traditionally not paid for under a fee-for-service model, but that are recognized as providing significant value to the patient, such as intensive care management and care coordination services. The PCMH delivery model is typically complemented by a supplemental payment that financially supports the practice for the added functions it performs. The underlying payment model typically remains fee-for-service.

Most of the states that the Cabinet studied have or are now expanding their delivery system reform strategy beyond primary care to incorporate broader systems of care that include institutional providers, such as hospitals and skilled nursing facilities, and specialist providers, including behavioral health providers. These new delivery system models go by several names, including coordinated care organizations, accountable care organizations (ACOs), and in

Connecticut "Advanced Networks." They may be hospital-based or physician organization-based. They focus on promoting the health of a defined group of patients receiving their care from the system's primary care providers. They use health care data extensively to drive delivery system change by, for example, identifying high-utilizing patients and comparing quality processes and outcomes across providers.

To financially support these new models of integrated care, state Medicaid and commercial payers are moving toward value-based payment. Value-based payment is a concept used to describe the move away from a volume-based incentive payment model i.e., solely fee-for-service to one that rewards providers for delivering high quality care in an efficient manner. Value-based payment models range from pay-for-performance where providers receive bonuses based on quality performance, to population-based payment models where providers have a per-member per-month budget for providing care needed and the opportunity to share in savings if the costs at the end of the year are below budget. Value-based payment models are generally believed to influence the cost and quality of health care.[65]

In some of the states studied, Medicaid and commercial payers are now supporting ACOs and other integrated delivery system models with population-based payment models. All the payment models include carefully defined quality targets that must be achieved in order to share savings. Among the studied states, some payers are using prospective payments, including some commercial payers in Massachusetts, and Medicaid in Oregon. Many payers, however, continue to pay fee-for-service and conduct a year-end reconciliation. Consistent with the direction of Medicare,[66] commercial and some Medicaid payers are introducing risk-sharing models in recognition that meaningful downside risk is an important, if not essential, incentive to drive delivery system reform. A brief synopsis of each state's activities with respect to delivery system and payment system reform follows.

- Maryland. Maryland's dominant commercial carrier, CareFirst, implemented a network-wide PCMH initiative in 2011. It is characterized by a robust suite of data, behavioral health, pharmacy management and care management support services which are provided by the health plan to the PCMH practices and patients. The model rewards providers for their engagement through higher fee-for-service payments. The plan has reported significant increases in quality of care and cost savings.[67]

  In 2014, Maryland entered into an agreement with CMS to implement an all-payer annual hospital per capita revenue growth ceiling of 3.58 percent for Maryland

[65] Cheryl Damberg et al. "Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussion," Rand Corporation 2014.
[66] The Medicare Shared Savings Program (MSSP) and Next Generation ACO model both include risk-sharing provisions. Medicare's episode-based payment models also include risk sharing.
[67] CareFirst 2014 PCMH Program Performance Report. See https://member.carefirst.com/members/news/media-news/2015/quality-remains-strong-as-cost-increases-for-members-in-patient-centered-medical-home-program-slow-dramatically.page. Last accessed November 27, 2016.

residents.[68] To implement the hospital cost growth cap, hospitals must adhere to a state-approved annual budget that covers all inpatient and outpatient services. Fee-for-service payment levels are adjusted up or down over the course of the year based on the volume of services provided in order to achieve the target budget payment level. Hospitals are, therefore, incentivized to reduce inpatient and emergency department utilization and coordinate with community-based providers to improve patient health in order to reduce utilization of these services and generate a margin. Per the terms of Maryland's waiver agreement with CMS, Maryland will expand the scope of the budget to include all community-based services.[69] An assessment of the first year's results indicated cost growth significantly below the annual target and improved quality performance with respect to reducing preventable conditions (such as central line infections) and preventable admissions.[70]

- Massachusetts. Delivery system and payment reform in Massachusetts has been driven by Blue Cross Blue Shield of Massachusetts (BCBSMA), the dominant commercial payer in the state. In 2009, BCBSMA initiated its Alternative Quality Contract for ACOs, which rewards providers for improving quality and reducing costs. All of these contracts include both upside and downside risk, and limit the rate of cost growth over the multi-year term (usually five years) of the contract. An evaluation of the Alternative Quality Contract showed both statistically significant improved quality and cost savings.[71] Other commercial insurers have implemented similar risk-sharing contracts with providers.

  The Massachusetts Medicaid program, MassHealth, began promoting PCMH practice transformation in 2011, supported by a payment model that included supplemental care management and infrastructure payments. MassHealth then implemented a three-year pilot population-based payment model that was focused on PCMH practices improving their behavioral health integration and taking financial responsibility for a large majority of health care services. MassHealth has more recently moved its focus away from PCMH and towards a broader ACO strategy.[72] A procurement involving three different models of risk-sharing was underway as of the date of this report.

- Rhode Island. The Rhode Island Office of Health Insurance Commissioner (OHIC) is the driving force for delivery system and payment reform in the state. OHIC has

[68] Health Services Cost Review Commission. Report to the Governor. October 2015. www.hscrc.state.md.us/documents/pdr/ar/Governor-Report-MD-HSCRC-2015.pdf
[69] Centers for Medicare and Medicaid Innovation. Maryland All Payer Model Description. https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
[70] A. Patel, JD, R Rajkumar, MD, JD, et al. "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model" *New England Journal of Medicine;* November 12, 2015.
[71] Z. Song, D G Safran, B E Landon, et al. "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract" *New England Journal of Medicine;* 365:909-918 September 8, 2011.
[72] McCluskey PD. "Overhaul planned for MassHealth insurance model" *Boston Globe*, April 15, 2016.

implemented a series of requirements, referred to as Affordability Standards,[73] which are designed, in part, to strengthen the primary care sector. Created in 2010 and last revised in 2015, the Affordability Standards require commercial insurers to pay at least 10.7 percent of total medical spend for primary care services, 9.7 percent of which must be for the direct benefit of providers, such as payments for providing health care services, for meeting quality goals, and for infrastructure payments. The Affordability Standards also set PCMH targets for commercial payers, specifically that no later than 2019 80 percent of primary care practices must function as a PCMH. The Rhode Island Medicaid program has also adopted this target.

The Affordability Standards also establish ACO contracting targets that require commercial payers by the end of 2016 to have 45 percent of their covered lives under population-based contracts, with at least 10 percent covered by a contract with shared downside risk. OHIC will set additional targets for 2017 and beyond.

Finally, the Affordability Standards set targets regarding the types of alternative payments methodologies (APM) payers must employ. In aggregate, during 2017, commercial insurers are expected to have 40 percent of their payments under APMs, rising to 50 percent in 2018. Eligible APMs include capitation, shared risk, shared savings, bundles, and (for 2017 only) supplemental payments. In addition, during 2017 commercial insurers must have 6 percent of their medical payments in the form of non-fee-for-service payments, which includes bundles, capitation, quality payments, shared savings, and supplemental payments. This target rises to 10 percent in 2018.

- Oregon. Oregon has a three-pronged strategy regarding delivery system and payment reform. First, Oregon has promoted PCMH transformation among primary care providers since 2009.[74] Oregon certifies primary care practices as PCMHs when they achieve specific standards. To assist practice efforts, Oregon provides technical assistance to practices undergoing transformation. By 2014 over 80 percent of Medicaid beneficiaries enrolled in Coordinated Care Organizations (CCOs) were served by a recognized PCPCH.[75] A recent evaluation found that PCPCHs had produced cost savings.[76]

  Second, the Oregon legislature created the Oregon Health Evidence Review Commission in 2011 as a successor to two prior commissions dating to the 1992.[77] The Health Evidence Review Commission is responsible for reviewing research of well-established medical evidence review organizations to assess comparative effectiveness of services

[73] See www.ohic.ri.gov/ohic-reformandpolicy-affordability.php. Last accessed November 27, 2016.
[74] See www.oregon.gov/oha/pcpch/Pages/about_us.aspx. Last accessed November 27, 2016.
[75] Patient-Centered Primary Care Home Program 2014 -2015 Annual Report, Oregon Health Authority, October 2015.
[76] Gelmon et al. "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Findings" Portland State University, Portland, OR, September 2016.
[77] See www.oregon.gov/oha/herc/Pages/About-Us.aspx. Last accessed November 27, 2016.

and pharmaceuticals. The Commission uses the comparative effectiveness research to prioritize Medicaid coverage. Commercial insurers use these analyses to assess under what circumstances services (such as surgery for low back pain) is most appropriate and what treatments should be tried first.

Third, Oregon Medicaid has contracted with regional organizations, called Coordinated Care Organizations (CCOs), which are responsible for providing all services to Medicaid beneficiaries within each region and for improving the health of the broader population. At the direction of the state, the CCOs have been implementing alternative payment models within their provider networks to promote more efficient and higher quality care.[78]

- Vermont. The Vermont Blueprint for Health,[79] initiated in 2003, is built on primary care PCMHs that are supported by regional multi-specialty Community Health Teams (CHTs). The CHTs include both clinical staff such as nurse care managers, pharmacists and behavioral health clinicians, and also social service staff. CHTs focus on assuring that the highest risk patients receive integrated, coordinated services. In addition to fee-for-services payments, PCMH practices receive a supplemental per-member-per-month payment for achieving NCQA PCMH recognition and are eligible for a quality incentive for achieving quality targets. All of the state's major commercial and public payers, including Medicare, contribute to practice payments and to the costs of the regional CHTs. PCMHs do not assume any downside risk.

  Effective January 1, 2018, most Vermont providers will be participating in a single, state-wide, all-payer ACO.[80] The ACO will receive a single risk-adjusted, prospective, capitated payment for services to be provided to each participating member from Medicaid, Medicare and in all likelihood, the state's dominant insurer. The majority of health care services will initially be included in the all-payer ACO, with the exception of pharmacy, long-term care, and some behavioral health care. Those services are targeted to grow at 3.5 percent per year across all payers for five years, with a ceiling of 4.3 percent per year. For providers that do not participate in the single ACO, the Green Mountain Care Board, a quasi-independent state agency responsible for developing and implementing state health care policy, may exercise its authority to determine the payment rates.

- Washington. Delivery system and payment reform efforts in Washington are being directly promoted by the Washington Health Care Authority, which oversees the state's Medicaid program and the state employee and retiree health plan (PEBB). In 2016, PEBB

[78] Leof A, Curtis P, Gordon C, Thielke A, Evans R and Pinson N. "Alternative Payment Methodologies in Oregon: The State of Reform" Center for Evidence-based Policy, Oregon Health & Science University, Portland, OR, 2014.
[79] See http://blueprintforhealth.vermont.gov/. Last accessed November 27, 2016.
[80] See http://gmcboard.vermont.gov/payment-reform/APM. Last accessed November 27, 2016.

began to contract with ACOs on a total cost of care basis and has plans to expand the program in 2017. In October 2016, CMS approved the Washington Health Care Authority's Section 1115 Medicaid demonstration waiver application, which provides up to $1.5 billion in federal funding for provider delivery system reform activities, and aims to hold Medicaid per capita cost growth to two percentage points below national trend through a reduction of avoidable use of high-cost services, improvement in population health, and advancing value-based payment models.[81] Washington is also establishing Accountable Communities of Health, which are regionally governed, public-private partnerships that align initiatives to achieve healthier communities and populations.[82]

Finally, Washington, like Oregon, pursues a strategy to promote evidence-based care. The Washington Health Technology Assessment Program reviews six to ten new health technologies annually with the goal of providing coverage recommendations that will be used by all state agencies to make informed, consistent coverage decisions. Another entity, the Bree Collaborative, which is a consortium of public and private agencies (employers, union trusts, health plans, providers, hospitals) created by the legislature in 2011, annually reviews up to three health care services with significant variation in care delivery. The Collaborative's goal is to develop evidence-based recommendations to reduce variation. The HCA is incorporating these recommendations into state Medicaid MCO contracts to reduce service variation.

