

Health Care Cabinet Cost Containment Study

Discussion and Feedback of Bailit Straw Proposal

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The Healthcare Cabinet Cost Containment Study is a Partnership



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Today's Topics

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

Legislative Charge to Health Care Cabinet

- PA 15-146 charged the Cabinet by December 1 to send the legislature a recommended “blueprint” for:
 - Monitoring and responding to health care cost growth, which may include setting benchmarks or limits;
 - Identifying and mitigating factors that contribute to health care cost growth
 - Creating the authority to implement and monitor delivery system reforms to designed to promote value-based care and improved outcomes
 - Development and promotion of insurance contracting standards and products that reward value-based care

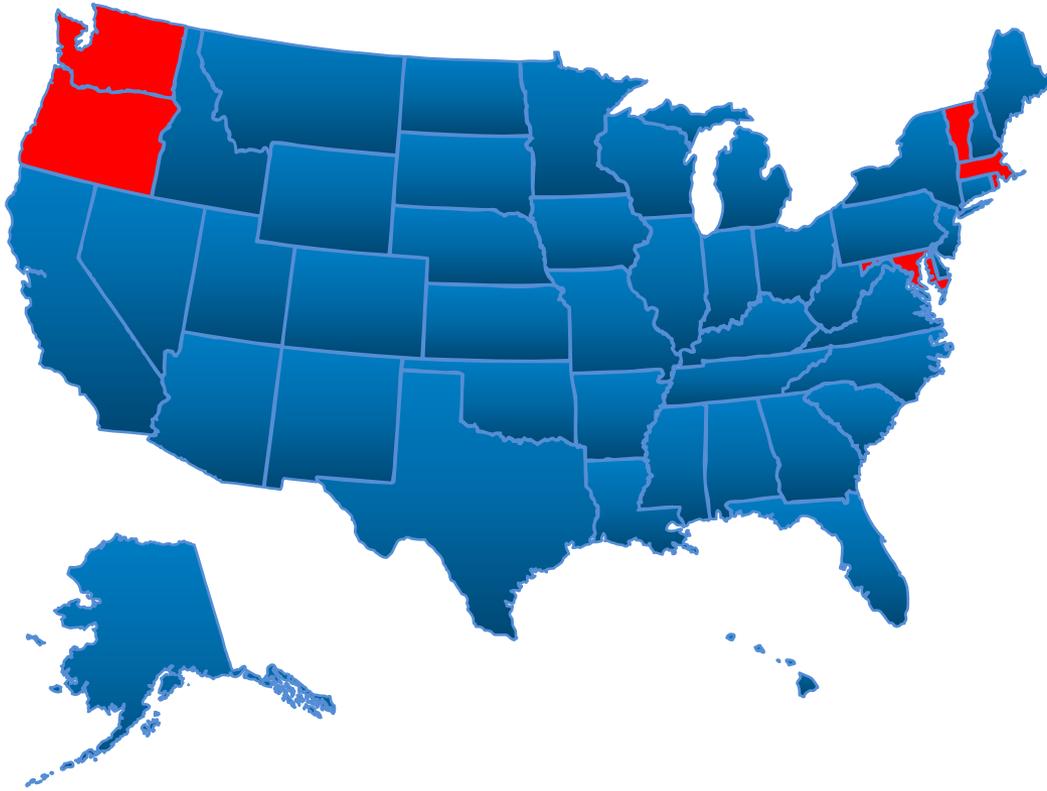
Health Care Cabinet's Principles

- 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 Legislature was concerned about a number of trends and events:
 - Consolidation of providers, resulting in large facility fees
 - Increased physician prices due to hospital ownership
 - Increased costs not related to quality
 - State budget shortfalls
- It wanted to draw upon the experiences of other states actively engaged in cost containment measures.

