Cost Containment Straw Model and Significance for Consumers

Discussion and Feedback

Megan Burns & Marge Houy

August 9, 2016

bailit health

Today's Topics

- Health Care Cabinet's legislative charge
- Why there is a need for more cost containment activities
- Overview of Bailit Health's straw model
- Key straw model recommendations and relevance to consumers
- Discussion and feedback

Legislative Charge to Health Care Cabinet

- By the end of December, send the legislature recommended strategies to:
  - Identify the reasons that costs are increasing
  - Implement cost containment strategies that address the cost drivers, while improving quality of care
  - Identify high cost providers and provide assistance so that they can lower their costs
  - Address provider price disparities (different prices charged for the same service by different providers)

Health Care Cabinet's Principles

- The Health Care Cabinet wishes to ensure any recommendations they make to the legislature meet their principles of:
  - Improved physical, behavioral and oral health
  - Reduced disparities based on race, ethnicity, gender and sexual orientation
  - Sustainability
  - Accountability and transparency
  - Inclusive of all voices
  - Actionable

Why is the Legislature Concerned about Rising Health Care Costs

- The State is facing a budget crisis
  - We have seen the impact on Connecticut residents with cuts in services
  - For example, Medicaid has narrowed eligibility criteria
- State agencies have been working to reduce costs and more needs to be done
- More can also be done by the private payers and providers
- Connecticut's "numbers" on costs and quality of care suggest that there are other opportunities to improve both

Cost Drivers (Unit Price + Utilization)

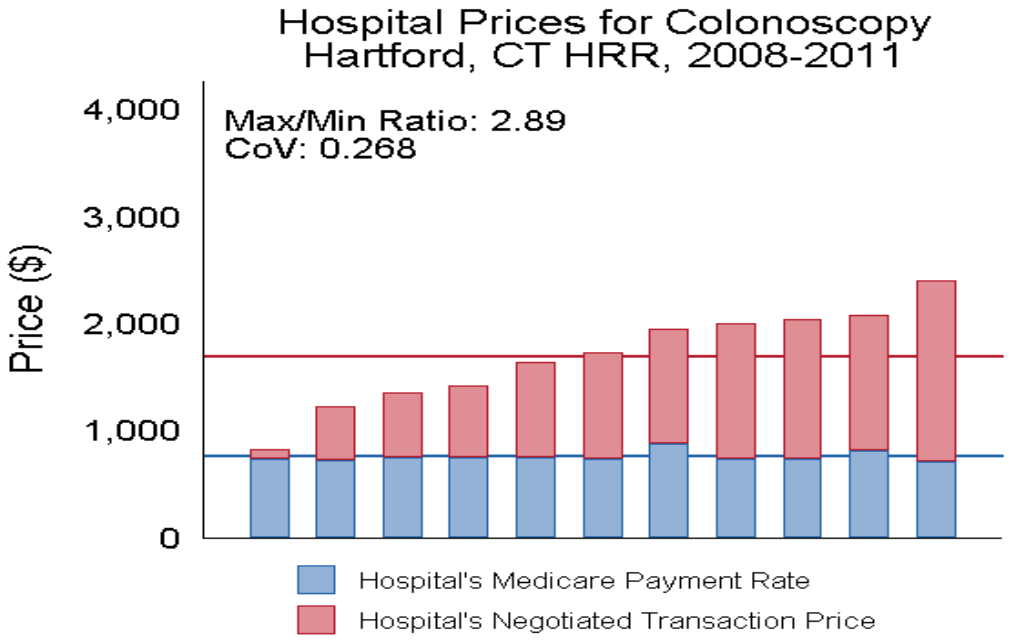
- Price
  - CT's non-profit hospital adjusted expenses per inpatient day is 4th highest the NE and exceeds NY and national averages

Location	Non-Profit Hospitals
1. Massachusetts	$2,862
2. Rhode Island	$2,725
3. New Hampshire	$2,535
4. Connecticut	$2,394
5. Maine	$2,371
United States	**$2,346**
6. New York	$2,324
7. Vermont	$2,033

Source: Kaiser Family Foundation, State Health Facts, 2014

Price Variation

- There are substantial price variation within key markets for key services



Unnecessary Utilization

Measure	Connecticut Rate	US Rate	Selected Regional Comparisons
Potentially avoidable ED visits (Medicare/1000 beneficiaries)	189	181	NY: 165 RI: 116 VT: 178
Medicare 30-day hospital readmissions/ 1000 beneficiaries	34	30	NY: 31 RI: 27 VT: 27
Summary Ranking: Avoidable Use and Cost	28	N/A	NY: 26 RI: 22 VT: 13

Source: The Commonwealth Fund: Scorecard on State Health System Performance, 2015

