Cost Containment Data Workgroup: Recommendations

Presentation to the Healthcare Cabinet

March 12, 2019

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Presentation

Areas of Discussion
Background
Process
Areas of Interest
Selection and Prioritization Criteria
Data Availability and Feasibility
Recommendations
Discussion and approval

Healthcare Cabinet - Background

- Public Act Number 15-146, Section 17
- *Recommended Health Care Cost Containment Strategies: Healthcare Cabinet Report*
  - Transform the delivery and payment systems;
  - Directly reduce cost growth;
  - Coordinate and align state strategies;
  - Support market competition;
  - Support provider transformation;
  - Support policymakers with data; and
  - Incorporate use of evidence-based research into state policy making
- Healthcare Cabinet's June 12, 2018 Meeting
  - Commissioned workgroup to review data resources to support cost containment initiatives

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Cost Containment Data Workgroup Members

- Susan Adams (Masonicare)
- Ellen Andrews (Connecticut Health Policy Project)
- Pat Baker (Connecticut Health Foundation)
- Ted Doolittle (Office of the Healthcare Advocate)
- Kelly Sinko (Office of Policy and Management)
- Shelly Sweatt (TR Paul Inc.)
- Victoria Veltri (Office of Health Strategy)
- Josh Wojcik (Office of the State Comptroller)

- Support provided by:
  - Allan Hackney, HITO, OHS
  - Rob Blundo, Access Health CT
  - CedarBridge Group, LLC

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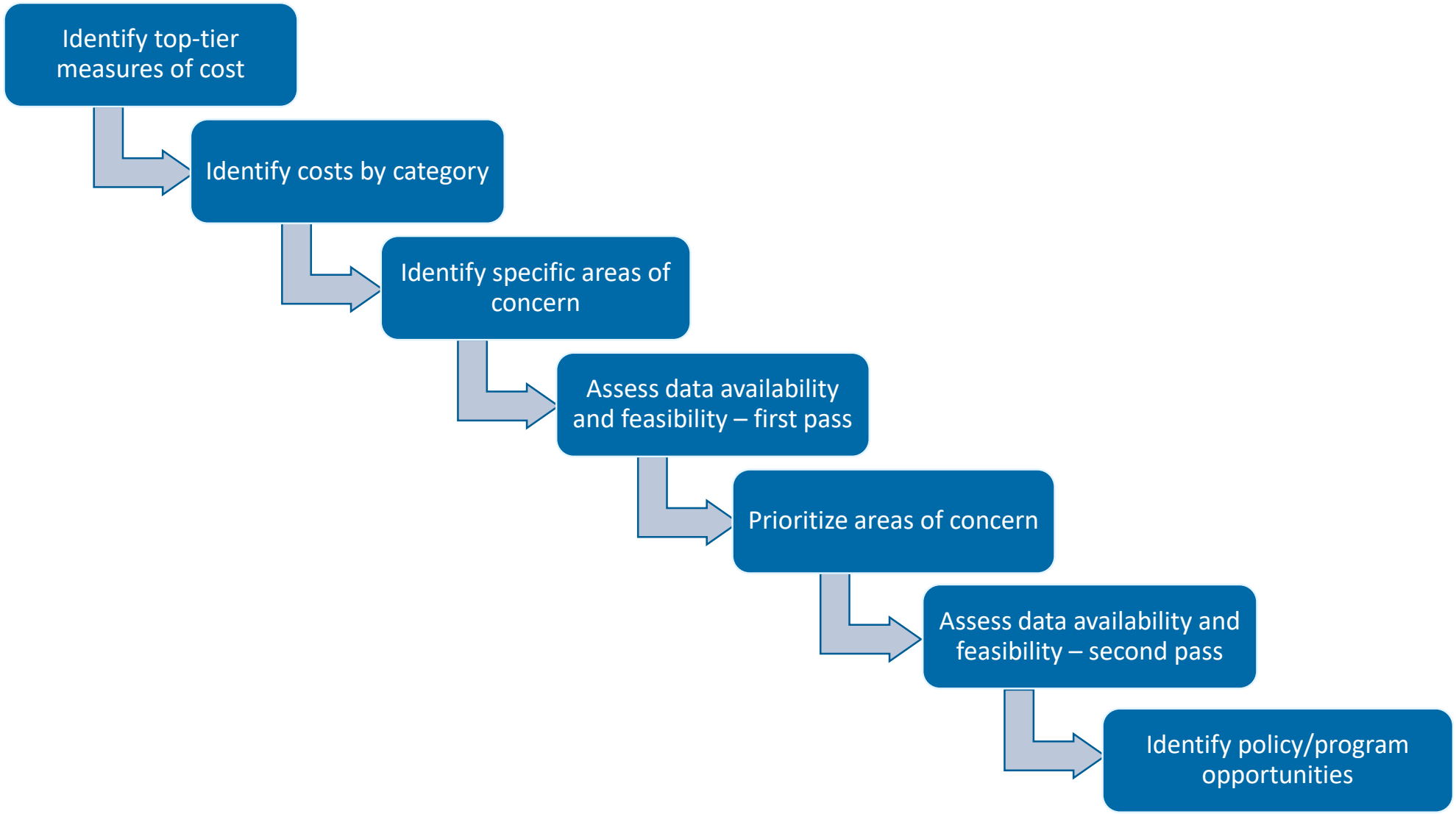
Process



