Connecticut Health Policy Project

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31 ways to save on healthcare in Connecticut's budget

Connecticut's state budget is facing future deficits and health spending is a large share of the budget. The state now spends $3.8 billion between Medicaid and the state employee health plan to cover about a million state residents.[1] Health care spending outside the state budget is also growing. Connecticut has the sixth highest per capita healthcare spending among states (2014) but we are doing a better job than most states in controlling those costs.[2] Next year state policymakers will be making difficult decisions to cover the deficit.

It is estimated that 30% of US health care spending is wasted on unnecessary services, excessive administration, fraud and missed opportunities for prevention.[3] While that number is disappointing, it offers opportunities to control costs while improving the quality and effectiveness of care.

We have collected dozens of opportunities for Connecticut policymakers to do that. Some of these options are specific to state programs and some will lower costs across all payers. Some provide immediate savings, and some are long-term opportunities. Most do not require new funding to implement. Some require redirecting current staff functions and duties. Many use the state's considerable power, as the largest funder of health coverage, the regulator of providers and payers, the main funder of public health activities, and government's convening and education roles, to lead our fragmented system into sensible reforms.

Paying differently for care

- **Reward higher quality providers with better payment rates and/or direct payments for quality performance**. The state is the largest purchaser of healthcare coverage in Connecticut, largely paying providers the same rates for services by program regardless of the quality of care provided. Pay for Performance (P4P) is an established payment model of directly paying providers separately from rates for better performance, such as prescribing asthma controller medications and hemoglobin testing for people with diabetes. Performance measures are often chosen because they both improve health outcomes and lower overall costs. Incentives should focus on challenge areas, be linked with provider education and tools to improve, and include regular feedback on performance. Thoughtfully risk

[1] Annual Report of the State Comptroller Statutory Basis, FY 2017, October 2017
[2] National Health Accounts, CMS
[3] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Institute of Medicine, September 2012

adjust expectations and performance standards to reward providers who care for fragile patients.
    - To avoid serious unintended consequences, avoid incentives and include significant financial disincentives to deny people necessary care or to dump less lucrative patients (adverse selection). [4]
- **Start with Medicare prices in negotiating rates** – Montana has saved millions in their state employee plan by not using hospitals' charge prices for services and negotiating down, but starting with Medicare prices as a baseline and negotiating up. Medicare prices are set by calculating the cost of providing services and types of diagnoses, with an extra factor for a fair profit. Montana saved $15.6 million this year and hospitals are doing fine.[5]
- **Use Comparative Effectiveness benchmark prices in negotiations** – Insurers, Medicare plans, Medicaid programs and the Veterans Administration use comparative effectiveness benchmark prices in negotiations with pharmaceutical companies. Comparative effectiveness is a growing area of research that evaluates the clinical effectiveness and value of treatment options compared to current treatments, incorporating patient input, potential for long-term value and the costs to state governments among other factors. A leader in this area, the nonprofit Institute for Clinical and Economic Review (ICER), evaluates whether new medications and other treatments are worth the price and give an evidence-based benchmark range of prices at which they would be a good value.[6]
- **Avoid payment models that rely on provider or insurer financial risk** to indirectly lower costs and improve quality. There is a growing consensus among researchers that shared savings models, which place financial risk on providers, are failing. Despite significant investments by the federal government, Medicare's shared savings program has, in fact, increased federal spending.[7] Capitation through private insurers failed Connecticut's Medicaid program, as in other states, in the 1990s and 2000s. Since shifting in 2012 to a care management model with quality incentives, our state is saving hundreds of millions of tax dollars every year with strong improvements in quality and access to care.[8]
- **Consider non-financial incentives** which are often more salient for providers than money. Doctors especially are motivated by doing a good job and improving the health of their patients.[9]

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[4] Safeguarding Against Under-Service and Patient Selection in the Context of Shared Saving Arrangements, SIM Equity and Access Council, June 2015

[5] 'Holy Cow' Moment Changes How Montana's State Health Plan Does Business, Kaiser Health News, June 20, 2018

[6] Institute for Clinical and Economic Review

[7] Medicare Accountable Care Organizations Have Increased Federal Spending Contrary to Projections That They Would Produce Net Savings, Avalere Health, March 29, 2018

[8] Rest of US Catching Up with Connecticut – Medicaid Managed Care Doesn't Work, CT Health Policy Project, May 29, 2018; Connecticut Moves Away from Private Insurers to Administer Medicaid Program, Wall Street Journal, March 18, 2016; Financial Trends in the HUSKY Health Program, DSS presentation to MAPOC, Feb. 9, 2018

[9] M. Zezza, Provider Incentives: Thinking Beyond Financial Rewards and Penalties, Commonwealth Fund, Sept. 2, 2014