Focus States



Six States of Inquiry:

1. Maryland
2. Massachusetts
3. Oregon
4. Rhode Island
5. Vermont
6. Washington

Cost Drivers (Unit Price + Utilization)

- Price

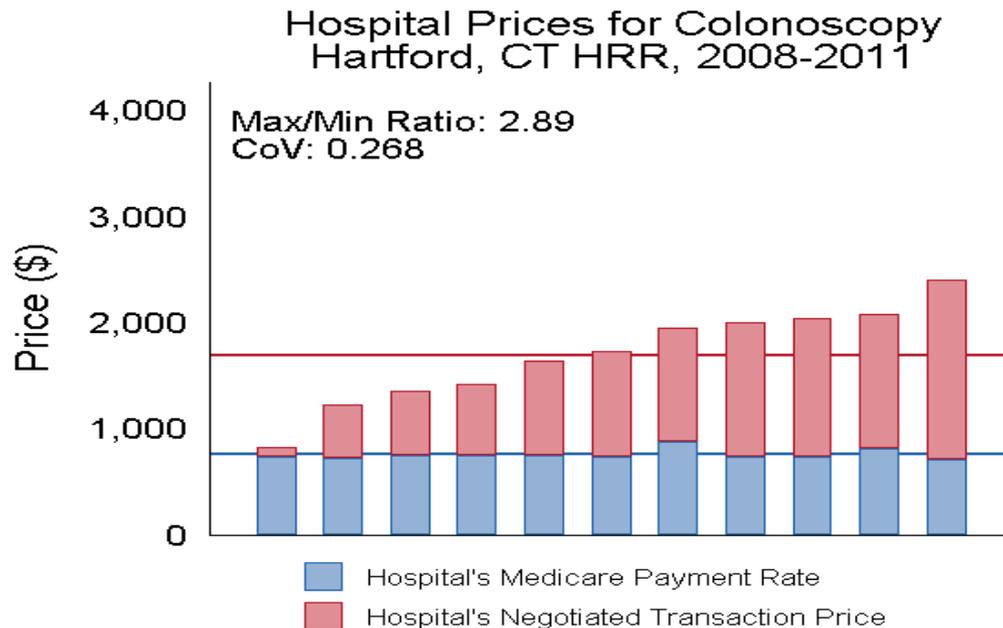
- CT's non-profit hospital adjusted expenses per inpatient day is 4th highest the NE and exceeds NY and national averages

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



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 max/min ratio of hospital's negotiated transaction prices within the HRR. Horizontal lines indicate average rates and prices within the region.

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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

