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Health Care Cabinet Report to the Connecticut General Assembly per PA-146
Minority Report
Ellen Andrews, PhD
CT Health Policy Project
Member, Connecticut Healthcare Cabinet

I want to thank the Cabinet membership and consultants for the process to arrive at our recommendations. It involved a great deal of work by all and we learned a great deal. I learned more about the perspectives of other Cabinet members, and members came to understand and acknowledge consumers' perspectives. The process opened important conversations about reform and what Connecticut's health system should be, both within the Cabinet and beyond its membership to the larger Connecticut health care community. Hopefully these discussions will be part of breaking down a few silos. The process will be immensely improved by getting public input.

Independent consumer advocates are very grateful that, over the last months, Cabinet members came to acknowledge the hard work and successes our state's Medicaid program has earned over the last four years, including historic cost control achieved at the same time as improvements in quality and access to care, much better provider participation and consumer satisfaction, all while significantly expanding the program. Cabinet members now appreciate what could be lost in the program that serves one in five state residents.

However, despite some improvements from the original Strawman proposal, the final recommendations are significantly flawed and are missing critical elements for successful health reform in Connecticut necessitating this Minority Report. Instead of improving the state's health system and improving state government's growing deficits, if enacted the recommendations would add to our costly problems and undermine financial security. As an independent consumer advocate, my comments are my own. But they reflect and are informed by dozens of meetings and conversations with diverse stakeholders across our state who do not feel their concerns or interests have been represented in the Cabinet's discussions. Those stakeholders include many other independent consumer advocates, but also providers, payers, businesses, taxpayers, community leaders, elected officials, social service providers, and citizens. I feel confident that all these constructive conversations will continue.

The **lack of trust**, and its corollary – the need for better communications, tops the list of issues missing from the Cabinet's recommendations. The consultants correctly identified this pervasive problem, crossing virtually all stakeholder groups, as the main barrier to effective reform in Connecticut, and many members have confirmed that observation. Unfortunately the report includes no effective proposals to build trust and several that will further undermine it. The report relies

heavily on top-down authority structures and a new, costly state agency. The report ignores **critical problems** including the need to improve health policy capacity both inside and outside state government, a pervasive culture of conflicted interests driving policy, and the wisdom of decentralized crowd-based problem solving. I offered several policies and options to improve trust and communications in my comments on the Strawman proposal.

The Cabinet's recommendations do not recognize the **unique nature of different programs and populations** in our state. Features from other, very different states are copied without thoughtful consideration about their feasibility or advisability for Connecticut. The report relies heavily on blindly following the federal government, which was a bad idea even before the recent election. Unfortunately this report follows a historic trend in Connecticut policymaking. Problems are identified in other sectors, but because the state only controls Medicaid (and possibly the state employee plan) solutions are applied there, ignoring the reality that Medicaid is saving money and building value.

While citing the **mediocre quality** of health care in our state, the recommendations include nothing to support improvement. A symbolic nod to quality benchmarks to access savings bonuses is less than insufficient. Medical care is estimated to account for only 10 to 20% of health outcomes. Despite citing population health, the report does nothing to address **social determinants of health** or the crying need for investments in proven, evidence-based **public health interventions**.

The Cabinet's first recommendation, to impose **downside risk** on Medicaid and state employees, is the most troubling. The irrational exuberance for this untested economic model is baffling. Despite the fact that this risky payment model is untested, not attractive to health systems nationally, and it just doesn't make sense, downside risk appears to have strong support among some Cabinet members. The model is based on tenuous economic theory and very similar to capitation, which "failed spectacularly" in Connecticut's past. Assurances that things will be different this time are empty and unpersuasive. Downside risk jeopardizes the provider-patient relationship, the foundation of effective health care. Downside risk in the past prompted physicians to leave the Medicaid program, a problem we cannot afford as the program's enrollment has grown substantially.

The report is silent on avoiding past failures and harm to Connecticut residents and taxpayers from the very similar capitation payment model. Despite universal acknowledgment that provider financial risk models carry significant danger of promoting **underservice**, the Cabinet's proposal doesn't even include monitoring for the problem.

The proposal encourages vertical and horizontal **provider consolidation** despite evidence of higher prices and less consumer choice as health systems consolidate. The proposal also ignores the model's disincentives to invest in data, care

coordination, patient engagement, community and social service connections or other potentially cost shaving innovations.