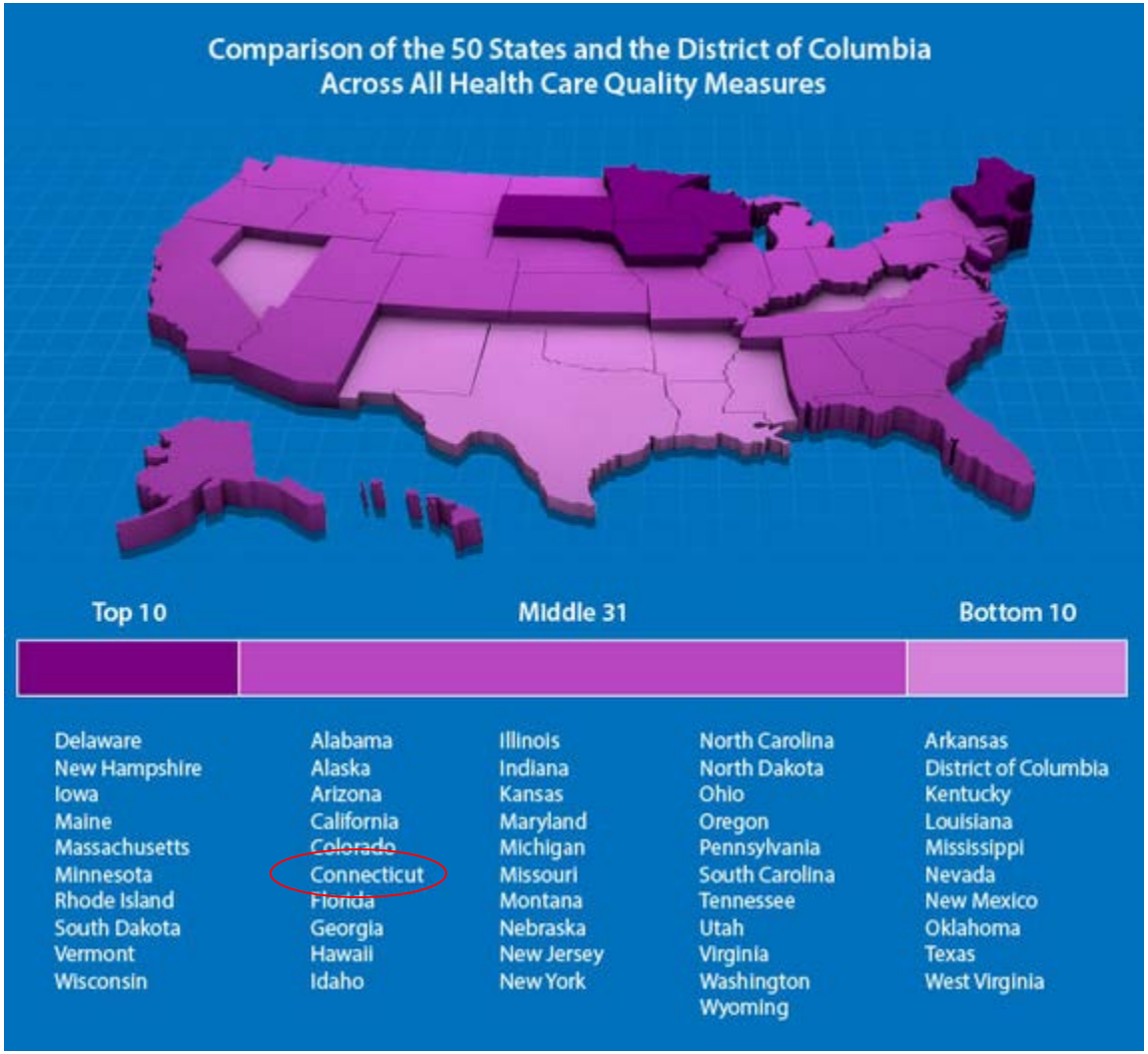
CT's Per Capita Spending: Price + Utilization

- CT's per capita spending is second highest in the NE and exceeds NY average and the US average
- It's also the 4th highest in the country

Location	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	**$6,815**

Source: Kaiser Family Foundation, State Health Facts, 2009

Connecticut Ranks in the Middle on Quality of Care



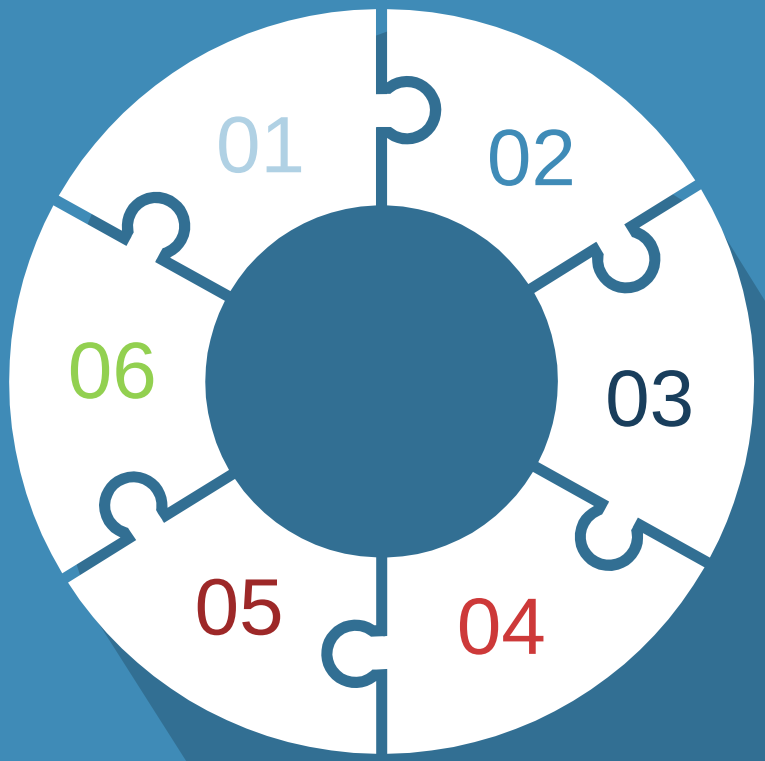
Source: AHRQ State Snapshot

State Levers to Control Costs with Examples

1. Purchasing power: use Medicaid and state employee plans to implement payment reform and evidence-based coverage decisions
2. Regulation of commercial insurers: to promote payment reform and to require cost caps in contracts
3. Provider rate setting: to promote payment equity and contain cost growth
4. Data sharing: to identify cost drivers and direct policy decisions
5. Bully pulpit: to set and then address cost targets
6. Legislation: to create new delivery models and control cost increases