Lower healthcare costs

- **Invest in preventing disease through proven public health initiatives**. Connecticut ranks 30th among states in the rate of hospital admissions for children with asthma, 29th for avoidable ER visits for adults ages 18 to 64 years, and 36th in avoidable admissions for Medicare beneficiaries.[10] Proven public health initiatives can reduce teen pregnancy, healthcare acquired infections, motor vehicle accidents, tobacco use, food safety risks, reduce antibiotic-resistant bacteria, and infectious disease. Through an inclusive process, our state Department of Public Health has developed Healthy People 2020, a workable plan to implement proven public health initiatives that meet Connecticut's needs.[11]
- **Food as Medicine programs show great promise to improve health and save money, especially in Medicaid.** Healthy food delivery and counseling programs for Medicaid members have been implemented in California, Pennsylvania, New York, Massachusetts and Maine. Food tailored to individual medical needs offered the best results in lowering costs, ED visits and hospitalizations for Massachusetts' program. Maine's program lowered hospital readmissions and returned 387% on the investment.[12] Geisinger, a large Pennsylvania health system, has reduced treatment costs for their patients, including non-Medicaid members, with diabetes by 80% with their Fresh Food Farmacy nutritious food and education program.[13]
- **Use data and evaluation tools**. Other states are using sophisticated health data and analytical tools for smarter planning, to define the scope of problems, identify gaps, target resources only where they are needed, and evaluate effectiveness. Using "hot-spotting", providers in Camden NJ are able to direct individualized care to high-cost, high-need patients getting them exactly the care they need, saving money and directing just what patients need only to them.[14] For example Development of an All-Payer Claims Database (APCD) has been frustratingly slow in Connecticut. In at least 18 states, APCDs collate healthcare claims data across payers and programs allowing smart, evidence-based policy decisions, identification of gaps, assisting in evaluating policies and programs, and helping consumers make the best choices for their care.[15] If a hotspot of seniors with high ED visits is found and access to primary care is a problem, a clinic site can be added in their senior center, not every senior center in the city. Evaluation of new initiatives is critical. Impressive data analytics resources exist at UConn to evaluate Medicaid's new payment model but are not being used.[16] Massachusetts is generous in sharing healthcare data with researchers and even the public to identify hidden trends and generate unique, feasible solutions.

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[10] State Health System Rankings, Commonwealth Fund

[11] Healthy People 2020, CT DPH

[12] A Martin et. al., Simply Delivered Meals, Am J Managed Care 24:301-304, 2018; S Berkowitz, et. al., Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries, Health Affairs 37:535-542, 2018; Rx: Zucchini, Brown Rice, Turkey Soup. Medicaid Plan Offers Food As Medicine, Kaiser Health News, June 25, 2018

[13] Diabetes Defeated by Diet, CNBC, June 21, 2018

[14] A Gawande, The Hot-Spotters, New Yorker, Jan. 24, 2011; Camden Coalition of Healthcare Providers

[15] Data for Change: How States Have Used APCDs to Drive Innovation, NASHP, July 2016

[16] MAPOC: Harnessing the Power of Data Analytics to Improve Health, CT Health Policy Project, Dec. 20, 2017

- **Use transparency and market forces to improve cost effectiveness of care by providing consumers with comparative quality and cost data.** Maine, Massachusetts, Pennsylvania and Minnesota have led states in developing publicly available comparisons among providers based on quality and cost data. Public quality reporting gives consumers tools to choose the best health care value, putting downward pressure on prices for all payers.[17] Comparisons with colleagues have been very effective in motivating providers to improve.
- **Use state regulatory power to encourage and support competition in Connecticut's marketplace.** The state's authority to approve, modify or reject Certificate of Need applications is a powerful tool to preserve competitive markets. Historically it has been used sparingly, but more recently merger approvals have been expanded to include conditions such as limiting rate increases, monitoring for community impact, and requiring community forums to collect feedback.[18] The state should exercise its anti-trust authority to preserve and expand a competitive environment.
- **Create a state Accountable Care Organization accreditation program available to all payers.** Accountable Care Organizations (ACOs) are integrated networks of local providers across the care continuum, including hospitals, physicians and affiliated providers that are paid based on their ability to provide quality care and restrain costs. ACOs hold great potential to improve quality and control health costs. CMS is currently granting certification to ACOs for Medicare, but New York and Massachusetts are creating state ACO certification standards applicable to all payers.[19] Massachusetts intends to give a preference to state-certified ACOS in state health programs. While preserving competition and recognizing anti-trust concerns, the state should take a lead role in developing ACO arrangements in Connecticut to align incentives for efficiency and quality among providers across the care continuum.
- Connecticut should **carefully study creating a public option** insurance plan. A publicly run health insurance option could compete with private insurers to give consumers another choice and serve as competitive pressure to keep premiums affordable. A bill to study creating a public option did not pass this year, but plans continue for the study. Suggestions to build the new plan on Connecticut's Medicaid program have great appeal but must be done carefully.[20]
- There are **many state options to control prescription drug costs**. The escalating cost of prescription drugs are driving Connecticut health costs and squeezing out other priorities in family and state government budgets. Connecticut spends more per capita on prescription drugs than all but one other state (2014). Prescription spending rose by $1,186 per Connecticut resident from 1991 to 2014, faster than all but two other states.[21] Last year Connecticut's Health Care Cabinet took a deep dive into the problem and developed state options to address the problem. Options

