Recommendations for Further Discussion by the Health Care Cabinet
October 6, 2016

Purpose of this document: The purpose of this document is to provide more written detail on three of the four cost strategies that were discussed during the September 13, 2016 Health Care Cabinet meeting so that Health Care Cabinet members can have a more informed discussion about the strategies. It is expected that Cabinet members will have read this document prior to the October 11, 2016 meeting and will be prepared to discuss these strategies. This document incorporates some suggested modifications that Cabinet members have made to the Straw Proposal. **This document is a draft and has not been reviewed or approved by the Cabinet.**

1. Provide More Coordinated, Effective and Efficient Care

Goal of Strategy: Reduce costs in the health care system by promoting delivery system and payment reform, through models that engage providers to provide services in a more coordinated, effective and efficient manner; that address issues of underuse, overuse, misuse and ineffective use, and that reduce the impacts of social determinants of health and health inequities.

Recommendation: The Legislature should require 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 a fee-for-service approach, with a retrospective reconciliation that holds providers accountable for their quality performance, patient access and efficiency.

Rationale: This recommendation seeks to build 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 seeks to introduce shared-risk over time to give providers greater incentives to change the way they deliver care than shared savings programs have, 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. (*Please see Strategy #3 Office of Health Reform for more information on how this strategy can be made multi-payer.*) 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.[1]

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.[2] 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.[3]

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.

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

- the CCO has 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;
- a separate consumer advisory board be formed with a direct advisory relationship to the CCO governing body;
- CCOs meaningfully participate in Community Health Collaboratives, and

[1] Medicaid Accountable Care Organizations: State Update. Center for Health Care Strategies, September 2016.

[2] 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

[3] 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 would likely be a "qualifying" value-based payment model. The PCMH+ model is not a qualified model under MACRA's currently proposed rules.

- 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.[4,5]

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).[6]

Requirements Specific to Medicaid: The Legislature should recommend 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 #2), 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 Comptroller, under the direction of the Office of Health Reform. The payment model should be consistent, to the extent possible, with the SIM Care Management Committee and Equity and Access Council recommendations.

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).

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[4] 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

[5] CCIP standards are intended to apply to all payers/populations. .

[6] 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.

- 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.[7]

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% and no higher than 5% of the total cost of care on a per member per month basis. Higher risk caps and higher potential savings percentages, similar to the Medicare NextGen model, could be considered for qualified CCOs.
- The risk cap may vary between the Medicaid program and the state employee health program.

Quality 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, 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. 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 Reform, which will lead efforts to align quality measures with other payers.

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.

[7]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.

Other providers will have had experience in shared savings and shared risk models offered by Medicare[8] 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 and ensure the availability of Medicaid staff and contracting resources top perform this work.

To account for the variation in experience in value-based payment in the state and the administrative capacity of the Medicaid Department, the following timeline should be utilized for implementation of CCOs, unless the Office of Health Reform adjusts the timeline to better align existing and ongoing initiatives:

- Begin contracting with CCOs on January 1, 2019
- All CCOs are 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 if the CCO voluntarily chooses, and demonstrates the capacity, to assume shared risk.
- 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 during the SIM initiative.
- CCOs that did not exist in any form or did not have prior experience with shared risk, 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 state should 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 participate in peer learning on aspects of CCO performance that are critical to success.

The following table summarizes key differences between the current PCMH+ initiative and the proposed CCO model.

[8] 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.

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.
Consumer Involvement	Continue to participate at the state policy level through MAPOC and SIM. No direct input into delivery model with providers unless provider creates consumer advisory group.	Consumers are involved at the provider level by sitting on the CCOs' boards of directors and by participating in CCO consumer advisory groups.

Model Feature	PCMH+	CCO
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)

2. Directly Reduce Cost Growth

Goal of Strategy: Reduce cost growth by setting a cap on annual increases; setting targets for adoption of Alternative Payment Models (APMs), and developing mechanisms to 1) track and assure adherence to the cost growth cap and APM target and 3) make data transparent to the public.

Recommendation: The legislature should A) adopt a state-wide health care cost growth cap, B) set targets for value-based payment for all payers in the state.