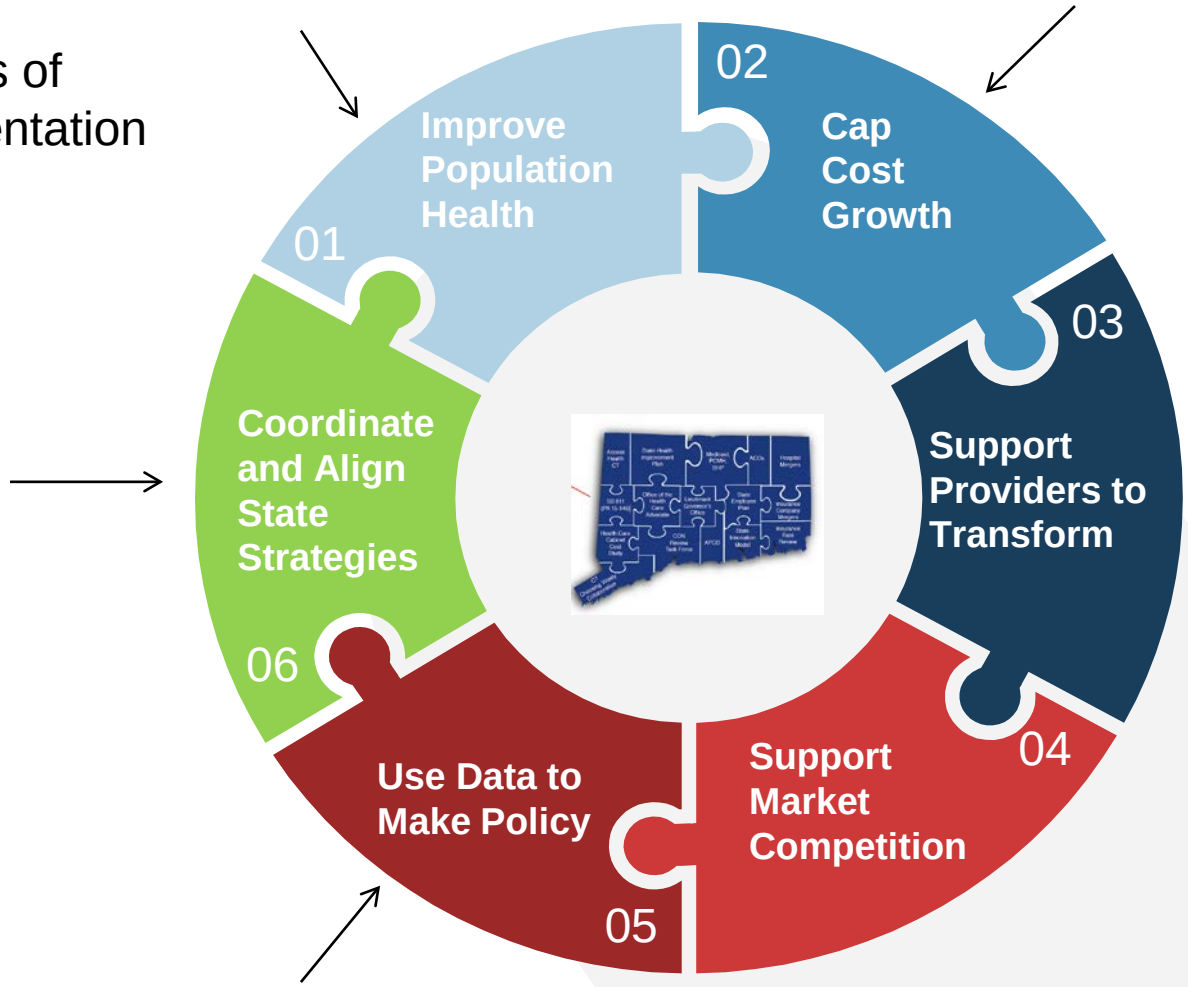
What is a Straw Model?

"A straw model is **not expected to be the last word**; it is refined until a final model is obtained that **resolves all issues** concerning the scope and nature of the project."



Bailit Health's Straw Model

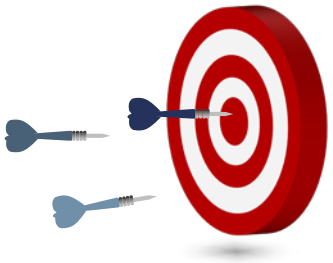
Focus of Presentation



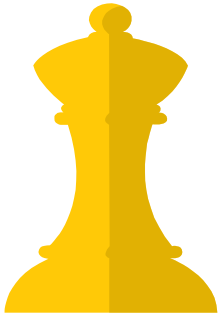
1. Improve Population Health

- Problem: today's health care system is fragmented and uncoordinated because providers are paid on a fee-for-service basis and are not incentivized to coordinate care
- Consumer Impact:
  - there is little emphasis on prevention,
  - patients might get duplicate services,
  - patients might not get the services they need, especially if those services are not "high priced"
  - patients with multiple illnesses can get lots of services, but their condition is not well managed
  - patients have to be able to navigate themselves through the health care system to be sure to get the care they need, and that is very difficult for most people to do

Recommendations to Improve Population Health



Goal: Implement delivery system AND payment reforms designed to reward providers for ***improved population health outcomes*** by emphasizing prevention, better coordinating care and better managing chronic conditions.