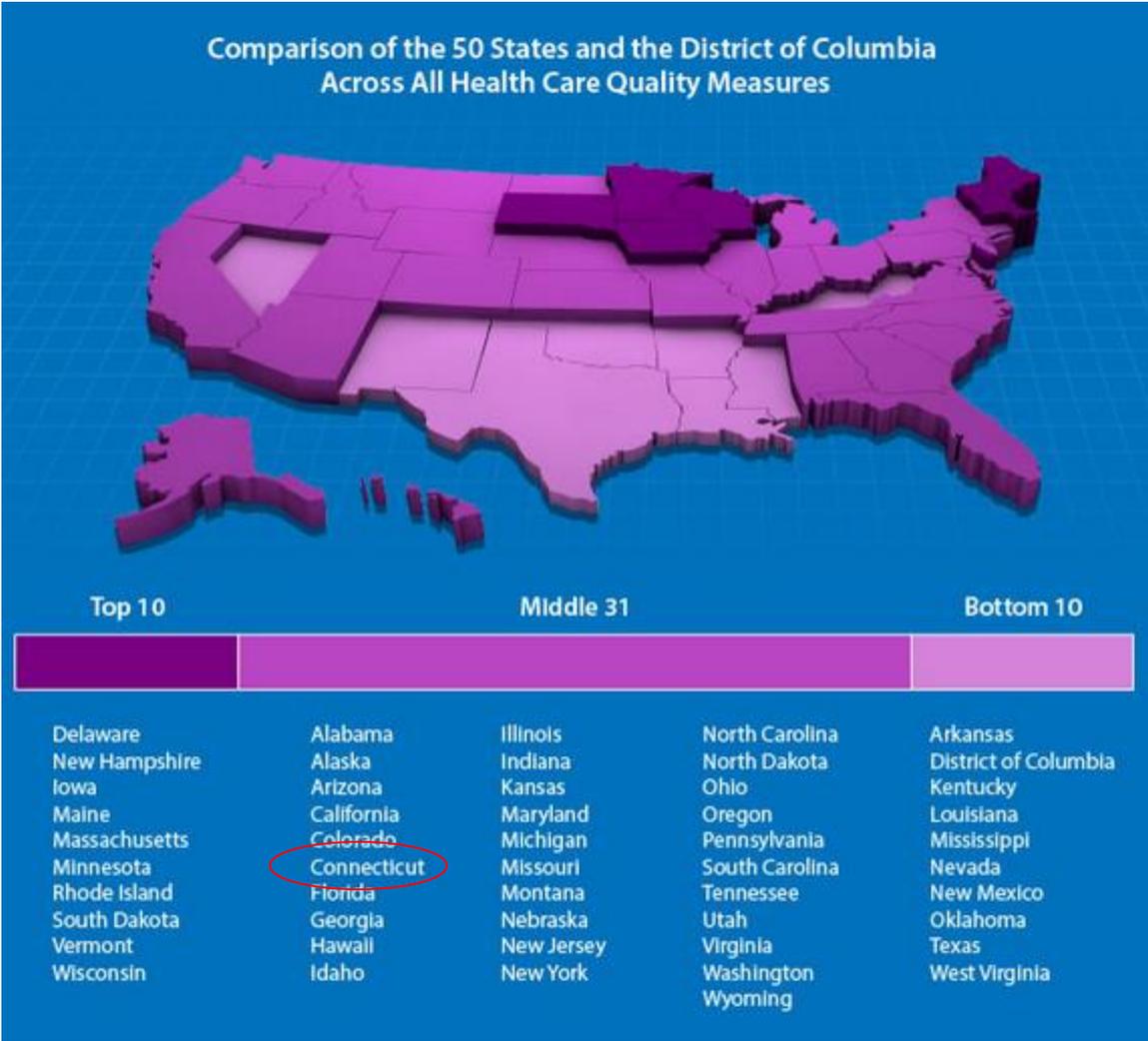
CT's Per Capita Spending: Price + Utilization

- 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



General State Levers to Control Costs

Generally, these are the types of levers states use to control costs:

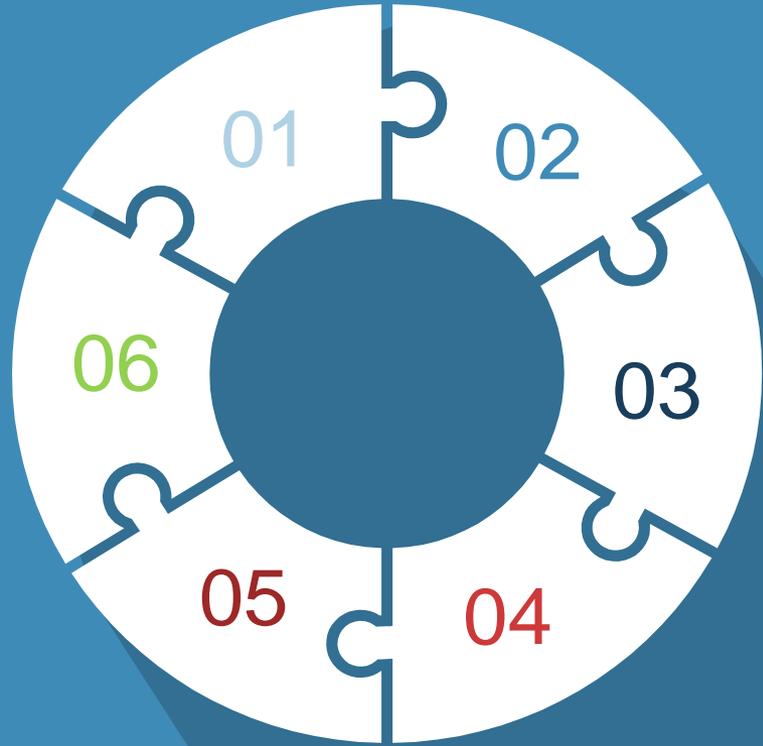
1. Purchasing power: use Medicaid and state employee plans to implement payment reform and evidence-based coverage decisions
2. Regulation of commercial insurers: to promote payment reform and to require cost caps in contracts
3. Provider rate setting: to promote payment equity and contain cost growth
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