Rationale: Setting a cost growth cap will focus the attention of all providers and payers on containing costs, which would necessarily consider both service prices and utilization of services. A cost growth cap, applicable to both the public and private sector is consistent with SIM's goals of limiting Connecticut's health care cost increases to sustainable levels. Setting a target for APM adoption will further move providers and payers towards payment models that reward a more coordinated, efficient and higher quality care model.

The Connecticut health care market place is rapidly evolving into a limited number of large hospital-based integrated systems that include primary care, specialists and "downstream" providers. Work by economists, such as Professor Zack Cooper, has demonstrated that this type of consolidation leads to higher unit prices. By developing and implementing payment models that fits with the structure of an integrated health care system, but creates financial consequences for efficiency and quality performance, this strategy , when combined with the cost growth cap, counters the ability of large providers to dictate price to employer purchasers.

A. State-wide health care cost growth cap: The legislature should require that the State of Connecticut annually adopt a state-wide health care cost growth cap that is based either on the projected gross state product or upon another external economic indicator, such as the Urban Consumer Price Index. The goal is to establish a growth rate cap that is reasonable and results in more affordable health care. 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)."

The responsibility for developing the methodology for determining the annual cap should lie with the newly created, semi-independent Office of Health Reform. Please see the separate discussion of the Office of Health Reform for more details regarding its roles and responsibilities (Strategy #3).

Obtaining required data to implement a cost growth cap: Having appropriate data is key to implementing a cost growth cap. Until the state's All-Payer Claims Database (APCD) is fully functional, the state should pursue the following incremental strategies for collecting needed data and implementing the cost growth cap:

- The CID should annually collect per member per month information from all health insurers selling products in Connecticut. Data should be submitted using definitions developed by and in the manner required of CID and should cover all insured products.
- The Comptroller's Office should collect data using the same format and time periods that CID is using.
- Medicaid should also use its robust database to continue to calculate per member per month growth rates and to the extent possible analyze data in a manner that is consistent with CID and the Comptroller's Office.

Once the APCD is operational, data from the APCD should be used to assess compliance at the insurer and Advanced Network and FQHC levels on a per capita basis that includes all health care costs and by key cost drivers. These data should be available for use by researchers, while protecting patient privacy.

Implementation and enforcement of a cost growth cap: The cost growth cap should be implemented over several years' time, both in terms of its scope of impact and in term of regulatory consequences for not meeting the cap.

Scope. Until the APCD is operational:

- The cap should be applied to commercial insurance plans.
- The Comptroller's Office should apply the cost growth cap to its insurer contracts.
- Medicaid should also apply the cost growth cap to any CCOs with which it contracts.
- The Office of Health Reform should urge large employers and employer coalitions to adopt the health care cap for its self-insured products.

Once the APCD is operational, the cap should be expanded to include Advanced Networks with sufficient attributed lives to impact health care costs in Connecticut. At this stage of implementation, the cost growth cap will be directly applicable to all providers participating in an Advanced Network. In light of the rapid consolidation occurring in Connecticut, Advanced Networks could represent a significant portion of the health care market.

Regulatory Approach. It is recommended that for the first two years sanctions for non-compliance be minimal and that sanctions be increased over time for any entity subject to the cap.

Specifically, for the first two years Advanced Networks and/or insurers that are subject to and exceed the per capita cost growth cap should be required to a) submit a plan of correction detailing steps they will take to reduce their cost growth rates, and b) come before the Office of

Health Reform to explain why they exceeded the cap and what steps they are taking to reduce their growth rate. The Office of Health Reform should have the authority to accept, reject or modify the plan of correction. Any insurer or Advanced Network that fails to submit a plan of correction would be subject to a daily fine until the plan is submitted.

Beginning in Year 3 of being subject to the cost growth cap, insurers should be subject to regulatory sanctions from the CID if the cost growth cap is not met. The CID will also be responsible for periodically reviewing insurer-provider contracts to confirm that provider contracts are consistent with the cost growth cap. The Office of Comptroller should also build in penalties into its contracts with its insurers for failing to meet the cost growth cap by year 3.

At this stage of implementation, the state agency implementing the CON would consider the cost growth cap as integral to the CON review process.