2. Data

Delivery system redesign and payment reform are built on a foundation of data. Most of the six states included in the study have developed very strong data collection, analytic and reporting capabilities. Some states have developed the capability within state government, while others partner with external organizations. States use data for four key purposes:

1. to collect and report data on state-wide cost trends, including understanding key cost drivers by type of service and type of service provider;
2. to measure and track attainment of specific cost and quality goals by health care providers;
3. to provide an electronic platform to allow consumers and providers to share meaningful clinical data (Health Information Exchanges (HIEs[83])); and

[81] See www.hca.wa.gov/assets/program/waiverfactsheet_0_0.pdf. Last accessed November 27, 2016.
[82] See www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach. Last accessed November 27, 2016.
[83] "A Health Information Exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically – improving the speed, quality, safety and cost of patient care." Health IT.Gov www.healthit.gov/providers-professionals/health-information-exchange/what-hie

4. to provide consumers with cost and quality data at the provider and service level to support informed decision-making.

Data transparency is a key component of each state's data strategy. States have found that shining a light on cost and quality trends is a powerful tool for changing the nature of discussions with providers and for accelerating adoption of payment and delivery system reforms.[84] A summary of each state's data strategy follows.

- Maryland. Maryland has a comprehensive statewide data collection strategy for the purposes of policy making, evaluation and demonstration of programs, and quality reporting operated by the Maryland Health Care Commission which collects, maintains, releases and reports on data from health facilities and insurance companies.[85] The Health Services Cost Review Commission, the independent agency responsible for regulating hospital rates collects, collects myriad data regarding hospital inpatient and outpatient costs, which are needed to implement the state's all-payer global hospital budget initiative.[86] The state collects and reports on specific cost and quality measures required by CMS, including all-cause readmissions rates, per capita spending levels, reductions in potentially preventable conditions, and rates of infection due to central venous catheters and catheter-related urinary tract infection.

  The dominant commercial insurer, CareFirst, has developed a robust data reporting system for all primary care providers participating in its PCMH initiative. CareFirst distributes provider reports on levels of PCP engagement in the PCMH initiative, appropriate use of services, effectiveness of care, patient access and structural capabilities around e-prescribing, use of electronic medical records, and medical home certification. This type of reporting and information sharing with providers can help providers engage in new delivery system and payment reform models. CareFirst also tracks and reports publicly on 10 cost and utilization measures, such as per member per month costs, cost per emergency room visit, admissions and days per 1000 members, and all-cause readmissions per 1000 members.[87]

  In addition the state has a Health Information Exchange (HIE) that has been in operation for five years. All hospitals participate by sharing clinical information about individual

[84] David Cutler and Steven M. Walsh, "The Massachusetts Target on Medical Spending Growth," NEJM Catalyst, May 11, 2016. http://catalyst.nejm.org/massachusetts-target-medical-spending-growth/
[85] Maryland Health Care Commission. Health Data and Quality. https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/ Last accessed November 30, 2016.
[86] For a listing of databases see: www.hscrc.state.md.us/hsp_Data1.cfm Last accessed November 30, 2016.
[87] Care First Blue Cross and Blue Shield. "2014 PCMH Program Performance Report." July 30, 2015. https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-performance-report-2014.pdf

hospital health encounters and other clinical information. Some ancillary providers (i.e., labs and radiology sites) and long term care facilities also participate in the HIE.[88]

- Massachusetts. Massachusetts is a data rich state. It has implemented a robust, multi-pronged data collection and reporting strategy. In 2008, the state legislature gave the Attorney General broad subpoena power to collect confidential information from plans and providers for the specific purpose of examining and reporting on cost trends. The Attorney General's office sent four cost reports to the legislature between 2010 and 2015.[89] These reports disclosed market power as the reason for price variation among providers, price as the key driver of cost increases, and examined the impact of global payment models on medical spending.

  In 2012, Massachusetts created the Center for Health Information and Analysis (CHIA), a quasi-independent entity charged with the responsibility of collecting, analyzing and reporting data on cost and quality trends.[90] CHIA is funded through insurer and hospital fees. It maintains five different databases:

  - an All-Payer Claims Database (APCD);
  - an acute hospital case mix database which has patient-level data from hospital inpatient, observation and emergency department visits;
  - hospital financial performance data;
  - long-term care data; and
  - payer data, including total medical expense, relative prices, alternative payment methods being used and provider payment methods being used.

  CHIA-produced data are used by state agencies to make policy decisions. In addition, market participants (payers and providers) use CHIA data for benchmarking, strategic planning, and market analyses, and researchers access de-identified data for research studies.

  The state's Health Policy Commission, also created in 2012, uses CHIA databases to create its own reports that focus on aggregate cost trends and whether the Massachusetts statewide per capita cost growth target has been met.

[88] Maryland Health Care Commission. "Maryland HIE Evaluation Results Report." April 2014. http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_MD_HIE_Evaluation_Rpt_20140401.pdf
[89] The Massachusetts' Attorney General's annual reports on cost trends and drivers may be accessed at www.mass.gov/ago/bureaus/hcfc/the-health-care-division/
[90] See www.chiamass.gov/chia-data/ Last accessed November 30, 2016.

Finally, and also in 2012, the state launched one of the first HIE's in the country.[91] The state requires all providers to have electronic medical records and computerized order entry systems to help facilitate the exchange of clinical data among providers.

- Oregon. Like Massachusetts, Oregon has a statewide data collection and reporting strategy. Unlike Massachusetts which created a quasi-independent agency (CHIA) to lead reporting efforts, Oregon embeds its data reporting and analytic function within the Oregon Health Authority (OHA), which is responsible for managing all state-purchased health care programs and establishing statewide health care strategies.[92] The OHA has also partnered with academic medical centers to enhance its data analytic capabilities. In exchange for easier access to data, the academic medical centers provide timely research results to OHA. Oregon Medicaid (a part of OHA) collects and publicly reports comparative data on 17 quality metrics that are tied to Coordinated Care Organization financial incentives, and on 33 quality and access metrics for which OHA is responsible to CMS. The reporting also includes data on changes in health disparities over time. OHA's reports promote public accountability on the part of the CCOs to provide quality health care to Oregon Medicaid beneficiaries.

  Oregon also has a Health Information Technology Oversight Council (HITOC) that is tasked with setting goals and developing a strategic health information technology plan for the state, coordinating the adoption of electronic medical records and development and participation in the statewide HIE.[93]

- Rhode Island. Rhode Island is in the early stages of building an APCD and HIE. Most of the data collected and reported by the state, therefore, has been done by the Office of the Health Insurance Commissioner for the purposes of tracking payer compliance with the Rhode Island Affordability Standards, described earlier. The data collected tracks information such as the percentage of total insurer spending going to primary care providers, the percentage of primary care providers functioning as PCMHs, and the percentage of health care payments made pursuant to population-based contracts with upside and/or downside risk, and the percentage of health care payments made under non-fee-for-service methodologies. The Office of the Governor is currently considering implementing a statewide cost growth cap and a methodology for collecting and tracking adherence.

- Vermont. The Blueprint for Health, the state's PCMH program, administered by the Department of Vermont Health Access, distributes all-payer, practice profile reports that

[91] MassHIway http://mehi.masstech.org/ehealth/health-information-exchange/mass-hiway Last accessed November 30, 2016
[92] See www.oregon.gov/oha/analytics/Pages/index.aspx Last accessed November 30, 2016.
[93] See Health Information Technology Oversight Council. www.oregon.gov/oha/ohpr/hitoc/Pages/index.aspx

compare Blueprint practices to other practices in their region and to statewide aggregate measures.[94] The reports include comparisons of panel characteristics, risk-adjusted resource utilization, cost and 13 quality measures. In the future, these reports incorporate measures included in ACO contracts and in the future will integrate clinical data collected from Vermont's health information exchange. All analyses are conducted by Vermont Information Technology Leaders (VITL), the independent, non-profit organization that built and operates the Vermont health information exchange. VITL, under contract with the State, uses Vermont's All-Payer Claims Database and functional HIE data as the key data sources for the reports it produces.

The Green Mountain Care Board, which is responsible for developing and implementing Vermont's health care strategies, also draws data from the state's All-payer Claims Data Based and from the state's Health Information Exchange. These databases are used, for example, to report on spending growth drivers in the state, and variation in care across the different regions of the state.

- Washington. The Washington Health Alliance, a statewide multi-stakeholder collaborative, maintains a voluntary APCD with claims-level insurance data on four million Washingtonians. The Alliance produces the Community Checkup, an annual report of quality performance scores by provider/clinic for asthma, chronic obstructive pulmonary disease (COPD), depression, diabetes and heart disease.[95] The Community Checkup also provides information on statewide health care spending growth, and Medicaid and public employee spending per enrollee. The Alliance publishes statewide patient experience survey results and reports on price and care utilization variations. At the behest of the state, the Alliance led an effort in 2014 to develop a common measure set that is used by all public and private payers to consistently track quality and cost performance.[96] The common measure set results are now included in the annual Community Checkup. Washington also has an HIE that consists of multiple HIEs coordinated through a central hub.[97]

3. Alignment of State Strategies

Five of the six states included in this study created specific organizational infrastructures to align state strategies across state government and/or across all payers in the state (Rhode Island has not). This alignment, and in some cases purchasing power, gives states significant leverage to drive delivery system and health care payment reform. The purchasing power is enhanced

[94] See http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles Last accessed November 30, 2016.
[95] See www.wacommunitycheckup.org/ Last accessed December 1, 2016.
[96] See www.hca.wa.gov/sites/default/files/pmcc_final_core_measure_set_approved_121714.pdf. Last accessed November 27, 2016.
[97] The Office of the National Coordinator for Health Information Technology. Washington State Profile. www.healthit.gov/sites/default/files/wa-state-hie-profile.pdf

by state actions to align both public and private payer initiatives, which states have found more challenging, but valuable to do. A summary of the five states' alignment initiatives follows.

- Maryland. Maryland has a consolidated state agency, the Department of Health and Mental Hygiene, which is comprised of the Medicaid program, public health services, behavioral health services, and developmental disability services.[98] The agency is responsible for coordinating and overseeing the policies and programs associated with these services. A separate independent agency, the Health Services Cost Review Commission is responsible for the state's principal cost savings strategy, which is an all-payer limit on the rate of per capita health care cost increases implemented through global hospital budgets.[99] The budgeting will be based on total cost of care by 2019. The Commission consists of seven members, three of whom are from the provider community. The Commission's decisions are directly appealable to the state courts, minimizing regulatory capture.