Strategy: Medicaid and the state employees contract on a shared risk basis with Advanced Networks to create Consumer Care Organizations to promote efficient use of services and improve quality.

What are Consumer Care Organizations?

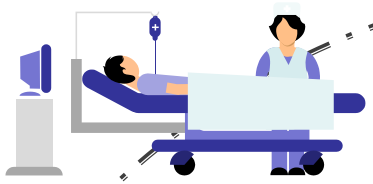
- Consumer Care Organizations (CCOs) would be groups of providers that **voluntarily** come together to coordinate a comprehensive set of services for an attributed patient population.
  - Much like an "Accountable Care Organization (ACO)"
- Consumers' interests would be addressed by requiring CCOs to:
  - have a governing body that is representative of the provider-types that make up the CCO
  - include proportionate consumer representation on the governing body across its lines of business
  - establish a separate consumer advisory board with a direct advisory relationship to the CCO governing body

How are Consumer Care Organizations Different than Accountable Care Organizations?

- The key distinguishing feature of our recommended Consumer Care Organization is:

The Consumer

Consumer Care Organizations

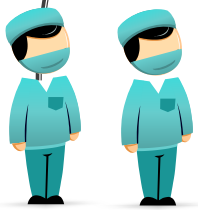


Long-Term Care Providers

Home and Community-Based Providers

Consumers

Primary Care Providers



Specialists

Behavioral Health Providers

Hospitals

What Health Care Services Should Consumer Care Organizations Provide?

- Structure services and payments using the principles of:
  - Patient-Centered Medical Homes (PCMHs) for primary care
  - Paying for outcomes and improved health status
  - Measuring performance and shared accountability, including on reducing social determinants of health
  - Coordinated and integrated care across the continuum of care and over time
  - Sustainable rate of growth in total cost of care
- Initially, the CCO must provide integrated medical and mental health and substance use services
- Medicaid CCOs must develop the capacity to provide dental care within 3 years.
- LT Support Services should be integrated within 3 years.

How Should Consumer Care Organizations be Paid?

- Create a consolidated stream of funds for the medical, behavioral health, LTSS and oral health needs of the designated population served by the CCO
  - Implement a shared risk model when the CCO is ready to assume risk
- Withhold 2-5% of the payment to be earned based on the CCO meeting standard quality measures that include patient experience measures, and clinical process and outcome measures
- Use existing Medicaid Administrative Services Only (ASO) organizations to pay the CCOs.
- Encourage participation by limiting future rate increases for non-participating providers

Consumer Care Organizations Are Not….

- …Medicaid Managed Care Organizations
  - They will not be taking insurance risk, paying claims, credentialing providers
- …just for large hospital systems
  - They must include providers across the continuum of care
  - They must develop infrastructure to manage high-risk patients
  - They could be started and operated by entities other than hospitals
  - They must have proportionate consumer representatives on their Boards of Directors

Consumer Care Organizations Are…

- …able to build upon the Patient- Centered Medical Home model to include other key health care providers (e.g., hospitals, SNFs, etc.)
  - PCMH providers create an important foundation in any CCO and allow them to continue to grow and evolve
- …able to build the connecting infrastructure to better address social determinants of health
- …capable of being formed by any willing provider
  - E.g., Coalitions of independent practices
- …designed to accept shared risk with the state and move beyond PCMH+
  - PCMH+ is an important step to prepare organizations to become CCOs
- …able to accommodate future Medicaid payment innovations
  - If the Medicaid program develops an episode-based payment model, those episodes can be the model by which the CCO providers are paid

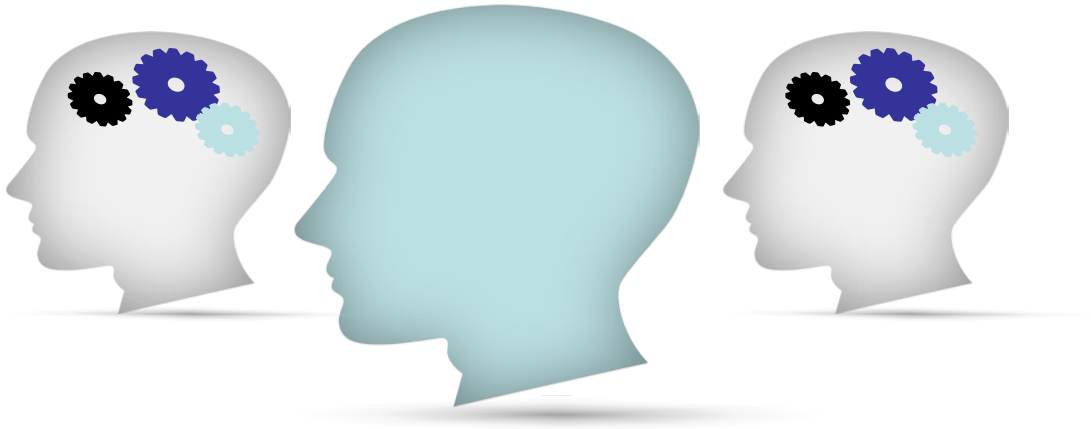
Why Do We Think This Will Work?