The CID, Medicaid, the Comptroller's Office and the agency implementing the CON should be expected to submit information to the Office of Health Reform for inclusion in its annual report to the public and to the legislature. It is essential that cost growth data be reported in a robust and transparent manner to the public in order to bring attention to cost growth issues and change the public conversation and expectations regarding the need to contain costs.

In all cases, the regulatory and /or contracting agency would be using the state-wide per capita cost growth cap as the limit on how much per capita costs could go up for the population for which they are responsible. By applying the cost growth cap to large entities – insurers, large Advanced Networks – it is reasonable to expect them to keep costs below the cap by implementing delivery system and payment reforms that reward efficiency and quality.

B. Set targets for and adopt value-based payment models

In 2015, the U.S. Department of Health and Human Services set a goal that 30% of U.S. health care payments would be in value-based payment models by 2016 and 50% 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."[9]

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

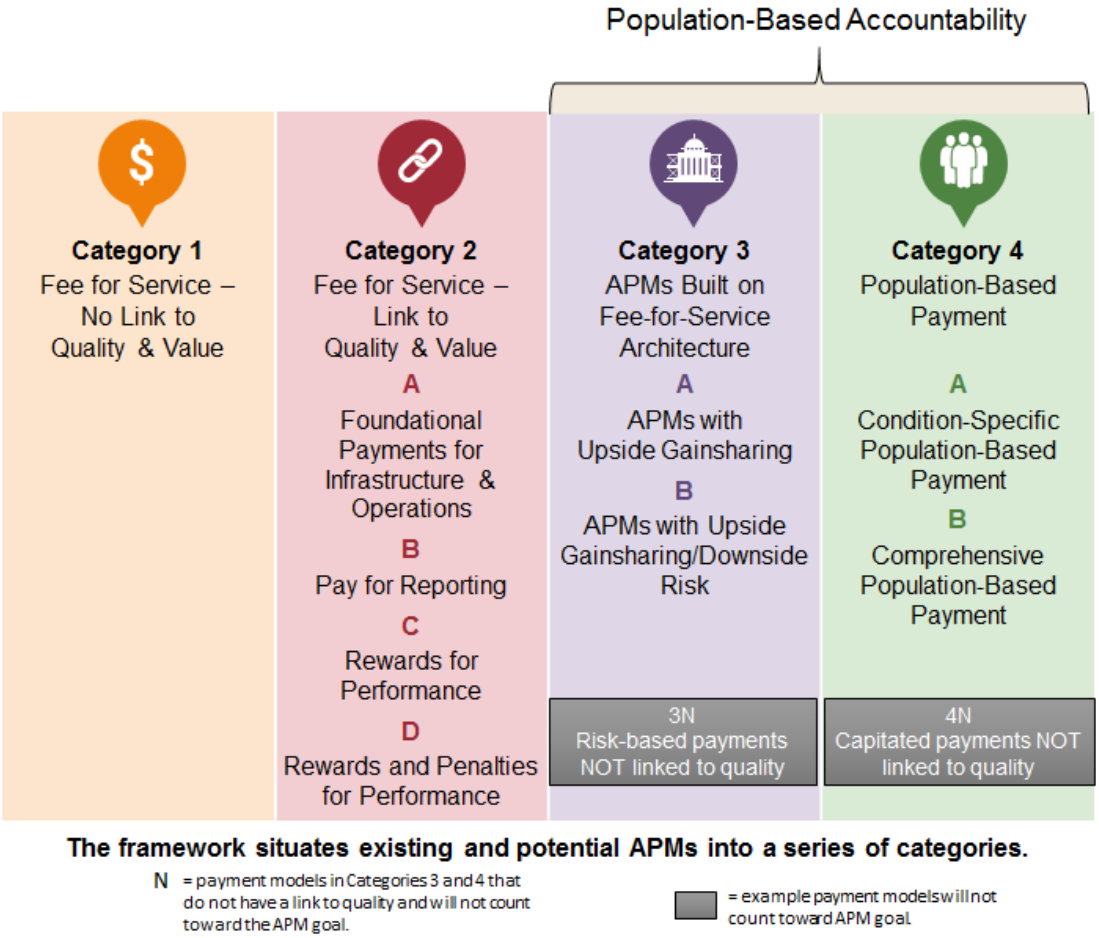
[9] Alternative Payment Model (APM) Framework. January 12, 2016. https://hcp-lan.org/groups/apm-fpt/apm-framework/

initiative has set a goal to have 89% of Medicaid beneficiaries in the PCMH+ program, and 88% of the Connecticut population going to a primary care provider responsible for the quality and cost of their care by 2020.

