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Healthcare Cabinet Cost Containment Data Workgroup:

Findings and Recommendations

March 12, 2019

Introduction:

Public Act Number 15-146, Section 17, enacted June 30, 2015, instructed the Connecticut Healthcare Cabinet to make recommendations on health care cost containment strategies for Connecticut. On January 5, 2017, the Healthcare Cabinet released the report titled, *Recommended Health Care Cost Containment Strategies: Healthcare Cabinet Report in Response to PA 15-146.* This report contains recommendations for cost containment initiatives, including:

1. Transform the delivery and payment systems;
2. Directly reduce cost growth;
3. Coordinate and align state strategies;
4. Support market competition;
5. Support provider transformation;
6. Support policymakers with data; and
7. Incorporate use of evidence-based research into state policy making.

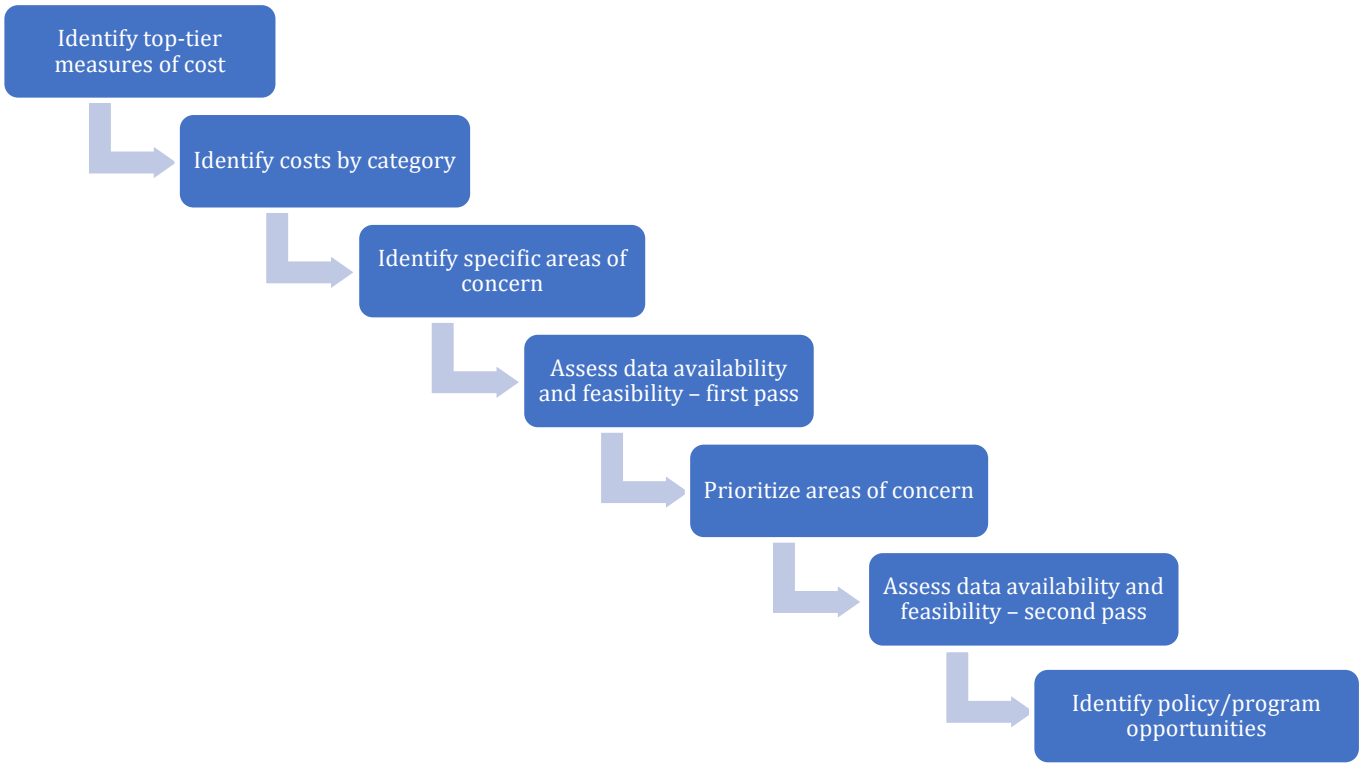
Since the publication of these recommendations, the containment of healthcare costs has continued to be an issue of importance to the Healthcare Cabinet. At its June 12, 2018 meeting, the Healthcare Cabinet commissioned a special ad hoc workgroup to develop an updated review of available data resources that could support initiatives in cost containment. This assessment was to be conducted in close collaboration with the All-Payer Claims Database (APCD) program. This ad hoc workgroup was formed on August 22, 2018 as the Healthcare Cabinet Cost Containment Data Workgroup, and has been convened six times. Membership on the Data Workgroup included:

- 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 for the Data Workgroup was provided by Allan Hackney, Health Information Technology Officer, within the Office of Health Strategy, Rob Blundo, within Access Health CT, and CedarBridge Group, LLC.