- There is evidence that ACO programs in Medicaid are saving money, while also improving quality.
- Costs:
  - **Colorado**: $29-33 million in net savings over three years.
  - **Oregon**:
    - PMPM inpatient care spending down 14.8%;
    - PMPM outpatient spending down 2.4%;
    - spending on primary care **up** 19.2%.
  - **Minnesota**: $14.8 million in 2013 and $61.5 million in 2014 compared to expected costs

Why Do We Think This Will Work?

- Quality:
  - **Colorado**:
    - ED visits that did not result in an admission decreased
    - Well-child visits increased
    - Post-partum care increased
  - **Oregon**:
    - Significant improvements in adolescent well care visits, SBIRT screening, dental sealants for kids, assessments for kids in DHS custody, number of people without poorly controlled diabetes, etc.
  - **Minnesota**:
    - In 2013, all Integrated Health Partnerships (IHPs) met their quality goals.

Discussion



- What are your thoughts about the proposal to create CCOs?
- What are your concerns?
- What recommendations do you have to enhance their performance?

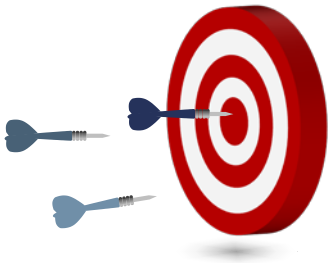
2. Use Data to Make Policy Decisions

- **Problem**: Without data it is not possible to know if policy initiatives are achieving intended goals. Moreover, without data, it is not possible to measure effectiveness, quality, track improvement, make necessary changes, if policy initiatives are "off track."
- **Consumer Impact**:
  - It is estimated that up to 30% of all treatment does not bring about patient benefit. This is costly to everyone and exposes patients to unneeded risk of adverse consequences.
  - Consumers are not informed of the cost and quality of the services they are receiving making it difficult to make informed health care choices.

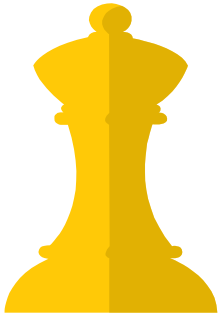
Recommendations on Use of Data to Make Policy

Use Data to Make Policy

05



Goal: Enable the state to monitor cost growth, use data to inform policy making, and make coverage decisions based on comparative effectiveness data



Strategy: (1) Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange. (2) Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services. **(We're only going to address recommendation #2 in this presentation)**

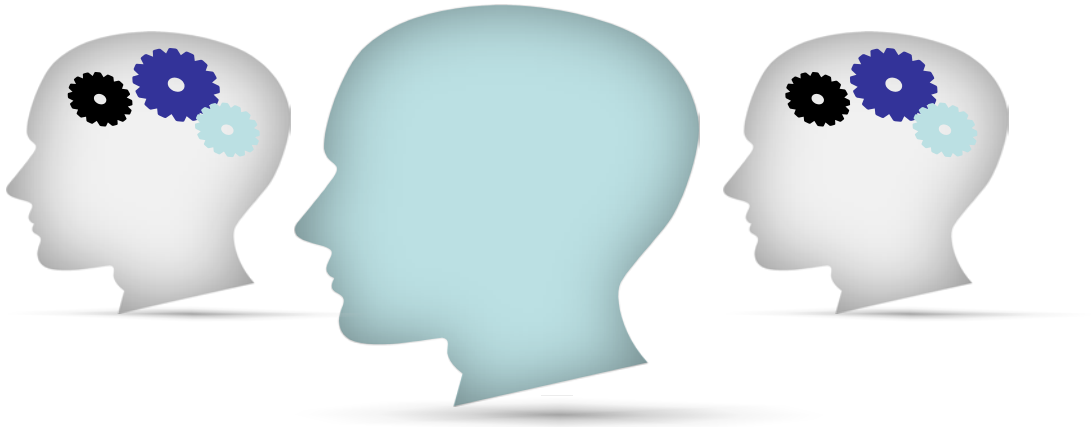
Adopt an Evidence-based Coverage Strategy

- The Legislature should enact legislation mandating that the best available scientific evidence should guide coverage decisions for every agency of the state government that purchases health care
- Approximately 30% of all health care spending may produce no benefit to the patient – and some of it produces clear harm
  - Unexplained variation in the use and intensity of the end-of-life care, CABG surgery and angioplasty alone is estimated to cost the health care system $600 billion (New England Healthcare Institute, 2008).
  - $1.1 billion is spent just on unnecessary antibiotics for respiratory infections (O'Connor, 2013)
- Adopting evidence-based coverage decision-making can reap savings. For example Washington has seen:
  - 94% reduction in spending on bariatric surgery
  - a $10 million savings from reducing tube feeding spending
  - 3:1 Return On Investment in ADD spending for children by using second opinions

To Enact This Strategy, Relevant State Agencies Should…

- Implement a transparent process that allows for public input into determining medical necessity of medical, behavioral health and dental services
- Establish a state health technology assessment committee to determine safety and effectiveness of medical devices, procedures and tests
- Expand the scope of the current Medicaid Pharmacy &Therapeutics Committee to cover all pharmacy benefits offered under all state-purchased health care services

Discussion



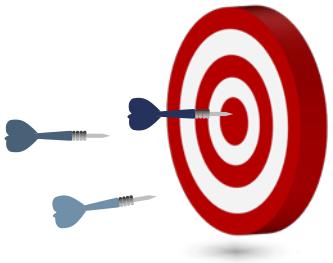
What are your thoughts about using evidenced-based research to guide coverage decisions?