Bailit Health's Straw Model

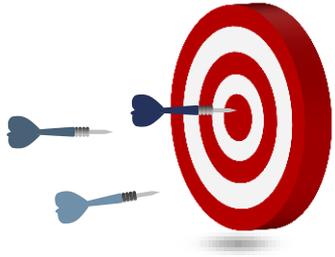
- Bailit Health was asked by the Cabinet to use the information collected from our study of six states, to formulate a straw model that meets the goals of the legislation and the principles of the Cabinet.
- The Straw Model is undergoing revisions based on the 9-13 Cabinet meeting. **This presentation contains the *modified* proposal that includes Cabinet input.** However, it is still in **draft form** and the Cabinet has not adopted these strategies.
 - These strategies have evolved since public comment has been submitted.
- The Straw Model will continue to undergo revisions until a set of Cabinet recommendations are formulated.

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.”



1. Provide More Coordinated, Effective and Efficient Care



Goal: Reduce costs by **engaging providers** (both professionals and institutions) to provide services in a more **coordinated, effective and efficient manner** (addressing issues of under use, overuse, misuse and ineffective use, health inequities and social determinants of health) through implementation of **delivery system and payment reform models**.



Strategy: Implement risk-based contracts with Consumer Care Organizations using **aligned** contracting and purchasing strategies for Husky Health and State of Connecticut Employee Health 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 “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

What are Consumer Care Organizations?

Cont'd.

- Consumer Care Organizations (CCOs) would contract with the Medicaid program and the state employee health benefit program.
- Medicaid at the state employee health program would have aligned standards (not jointly purchased). Such standards would include:
 - the composition of consumers advising the CCO
 - participation in Health Enhancement Communities
 - compliance with the Community and Clinical Integration Program (CCIP) standards set forth by the SIM program to address health inequities and social determinants of health.