Process:

The Healthcare Cabinet Cost Containment Data Workgroup met six times from August 2018 to February 2019. A deliberative process was employed by the Data Workgroup in order to: generate a broad set of possible areas of interest or concern, assess availability of data to support those areas of interest, apply criteria for establishing priorities, and develop recommendations for consideration by the Healthcare Cabinet. This process is displayed graphically below. The data elements defined for each of these areas of interest or concern follow the below graphic.



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)

Costs 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

Specific Areas of Concern

- 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
- 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

Selection Criteria and Prioritization:

The Healthcare Cabinet approved a set of Operating Principles at its June 14, 2016 to help guide its work in policy and strategy development. The Data Workgroup carefully considered these Operating Principles and made the decision to utilize them for prioritizing specific areas of interest for data acquisition and analysis related to cost containment. The Operating Principles are as follows:

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.

Over the course of two meetings, the specific areas of interest or concern were assessed based on their alignment with these Operating Principles and the ability to maximize the utility of recommended efforts. This resulted in the identification of four priority areas for further development related to data availability and feasibility, organization, and analysis as displayed in the graphic below:

	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

Subsequent to the selection of these four priority areas, a semantic alignment discussion was held to ensure consensus regarding what is encompassed within each of these categories. Additional descriptions of each are as follows:

1. Variations in price and utilization includes the ability to assess these variations by the following factors:
    - Race, ethnicity, and language
    - Before and after a merger/consolidation, both vertical or horizontal mergers
    - Geography
    - Size of health system/practice
    - Quality of care
    - Volume
    - Category/setting of care, such as hospitals, solo vs. group practices, community health centers, urgent care centers, retail clinics, outpatient services, labs, pharmacies
2. Out-of-pocket cost burden should represent the "all-in" cost for the consumer, including premium contributions and all healthcare costs, as well as the ability to track trends across time
3. Waste, under-utilization and over-utilization includes several dimensions of cost and potential for cost containment: industry-accepted definitions of waste should be utilized; "under-utilization" and "over-utilization" may each represent quality and cost containment opportunities; and price transparency and plan design should be considered in analysis in these areas.
4. Preventable hospitalizations, emergency department visits, and readmissions should also consider impacts of plan design (e.g., perverse incentives) and social determinants of health

Data Availability and Feasibility:

The Data Workgroup, with support from CedarBridge, focused much of its work on the availability of data from the APCD to support healthcare cost containment strategy and policy development. Two discussions were held: the first review was made relative to the entire list of potential areas of interest or concern; and the second review was specific to the four identified priority areas.

As the table below indicates, both the availability of data from the APCD and the level of effort required to acquire and analyze that data were assessed. In general, the APCD was seen as a viable and meaningful source of data for the priority categories of interest. It was noted that the level of effort to organize and analyze such data requires moderate to high effort and additional resources would be needed for such an exercise. However, it should also be noted that as these categories of interest become more precisely defined, the level of effort will be re-assessed and adjusted, if appropriate. In addition, the Office of Health Strategy will be expanding its analytical capabilities and some of these capabilities can be applied to analysis of APCD data in support of cost containment.

One final consideration relates to the limitations of using only APCD data in cost containment policy and strategy development. In particular, given that the data contained in APCDs are provided by payers, uninsured and self-insured ERISA populations are not included in the database. Some inference of quality of care can be made from claims-based data, however deliberate care should be taken to not use APCD as a definitive reference for quality determinations. The below table provides a snapshot of the APCD data availability and feasibility analysis that was conducted specific to the prioritized areas.

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**

It should be noted that OHS houses numerous databases, reports and other information that can be utilized to support healthcare cost containment strategy and policy development. Such information includes: patient data (inpatient, outpatient, surgical facilities, emergency); financial

data; and an inventory of facilities and services. This report will inform future data and reporting activities of OHS.

Recommendations:

The Healthcare Cabinet Cost Containment Data Workgroup presents the following recommendations for the Healthcare Cabinet's review and consideration. These should be viewed as guideposts for future capabilities development and resources planning. Detailed analysis of costs to implement these recommendations was beyond the scope of the Data Workgroup. However, the Data Workgroup recommended that any future considerations of costs should include the financial impact of implementation on entities that are mandated, or otherwise required to provide such data.

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

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.

Concluding Thoughts and Next Steps:

These recommendations were approved unanimously by the Healthcare Cabinet at its March 12, 2019 meeting. These recommendations will now be incorporated into the OHS annual strategic planning process to address timing, costs, implementation, analytics support, operations and funding.

In conclusion, we express our gratitude to the Healthcare Cost Containment Data Workgroup for its thoughtful contributions to this report. Your input and guidance have been invaluable.