Shifting financial risk onto insurers or consumers did not work in the 1990s and 2000s. Rather than simply following another economic theory shifting that risk now onto providers, Connecticut needs to identify and address the real-world drivers of rising health costs where they are rising. This will be far more difficult than just shifting risk and hoping for the best, but it is the only way we will address the "burning platform".

Also troubling is the Cabinet's proposal to create an **Office of Health Strategy** as a new agency within state government. The proposal would give the Office extraordinary authority to officially decide who is over-spending and to develop corrective plans to enforce their opinion without public accountability. Rather than addressing the trust issues in our state, this Office would only exacerbate the problem. Connecticut needs to build trust and faith in leadership and government before such an Office is even discussed. Data systems the Office would need for the proposed work do not exist in Connecticut. While similar offices in other states are helpful, in Connecticut it would be premature and counter-productive. It's been suggested that other state agencies perform similar functions now.

The Cabinet's **cost growth "targets"** proposal is also premature. Advocates have compared this plan to capitation for the entire state. Data to support development of the targets or information to draft intelligent corrective action plans as well as tools to implement solutions do not exist. Like many of the Cabinet's recommendations, this proposal would be very susceptible to Connecticut's usual pattern of conflicted interests driving policy. Even if it were possible, the cost to implement and execute anything meaningful would be prohibitive.

Hopefully unwise **1115 and DSRIP Medicaid waiver** Cabinet proposals are moot given the recent election results. The Cabinet's proposal to integrate **comparative effectiveness research** findings into policymaking across the state is positive. However, creation of another policymaking committee to review the research and make recommendations is duplicative and creates another opportunity for inappropriate influence of conflicted interests on policymaking. Connecticut has an unfortunate history of loosely interpreting statutory qualifications for appointments to policymaking councils and committees.

Alternatives to the Cabinet's proposals

Some alternatives to the Cabinet's proposals to achieve the same goals, and other options to achieve goals that were missed from my comments to the original Strawman proposal follow.

Building trust is critical. Effective reform requires all stakeholders at the table, working together in good faith, to see others' perspectives, working to find solutions that work for everyone, and, most importantly, honor the agreements. Without this, nothing else will work. Perceptions matter. It will take time and patience to build a culture of collaboration and inclusion, and listening to develop feasible solutions that aren't imposed by one group. Connecticut needs to build these muscles.

- *Start small* – We need some easy wins, some pilot programs to build trust among Connecticut stakeholders. We also need pilots to test ideas – no one knows what is going to work. Possibilities include joint purchasing (when possible), sharing data and analytics, public health and social determinants project support/engagement, high cost high need people projects, social service connections/support, literacy and language support resources, using comparative effectiveness and best practices, and learning collaboratives.
- *Public transparency and accountability*
    - Meetings should be held at the Legislative Office Building and prominently noticed in the Bulletin, no secret meetings
    - Data transparency – show the math, let everyone crunch your numbers, crowdsourcing is powerful, and others may find something you missed
    - Everyone needs to be working from the same information -- respond fully to all FOI requests, including those that are inconvenient or do not support the agenda
- *Strong conflict of interest protections* -- Unfortunately Connecticut has a very poor history in this area that causes pervasive harm to policymaking in our state. Outsiders have no reason to perform or take risks that could improve care, as they are unlikely to be rewarded with grants or favorable policy changes. Conversely, insiders have little incentive to make the effort to perform well as they know they will get the next opportunity as well, either way.
    - Fix the loophole in the law reflected in SB-361 from this year's session that would apply Connecticut's Code of Ethics for Public Officials to all appointees to policymaking councils, taskforces and committees
    - Avoid even the perception of conflicted interests; perceptions are powerful inhibitors of performance
    - Hire and appoint based on competence and independence
    - It is very easy to get input from interests without giving them a vote on decisions that affect their bottom line. There are lots of models, in Connecticut and elsewhere that work extremely well.
- *Everyone must honor commitments.* -- Once decisions are made, shifting priorities, changing consumer notices, or cutting funds when people have invested time and resources not only undercuts the specific project but also whittles away at the interest to engage next time. Inconsistent policymaking and budget commitments are a strong disincentive to future participation or any interest in making changes.