- Massachusetts. Massachusetts has a long-standing Executive Office of Health and Human Services (EOHHS), which incorporates all health care programs and human services programs, except for the state employee health plan.[100] EOHHS is headed by a Secretary, who is responsible for developing a single agency budget, and for coordinating and aligning strategies across all departments in order to achieve the state's cost targets.

  Specifically for the purposes of cost containment, the Massachusetts legislature created the Health Policy Commission (HPC)[101] in 2012 and charged it with responsibility for implementing the statewide per capita spending cap and promoting strategies to assure it will be achieved. Massachusetts' approach can be described as "light-touch" regulation, implemented by the HPC through four main functions.

  1. Set the health care cost growth benchmark and hold providers responsible through monitoring and reporting on provider performance. Non-compliant providers are required to submit performance improvement plans and may be subject to a modest fine for failure to make a good faith effort to meet the target.
  2. Change the delivery system to be more efficient by creating PCMH and ACO standards and providing innovation grants for less well-resourced community hospitals.
  3. Make payment models support new health care delivery models through use of its convening powers to create a common set of quality measures for voluntary

[98] See http://dhmh.maryland.gov/Pages/about.aspx. Last accessed November 30, 2016
[99] See www.hscrc.state.md.us/aboutHSCRC.cfm Last accessed November 30, 2016
[100] See www.mass.gov/eohhs/. Last accessed November 30, 2016.
[101] See www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/. Last accessed November 30, 2016.

adoption and by supporting Medicaid in its implementation of legislative mandated adoption of alternative payment models.

4. Improve marketplace performance by collecting data on and analyzing the economic impact of provider organizational changes (including mergers and acquisitions). If the analysis indicates a negative impact, the state Attorney General is alerted and is free to take action to implement state anti-trust laws.

The HPC, the State Attorney General and MassHealth coordinate on an informal basis to align strategies. This approach has been successful because of the long-term, positive working relationships that have been developed among the top staff at each agency.[102]

- Oregon. Oregon created a consolidated state agency in 2009. The Oregon Health Authority (OHA) is comprised of Medicaid, public health, mental health, state employee and public teacher benefits and analytic and transformation support. Medicaid is pursuing a cost containment strategy of implementing regional Coordinated Care Organizations that receive a capitated budget and are responsible for both paying for and delivering care; CCOs' underlying focus is on improving population health. The OHA is coordinating strategies across divisions by jointly funding the CCOs, as well as developing and reporting on a common set of performance data. The state employee and teacher's health insurance programs recently issued an RFP that requires commercial health insurers to implement key CCO performance requirements. OHA's analytic support function provides data to all OHA component agencies. OHA provides technical support to assist CCO transformation into an integrated payment and delivery system.

- Vermont. The Vermont legislature created the Green Mountain Care Board (GMCB) in 2011 to serve as the policy-making body for the state. It is a five-person independent board appointed by the legislature with full authority to make decisions within three major areas of activity:
    - regulate insurance rates, hospital budgets and major hospital expenditures;
    - drive innovative payment and delivery system reform; and
    - evaluate the impact that innovation has on Vermont's economy and proposals for funding a health care system.

  The GMCB is also responsible for overseeing the state's All-Payer Claims Database.

  The GMCB has been successful in reducing cost growth and driving innovation. In 2015, through aggressive review of hospital budgets, the GMCB limited system-wide and per-hospital net patient revenue to its target of 3.5 percent. It has also worked with

[102] Consultant interview with David Seltz, Executive Director of the Health Policy Commission (February 17, 2016) Dan Tsai, Assistant Secretary for MassHealth (February 17, 2016), and Karen Tseng, Health Care Division Chief for the Attorney General (February 23, 2016).

multiple stakeholders to negotiate the terms of a statewide ACO payment and delivery system model, which is the backbone of Vermont's new Section 1115 all-payer waiver.

- Washington. Washington constructed its Health Care Authority in 1988. It has responsibility for Medicaid, the state employees' health benefit plan, a health technology assessment program and prescription drug program. The agency focuses on implementing cost containment initiatives through its purchasing powers. The key strategies being pursued include increased value-based contracting, full integration of behavioral and physical health services for Medicaid enrollees and adoption of evidence-based coverage for both health care services and prescription drugs. Under its CMS-funded State Innovation Model (SIM) initiative, the Authority is pursuing delivery system innovation through the implementation of Accountable Communities of Health, which are multi-stakeholder, regionally-based organizations responsible for improving the health status of everyone living within the designated regions.

4. Marketplace Dynamics Play an Important Role

Health care is truly local, and the marketplace dynamics within any given state can play an important role in the type of cost containment models the state is able to employ. For example, having a preponderance of national plans, especially when they are dominant, can sometimes limit market-specific health care reform efforts, and markets with dominant state-based "domestic" plans sometimes fare better.[103] In the states that were studied, the majority of the commercial marketplaces were served by domestic plans, wherein Connecticut, over 80 percent of the commercial market place is served by publicly traded national plans. National plans are not devoid of payment and delivery system reform strategies, however, they are less likely to be state-specific strategies.[104] In Connecticut, the four largest plans have all reported being active with payment and delivery system reform.[105] Whether and to what extent these payers will prioritize and implement state level alignment with competitors and Medicaid remains to be seen.

[103] Bailit Health Purchasing, LLC. "Facilitators and Barriers to Payment Reform." Robert Wood Johnson Foundation. September 2013. www.rwjf.org/en/library/research/2013/09/facilitators-and-barriers-to-payment-reform.html. Last accessed December 2, 2016.
[104] Ibid.
[105] Sources: (1) Japsen, B. "Anthem Blue Cross' $38 Billion Move From Fee-For-Service Medicine." Forbes Magazine. January 29, 2015. http://www.forbes.com/sites/brucejapsen/2015/01/29/anthem-blue-cross-38-billion-bolt-from-fee-for-service-medicine/#7dc7a3dd10ed Last accessed December 2, 2016. (2) Japsen, B. "Value-Based Care Will Drive Aetna's Future Goals." *Forbes Magazine*. May 15, 2015. http://www.forbes.com/sites/brucejapsen/2015/05/15/value-based-care-may-drive-aetna-bid-for-cigna-or-humana/#2baa91f96512 Last accessed December 2, 2016. (3) Gruessner, V. "Why Cigna Succeeds in Value-Based Care Reimbursement Model." May 20, 2016. http://healthpayerintelligence.com/news/why-cigna-succeeds-in-value-based-care-reimbursement-model Last accessed December 2, 2016.

5. Trust among Key Stakeholders and the Role of Leadership

A common theme across all of the six states is a general sense of trust among key public and private stakeholders, which was articulated through a series of interviews conducted by the Cabinet's consultants, and with the experience the consultants had in working in some of the states. In Washington State, the Health Care Authority staff describes an informal, collegial management style that cuts across agency silos. The Health Care Authority leadership also reports having close working relationships with legislative committees. The tone is set by the Governor whose policy staff holds weekly meetings with leadership from the Health Care Authority and Office of Financial Management to maximize coordination and take a team approach to resolving problems. Massachusetts coordinates strategies across separate state agencies, each with a role in controlling costs, because of the trust developed among top staff over time. In fact, Massachusetts staff report a friendly competition between agencies for which agency can produce the most impactful report using common data.[106] In Maryland and Vermont the ability of the regulatory agencies to be successful is directly tied to the high level of respect and trust that the regulators have earned in implementing their rate setting (Maryland) and hospital budget approval (Vermont) processes. In Vermont, participants working on developing the statewide ACO payment and delivery model sometimes agree to policy decisions that are counter to their particular interest because compromise was key to making the broader endeavor successful.[107]

Building the necessary trust also requires strong leadership capable of implementing a long-term vision. The Oregon Health Authority is able to increasingly function as a coordinated agency, because of the strong leadership that worked to break down silos and promote cross-agency collaboration. In Vermont, Massachusetts, Washington and Oregon, the state legislature has demonstrated leadership in setting out clear cost containment agendas. In Maryland, the legislature supported the state's Section 1115 waiver that gave birth to the global hospital budget initiative.

The experience of these states in developing effective cost containment strategies indicates that multiple factors contribute to the success. Key is the political will among all stakeholders to focus on a common goal and engage in difficult decision-making that involves all parties. Coming to agreement requires the willingness to break from the status quo and to take risks on new strategies. It also requires strong, committed leadership from the legislature, the governor and from executive branch agency staff.

[106] Consultant interview with David Seltz, Executive Director of the Health Policy Commission (February 17, 2016) and Karen Tseng, Health Care Division Chief for the Attorney General (February 23, 2016).
[107] Consultant experience in working with Vermont on their reform efforts.

Appendix C
Key Model Features of PCMH+ and Recommended CCO Strategy

Model Feature	PCMH+	CCO
Providers eligible to earn shared savings	PCPs	PCPs, specialists, hospitals, "downstream providers," such as SNFs, VNAs, and participating social service agencies
Covered Patient Populations	All Medicaid patients attributed to a PCP	All Medicaid patients, and state employees attributed to a PCP
Budget upon which savings are determined	All Medicaid claims costs for covered benefits, except: • Hospice • LTSS, including institutional and community-based services • Non-emergency medical transportation	For Medicaid: All Medicaid claims costs for medical and behavioral health services. Within 3 years the addition of dental and LTSS For OSC: All employee claims costs for medical and behavioral health services
Quality Measures	PCP-oriented, including clinical quality and access measures	Measures would be included for services provided by PCPs, medical specialists, behavioral health clinicians, and hospitals. When LTSS and dental are added to Medicaid CCOs, measures for dental and LTSS providers would be added.
Payment Model	Shared savings	Shared risk
Goal	Improve the health of the attributed population through a focus on strengthening primary care services by providing incentives to PCPs to better coordinate care and implement patient-centered care models.	Provide strong incentives to improve the health of the attributed population by engaging the full spectrum of providers in becoming more efficient and effective in providing person-centered care.

Model Feature	PCMH+	CCO
Consumer Involvement	Continue to participate at the state policy level through MAPOC and SIM, as well as be contractually required to include a specific means of consumer participation in governance and feedback.	Consumers are involved at the provider level by sitting on the CCOs' boards of directors and by participating in CCO consumer advisory groups.
Limitations	Focuses on PCPs and not the entire continuum of care. Does not address rising pharmacy costs.	Requires previously unrelated entities to formally join together to change their care delivery model. Does not address rising pharmacy costs.
Potential Impact on Health Care Costs	Minimal because of PCP focus	Potentially significant because of focus on full continuum of care
LAN Category	3A (APMs with upside gainsharing)	3B (APMs with upside gainsharing/downside risk)

Appendix D
Existing Financial Support Programs Available to Providers in Connecticut

The state will continue to utilize existing financial support programs to assist providers with delivery system reforms, including through existing support available through the Person-Centered Medical Home program, the electronic health record incentive program, Behavioral Health Homes and the SIM programs, so long as federal financing is still available for these programs. As providers across the country, and the State of Connecticut, are moving toward new delivery system and payment reform models by federal, state and commercial payers. This rapid transformation of the health care system requires providers to deliver health care in a new manner, utilize new technology (e.g., population health analytic tools and electronic medical records), and hire new staff (e.g., care managers, community health workers). Providers need financial and technical support to operate in this new manner.