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Top Tier Measures of Cost

- Total costs of healthcare provided to residents of Connecticut
- Per capita costs (per member, per month)
- Trends in total costs of healthcare over time
- Total "all-in" costs to the consumer, including out-of-pocket expenses, premium contributions, copays, and deductibles
- Total cost and per capita costs, including trends over time, broken down by payer type (e.g., commercial, Medicare, Medicaid, and the state employee health plan)

Cost by Category

- Total cost of care distribution by category of care (e.g., hospital, providers, prescription drugs, etc.) and payer type (e.g., commercial, Medicare, Medicaid, and the state employee health plan)
- Comparisons of costs for similar patient populations, broken down by providers and health systems
- Total cost of care distribution by diagnosis
- Total cost of care distribution by race, ethnicity and language
- Variations in utilization by diagnosis and outcome
- Incidence of cost and utilization outliers, both high and low outliers
- Total and per capita administrative costs, including expenditures for quality improvement activities
- Emergency department visits for behavioral health (by payer)
- Impact of waste on total healthcare costs, using industry-accepted definitions of waste

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Specific Areas of Concern (1 of 2)

- Out-of-pocket cost burden for the consumer and trends over time
- Ability to track price and utilization variations
  - Before and after a merger/consolidation, both vertical or horizontal
  - By geographic area
  - By size of health system and/or practice
  - By quality of care
  - By volume
  - By category or setting of care, such as hospitals and health systems, community health centers, provider groups, and urgent care centers
- High-risk, high-cost populations
  - Trends over time
  - Tracking whether high-risk, high cost patients persist over time or are episodic
  - By payer type (including Worker's Comp when available)
- Primary care costs, utilization and total cost of care before and after hospital primary care conversion to community health centers
- Impact of cost of new drugs, procedures, and devices
- Over-utilization and under-utilization of services

Specific Areas of Concern (2 of 2)

- Cost-shifting from one covered population to another
- Impact on healthcare cost resulting from transitioning to and from Medicaid
- Impact on quality and cost of movement to value-based care and provider risk
- Readmission rates and costs
- Costs and predictors of preventable hospitalizations and emergency department visits
- Price and utilization of resources for patients seen by primary care physicians vs. specialists
- Utilization of home care services and impact of home care agency closures and rate cuts
- Impact of facility fee notification
- Total costs of waste, using industry-accepted definitions
- Relative drivers of cost over time, including pricing, utilization, and enrollment

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Operating Principles → Prioritization Criteria

