Hartford HealthCare

TESTIMONY OF
JAMES CARDON, MD
SUBMITTED TO
THE GOVERNOR'S HEALTHCARE CABINET

TUESDAY, NOVEMBER 15, 2016

Thank you for this opportunity to comment on the recommendations of the cost containment study of the Connecticut Healthcare Cabinet.

My name is Dr. James Cardon, and I am the Executive Vice President and Chief Clinical Integration Officer for Hartford HealthCare, an integrated healthcare delivery system that serves more than 100 of Connecticut's 169 cities and towns.

My colleagues and I applaud the work of the Healthcare Cabinet and its goals. The Cabinet's stated ambitions are identical to those expressed in healthcare's vaunted "Triple Aim": improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations. Transforming these noble objectives into actions and measures is difficult work, however, it is imperative to recognize that this challenge is compounded by the realization that Connecticut's Medicaid system is woefully underfunded. Without acknowledging this premise — and without a clarion call linking payment reform to care delivery improvements — the Cabinet's recommendations are likely to remain largely unrealized, simply because they are unrealistic.

Before even addressing specific recommendations, I implore the Cabinet to include acknowledgement of the impact our state's seriously inadequate funding of Medicaid has on our system of care. To do otherwise is to treat the symptoms rather than attack the disease. Also, the Cabinet needs to recognize that in order to reduce health care costs in Connecticut, a serious discussion of meaningful tort reform should be included in final recommendations.

As for the Cabinet recommendation regarding the creation of Consumer Care Organizations (CCOs), although this model holds promise to be able to deliver value there are critical issue in the design that have challenged their success at the federal level: This is a collection of providers that voluntarily come together to coordinate a comprehensive set of services for a defined population. In theory, CCOs would create a shift away from the costly and often ineffective fee-for-service model — but it must be understood that the attribution model, where patients do not commit to an established

primary care provider and are free to seek services without input from the accountable primary care provider will present a significant barrier to successful cost management. The foundation for all accountable care organizations is the relationship with the primary care provider. The guidance and trust between patient and PCP allows for management of complex conditions. Access to, and management of, specialists is critical to quality and cost. Given the current payment baseline, there is not meaningful financial incentive to attract providers; therefore, access to appropriate primary and specialty care will remain challenging.

In order to build the critical foundation instead of starting with CCO's an alternative is to adopt and align with the Center for Medicare and Medicaid Services' (CMS) approach to attaching Medicaid patients to primary care services. The Comprehensive Primary Care Plus (CPC+) alternative payment model would enhance the willingness and ability of primary care providers (PCPs) to care for Medicaid populations. Focusing on PCP capabilities and access addresses the foundational problem of both cost containment and improved outcomes. It would bring together an essential care team that focuses on the patients holistic needs: primary care, behavioral health, social services and pharmacy.

After building a robust primary care foundation incorporating additional enhancements to the CCO model would improve the chance for meaningful, and sustainable success. Suggestions include moving away from attribution to a defined panel, incentivizing members to remain within the CCO network to allow for care coordination and management, maintaining the program on a voluntary (rather than mandatory) basis, and not assuming downside risk until we understand that the model is delivering the value we seek. Quality measures for CCOs should be aligned with CMS, Merit-Based Incentive Payment Systems (MIPS) and the Group Practice Reporting Option (GPRO) so providers are able to focus on a consistent body of work.

It is also important to address the efficiency and effectiveness of the regulatory burden on health systems and hospitals. The recommendation to create a new state Office of Health Strategy could have the unintended consequence of adding another agency — an additional layer of bureaucracy — atop what is already a burdensome environment. The Cabinet should instead recommend a review of the components of Connecticut healthcare regulatory landscape, with an eye toward streamlining operations, consolidating oversight, aligning policy objectives and eliminating redundancies.

Lastly, reducing the growth of healthcare expenditure by creating a statewide cost target is a deceptively simple solution. But it is based on a faulty premise: that current payment is covering the cost to deliver effective care and fund the infrastructure required to reduce unnecessary utilization. That has certainly not been the situation in Connecticut. The Cabinet should redeploy savings attained from streamlining the current regulatory and delivery framework, and make infrastructure investments aimed at enhancing access to Medicaid patients.

Thank you for your work on behalf of Connecticut's citizens, and for extending this privilege of presenting these comments to the Healthcare Cabinet. I appreciate your kind consideration of these views.

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