Description of Current Financial Support for Provider Transformation Activities:
DSS's Person-Centered Medical Home Program (PCMH)
DSS' PCMH initiative supports eligible primary care practices (independent private practices and hospital-based outpatient clinics) with:

- a "glide path" and no-cost multi-disciplinary coaching to enable practices to become recognized, and to renew recognition, as NCQA or JCAHO medical homes;
- enhanced fee-for-service payments, both during an 18-24 month "glide path" as practices work toward recognition, and ongoing after recognition is received; and
- for practices that achieve recognition, performance and year-over-year improvement payments that are based on quality measures.

The PCMH initiative also provides no-cost multi-disciplinary practice coaching to Federally Qualified Health Centers, in support of their recognition as medical homes by NCQA or JCAHO.

DSS' medical Administrative Services Organization (ASO), the Community Health Network of Connecticut, Inc. (CHN-CT), provides the multi-disciplinary coaching. Coaching is led by a Community Practice Transformation Specialist, in consultation with a team that includes clinical, administrative and legal expertise.

Practices receive enhanced FFS payments[108] for 18-24 months while practices are working toward achieving recognition, and enhanced FFS ongoing when practices are recognized by NCQA at Levels 2 or 3.

Additionally, practices recognized at NCQA Levels 2 or 3 are eligible for performance and year-over-year improvement payments based on quality measures. These quality measures were adopted in common with those used by the State Employee Health Plan. See this link for the involved measures:
www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Quality_Performance_Measures_2016.pdf

See this link for information on the performance and improvement payments:
www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Performance-Based_Payment_Program.pdf

These payments make the PCMH program a Learning and Action Network (LAN) Category 2C Alternative Payment Model (APM) (fee-for-service with rewards for performance).

As of October, 2016, 108 practices (affiliated with 435 sites and 1,518 providers) were participating in the DSS PCMH Program, serving 328,169 beneficiaries (over 43% of Medicaid members).

DSS's Electronic Health Record Incentive Program
The Medicaid EHR Incentive Program provides financial incentive payments for Medicaid participating physicians, dentists, nurse practitioners, and certified nurse-midwives to adopt and use certified electronic technology. DSS administers the program with federal support from CMS. Eligible providers[109] may be entitled up to $63,750 in incentive payments over a six-year period for participating in the program. The incentive payment is a fixed amount each year for adoption, implementation or upgrading to a certified EHR technology system. Payments in subsequent years are $8,500.

DMHAS's Behavioral Health Homes
DMHAS invested $9,000,000 in 14 designated Behavioral Health providers to enable them to hire diverse staff with medical knowledge and expertise to augment existing traditional behavioral health staff. Together, the Behavioral Health Home (BHH) team works with individuals with a diagnosis of severe mental health and co-occurring medical conditions, a traditionally underserved population. An additional $1,000,000 financed an Administrative Services Organization to provide technical support and assistance to designated providers as

[108] FQHCs are not eligible for enhanced FFS payments.
[109] To be eligible a Medicaid provider must have 30% or more Medicaid patient volume, or 20% for pediatricians, are not hospital-based, and are in good standing with the state and federal government agencies.

they expand their expertise to work with the "whole" person. There is an enhanced FMAP 90% for the first 8 quarters, which reverts to 50% thereafter. The project is initially front-loaded by grant dollars, although payment methodology may transform over time. There are very specific outcome measures attached to the project, some required by CMS, such as reducing hospital readmissions and others specific to Connecticut, such as increasing the number of tobacco users who received cessation intervention.

SIM's Advanced Medical Home Initiative (AMH)

As part of the overall SIM grant, funds were made available so that primary care practices were able to receive free transformation services offered by Qualidigm and Planetree. Services included interactive learning collaborative, practices facilitation visits, and a variety of evidence-based quality improvement interventions.

SIM's Community and Clinical Integration Program (CCIP)

As part of the overall SIM grant, $5.5 million dollars has been devoted to providing technical assistance, peer learning support and financial awards to Medicaid providers that are participating in the PCMH+ initiative to help them achieve best practice standards in improving care for individuals with complex health needs, introduce new care processes to reduce health equity gaps, and to improve access to and integration of behavioral health services. Technical assistance will also be provided on e-consults, comprehensive medication management, and oral health integration. SIM funded technical assistance and peer learning support in the form of a learning collaborative are the primary means by which organizations will be supported in achieving the these best practice standards. In addition, awards of up to $500,000 will also be made available to CCIP participants to help support the costs associated with working toward achievement of the standards.

Appendix E
Summary Comments Received on Preliminary Recommendations

The following is a summary of the written stakeholder feedback that was received by the Health Care Cabinet in response to the strategies that were voted upon on November 1, 2016.[110] The Cabinet received written comments from 43 different stakeholders. The comments are organized by strategy, concluding with additional feedback that was not specific to any one strategy.

1A: Build on SIM Agenda and Current Success in the Medicaid Program

Ten (10) stakeholders (25% of respondents) provided feedback on this strategy, all of whom expressed support for the strategy. There were no commenters that opposed the strategy.

1B: Provide More Coordinated, Effective and Efficient Care through CCOs.

Thirty-two stakeholders (74% of respondents) provided feedback on this strategy. Thirty-eight percent (38%) expressed neutral feedback, 38% were opposed to the strategy, 13% provided mixed opinion, and 13% were in full support of the strategy.

The **39% that expressed neutral feedback** asked the Cabinet to consider additions to the CCO strategy. For example, it was suggested that:

- the provider community be involved in the development of integrated care models;
- chiropractic services be included within a CCO;
- a primary care attribution model for the CCOs be developed with input from a multi-stakeholder group;
- program integrity strategies be implemented concurrently with CCOs;
- clear language identifying third-party liability responsibility should be in the CCO contracts;
- a strategy for funding charity care be included, and
- a robust primary care strategy be the foundation to the CCO strategy.

The **35% that were opposed to the strategy** mainly had concerns that were related to the shared-risk aspect of the strategy and specifically suggested that shared-risk not be considered, for concerns of unintended consequences and potential harm to Medicaid enrollees. Additional comments opposing the strategy included that:

[110] Comments from the Medical Assistance Program Oversight Council were received on October 27, 2016 prior to the Cabinet's initial vote, and are included in this summary.

- the CCO construct would force primary care physicians to see fewer patients per day and possibly leave independent medicine to join CCOs;
- the CCO strategy disincentivizes physicians from practicing primary care in the Medicaid program or from seeing seriously ill patients;
- ACO-type models are not effective;
- the strategy is too complex to implement and may not have sufficient impact on reigning in costs and improving quality;
- it will result in further consolidation of the health care system in the state; and
- the quality model associated with the strategy is insufficient to prevent harm from denied care.

The **13% that had mixed opinions** expressed concern about the shared-risk aspect of the CCO strategy, but also recognized that the coordinated system of care model is appealing. Commenters specifically articulated that:

- CCOs have the potential to reduce the impacts of social determinants of health and help consumers be more active participants in their health care, however, there are too many unknowns regarding the shared-risk aspect of the model;
- instead of the shared-risk proposed in the CCO strategy, any savings generated could be used to fund traditionally non-reimbursable expenses to minimize the risk that providers would withhold needed treatments for patients for personal financial gain, and any losses be penalized with reduced fee-for-service;
- alignment of state purchasing strategies, particularly around the use of up-front payments to support practice transformation and diversification of the care team is good, but shared-risk is premature, and
- the state should move forward consistent with the rest of the country toward value-based payment models for accountable and consumer-driven care organizations, however, implementation issues for the CCO strategy must be addressed to ensure the approach is feasible and effective.

The **13% that were in support** of the strategy were generally in support of the concept of pursuing an integrated model of care delivery, along with a population-based payment. Specifically, the supporters stated that:

- providers that are able to manage population-based payments (i.e., shared-risk or capitation) should be able to adopt such payments;
- it is important to continue to transform the health care delivery and payment system with coordinated care utilizing a CCO model, developed out of the current SIM advanced medical home program; and
- fear of shared-risk is unwarranted as hospitals and other providers are already engaging in risk-based contracts.

1C: Create Community Health Teams to Address Complex Health Needs

Eight (8) stakeholders (20% of respondents) provided feedback on this strategy. Sixty-two (62%) expressed support for the strategy. Two respondents (25%) expressed mixed feelings, and another one (13%) expressed neutral considerations.

The 62% that expressed support for the community health team strategy all supported the idea of using community health workers, or other disciplines to support primary care providers in connecting patients to community-based resources. Commenters specifically remarked that:

- all-payer community health teams are proven to achieve improved health outcomes for high-volume ED visitors and offer relief to behavioral health providers, providing potentially substantial and sustainable Medicaid cost savings, and the model could be limited to high-volume ED patients, and
- community health teams make sense, but do need to be integrated into existing community systems and services to avoid duplication and maximize effectiveness.

The 25% that expressed mixed feelings liked the concept of community health teams, but had concerns about the expense of the teams. For example, respondents noted that:

- the recommendation for community health teams would help independent physicians, but would be unnecessarily expensive and by paring down the concept to include only community health workers would make it more affordable and practical; and
- this could be a cost effective strategy, but further research should be done first to avoid duplication of existing services in the state and ensure it would result in a positive return on investment.

The 13% (one respondent) who had neutral feelings noted that community health teams should be aware of the benefits that the chiropractic profession can to reducing costs and providing naturally based health care.

2A: Adopt Statewide Health Care Cost Growth Target

Fourteen (14) stakeholders (33% of respondents) provided feedback on this strategy. Seventy one (71%) expressed opposition to the strategy and 29% were in favor of the strategy.

The 71% who expressed opposition to the strategy were most aligned around the concerns that a cost growth target cannot be implemented by Medicaid without first fixing the "deficient reimbursement environment" both among hospital and long-term care providers. Other commenters opposed to this strategy said that:

- cost growth targets for Medicaid would disincentivize providers from joining CCOs, and that commercial payers would restrict access to care, narrow their networks, deny care or lower provider rates; and
- Connecticut lacks the data to establish a reasonable cost growth target.

The 29% who were in favor of the strategy expressed support of the concept and offered the following additional supportive statements or suggestions:
- the target used for health care cost growth should also be used for global hospital budgeting and rate setting for commercial insurance and CCOs;
- there was support for the work group of stakeholders to help inform the development of a cost growth target, and
- significant fact finding needs to couple the development of this strategy to ensure consumer protection.

2B: Set Statewide Targets for Value-Based Payment

Eight (8) stakeholders (19% of respondents) provided feedback on this strategy. Fifty percent (50%) expressed support for this strategy, 37% expressed mixed feelings, and 13% (one commenter) was opposed.