1. **Commitment to Impact:** Contribute to the improved physical, behavioral, and oral health of all Connecticut residents as seen in the following:
    - The number of individuals and/or constituencies affected
    - The depth and/or intensity of the problem
    - Reduction of barriers and burdens for those most vulnerable
    - The time frame in which change can occur
    - The cost effectiveness of health and health care purchasing that promotes value and optimal health outcomes
    - 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:
    - Make the best use of past and current knowledge and expertise
    - Maximize the opportunities provided through initiatives from the public and private sector
    - Be informed by data and evidence-based practice and research
    - Be sustainable
4. **Accountability and Transparency:** Be fully accountable to the public in a transparent process that meets the objectives of PA 11-58.
    - Identify and measure outcomes that demonstrate meaningful results
    - 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.

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Priorities

	Item
Top 4	**Track price and utilization variations**
	Over-utilization, waste, and under-utilization
	Preventable hospitalizations and ED visits – costs and predictors
	Out-of-pocket cost burden – trend over time
	High-risk, high-cost population (patterns of care 5-10 years prior)
	Cost-shifting from one covered population to another
	Provider risk models – impact on quality / cost
	Track utilization of home care vs. hospitalizations, track with home care agency closures and rate cuts
	Track resource gap between primary and specialty care – price/utilization vs. total cost of care, by geography and payer

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Data Availability and Feasibility

Item	Currently Available Through APCD?	If Available – Level of Effort Required to Utilize Data (H/M/L)
Identify cost of waste (using standard definitions)?	**Y/N**	**M/H**
Over- and under-utilization	**Y/N**	**H**
Out-of-pocket cost burden - trend over time	**Y/N**	**M**
Track price and utilization variations - CONSOLIDATED		
Before and after a merger/consolidation - vertical or horizontal)	Y	H
Price and utilization variations (geographic)	Y/N	M
Size of health system / practice	Y	H
Sort with quality	Y	H
Sort with volume	Y	M
By category / setting of care	Y	M
Readmission rates and costs	**Y**	**M**
Preventable hospitalizations and ED visits - costs and predictors	**Y**	**M**

Note "Level of Effort" may be adjusted as categories become more precisely defined.

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Healthcare Cabinet Cost Containment Data Workgroup Recommendations

Recommendation 1: Priority should be established for gathering, organizing, and making accessible data in the following categories related to healthcare cost and utilization:

1. Variations in price and utilization, with ability to analyze by a wide range of factors including race, ethnicity, language, payer type, care site and quality of care
2. Out-of-pocket cost burden, including trends over time
3. Waste, under-utilization and over-utilization
4. Preventable hospitalizations, emergency department visits, and readmissions

Recommendation 2: User-friendly tools and training for accessing and analyzing healthcare cost and utilization data should be made available to support the following:

1. Fact-driven policy development
2. Consumer-focused information for cost and utilization comparisons
3. Value-based care purchasing decisions by employers and payers
4. The ability to analyze the data by such factors as race, ethnicity, and language
5. The ability to evaluate new initiatives
6. The ability to identify and monitor cost and utilization outliers
7. Public health and academic research interests

Healthcare Cabinet Cost Containment Data Workgroup Recommendations

Recommendation 3: The APCD should continue to be leveraged to support ongoing efforts to contain healthcare costs through:

1. Consumer website enhancements
2. Ease of data release policies and processes
3. Publication of standard report sets of interest to stakeholders
4. Provision of a self-service, user-friendly business intelligence tool for consumers, researchers, and other stakeholders

Recommendation 4: In addition to APCD data, supplemental data should be acquired, organized, and made accessible, especially for the following:

1. Uninsured patients, undocument patients and other populations in the state whose clinical encounters are not be captured in claims-based data
2. Measures of quality of care, given limitations of assessing quality based on claims data only

Recommendation 5: Responsibility for supporting ongoing data acquisition and access should be established:

1. Support for systems and processes for data acquisition, access, analysis and communication, including annual updates to the Healthcare Cabinet, is recommended to be provided by OHS.
2. Oversight and policy development related to data acquisition and access as part of its overall responsibilities including cost containment strategies is recommended to be provided by the Healthcare Cabinet.

DISCUSSION

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