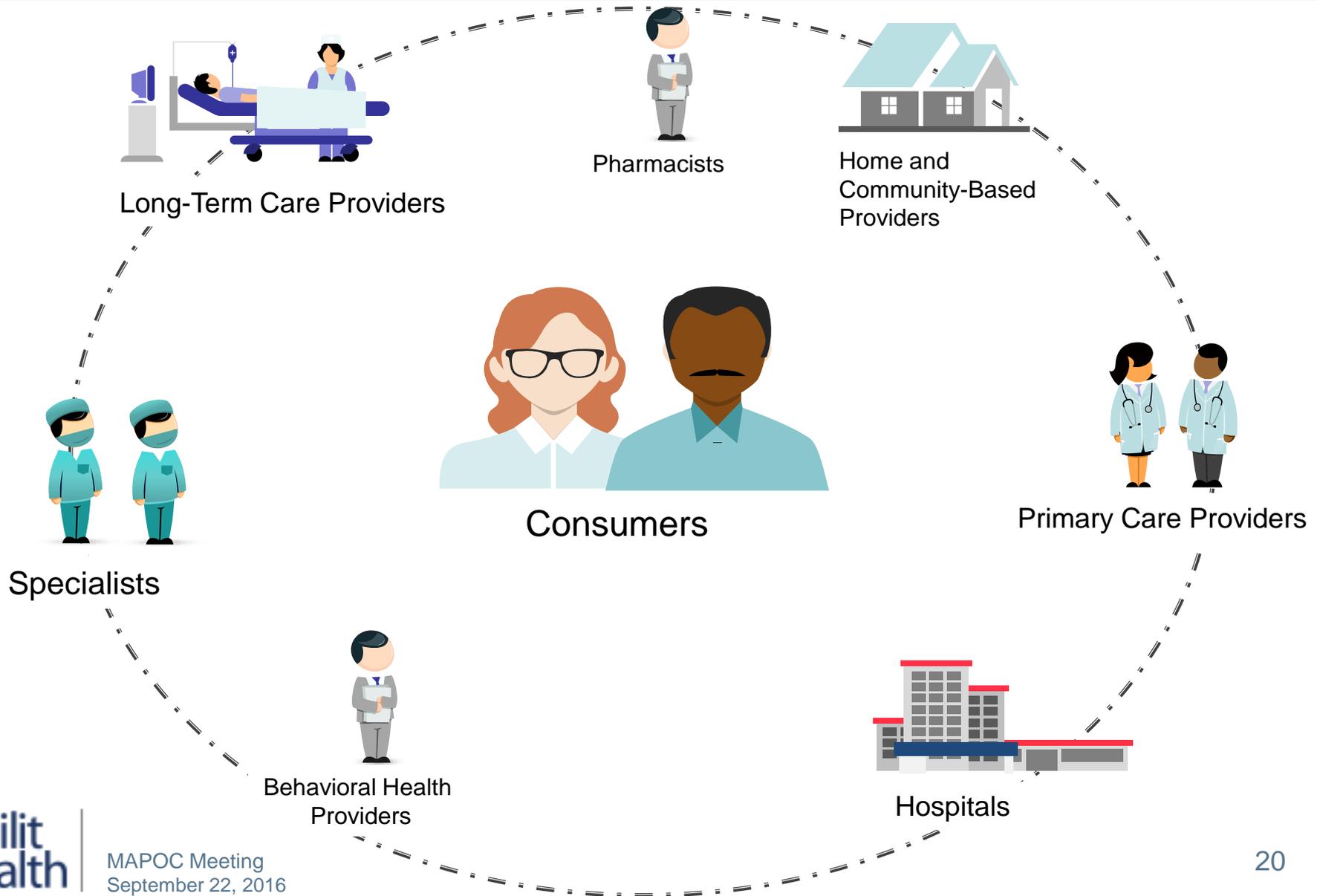
How are Consumer Care Organizations Different than Accountable Care Organizations?

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



Consumers

Consumer Care Organizations



What Health Care Services Should Consumer Care Organizations Provide?

- CCOs will provide the broadest range of services possible.
- 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.
- LTSS services should be integrated within 3 years.

How Should Consumer Care Organizations be Paid?

- CCOs will be paid using a value-based payment that holds providers accountable for the “total cost of care” on a shared-risk basis.
 - Shared-risk is phased in over time to allow CCOs to demonstrate capacity to accept some risk, and will not be started until the conclusion of the SIM initiative
 - Bailit recommends shared-risk be available to Medicaid providers on a voluntary basis during the SIM program
- Shared-risk is a concept where providers share in savings if the cost of services are below a pre-determined budget and share in losses if costs are above the budget.
 - It is not full-risk.
 - It is not capitation.
- Bailit Health believes shared-risk is important because:
 - Shared savings have tended to yield limited change in provider behavior and savings.
 - Results from the 2nd and 3rd years of MSSP showed that only 25% and 31% earned savings during the two years, respectively.
 - Providers respond to risk of loss in a greater way than they do the possibility of reward.
 - Medicare and commercial payers are moving in this direction, too.

How Should Consumer Care Organizations be Paid? Cont'd.

- **Quality is an important component of the payment model.** Performance on quality 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.
- Quality measures should be **consistent with the core measurement set created by the SIM Quality Council**, and target opportunities for performance improvement, as well as ensure that there is no diminishment in access to services.

How Do CCOs Fit into the PCMH+ Program?

- The PCMH+ program lays an important foundation for the CCOs, and is an important first step, giving providers the opportunity to understand what it means to be responsible for TCOC.
- The CCO strategy goes beyond the PCMH+ by expanding on the number and type of providers that are anticipated to join.
- The first year of the CCO program, all CCOs, unless otherwise willing, would participate in the PCMH+ model.