The 50% who were in favor of the strategy noted the benefits of moving to value-based payment models as being important and consistent with national trends. Specifically commenters suggested that:
- changing the health care payment system to one that rewards the quality and efficiency of care will produce both improved quality and improved efficiency;
- there is support for expanding the adoption of value-based payment to specialty care and commercial coverage;
- the longer the state delays in moving to value-based payment, the further Connecticut will behind the rest of the health care market and create an undesirable payment market for Connecticut-based providers, resulting in continued loss of providers and reduced access; and
- there may be systemic and patient-level benefits from value-based contracting models.

The 37% who had mixed feelings about the strategy had some concerns with how the strategy would be implemented. For example, commenters said that:
- while value-based payment is important, making insurers the only entity singled out for corrective action was disheartening;
- it was not clear what role the CID would play in ensuring compliance, nor what consequences would exist; and
- there were concerns for unintended consequences of alternative payment models.

The 13% (one commenter) who opposed the strategy did not believe that DSS should be subject to an alternative payment target and that DSS should continue to build upon alternative payment models that have already demonstrated success.

3: Create an Office of Health Strategy

Twenty-one (21) stakeholders (53% of respondents) provided feedback on this strategy. Forty-eight (48%) expressed support for this strategy, 38% were opposed, 9% provided neutral feedback and 5% expressed mixed feelings.

The 48% who expressed support for the strategy noting generally that further coordination at the state level is important and that an oversight body could be helpful. They specifically commented that:

- the state government must play a more effective role in planning, coordination, accountability and oversight and that the Office of Health Strategy is important. This particular commenter also supported an inter-agency council like the one that failed to advance in the straw proposal;
- expanding the membership of the Health Care Cabinet and creating and Office of Health Strategy along with a stakeholder advisory board will further the goal of coordinating state health care strategies;
- the establishment of such an office could and should assist in efforts to increase the ability of physicians to communicate and negotiate on quality, cost, and payment issues that can be accomplished under federal anti-trust laws such as the state action doctrine;
- that while this particular commenter did not support the creation of an umbrella agency that would involve restructuring state government, they did believe it was critical that the Office of Health Strategy have specific direction and authority to promote interagency collaboration on health policies and practices;

The 38% who were opposed had concerns about the availability of state resources to create this office, redundant bureaucracy, and the inclusion of Medicaid in any aligned strategies. Specifically those who opposed expressed concerns that:

- moving staff out of other agencies to make the Office of Health Strategy is not advised as those staff are needed in their current positions;
- the Office of Policy and Management is already the governmental organization for focusing on cross agency initiative and therefore, a new Office of Health Strategy is not needed;
- moving Medicaid under control of the Office of Health Strategy would infringe upon DSS's responsibility of acting in the best interests of beneficiaries as required by federal law;

- the Health Care Cabinet could serve this purpose with an expanded membership to represent all stakeholders, including providers, hospital representatives from various disciplines, including finance, clinical support and strategic planning
- incorporating consumer affordability into the Insurance Department's rate review process as health plans are already subject to rigorous state review and rates must be sufficient to cover anticipated claims;

The 9% with neutral comments noted the following:

- that health equity be addressed by the Office of Health Strategy through a unified plan to address health equity from the three other similar offices within state agencies;
- that the Office of Health Strategy should maintain regular communication with all Healing Art Practitioner disciplines to assure all appropriate and reasonable data is utilized to achieve its seven key responsibilities.

The 5% (one respondent) with mixed feelings about the strategy was concerned with the vagueness and purpose of the Office and suggests that authority for the Office of Health Strategy be articulated, and that little collaboration, coordination or cooperation from various related health agencies is currently happening.

4. Support Market Competition by Expanding the Attorney General's Powers to Monitor Health Care Trends

Six (6) stakeholders (15% of respondents) provided feedback on this strategy. Sixty-seven (67%) expressed support for this strategy, 17% (one responded) were opposed and 17% (one respondent) provided neutral feedback.

The 67% who expressed support for the strategy noted that the strategy would improve the transparency of the health care system, protect consumers from price gouging, and that the expanded powers of the AG would fit well with the upcoming recommendations of the CON Task Force.

The one respondent (17%) that opposed the recommendation believes there are not enough state resources to support the expanded role of the AG.

The one respondent (17%) that provided neutral input noted that its organization would assist the AG wherever needed to obtain accurate measures of health care market trends.

5. Augment Existing Funds and Programs to Support Provider Transformation Through Applying for Federal DSRIP Funds

Six (6) stakeholders (15% of respondents) provided feedback on this strategy. Eighty-three (83%) expressed support for this strategy, 17% (one respondent) provided opposing viewpoints.

The 83% of supporters of this strategy generally noted that seeking to leverage DSRIP funds could be beneficial for provider transformation. Specific comments included that:

- while DSRIP is recommended, looking for other appropriate funds (outside of the health care cost growth cap) to improve the sustainability of funds for information technology is important;
- there are few better ways available to advance the state's cause for improve care and that other states have used DSRIP dollars well, cautiously and mitigated risk to specifically address social determinants of health;
- DSRIP is a logical vehicle to create funding streams and logical mechanism to support the creation of community-based organizations;
- DSRIP funds have been used by other states to obtain much needed investment in provider transformation efforts and that if Connecticut pursue a DSRIP it do so with working aggressively to protect consumers.

The one respondent who opposed the strategy expressed concern over the budget neutrality requirements that would be imposed by CMS under an 1115 waiver (which is required for DSRIP funds). This respondent also suggested that specific rigid restrictions on the state's ability to not reduce services, scope of program, or eligibility needs to be in place before a waiver is considered.

6. Support Policy Makers with Data

Nine (9) stakeholders (22% of respondents) provided feedback on this strategy. Sixty-seven (67%) expressed support for this strategy, 33% provided neutral comments.

The 67% who supported the strategy articulated the need for data in policy making and in meaningful reform efforts. Specifically, the supporters stated that:

- it is important to follow-through with a broad data strategy, with necessary funding, technology, standardization and mandates to ensure that data are available for health care transformation efforts;
- a working APCD and HIE will assist the state in evaluation of provider performance and align cost and outcomes so that patients may make informed decisions; and
- the work of securing data is complex and difficult but must be done to provide the state with the ability to evaluate and improve the quality and cost of health care.

The 33% who provide neutral comments said that:

- the Cabinet should consider progress already made at the provider level (including for post-acute and long term services and support providers) so as not to impose inefficiencies or unnecessary added expense;
- there is a need for uniform approach to capturing race, ethnicity, language and status across the delivery system and social and behavioral health data should be included.

7. Incorporate Use of Evidence into State Policy Making

Four (4) stakeholders (10% of respondents) provided feedback on this strategy. One commenter was opposed to the strategy (25%) and three (75%) expressed mixed concerns.

The three respondents who expressed mixed concerns were generally supportive, but concerned about how the strategy would be implemented. Comments specific to the three commenters include:

- it is important that a broad understanding of the type of research to be conducted and incorporated as some studies are limited in scope which might restrict validity of the study;
- concerns about consumer protection, transparency and consistency with national standards were suggested as areas that need to be addressed to ensure consumers were not adversely affected;
- suggestions that the decision making process be developed and structured in a way that will allow the system to efficiently respond to and recognized rapid developments made in the health field – including for post-acute rehabilitation, and long term supports and services.

The one respondent who was opposed to this strategy noted that more information is needed before adoption, as the respondent thought the strategy would take a considerable commitment of state resources and it was unclear how stakeholders would be involved in the process.

Additional comments from stakeholders included reaction to the draft pharmacy strategies that were not considered by the Cabinet, which the Cabinet recommends being part of its deliberations as described in Section VII.

Links to Written Feedback from Stakeholders		
	Stakeholder	**File**
1	Connecticut Association of Health Plans	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CAHP-comments.pdf?la=en
2	Community Health Center Association of Connecticut	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CHCACT-Comments-on-CT-Healthcare-Cabinet-Recs-111116.pdf?la=en
3	Dr. Larry Rifkin	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Larry-Rifkin-MD-comments.pdf?la=en
4	LeadingAge Connecticut	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Comments-of-LeadingAge-CT-to-the-Health-Care-Cabinet.pdf?la=en
5	Dr. Stephen R. Smith	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Comments-on-the-Preliminary-Report-of-the-Health-Care-Cabinet_Smith.pdf?la=en
6	Planned Parenthood of Southern New England	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Comments-of-Planned-Parenthood-of-Southern-New-England-on.pdf?la=en
7	Universal Health Care Foundation of Connecticut	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/UHCF-public-comment-for-11152016-cabinet-meeting.pdf?la=en
8	Prospect Medical Holdings, Inc.	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/TESTIMONY---PROSPECT-MEDICAL-HOLDINGS-Health-Care-Cabinet-11-14-16.pdf?la=en
9	Supriyo B. Chatterjee	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/SBC-HealthcareCabinet-PUB-COMM.pdf?la=en
10	Connecticut Association for Healthcare At Home	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/11-15-16Testimony-Hoyt-HC-Cabinet-Cost-Savings.pdf?la=en
11	Sheila B. Amdur	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Amdur-health-care-cabinet-testimony-november-15.pdf?la=en
12	Joint letter from: LeadingAge Connecticut	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Collaborations-final-testimony.pdf?la=en

Links to Written Feedback from Stakeholders		
	Connecticut Association of Health Care Facilities Connecticut Association for Healthcare at Home Connecticut Hospital Association Connecticut State Medical Society	
13	National Alliance on Mental Illness Connecticut	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Bailit-proposal_testimony-by-NAMI-Connecticut_Nov-15-16.pdf?la=en
14	Connecticut Business and Industry Association (CBIA)	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CBIA_comments_cost-containment-recommendations_11-15-16.pdf?la=en
15	Connecticut Chiropractic Association	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CCAResponseHealthCabinetRecommend20161115.pdf?la=en
16	Connecticut Hospital Association	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CHA-comments.pdf?la=en
17	Health Management System	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/HMS_CT-Testimony.pdf?la=en
18	Connecticut Association of Health Care Facilities, Inc.	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CT-Association-of-Health-Care-Facilities.pdf?la=en
19	Connecticut State Medical Society	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/CSMS-comments.pdf?la=en
20	Janet Vantassel, Esq.	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Jan-Van-Tassel-comments.pdf?la=en
21	Crescent Group	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/JPakutka-Testimony-111416.pdf?la=en
22	Susan Hackett	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Susan-Hackett-comments.pdf?la=en

Links to Written Feedback from Stakeholders		
23	Patricia Checko	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Patricia-Checko-comments-111516.pdf?la=en
24	St. Vincent's Medical Center	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/TESTIMONY-OF-ST-VINCENTS-MED-CTR-TO-HEALTHCARE-CAB-111516.pdf?la=en
25	Yale Medicine	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Yale-Medicine-Written-Statement-for-the-Governors-Health-Care-Cabinet-November-15-2016.pdf?la=en
26	Qualidigm	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Qualidigm-Testimony_11142016_FINAL-1.pdf?la=en
27	Western Connecticut Health Network	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Testimony-HC-Cabinet-Recommendation-11-15-16.pdf?la=en
28	Trinity Health-New England	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/TRINITY--HCCRECTEST1116.pdf?la=en
29	Senator Martin M. Looney	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/MML-Bailit-comments.pdf?la=en
30	P*h*RMA	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/PhRMA-complete-comments.pdf?la=en
31	New Haven Legal Assistance Association, Inc.	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Sheldon-Toubman-Comments.pdf?la=en
32	Gaye Hyre	http://portal.ct.gov/-/media/3D6658D8A0BF4E75B3E2D050FABCF4E1.ashx?la=en
33	Connecticut Oral Health Initiative	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/COHI-Comments-on-Health-Care-Cost-Strategies-20161115.pdf?la=en
34	Pfizer	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Health-Care-Cabinet--Pfizer-Comments--Submitted-11152016.pdf?la=en