Effective communications are the foundation of good policymaking and **trust** building. There is enormous opportunity to improve two-way communication between government and the rest of the health system.

- It's critical to create a formal function for this, preferably outside government. Centralizing health communications would give the public one place for information and to provide input. This doesn't have to cost a lot or require a new agency; it could be included in the scope of an existing entity. The formal function would benefit from an advisory group of state and non-state health stakeholders. Just the act of reaching out to other stakeholders and asking for input would help build **trust.**
- The state must emphasize two-way communication. Most of health care happens outside state government, e.g. free clinics, nonprofits, community coalitions, and faith-based, academic, nonprofit advocates.
- This communications function could also connect with other states collecting independent information and report back to policymakers and stakeholders. It is critical that this entity be seen as independent, not advocating one agenda, but an impartial source of trusted information.
- More information about ongoing projects and proposals should be online and accessible. People shouldn't have to attend dozens of meetings to find out what is happening. The state needs to pursue technology options like webinars and online meetings to expand participation and understanding.
- This group could connect with public and provider education efforts around value. Options include consumer information on over and under treatment, comparative effectiveness for providers and consumers, or a provider value-based purchasing education campaign similar to New York's.

Trusted sources of health policy information are critical but the Cabinet's proposal to create a new quasi-public agency is expensive and unworkable.

- Connecticut should build on the diversity of resources that already exist here including nonprofits, academics, state agencies, consultants, and legislative research staff. These sources are already trusted and diversity of opinions and different perspectives lead to better solutions.
- Crowd source all data (protecting patient privacy) and let the diversity of opinion lead to consensus and new learning.

Payment reform has to support delivery reform. Expecting incentives alone to drive change has failed repeatedly in Connecticut and elsewhere, with grave results. Financial incentives are only one of many drivers for human behavior. Overreliance on financial incentives can backfire. Savings should be shared with the providers who generate them, but that can't be the starting point. Connecticut's Medicaid program is an excellent model for overcoming huge challenges with limited resources.

- **Build on what we have and, over time, move larger percentages of compensation from volume to quality.**

- **Connecticut's Medicaid program has had great success by using quality incentives that also save money**, e.g. lowering ED visits, and paying directly for things we know save money, e.g. care coordination. We measure everything to be sure it is working and adjust when necessary.
- **This can't be rushed and one-size-does-not-fit-all**. Different programs, providers and populations are unique and are at different places.
- **Start slow, pilot everything, evaluate and adjust.** Don't be overly committed to one model or dogma – flexibility is far more likely to succeed. We have a better chance of getting it right if we try many things, and learn from experience.
- The Cabinet consultants are right that **shared savings has not met expectations**. But it would be a great mistake to double down into more extreme downside risk without evaluating what isn't working.
- **Support pilots with proven records of success** such as bundles.
- Employ **real efforts to lower premiums** and ensure value in insurance plans across payers.
    - Negotiate rates
    - Monitor access to care, network capacity, quality, etc. with meaningful penalties, and then be willing pull the trigger
    - Risk adjustment, reinsurance, risk corridors
    - Encourage and assist rather than discouraging new, non-profit insurers
    - Reward insurer efficiency and meaningful, effective quality improvement efforts
- **Set up and support data systems** to help providers to deliver better care, such as an HIE or, even better, the consumer-centered Hugo project, provider portals with usable patient utilization and clinical information, analytics to see how practice patterns compare with best practices and with their peers.
- Payment reform doesn't happen in isolation. It cannot be designed to benefit payers at the expense of already underserved state residents. **It is critical to monitor for unintended consequences including underservice and adverse selection, both inside and outside the health system placed at risk.** Monitor for impact on the safety net and other social services, access to care for the un- and under-insured, high need or complex patients. When underservice problems are identified, there must be robust corrective plans with resources and enforcement when necessary.
    - SIM's Equity & Access Council developed a detailed plan with policies for monitoring plans that connect with the rest of Connecticut's complex health system.
- Any reforms should be designed to correct historic imbalances between primary and specialty care reimbursement.

Regulate ACOs and large health systems With growing market concentration and monopolies in Connecticut's health care landscape, preventive regulation is essential. As ACOs assume financial risk, combined with provider authority to order

treatments, the risks to consumers are amplified. The usual regulate-after-there's-a-problem response will be too late to avoid, or unravel, massive market failure.