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

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
- ...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 IHPs met their quality goals.

Cabinet Discussion Regarding CCOs

- One Cabinet member and several external advocates have said there was a commitment to not move Medicaid providers to downside risk during the SIM program. Others were in strong support of a shared-risk model, but recognized the importance of timing.
 - The straw model was changed to account for shared-risk being phased in post-SIM.
- There were concerns about what would incentivize providers to join a CCO.
 - The straw model was changed to increase the proportion of shared savings available for CCOs.
- We anticipate further discussion at the next meeting about CCOs.

2. Directly Reduce Cost Growth



Goal: Reduce cost growth by setting a limit on annual increases and developing mechanisms to 1) track actual costs against a target, 2) identify key cost drivers, and 3) make data transparent to the public.



Strategy:

- A. Cap advanced network cost growth
- B. set targets for APM adoption

2A. Impose a Per Capital Cost Growth Cap

- Adopt a per capita cost growth that is reasonable and results in more affordable care and base it on an external economic indicator. For example:
 - Projected gross state product
 - Urban Consumer Price Index
- The Office of Health Reform would set the growth rate (to be discussed).
- It would apply initially to commercial plans, the plans and CCOs contracted with the Comptroller's office and the CCOs contracted with the Medicaid program.
 - When the APCD is operational, the cap would be applied to Advanced Care Networks.

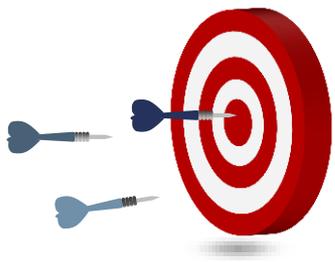
2A. Impose a Per Capital Cost Growth Cap, Cont'd.

- Sanctions for non-compliance in the first two years of the program are minimal, but would increase over time.
 - Insurers and advanced care networks that don't comply will need to submit a plan of correction detailing the steps they will take to reduce their cost growth rates;
 - In subsequent years, regulatory sanctions could be applied by the CID on insurers. The Comptroller's office would build penalties for non-compliance into their plan contracts. Medicaid would set CCO rates increases in a manner consistent with the cost growth cap.

2B. Set Targets for Value-Based Payment Adoption

- In keeping with the direction of the US Department of Health and Human services, and the SIM Program, Connecticut should set goals to adopt value-based payment models for primary care and non-primary care providers.
- Targets should be set with regard for plan enrollment, geographic concentration of enrollment and current levels of adoption.
- Goals should encourage the movement toward population-based payment models which reward value and efficiency.

3. Office of Health Reform



Goal: Provide a single locus of responsibility for developing and implementing health care strategies in Connecticut state government in order to improve coordination and alignment of strategies across state agencies and within the private sector.



Strategy: Create an Office of Health Reform, to reside in the executive branch, that would implement health care reform strategies in a coherent and consistent manner.

Cabinet Discussion Regarding Reducing Cost Growth

- Some were supportive of setting a cost growth cap, but noted that it is important to expand the state's analytical capability to fully realize this strategy.
- Others noted that if the state were to set a cost growth cap, it would need to do so transparently.
- One member was opposed with concerns that high cost patients wouldn't be cared for if a cap was imposed.
- The Cabinet asked us to put more detail around how the cap would be set and applied for the next iteration of this strategy.

Key Responsibilities of Office of Health Reform

1. Develop and implement the cost growth cap
2. Track and report on the progress all payers are making toward value-based payment
3. 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.
4. Annually publish a report that reports compliance (or non-compliance) patterns, cost drivers, and recommendations for meeting the cost growth cap, if it is not achieved.

Cabinet Discussion Regarding OHR

- Many Cabinet members expressed support for an Office of Health Reform noting that it would be in the state's long term interest to develop strategic health reform programs.
- One Cabinet member opposed the creation of the OHR because of perceived lack of trust about state government.
- The Cabinet asked Bailit to flesh out the strategy, and include a cost estimate to run the office for the next iteration of the strategy.