Links to Written Feedback from Stakeholders		
35	Connecticut Bioscience Growth Council	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/HealthCare-Cabinet-111516mtg-Written-Comment-from-P-Pescatello.pdf?la=en
36	Arlene Murphy	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Arlene-Murphy-Health-Care-Cabinet-Comments-11-15-16.pdf?la=en
37	Arvind Shaw	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Arvind-Shaw---Healthcare-cabinet-recommendations-Nov-15-2016.pdf?la=en
38	Hartford HealthCare	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Cardon_Healthcare-cabinet-testimony-2016-11-15-v2.pdf?la=en
39	Betsy Glassman	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Betsy20Glassman20comments.pdf?la=en
40	Myles Walsh	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/Myles20Walsh.pdf?la=en
41	Behavioral Health Partnership Oversight Council	http://portal.ct.gov/-/media/BHPOCHealthcareCabinetLtr12-1-16FINAL-(3).pdf?la=en
42	Medical Assistance Program Oversight Council	http://portal.ct.gov/-/media/Office-of-the-Lt-Governor/Healthcare-Cabinet/2016-Meetings/MAPOC-letter-to-Health-Care-Cabinet---Final.pdf?la=en
43	State Employee Bargaining Agent Coalition	http://portal.ct.gov/-/media/SEBAC-Comments.pdf?la=en

Appendix F
Potential Strategies to Control Pharmaceutical Costs for Further Cabinet Deliberation

NOTE: During the course of the Cabinet's study of cost containment strategies, the Cabinet agreed that it was necessary to develop recommendations for strategies for controlling pharmaceutical costs. In October 2016, several volunteers from the Cabinet membership developed potential strategies that were consolidated into draft issue areas that the Cabinet could consider exploring further to identify a final set of strategies aimed at controlling pharmaceutical costs. Due to time constraints, the Cabinet was unable to explore, discuss, debate or vote on any of these individual issue areas for inclusion in the report. While the following represents the volunteer Cabinet members' ideas for issue areas for further exploration in 2017, it is important to note that these concepts are in draft form and have not been fully explored or endorsed by the full Cabinet, and do not reflect input from the industry or broad input from consumers and consumer advocates, researchers, health plans and others. Therefore, the concepts are included here for review only. In 2017, the Cabinet will hear from a variety of stakeholders, including industry experts, government leaders, researchers, consumers, providers, health plans and advocates, to help the Cabinet identify a set of detailed recommendations that will be made to the Legislature as an addendum to this report.

1. Strategies to better understand drug pricing

Because of the complexities of and lack of understanding around manufacturing costs and pricing methodologies, purchasers are at a significant disadvantage in negotiating agreements with insurers, pharmacy benefit managers and manufacturers regarding prescription coverage. There is a clear need for the state to promote transparency regarding pricing and industry practices that impact pricing by implementing the following strategies:

A. Consistent with other transparency strategies, enhance the Attorney General's powers to investigate the pharmaceutical industry with respect to manufacturing costs; pricing and reimbursement practices; utilization management programs; consumer incentive initiatives; the contractual relationships involving drug manufacturers, PBMs, insurers, TPA, and dispersing pharmacies; pricing practices of hospitals regarding their mark up above the cost of drugs under the federal 340B program. The Attorney General should have the power to subpoena claims data and other needed information in support of the Office's investigational activities to understand key cost drivers and pricing activities.

The Attorney General should be required to produce a report on his or her findings and hold a public hearing to help educate the public's understanding of the dynamics behind drug price increases. The Massachusetts Attorney General issued a report on October 7, 2016 on its findings after its year-long study of drug costs in the state,[111] which could serve as a baseline for the Connecticut Attorney General to build upon.

B. Strengthen unfair trade practice laws to address drug pricing at levels not supported by effectiveness pricing studies[112] or other benchmark pricing and to address deceptive and misleading marketing associated with promotion of manufacturer consumer discount coupons for brand drugs and coupons from retail pharmacists offering gift cards to consumers transferring prescription refills to a new pharmacy. [113]

C. Enact transparency legislation to address the following issues:

1) Require Pharmacy Benefit Managers to delineate in their contracts with pharmacists how generic drug maximum reimbursement pricing is calculated, allows the pharmacist to contest the amount paid under the contract and to receive retroactive payment adjustments, as appropriate. [114]

2) Require drug manufacturers to disclose to the Attorney General the following pricing information for up to a specified number of high-expenditure drugs which meet specific pricing triggers, such as 1) list price increases of 50% over the past five years, or 15% over the last year or 2) initial launch prices that exceed the average cost of drugs in the same class by 30%:[115]

- Total costs of production for specific drugs;
- R&D costs for specific drugs, including details on R&D paid with public funds;
- Marketing spending for specific drugs;
- Different prices charged for the drug, including international rates;

---

[111] Massachusetts Office of the Attorney General. Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17 Report for Annual Public Hearing Under G.L. c. 6D, § 8, October 7, 2016.

[112] Creating effectiveness pricing studies is a new area of analysis which is being conducted by the Institute for Clinical and Economic Research and others and tries to value a new drug coming onto the market based on the increased benefit it offers to patients using the drug, compared to other new drugs coming onto the market. For more information see: https://icer-review.org/ ROI pricing bases prices on the estimated long-term savings realized by use of the drug through reduced medical expenses, increased patient productivity, etc. It is in the theoretical stage, but worth monitoring its development and implementation over time.

[113] Coupons reduce out-of-pocket, but not third-party payer costs. As a result, they can effectively steer patients toward high-priced drugs despite the availability of clinically-comparable, lower-cost alternatives. This action places upward pressure on insurance premiums, which are ultimately borne by the same consumers enjoying these short-term savings.

[114] Iowa has enacted a similar law, HF 2297 enacted in March 2014. More information is available at: www.pbmwatch.com/mac-information-center.html. Last accessed December 1, 2016.

[115] Vermont has enacted a similar law, Vermont Act 165, An Act Relating to Prescription Drugs, which was signed into law June 2, 2016 and focuses on high cost, high volume drugs with significant price increases. The impact of this law on prices has been questioned by policy experts. See, for example: www.forbes.com/sites/theapothecary/2016/06/10/vermonts-wrongheaded-drug-price-transparency-bill-misses-the-mark/#699c24345ed5

- Total profit made from specific drugs;
- Percent of R&D budget spent on basic research;
- R&D efforts that have not resulted in any approved drugs, and
- Discounts and rebates provided to insurers and PBMs, including Medicaid providing coverage to Connecticut residents through Medicaid, private insurance programs, the state exchange and 340B programs.

Permit the Attorney General to make this information and his or her findings available to state purchasers, including DSS and the Comptroller's Office, and to policy makers in order to enable more informed program and policy decisions.

2. Strategies to maximize state purchasing and regulatory powers to reduce pharmaceutical costs

The state is a purchaser of prescription drug coverage principally through its Medicaid and state employee/retiree programs. To maximize the ability to influence prices, the state should implement the following strategies.

A. Medicaid functioning as contractor for pharmacy coverage

1) As a participant in a purchasing coalition, Top Dollar Program (TOPS), Medicaid should work with the coalition to adopt performance pricing[116] in its contracts with manufacturers, and use comparative effectiveness research[117] in developing its preferred drug list. All Medicaid program that are participating in TOPS should explore aligning their preferred drug lists, at least among some drug classes, and pharmacy management programs to maximize the coalition's purchasing power.
2) Investigate the feasibility of joining with the Comptroller's Office to jointly administer their pharmacy programs in order to increase negotiating leverage.
3) Medicaid should continue to review and track CMS' new pricing guidelines and make additional adjustments, as appropriate. Investigate the reimbursement

[116] Performance Pricing involves set final pricing of a particular drug based on whether the drug performs "in the field" as expected from clinical trials. The price is lower if the drug does not perform. The payment model would be based on the nature of the drug and how effectiveness is measured. For example, Cigna negotiat6ed with the manufacturer of a new class of cholesterol-lowering drugs that it would further discount the drug price if the patients taking the drug do not have results as expected, the manufacturer further discounts the cost of the drugs for all patients. The manufacturer of Bortezomib for myeloma pays for drug costs for any patient who fails to respond after four cycles of the drug, because effectiveness will be known by then. There are challenges to pursuing this contracting approach, including the need for significant and sustained purchasing power, a payer with the ability to collect and use both pharmacy and clinical data to implement the payment model, and a drug effectiveness can be measured in a relatively short period of time with clear biomarkers.

[117] The Drug Effectiveness Review Project (DERP), operated out of the Oregon Health and Science University's Center for Evidence-Based Policy is a key source of evidence based research reports.

methodology regarding physician purchasing and administration of in-office infusion drugs to maximize drug effectiveness and efficiency.

4) Monitor the Washington state and CMS negotiations and consider seeking a Medicaid waiver to enhance flexibility in managing the pharmacy benefit. Options include:[118]

   I. Seek a waiver of requirements of the Medicaid drug rebate law while maintaining access to the minimum and best-price rebates. Under this option, state Medicaid programs would continue to be guaranteed the minimum federal rebate and the best-price rebate but they would also be able to employ selective contracting, performance contracting and sole source contracting, etc., to enhance market leverage for better supplemental rebates.

   II. Seek a waiver to opt out of Medicaid rebate provisions for a limited number of drug classes. This approach could be used to innovate in specific classes of drugs by employing:

      - New service delivery options
      - A non-Medicaid purchasing pool or state PBM arrangement, or
      - Bulk purchasing of sole source products.

B. State agencies functioning as contractors for pharmacy coverage

1) Any state agency issuing RFPs or renegotiating a contract for services with either insurers or with PBMs should include in their RFPs requirements that the vendor -- without increased expenses to the state -- should a) support pharmaco-economic studies to assess relative effectiveness of selected new drugs compared to existing drugs and to share research findings with the state agency; b) negotiate performance pricing contracts with manufactures and c) develop the infrastructure for and implements indication-specific pricing.[119]

2) All state agencies purchasing health care coverage develop the capability and knowledge base to actively manage insurer and PBM contracts by meeting regularly with the vendors to review contracted pricing and rebates, as well as utilization trends, so that they may fully understand current cost drivers, new

---

[118] These strategies are included in a new NASHP report on possible strategies for states to impact prescription drug costs. These strategies have not been implemented by any states to date, but at least one state is in discussion with CMS regarding waiving Medicaid requirements. See NASHP's Pharmaceutical Cost Work Group. "States and the Rising Cost of Pharmaceuticals: A Call to Action". National Academy for State Health Policy. October 2016. Available at: http://nashp.org/wp-content/uploads/2016/04/Drug-Brief1.pdf

[119] Indication-specific pricing involves setting different prices for different indications or for distinct patient subpopulations eligible to use the medications, with prices varying based on relative clinical benefit. For example, Express Scrips is seeking differential pricing from manufacturers based on how a cancer drug, Tarceva, is used. Clinical trials have indicated that Tarceva performs better against lung cancer, compared to pancreatic cancer. Currently payment systems are designed to pay the same unit price, regardless of use, for each drug based on a unique identifier. Few payers have the systems in place to join clinical and pharmacy data to differentiate clinical uses. Indication-specific pricing can be implemented when the drug dosage or delivery system is changed to generate a separate unique identifier (e.g., botox for cosmetic purposes vs botox or bladder control).

drug pricing trends, specific cost-saving strategies being employed and to collaboratively identify areas for the vendor to focus its comparative effectiveness research and cost containment activities that focus on maximizing medication effectiveness. Negotiate annual price caps and cost increases with the PBM. Consider moving to PBM contracts that do not link the PMB's profits with the sales volume and cost of drugs that run through the PBM contract.