3. Coordinate and Align State Strategies

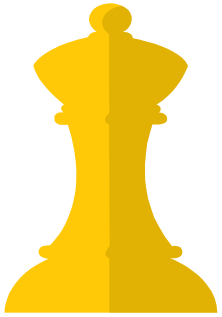
- **Problem**: Connecticut has a decentralized state structure for developing and implementing health care policy. As a result, opportunities to more closely coordinate strategies to maximize impact might be available.

- **Consumer Impact**: State government could play a more active role in coordinating delivery system reform and payment reform to improve quality and reduce costs, similar to other states

Recommendations to Coordinate and Align State Strategies

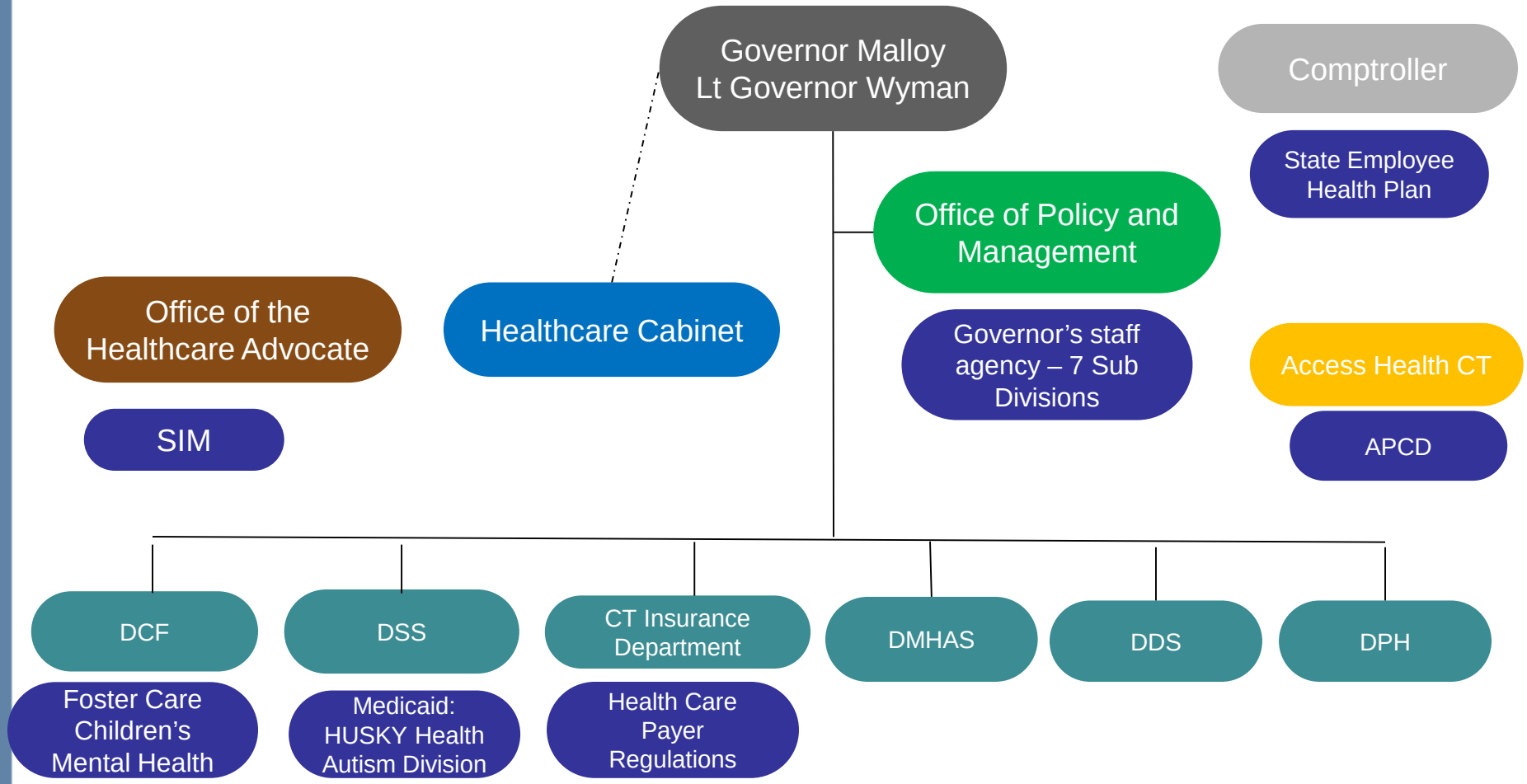


Goal: Align existing SIM initiative and other state health care strategies to maximize impact of the State's purchasing and policy levers



Strategy: 1) Create a quasi-independent agency to developing and overseeing state health policy and 2) restructure existing agencies into a single state entity composed of all health-related state agencies to align all state health policy and purchasing activities.