In support of the existing SIM goals for primary care providers and to further advance payment reform beyond primary care, the Office of Health Care Reform 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 Reform 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 (see page 7), 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 Reform on their use of value-based payment models. The Office of Health Reform 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 Reform, 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.

HCP-LAN Framework for APMs



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

3. Create the 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.

Recommendation: To implement health care reform strategies in a coherent and consistent manner across the state and across all payers, the Legislature should create an Office of Health Reform, which would reside within the executive branch.

Rationale: Other states, such as Massachusetts, report that having a single entity driving health care policy has resulted in a more coordinated, focused approach, which seems to be impacting health care costs.

The five key responsibilities of the OHR would be:

1. Develop and implement the cost growth cap, which will require close collaboration with CID, Medicaid, the Comptroller's Office and the agency implementing the CON and budget review processes.
2. Track and report on the progress all payers are making toward value-based payment, utilizing the HCP-LAN APM framework as guidance.
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. To meet this goal, OHR would be responsible for creating a stakeholder advisory board with representatives from consumers, providers, payers and employers, economists and health care policy experts. Reporting to the advisory board would be all other oversight bodies, including MAPOC, SIM CAB, the Health Care Cabinet and the Access Health advisory committees. The goal is to create a coordinated process for hearing stakeholder input as aligned strategies are developed across the state.
   OHR would also be expected to create a cross-agency health care strategy working group (including all health-related agencies, the Comptroller's office, SIM and Access Health CT) that would meet on a regular and frequent basis to identify common cost drivers and develop/implement coordinated responses. All strategies developed by this group would be shared and discussed with the stakeholder advisory group.
4. 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 cap, 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.
5. Drive efforts toward multi-payer alignment, for the CCO strategy, quality measurement and any other payment or delivery system reform strategies that benefit from consistency across payers. The Office of Health Reform should work closely with SIM to accomplish these goals.

The OHR should have a stakeholder advisory committee advise it on any major programmatic or policy decisions. Such advisory committee should include large employers, consumers, labor organizations, insurers, large health care systems, physicians, nurses, ancillary providers such as pharmacists, health services researchers, economists, the Department of Social Services, the Office of the Comptroller, and the Insurance Department. For example, the advisory committee would be instrumental in assisting the OHR with the development of the cost growth methodology and defining insurer and provider reporting requirements.

The OHR could be staffed by 5-6 individuals. The staff would consist of an (1) executive director ($150,000); (3-4) health care analysts ($100,000 each); and (1) administrative professional ($70,000). In addition, the Cabinet recommends the Office of Health Reform have access to $200,000 additional funds for the purposes of procuring external outside expertise (e.g., that of an economist or consultant). The total annual budget is projected to be $820,000. Given the state fiscal crisis, the Cabinet recommends that $400,000 of the annual budget come from the reallocation of existing state staff who are qualified to support the Office of Health Reform.

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

Goal: Give the Attorney General additional investigative and reporting powers to identify causes of cost increases that cannot be determined through publicly available data.

Recommendation: The legislature should give the Attorney General the necessary authority to 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 Reform, should be required by the legislature to hold a public hearing 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 would also be expected to provide testimony regarding any specific topics identified in advance by the Attorney General or the Office of Health Reform.

In anticipation of the annual public hearing, the Attorney General should be required by the legislature to 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 one of the keys 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 Reform on an annual public hearing, the Attorney General's Office would help continually 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 Reform 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.

Operational Considerations. To assure that the Attorney General was collecting appropriate data and correctly interpreting it, the Attorney General should seek consulting services from people with detailed 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 specific expertise needed might vary with the specific market practice or market segment under investigation.

By producing an annual report and by participating in an annual public hearing, 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. 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.