3) The Comptroller's Office should pursue efforts to negotiate manufacturer rebates from its medical plan vendors for infusion drugs administered as a medical benefit by physicians in ambulatory settings.
4) Consistent with CMS' policy direction, all commercial insurers, including those administered on behalf of the state's employees and retirees, should negotiate reimbursement arrangements for infusion drugs administered in an ambulatory setting that delink the administration fee from the cost of the drug, thus eliminating any incentives for physicians to use the most expensive drug, when equally effective, lower cost alternatives are available.
5) All state agencies verify that they are maximizing the pricing structure of the federal 340B program, and if not, to take steps to do so.

C. State as bulk purchaser

1) Following the vaccine purchasing model, enact legislation to empower the state to negotiate bulk purchasing and distribution of key public health drugs, such as Hepatitis C treatment drugs.[120] To implement this strategy it would require participation of commercial insurers, which may be difficult to obtain.

D. State as regulator

1) Expand the Connecticut Insurance Department's authority to establish requirements for insurers to promote pharmaceutical cost savings and to consider the insurers' effectiveness at doing so as part of the CID's rate review process. Requirements for insurers should include, but not be limited to:
    I. Use of performance pricing and indication-specific pricing;
    II. Implementing programs to enhance medication optimization, such as paying clinical pharmacists for therapeutic management services for complex patients and rewarding primary care clinicians for timely medication reconciliation, and
    III. Implementing reimbursement methodologies for infusion drugs administered in an ambulatory setting that delinks the administration fee from the price of the drug to eliminate any incentives for physicians

[120] NASHP's Pharmaceutical Cost Work Group. "States and the Rising Cost of Pharmaceuticals: A Call to Action". National Academy for State Health Policy. October 2016.

to use higher priced drugs when lower cost, equally effective drugs are available.

IV. Reimburse amounts made to hospitals for drugs purchased by the hospital under a federal 340B program and the level of mark-up the insurers accept.

2) Enact legislation similar to California Proposition 61[121] that prohibits state agencies from buying any prescription drug from a drug manufacturer at any price over the lowest price paid for the same drug by the United States Department of Veterans Affairs, except as may be required by federal law. Apply this requirement to any program where the state agency is the ultimate payer for a prescription drug, even if the state agency does not itself buy the drug. The amount of savings will depend on several factors, including the variance between current prices paid and the VA's prices and the willingness of the manufacturers to accept the VA price. The manufacturers could also respond by increasing the VA prices. The requirement would also need to be implemented in a manner that does not jeopardize Medicaid's best-price guarantee.[122]

3) Create a public utility model to oversee drug prices. Under a public utility model, the state could create a drug price review board to review, approve or adjust launch prices for all newly-approved drugs, or drugs with list prices above a certain dollar threshold. The board could also review price increases for brand or generic drugs that exceed a certain threshold (e.g., 10 percent for brand-name drugs and 20 percent for generics). As part of this review, the board could hold open hearings, review data submitted by manufacturers and collect other publicly-available information. It could also direct new research to assess the appropriateness of specific launch prices or price increases. The amount of savings would depend on several factors, including the variance between the regulated price and the current price and whether the manufacturer would continue to do business in the state. The initiative would need to be implemented in a manner that did not jeopardize Medicaid's best-price guarantees.[123]

4) Enact legislation requiring all providers prescribing or administering biologically based drugs to use biosimilar drugs, whenever available.

3. Strategies to optimize safe and effective use of medications

Medication adherence, which is an important element of maximizing effectiveness, is variable and well below desired levels. Research has consistently found that improved medication adherence can reduce total health care costs by reducing emergency department and inpatient

[121] https://ballotpedia.org/California_Proposition_61,_Drug_Price_Standards_(2016)
[122] For an analysis of the potential impact of this proposition on costs see: https://ballotpedia.org/California_Proposition_61,_Drug_Price_Standards_(2016)
[123] For a discussion of this strategy see NASHP's Pharmaceutical Cost Work Group. Pages 7-8

services, even though pharmacy costs have increased. [124] Because drug adherence and the reasons for non-adherence are complex, research has suggested that different approaches are needed based on patient characteristics, clinical conditions and types of interventions.[125]

It is also important to note that providing financial incentives through reducing or eliminating co-payments and deductibles for drugs that help control chronic conditions and associated medical services have also found to be effective in increasing adherence, but has not necessarily resulted in total decreased costs.[126]

To optimize safe and effective use of medications, the state should implement the following strategies:

A. Include behavioral health clinicians and clinical pharmacists as members of the Community Health Teams
B. Expand the funding to primary care practices participating in the PCMH+ initiative and CCOs to cover therapeutic management services by clinical pharmacists
C. Require all hospitals and nursing homes to adopt the use of a standard discharge form that would include a listing of the patient's prescribed medications and require PCMH+ practices and CCOs to implement protocol standards for community-based providers to complete timely medication reconciliation processes. Charge the Department of Public Health with the responsibility of working with stakeholders to develop the standard discharge form.
D. Restrict the ability of dispensing pharmacies to do automatic refills because the automatic refills often create waste in the system because changes in prescriptions or discontinuation of prescriptions are not recognized.
E. Promote the use of eprescribing systems to notify a dispensing pharmacy that a prescription is discontinued.
F. Promote the use of eprescribing systems to enable pharmacists to electronically communicate with prescribing clinicians regarding requests and questions.
G. Provide clinical pharmacists and community-based providers, such as home health nurses, with access to relevant clinical information for purposes of assessing effective use of pharmaceuticals.

---

[124] M. Christopher Roebuck, Joshua N. Liberman, Marin Gemmill-Toyama and Troyen A. Brennan. "Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending" *Health Affairs.* January 2011, Vol 30, No 1, 90-99.
[125] Meera Viswanathan, PhD; Carol E. Golin, MD; Christine D. Jones, MD, MS; et al. "Interventions to Improve Adherence to Self-administered Medications for Chronic Diseases in the United States: A Systematic Review: *Ann Intern Med.* 2012;157(11):785-795.
[126] Ibid.

Appendix G
Letter to the Cabinet from Commissioner Wade Regarding Opportunity to Further Consider Value-Based Benefit Design as a Cost Containment Strategy

November 1, 2016

Dear Members of the Connecticut Health Care Cabinet,

One of the areas that needs more attention in our work on health care cost containment is how Connecticut became a high cost state. Policy choices have been made in Connecticut over the years which have placed a premium on access. For example, hospital networks that have every hospital in the state. Connecticut consumers pay a higher price for this type of access.

Under current law, there are areas that should be reviewed and promoted both on and off the exchange that could produce meaningful cost savings for consumers. These include expanded options in benefit design and network design, including value based benefit design and innovative networks. In other parts of the country beyond the states that have been studied value to consumers are being realized. For example, in Florida network innovation is demonstrating real cost savings and in Iowa, HMOs are making a comeback because consumers are seeing a value to the product.

As with all product and network design, consumers need to be fully informed while they are purchasing coverage so they understand how the plan they are selecting will work. Consumers should have the ability to choose what plan works best for them and their families and fully understand the cost of the choice. Some consumers may want a more limited network which provides access to the providers and facilities they are interested in at a lower price, while others may want access to a more robust network but at a higher price.

CMS is proposing through rulemaking to remove potential obstacles to more consumer choice by allowing more flexibility in plan design without sacrificing consumer protections. In addition, HHS is committed to working with the states on network innovation. The Insurance Department worked with all stakeholders and the General Assembly on the passage of enhanced network adequacy standards to protect consumers. The Insurance Department stands ready to work with all stakeholders on product and network innovation.

Attached is correspondence between Governor Malloy and Secretary Burwell concerning insurance affordability.

Regards,

Katie Wade
Insurance Commissioner

Appendix H
Response and Alternative Recommendations by Cabinet Member Ellen Andrews

November 14, 2016

Health Care Cabinet Report to the Connecticut General Assembly per PA-146
Minority Report
Ellen Andrews, PhD
CT Health Policy Project
Member, Connecticut Healthcare Cabinet

I want to thank the Cabinet membership and consultants for the process to arrive at our recommendations. It involved a great deal of work by all and we learned a great deal. I learned more about the perspectives of other Cabinet members, and members came to understand and acknowledge consumers' perspectives. The process opened important conversations about reform and what Connecticut's health system should be, both within the Cabinet and beyond its membership to the larger Connecticut health care community. Hopefully these discussions will be part of breaking down a few silos. The process will be immensely improved by getting public input.

Independent consumer advocates are very grateful that, over the last months, Cabinet members came to acknowledge the hard work and successes our state's Medicaid program has earned over the last four years, including historic cost control achieved at the same time as improvements in quality and access to care, much better provider participation and consumer satisfaction, all while significantly expanding the program. Cabinet members now appreciate what could be lost in the program that serves one in five state residents.

However, despite some improvements from the original Strawman proposal, the final recommendations are significantly flawed and are missing critical elements for successful health reform in Connecticut necessitating this Minority Report. Instead of improving the state's health system and improving state government's growing deficits, if enacted the recommendations would add to our costly problems and undermine financial security. As an independent consumer advocate, my comments are my own. But they reflect and are informed by dozens of meetings and conversations with diverse stakeholders across our state who do not feel their concerns or interests have been represented in the Cabinet's discussions. Those stakeholders include many other independent consumer advocates, but also providers, payers, businesses, taxpayers,

community leaders, elected officials, social service providers, and citizens. I feel confident that all these constructive conversations will continue.

The **lack of trust**, and its corollary – the need for better communications, tops the list of issues missing from the Cabinet's recommendations. The consultants correctly identified this pervasive problem, crossing virtually all stakeholder groups, as the main barrier to effective reform in Connecticut, and many members have confirmed that observation. Unfortunately the report includes no effective proposals to build trust and several that will further undermine it. The report relies heavily on top-down authority structures and a new, costly state agency. The report ignores **critical problems** including the need to improve health policy capacity both inside and outside state government, a pervasive culture of conflicted interests driving policy, and the wisdom of decentralized crowd-based problem solving. I offered several policies and options to improve trust and communications in my comments on the Strawman proposal.