- **As large health systems become too-big-to-fail, stress tests** must be a part of prudent regulation and consumer protection. Some options for stress tests include
    - Ensure financial reserves to absorb serious losses
    - Evaluate quality incentives, analytics capacity
    - Model a bad flu season, public health disaster, or a hurricane like Katrina and impact on ACO capacity and finances
    - Primary care shortage or nursing grows, labor costs rise and workforce stress leads to high turnover
    - Health Information Technology (HIT) breakdown, or privacy hack such as has happened when hospital records are held for ransom
    - Sudden loss of critical personnel – HIT, clinical leadership
    - Long strike by workers
    - Substantial increase in uninsured patients with economic recession
    - Loss of access to capital
    - State regulatory changes – i.e. a mandate to cover expansive community health worker services; limits on family planning
- ACOs should be regulated and certified, ideally by an independent, credible outside entity, such as NCQA.
- Certified ACOs should include only primary care practices that have reached the highest level of Patient-Centered Medical Home certification. It is imperative to have a solid foundation of capacity to provide coordinated care within each practice before moving to wider, more difficult care coordination challenges.
- A robust underservice monitoring system should be required for any entity accepting financial risk.
- The state should prioritize creating multiple ACO choices in each community to maximize consumer choice. This is more important than getting to state-wideness. In other states, this competition for enrollment has been an important driver of quality improvement, consumer responsiveness, and cost control.
- Remove/prohibit any incentives or rewards for underservice – either to providers, ACOs, health systems or insurers. See recommendations from SIM's Equity and Access Council.
- Monitor the financial health of ACOs and their ability to continue providing services with sustained losses, just as the state does for insurers.
- Monitor anti-competitive impact on markets, safety net, small independent providers and other critical community resources.
- Monitor access to care, quality, and referral patterns to ensure consumer choice and independent second opinions.
- Monitor the efficiency of ACO spending, i.e. limit executive salaries (like nursing homes) and administrative overhead/profit (like insurers)
- Ensure connections to these services as a minimum:
    - Housing, utility bill assistance
    - Nutrition, food security

- Employment assistance
- Education, child care
- Transportation as a barrier to care
- Language and literacy training, resources
- Peer support services and networks
- Criminal justice system
- Elder support services
- Other state, local social service programs
- Local health departments

Multipayer high-cost, high-need patient analysis and intervention offers our best chance of both improving quality and controlling costs. It must be multipayer as many people with complex problems have more than one source of coverage. Exciting new models and best practices are being developed in other states.

- Design and pilot interventions, customized for each circumstance, e.g. different interventions for homeless populations than for people with severe disabilities or those in institutional care or seniors taking dozens of medications.
- Robust, meaningful, specific, detailed care plans that begin with consumer goals are critical.
    - Require approval by the consumer. People can't be compliant with a plan they've never seen, and it won't work if it doesn't track with their goals.
    - Include both services and self-management goals
    - Update regularly
    - Ensure that care plans are available to every provider who touches the patient, regardless of whether they are in the same health system or not.
    - Monitor and evaluate. Look for both problems and best practices
    - Care plans could be an important source of quality and underservice information.

Limiting monopoly power is crucial to controlling prices, consumer choice and effective regulation. The state must make preserving and supporting competitive markets a priority.

- There must be no CON approvals for more market mergers. We need to evaluate and unravel those that have already gone wrong such as for Windham Hospital.
- As both a deterrent and monitor, Connecticut needs to develop a structure and policy of robust anti-trust regulation and enforcement.
- Do not confuse coordination of care with corporate mergers; in practice they are entirely independent. There are many cases of corporate mergers, horizontal and vertical, where care coordination still happens the way it always did – with phone calls and FAXes. There are also many instances of effective care coordination between providers in different corporate entities.

In fact this will always be necessary, no matter what happens to Connecticut's shrinking market.
- The Governor's CON Taskforce is working on it. We should see if they come up with something better.