4. Support Provider Transformation



Goal: In recognition that implementing delivery system reform in a manner that improves health care and reduces costs is very difficult for providers, provide them with financial, infrastructure and technical support needed to change their care delivery models.



Strategy: Pursue a Section 1115 Medicaid Waiver, and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment

Why is an 1115 Waiver Necessary?

- Section 1115 of the Social Security Act gives HHS the authority to approve experimental, pilot or demonstration projects to promote the objectives of the Medicaid and CHIP programs
- It gives states the flexibility to design and improve their programs
- The reimbursement structure for the CCOs would require an 1115 Waiver
- An 1115 Waiver is required to access Delivery System Reform Incentive Payment (DSRIP) funds

What is DSRIP?

- Delivery System Reform Incentive Payments are part of 1115 Waivers and provide states with significant funds to support providers in delivery system transformation. Must be budget neutral for federal government.
 - Current DSRIP states use Designated State Health Programs funds, intergovernmental transfers, state funding of safety-net providers, provider taxes or state general funds for matching.
 - More work needs to occur to identify appropriate funding opportunities for Connecticut
- DSRIP funds can be awarded to providers for key activities (or projects) that support improvements in the delivery system and prepare providers for accepting risk-based payment

Summary of State DSRIP Program Funding

State	DSRIP Time Period	Total Funding
California	2010-2015	\$6.5 billion
Texas	2011-2016	\$11.4 billion
Massachusetts	2014-2017	\$1.35 billion
New Mexico	2015-2018	\$29.4 million
New Jersey	2014-2017	\$555.4 million
Kansas	2014-2017	\$99.8 million
Oregon	2014-2017	\$1.9 billion
New York	2016-2020	\$6.42 billion
New Hampshire	2017-2020	\$150 million
Arizona	Not yet approved	TBD
Washington	Not yet approved	Applied for \$3 Billion

How Are DSRIP Funds Being Used by States?

- The state has the flexibility to design the DSRIP in whatever ways are the most supportive of its providers. Examples of how DSRIP funds have been used (or proposed) include:
 - To support **care redesign**, like the integration of primary care with mental health and substance use services, improving care transitions, and reducing utilization of intensive services (e.g., ED and hospitals)
 - To support **infrastructure development**, like building new clinics (e.g., clinics integrated with probation / parole offices), hiring new staff (e.g., care managers), workforce development, disease registry development

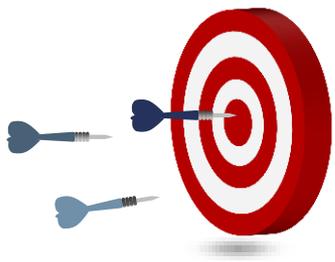
How Might DSRIP Funds Support Connecticut?

- Some ways in which DSRIP funds could support Connecticut. DSRIP funds could assist providers:
 - with the infrastructure development and necessary training to get connected to the state's developing HIE
 - in developing Consumer Care Organizations, especially independent practices, FQHCs or health care facilities that may wish to anchor a CCO
 - in PCMH transformation for practices that have not participated in the Medicaid PCMH program
 - to expand access to underserved communities and underserved population
 - in engaging in Health Enhancement Communities

Cabinet Discussion Regarding 1115 Waiver and DSRIP Funds

- There is concern among some Cabinet members that 1115 waivers have been used in ways that are not considered to be supportive of Medicaid recipients (e.g., to institute co-payments, work requirements).
 - Additional concern is the budgetary requirements that 1115 waivers require from participating states.
- Others see 1115 waivers as an important tool for innovation, as evidence from a number of the states we have studied.
 - In addition, other Cabinet members see the value DSRIP funds could provide Medicaid providers to help them succeed in a value-based world.
- The Cabinet has deferred further discussion of the 1115 waiver and DSRIP funds until after the other strategies have been identified.

5. Address Variation in Provider Payment



Goal: Address variation in provider payments by developing a better understanding of provider (particularly hospital) practices.