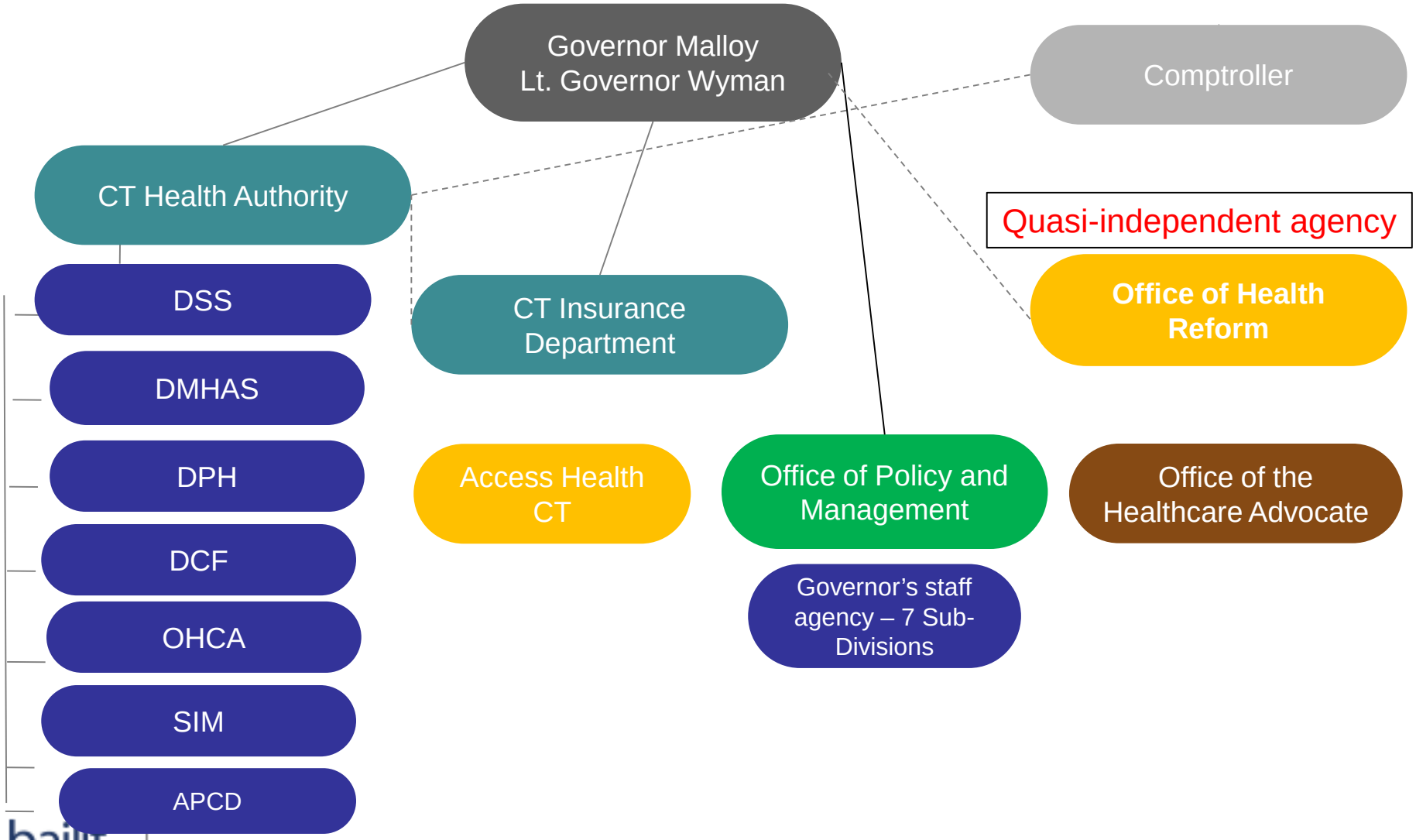
CT Government Oversight of Health Reform: Current Structure



Position of Agencies / Bodies are not meant to represent a hierarchy.

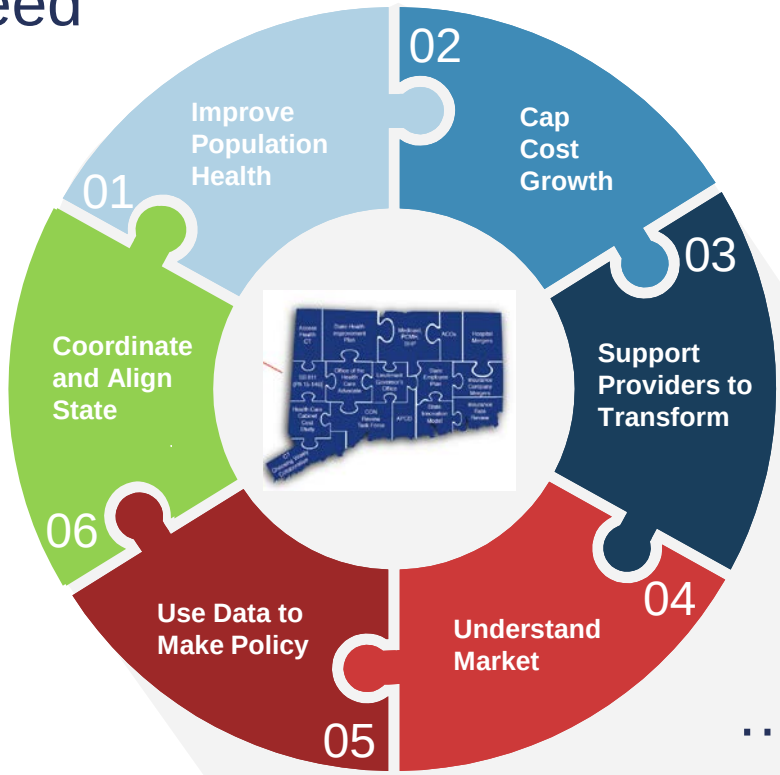
Note: This chart was created based on our assessment of Connecticut's organizational structure; it is not an official representation from the state.

Recommended Organizational Chart



Why Create a Single State Authority and Create an Office of Health Reform?

Because the pieces of the puzzle need to fit together…



…and be governed with a unified, trusted voice.