Drug costs are a significant and growing driver of health spending increases. As Congressional action is unlikely in the near future, states and other payers are stepping up and new, private tools for policymakers are emerging. Any option must be implemented with the overarching **principle of safeguarding high quality care and consumer access to necessary medications.**

- Use value-based benchmark pricing in negotiations or as hard stop. ICER and other independent nonprofits offer states and other payers critical tools for value-based purchasing.
- Use indication-specific pricing. A drug that is found effective and approved for one indication may warrant a high price. However the price needs to be different for off-label use of the same drug to treat other problems without justification of the value.
- Drug price transparency legislation – see Vermont's new law
- Expand use of medication therapy management. Too many people are taking too many drugs that aren't helping them. This has enormous potential to both reduce costs and improve health and patient safety.
- Risk-based contracting with drug manufacturers holds great promise. Something like a money-back guarantee, the concept is to withhold or clawback funds from drug companies if their products don't improve health and lower costs as promised. Cigna has implemented these contracts for a costly new class of cholesterol medications.
- State litigation for price gouging is an important tool to prohibit unfair trade practices. New York's Attorney General is investigating anticompetitive contracts with schools by the maker of EpiPen.
- Align with other payers and states on the best treatment protocols and guidelines for high cost drugs. Use evidence-based guidelines regarding when it's best to use lower cost, more effective medications. Be careful to ensure guidelines are independent of conflicts of interest.
- Use emerging best evidence to improve medication adherence. Drugs that aren't taken can't be effective and waste money.
- Prohibit all drug company payments and gifts to providers (individuals, institutions, health systems, schools, trainings, meals, trips, Continuing Medical Education, etc.)
- Prohibit use of consumer coupons for cost sharing. Any short term easing of costs for some consumers is more than out-weighed by increased costs to all consumers.

Workforce capacity issues are foundational. Heath care is not like other markets, providers can create their own demand and the costs of entry into the field are extremely high. Excess capacity can drive demand for their services, driving up costs

without a link to improved quality or value. Alternatively, shortages of critical professionals drives up labor costs and can lead to burnout, accelerating the problem. Unlike other fields, many health professional credentials are costly and time consuming to achieve without support. There are fine studies of Connecticut's current and future health workforce needs, with thoughtful planning to get us there. The problem has always been devoting the attention and resources needed. Any reform plan needs to address this critical foundation to our troubled heath system.

Protect consumer choice in all policies. Not only is it the right thing to do, it also allows market forces to build value.

- Crowds of consumers often have wisdom that we aren't capturing. Things we don't know to look for now can show up in consumers' choices.
- Educate consumers yes, but also listen – really listen.
- Do not be afraid of informing consumers of their rights, and enforcing them – they are important clues to what isn't working.
    - Often consumers are harmed by inefficiencies in the system and other things that shouldn't be happening.
    - Fix both the proximate problem and the system flaw that allowed it.
- Lower extra out-of-network costs. They are an important indicator of poor quality or low access to care that may not show up in current measures.
- Give consumers real, usable information on the quality of care.
    - Now consumers' best indicator of quality is price – but we are flying blind.

Data, HIT and evaluation capacity are critical to any effective reforms.
Unfortunately this has been an ongoing challenge for Connecticut, largely because of conflicted interests and turf battles. If we hope to improve, we must move toward success and away from failures, and trust the data to lead us there.

- This area especially needs very strong conflict of interest protections and clearly stated expectations that grants and control of information systems will be shared.
- Robust evaluation by independent researchers, with no interest in the outcome, should be a minimum for all pilots and programs. Equally important is the commitment to follow the evaluation's findings and adjust or abandon what isn't working. We can't be emotionally or philosophically attached to any policy option. At best, this delays improvement and sends good money after bad. At worst, Connecticut could entrench a bad system. (Note prior Medicaid managed care program).
- Thoughtfully expand on what is working. Devote resources and attention to smart program expansion.
- Hire smart, nonconflicted, independent, qualified people as both leaders and staff.
- Create strong boundaries around conflicted interest or other meddling.
- Use nationally respected, independent, national sources of comparative effectiveness information. Creating a new Connecticut entity to oversee this

powerful function is duplicative, invites conflicts of interest and would undermine **trust** and credibility.
- Public full transparency in all policy and grantmaking is critical (see communications option).
- We need to require solid science to back up all policymaking decisions. No post-hoc analyses when policymakers don't like the result. Proponents must release all data, and detail their methodology.

Quality improvement is key and Connecticut has a lot of room for growth in this area. Quality is half the value equation and just as important as cost control.