Strategy: Give the Attorney General additional subpoena powers to collect confidential information from plans and providers to examine and report on trends in costs to improve transparency and promote competition

Why Increase AG Subpoena Power?

- Health care is not operating in a free market
- Widespread cost-shifting has been proven to be a myth; rather, relative market power of plans and providers dictate prices
- Consumers are shielded from prices with insurance coverage and when they have pricing information, they often incorrectly equate high cost with high quality
- For these reasons the AG needs the authority to investigate and report on root causes of cost growth and price variation by accessing data not otherwise available

What is Needed to Increase the AG's Subpoena Power?

- Legislative action to increase the subpoena power of the AG to specifically review and analyze reasons for health care cost growth and price variation
 - Precedent set in Massachusetts in 2008, which resulted in revelations on reasons for and ill effects of price variation in the state
- Adequate appropriations are necessary to allow the AG to fulfill new requirements

Cabinet Discussion Regarding AG Authority

- Some members supported this strategy, while others were concerned about protecting the confidentiality of how certain information.
- Most members agreed that there needs to be alignment between this strategy and the work of the CON Task Force, which has an end date of 1/15/17.
- The next steps are for Bailit to redraft the strategy, and specifically provide estimates for the costs required to do this work.

6. Support Providers and Policy Makers with Data



Goal: Build the data and clinical information infrastructure necessary to support delivery system and payment reform at the provider level and to inform good state policy-making.



Strategy: (A) Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange. (B) Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services.

6A. Use of APCD and HIE

- The HITO should be required to work with the Office of Health Reform to ensure that OHR has the data necessary to examine the health care cost trends in the state, and to appropriately set the cost growth targets.

Support the Build of a Statewide HIE

- DSS and the Comptroller should use their purchasing powers to promote provider engagement in the HIE
 - Hospitals and other providers that do not participate in the HIE should not be eligible to participate in the Medicaid and state-employee health CCO strategy
 - The requirement should be phased in, beginning with hospitals and then expanding to PCPs, physician specialists, nursing facilities and behavioral health providers
 - Hospitals and other providers should receive financial support for infrastructure development for HIE participation through the DSRIP program, including
 - Funding support to connect to the HIE
 - Resources to develop reporting capabilities

6B. Adopt an Evidence-based Coverage Strategy

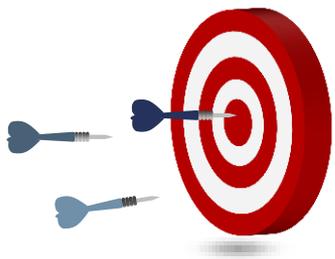
- The Legislature should enact legislation mandating that the best available scientific evidence should guide coverage decisions for every agency of the state government that purchases health care
- Approximately 30% of all health care spending may produce no benefit to the patient – and some of it produces 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 ROI in ADD spending for children by using second opinions

Discussion



- The Cabinet has not discussed this strategy.
- What are your thoughts about increasing the available data for clinical care and policy making?
- What are your thoughts about using evidenced-based research to guide coverage decisions?

7. Coordinate and Align State Strategies



Goal: Set a cohesive vision for health care in the state, improve planning and coordination of health care strategies, create alignment in the public health care sector, and effectively deploy resources



Strategy: Restructure existing agencies into a single state entity composed of all health-related state agencies to be responsible for aligning all state health policy and purchasing activities

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

Cabinet Feedback on CTHA

- The Cabinet has not discussed this strategy in detail, but we know from written feedback that there are mixed feelings about this strategy.
- Some like the strategy because it aligns state governments.
- Others dislike this strategy because of concerns about the costs and confusion of doing so.
- More discussion will occur at the next Cabinet meeting.

Discussion



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

Next Steps

- Bailit Health will provide a summary of MAPOC's comments to the Cabinet.
- The Cabinet will continue strategy / recommendation discussions in October.
- **October:** Finalize recommendations
- **November:** Review and Finalize report
- **December 1:** Submit report to the legislature