Consolidated Connecticut Health Authority (CTHA) Responsibilities

- The CTHA should be established to oversee state programs and initiatives that directly or indirectly purchase and / or regulate health care services or set state health care policy. It should work closely with the CT Office of Health Reform to develop a unified statewide strategy.
- The CTHA should produce one centralized budget for all of its component agencies
- It should direct the coordination of purchasing strategies with the Office of the Comptroller and Department of Corrections
- It needs to be supported with APCD and HIE data

CTHA Should be Mandated by Legislature to:

1. Set annual measurable targets around goals of:
   - Reducing cost increases
   - Improving population health
   - Promoting healthy children and families
   - Providing timely access
   - Promoting improved quality
   - Providing superior care experience
   - Reducing health status and health inequities
   - Reducing avoidable and wasteful spending

CTHA Should be Mandated by Legislature to:

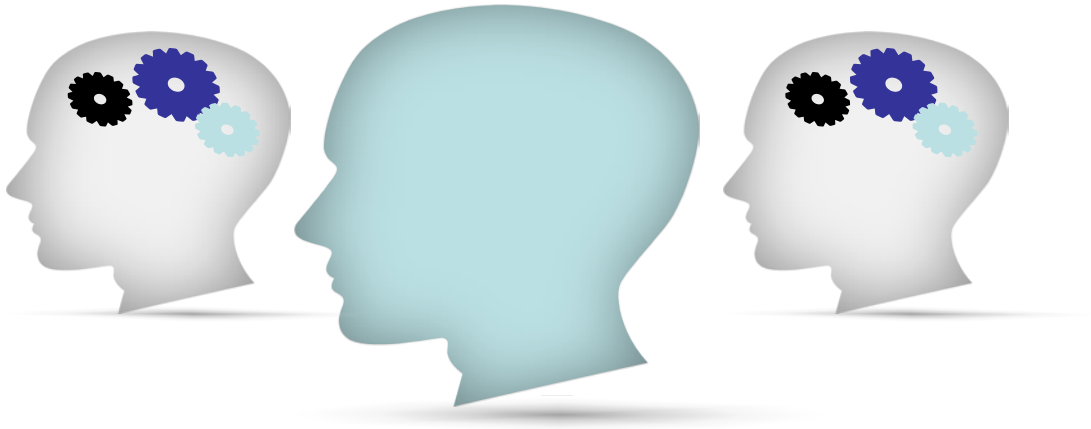
2. Coordinate the state's health care initiatives, including these recommended strategies, and the SIM initiative.

3. Submit an annual report to the Legislature on its progress toward meeting the aforementioned goals.

What are the Benefits to a Single State Agency?

- While Connecticut state staff currently do some informal coordination across agencies, today, a single state agency would:
  - establish more formal coordination and allow for accountability in developing an aligned set of strategies
  - facilitate the ability of the State to identify and quantify funds available to use as state contributed matching funds, which could expand access to federal funding sources

Discussion



What are your thoughts about the benefits and negative consequences of consolidating state agencies into a single Connecticut Health Authority?

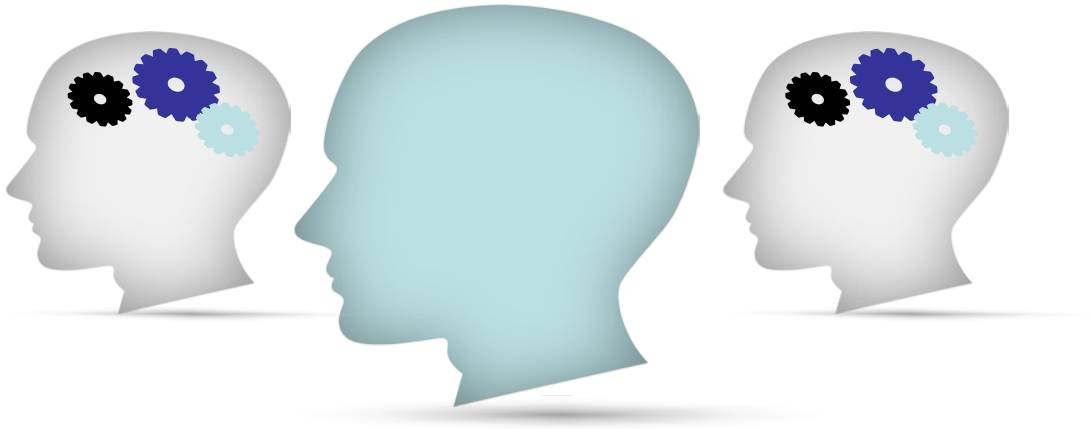
4. Connecticut Office of Health Reform

- Would have five major areas of responsibility focused on slowing the growth of health care costs, including creating a cost growth cap

What are the Benefits of an Office of Health Care Reform?

- Creates an objective, quasi-independent group to analyze cost drivers and set cost growth caps placed on payers and providers
  - Health Insurers would be required to include in contracts with Advanced Care Networks limits on how much the budgets for the Advanced Care Networks could increase each year
  - Medicaid would be expected to negotiate CCO budget increases that are consistent with the cost growth caps.
- Allows for concentrated efforts to address health care cost issues
- Promotes state government accountability

Discussion



What are your thoughts about the benefits and negative consequences of creating an agency to establish and monitor a cost growth cap?

Next Steps

- Bailit Health will document today's discussion and identify themes that require further investigation or conversation
- The Cabinet will continue strategy / recommendation discussions in August

- **September**: Finalize recommendations
- **October**: Review draft report
- **November**: Finalize report
- **December 1**: Submit report to the legislature

Study Timeline