The Cabinet's recommendations do not recognize the **unique nature of different programs and populations** in our state. Features from other, very different states are copied without thoughtful consideration about their feasibility or advisability for Connecticut. The report relies heavily on blindly following the federal government, which was a bad idea even before the recent election. Unfortunately this report follows a historic trend in Connecticut policymaking. Problems are identified in other sectors, but because the state only controls Medicaid (and possibly the state employee plan) solutions are applied there, ignoring the reality that Medicaid is saving money and building value.

While citing the **mediocre quality** of health care in our state, the recommendations include nothing to support improvement. A symbolic nod to quality benchmarks to access savings bonuses is less than insufficient. Medical care is estimated to account for only 10 to 20% of health outcomes. Despite citing population health, the report does nothing to address **social determinants of health** or the crying need for investments in proven, evidence-based **public health interventions**.

The Cabinet's first recommendation, to impose **downside risk** on Medicaid and state employees, is the most troubling. The irrational exuberance for this untested economic model is baffling. Despite the fact that this risky payment model is untested, not attractive to health systems nationally, and it just doesn't make sense, downside risk appears to have strong support among some Cabinet members.

The model is based on tenuous economic theory and very similar to capitation, which "failed spectacularly" in Connecticut's past. Assurances that things will be different this time are empty and unpersuasive. Downside risk jeopardizes the provider-patient relationship, the foundation of effective health care. Downside risk in the past prompted

physicians to leave the Medicaid program, a problem we cannot afford as the program's enrollment has grown substantially.

The report is silent on avoiding past failures and harm to Connecticut residents and taxpayers from the very similar capitation payment model. Despite universal acknowledgment that provider financial risk models carry significant danger of promoting **underservice**, the Cabinet's proposal doesn't even include monitoring for the problem.

The proposal encourages vertical and horizontal **provider consolidation** despite evidence of higher prices and less consumer choice as health systems consolidate. The proposal also ignores the model's disincentives to invest in data, care coordination, patient engagement, community and social service connections or other potentially cost shaving innovations.

Shifting financial risk onto insurers or consumers did not work in the 1990s and 2000s. Rather than simply following another economic theory shifting that risk now onto providers, Connecticut needs to identify and address the real-world drivers of rising health costs where they are rising. This will be far more difficult than just shifting risk and hoping for the best, but it is the only way we will address the "burning platform".

Also troubling is the Cabinet's proposal to create an **Office of Health Strategy** as a new agency within state government. The proposal would give the Office extraordinary authority to officially decide who is over-spending and to develop corrective plans to enforce their opinion without public accountability. Rather than addressing the trust issues in our state, this Office would only exacerbate the problem. Connecticut needs to build trust and faith in leadership and government before such an Office is even discussed. Data systems the Office would need for the proposed work do not exist in Connecticut. While similar offices in other states are helpful, in Connecticut it would be premature and counter-productive. It's been suggested that other state agencies perform similar functions now.

The Cabinet's **cost growth "targets"** proposal is also premature. Advocates have compared this plan to capitation for the entire state. Data to support development of the targets or information to draft intelligent corrective action plans as well as tools to implement solutions do not exist. Like many of the Cabinet's recommendations, this proposal would be very susceptible to Connecticut's usual pattern of conflicted interests driving policy. Even if it were possible, the cost to implement and execute anything meaningful would be prohibitive.

Hopefully unwise **1115 and DSRIP Medicaid waiver** Cabinet proposals are moot given the recent election results. The Cabinet's proposal to integrate **comparative effectiveness research** findings into policymaking across the state is positive. However,

creation of another policymaking committee to review the research and make recommendations is duplicative and creates another opportunity for inappropriate influence of conflicted interests on policymaking. Connecticut has an unfortunate history of loosely interpreting statutory qualifications for appointments to policymaking councils and committees.

Alternatives to the Cabinet's proposals

Some alternatives to the Cabinet's proposals to achieve the same goals, and other options to achieve goals that were missed from my comments to the original Strawman proposal follow.

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, changing consumer notices, 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, and 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 Cabinet's 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 Cabinet consultants 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. 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.

Appendix I

Suggested Alternative to Recommendation 1B by Cabinet Member Frances Padilla

December 23, 2016

At the December 13, 2016 meeting of the Health Care Cabinet, member Frances Padilla requested consideration of an amendment to Recommendation 1B. Recommendation 1B calls for "the Legislature to require the Medicaid program and the Office of the Comptroller to pursue a Consumer Care Organization strategy…" The proposed amendment did not go to a vote, but Lt. Governor Nancy Wyman invited Ms. Padilla to submit the amendment as an appendix to the final recommendations of the Health Care Cabinet.

Proposed Amendment

While not necessarily opposed to the CCO concept, the timeline and specific risk percentages delineated seem far too specific at this stage.

The amendment proposes that the Cabinet:

- Avoid making a recommendation that sets a definitive timeline for risk-sharing and a specific upside-downside formula for the recommended Consumer Care Organization (CCO) strategy.

- Recommend that a formal independent evaluation be conducted of the Connecticut Medicaid program and State Employee Health Plan (SEHP) quality and cost initiatives before making those decisions.

The purpose of this amendment is to ensure that the design of any CCO payment strategy adopted by the Connecticut General Assembly be completely informed by the results of formal evaluations and a better understanding of underlying drivers of health care costs in both the Medicaid program and the State Employee Health Plan.

Independent evaluations of the impact on costs and quality should be conducted and learnings incorporated into the next level design of CCO payment strategies. Programs to be studied would include the Medicaid agency's Intensive Care Management initiative, the SIM PCMH+ pilot which will be the "second generation" of the current PCMH program in CT Medicaid, and the SEHP experience with ACOs. Connecticut should also continue to track the experience of other states relying on ACO approaches

to their Medicaid programs, such as Washington, Oregon and Massachusetts, before committing to a definite timeline for downside risk and to specific risk percentages.

Also, there should be no move to downside risk in any potential legislation that may arise from the Cabinet's recommendations prior to a well-informed understanding of both its risks and benefits in terms of improving quality of care and containing costs, and, with regard to Medicaid recipients, averting adverse consequences on the poor, low-income working people, the elderly and disabled.

Case for the Amendment

The Health Care Cabinet has focused much of its recommendation deliberations on the strategy of Consumer Care Organizations ("CCOs"), a modified accountable care organization ("ACO") structure, within the state Medicaid program and State Employee Health Plan, with payment reform strategies involving both shared savings and downside risk.

Universal Health Care Foundation (UHCF), where Ms. Padilla serves as President, has provided written comment twice (August and November 2016), and public comment on November 15, 2016. These comments have focused on reservations about the strength of the CCO intervention as a cost containment strategy.

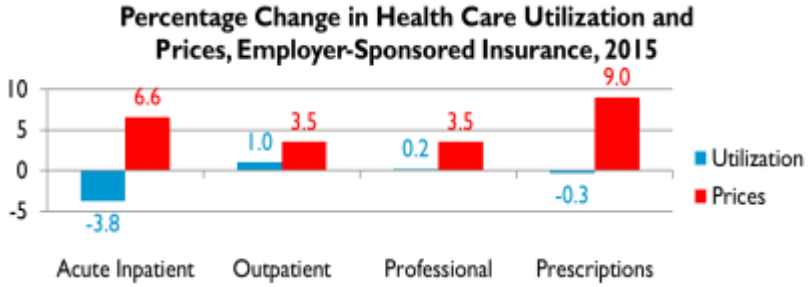
Health policy research literature points to the limits demonstrated thus far by coordinated care and ACOs, specifically, as a cost containment strategy. Coordinated care is in and of itself a worthy strategy for improving care and should be pursued to improve health outcomes and more effective use of health care resources. Connecticut is testing this through the Medicaid program's Intensive Care Management initiative and the State Innovation Model Patient Centered Medical Home Plus ("PCMH+) pilot, which will introduce shared savings in Medicaid (currently using a "managed fee-for-service" model). Through its own initiatives, the Office of the State Comptroller currently contracts with some 13 ACOs to provide care to state employees and retirees.

But UHCF maintains that the Cabinet's inordinate focus on coordinated care for the Medicaid and SEHP populations generally, with an added incentive of downside risk payments baked into the model, to achieve cost savings is misplaced. The CCO strategy ignores the underlying reasons for high health care costs and that those reasons are different in Medicaid and in the private insurance market. High hospital and prescription drug prices are underlying reasons for the high cost of care in the private insurance market, while expenses associated with a small percentage of high utilization, high need patients are the primary driver of cost in the Medicaid program.

Unfortunately, one of Connecticut's major limitations is the ability to collect, analyze and use data to better inform policymaking. The cost driver study required by PA 15-

146 was never conducted. Instead, the Cabinet's deliberations were mostly informed by the experience of other states in addressing cost containment (as directed by PA15-146); reporting by Connecticut state agencies on the cost drivers of their programs; and by comparisons of Medicaid and total health care costs with other New England states.

The CCO strategy does not address either cost driver in a targeted way. The chart below illustrates how nationally, despite health care utilization declining in 2015, prices increased at far greater rates. The story behind these data is about consolidation, mergers, and acquisitions in the world of hospitals and medical practices, and price gouging and other practices in the pharmaceutical industry. Coordination of high value, high quality services is good for patients, and should be employed, but it is not the complete solution. It may in fact increase costs as more of the right care is provided.



Source: Health Care Cost Institute, 2015 Health Care Cost and Utilization Report, Nov. 2016

In addition, state agencies and advocates for working and unemployed poor, disabled and elderly people have expressed their deep concerns about applying the downside risk payment model in Medicaid; that it may in fact create perverse incentives for doctors and hospitals to not accept or under-treat patients whose insurance coverage is the Medicaid program. Payment reforms like shared savings and downside risk are payment strategies being driven by the Centers for Medicaid and Medicare (CMS). While these strategies are being tested to simultaneously address quality and utilization in the

The public ranks the cost of prescription drugs as a top health care issue. They want government to do

Kaiser Family Foundation tracking polls, September and October 2016

- Top health care priority: affordability of high cost prescription drugs (74%)
- Favor government action to lower prescription drug prices (63%)
- Cost of prescription drugs is "unreasonable" (77%)

Poll of Maryland registered voters, August 2016

- 75% personally concerned about the cost of prescription drugs
- 43% "very", 32% "somewhat"
- 62% think prescription drug costs contribute "a lot" to rising health insurance premiums
- 84% favor suggested legislative proposals

Medicare program, where government already sets prices, their implementation in Medicaid managed care (which Connecticut abandoned several years ago) raises questions and concerns about adverse consequences.

Further, the Cabinet's recommendation to employ the CCO and shared risk strategies for cost-containment is based partially on the assumption that Connecticut state government can use its leverage via the Medicaid and State Employee Health Plan to turn the cost curves positively and stimulate similar response in the private market. It is unclear how this transfer of influence would work.

The reality of risk-sharing may be inevitable as CMS is incentivizing and even requiring adoption of these payment methods (i.e., MACRA). Given this policy trend, perhaps exacerbated by a federal move in the direction of block grants over the upcoming years, Connecticut should proactively prepare itself for a future of shared savings and shared risk. It seems premature, however, to establish a definitive timeline and identify downside risk sharing formulas this early in the process.