- Quality assessment must be independent, credible and above suspicion of conflicted interests. Use national measures and standards whenever possible.
- A tight list of quality performance metrics for contracting can be useful in focusing attention on problem areas. They should be identified through a clear process and data-driven. They should also be revised regularly as quality improves to ensure they remain meaningful and do not become easy-A's.
- However, no one should confuse quality metrics for payment purposes with protections from underservice. Most ACO programs have short lists of narrow quality standards so that, the joke is, only pregnant 3-year-olds with diabetes are protected from harm.
- Don't align measures across diverse populations. The need to have similar metric definitions is sensible, but that doesn't extend to using the same list for every population. Measures for adequate prenatal care are critical for Maternal and Child Health populations, but they are not relevant for the elderly in nursing homes. Aligned lists homogenize away meaning.
- Quality measurement should be constructive, not punitive for providers. Every report should come with resources to help improve. This is especially important in critical high-need shortage programs and populations such as Medicaid and primary care.
- Be patient and explore provider resistance to poor performance metrics – sometimes they are right. Quality measurement in health care is not an exact science. And if they aren't, they need to agree on the problem or nothing will be fixed.
- However, payers have to be willing to impose robust penalties when necessary for noncompliance with improvement plans.
- Both improvement and absolute performance should be rewarded. We need incentives across the spectrum of performance. Incentives should be tied to the level of improvement or performance, avoiding a cliff effect that reduces incentives to try.
- Be careful about "adjusting" for case mix. Never create even a perception that could result in avoidance of any population (either well or high need patients). New evidence suggests that adjusting for social determinants has had no impact on hospital Medicare readmission penalties.

- Oversample underserved populations. Good quality for the majority can mask a smaller number receiving unacceptable care.
- Don't worry about too many measures. Most are generated from claims data and there is no provider burden in the reporting. Effort is required to sort out concerns identified by the reports, but that is central to improving quality.

Social determinants of health are likely more important to good health than medical care. New evidence suggests that government spending on social services can reduce medical costs. There is a great deal happening to address social determinants in Connecticut, but it is not well supported by state government. The state should follow and support ongoing local efforts and proven interventions such as

- Affordable Care Act-mandated nonprofit hospital community health benefit plans formed across the state
- DPH's inclusive and thoughtful strategic plan
- Evidence-based home visiting services
- Fall prevention
- Health homes
- Healthy eating, weight control, safe housing and healthy lifestyle supports and resources
- Judicious deployment of Community Health Workers
    - Creating an entire, new health care workforce will increase costs if not carefully done, using best practices from non-conflicted, independent sources backed up with good science
    - Critical elements include effective supervision, training, evaluation/monitoring and only for conditions and patient populations with evidence of effectiveness
- Proven opioid addiction treatment services
- ER diversion programs
- Full access to smoking cessation resources

Effectively integrate behavioral health with medical care. Unmet behavioral health need drives higher costs and historic separation between the two treatment systems inhibits care.

- Take advantage of emerging evidence on effective integration and best practices
- Design and pilot interventions to specific populations (see high cost high need policy option)
- This will require good data and analysis capacity that crosses traditional treatment boundaries.

Meaningful consumer engagement – Patient-centeredness cannot just be a label, but is a completely different way of operating. It will be difficult for many, but it's important not only because it's the right thing to do. Consumers have the most at stake (our lives and we are the ultimate payers through our premiums, out-of-pocket costs, lost wages, and taxes) and we have untapped wisdom that is undervalued and dismissed.

- One example – A study published in JAMA Oncology last year debunked the myth that patient demands are common, usually inappropriate and consequently are driving up health costs. The researchers found that cancer patients make clinical demands in a small number of encounters (8.7%) and that in the large majority of cases (71.8%) the requested treatment is clinically appropriate and should be granted.
- Relying on one or two consumer Board members to represent the needs of an entire population in a few meetings is unfair to both. Real consumer engagement must be far more meaningful. See the Medicaid Study Group recommendations for proven ways for consumers to have real input. For example, other states have had success with Medicaid ACO consumer councils that are public, members are chosen by an independent process not appointed by officials, have a substantive role in decision-making and resources to ensure they can actively exercise that role. A separate council ensures that consumer voices are not drowned out by expert alphabet soup and that they have a comfortable forum where their input is respected.