[17] E Emanuel, et. al., A Systemic Approach to Containing Health Care Spending, New Eng J Med 367:949-954, September 6, 2012

[18] New London, Westerly hospitals to join Yale-New Haven system, CT Mirror, July 15, 2015

[19] National Academy for State Health Policy, December 2012; The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012

[20] Connecticut Should be Careful Building a Public Insurance Option Through Medicaid, CT News Junkie, April 2, 2018

[21] Chartbook: Connecticut Pharmacy Spending, January 2018, CT Health Policy Project; National Health Accounts, CMS, updated November 2017

included creation of a state board to review high prices and trends and referral of unjustified increases to the Attorney General for unfair trade practices enforcement. Other options include linking provider conversations with patients about drugs to providers' pay, creating a state Pharmacy Benefits Manager by extending the state employee plan's contract to other payers, to consider re-importation of drugs from Canada, and to study setting drug prices for the state in a public utility model.[22]

- **Direct Connecticut's Insurance Department (CID) to consider consumer affordability in rate setting decisions**. CID has regulatory review authority of some insurance policies but, under current law, affordability is not part of the process. It is likely that affordability/price elasticity trade-offs between losing customers and higher profits are calculated by insurers in setting their proposals. To protect affordability and lower the uninsured rate, insurers should be required to share that information in the rate review process.

Engage providers to lower costs

- **Integrate best practices into electronic health records**. Providers are increasingly moving from paper to electronic medical records to improve patient safety, provide instantaneous access to critical information, and improve monitoring. As a major payer of healthcare in Connecticut, the state could incentivize incorporation of comparative effectiveness and other research into online record systems to include best practices as default treatment options.
- **Support effective care management** – Effectively managing care can be lifesaving for patients with complex conditions and lower costs for payers. Good care plans, drafted in a collaboration between providers and patients/families, is the foundation of effective care management. Too often, care plans are generated from electronic health records, without patient input on goals or strategies, and without real-world input from providers. As a major payer of healthcare services in Connecticut, particularly for fragile state residents, the state could include evidence-based standards for care plans into payment decisions.[23]
- **Reduce prescription drug costs with a provider education (counter detailing) campaign**, on the relative costs and effectiveness of medications. Several other states have developed campaigns providing balance to pharmaceutical sales reps with independent clinicians visiting practices with information on less costly treatment options. There is evidence that counter detailing (also called academic detailing) programs can be effective in lowering costs.[24] Other options include encouraging medication management by pharmacists, limiting gifts to providers from drug companies and prohibiting direct industry funding of provider Continuing

[22] Recommendations on Pharmaceutical Cost Containment Strategies, CT Health Care Cabinet, February 2018
[23] Care plan best practice recommendations to DSS, Complex Care Committee, MAPOC, Jan. 2018
[24] The Rise of the Pharmaceutical Un-Sales Force, Forbes, April 25, 2011; Pharmaceutical strategies, National Governor's Association; K Yokoyama, et. al., Effect of Physician Profiles and Academic Detailing on Cost and Utilization of Selective Serotonin Reuptake Inhibitors, J Man Care Pharm, Jan/Feb 2002; Maine Independent Clinical Information Service, ME Medical Association

Medical Education training. All these measures have been adopted by Massachusetts in their health care cost containment reforms.[25]

- **Reduce pharmacy costs with prescriber incentives for conversations with patients** A minority of physicians talk to patients about the cost of medications they are prescribing. Physicians rate the cost of medications as the least important factor to discuss with patients.[26] But 88% of Connecticut residents regularly taking prescriptions are worried about their ability to afford them. Half are cutting back on pills, skipping doses or not filling a prescription due to cost.[27] Thirty five percent of Americans regularly taking drugs have never had their medications reviewed by a provider to see if they can stop any. But when they do have conversations, most often providers can suggest a less expensive alternative.[28] As provider payment models incorporate more quality incentives, including these conversations is critical. Payment should be based on consumer recollection of the conversations through regular surveys rather than provider self-reports. If consumers don't remember the conversations, then they aren't effective.

Be strategic about the healthcare workforce

- **Assess areas of over and under capacity in Connecticut's healthcare workforce** Unlike most economic sectors, excess healthcare provider capacity often does not reduce costs. In fact, excess provider capacity often drives utilization and costs up.[29] A thoughtful analysis of Connecticut's healthcare workforce needs in 2011[30] found that the recession temporarily eased workforce shortages but challenges remain for the future. Regular assessments are needed with the political will to make adjustments to educational and administrative changes. Proposed new categories of provider and expansions of scope of practice should be carefully studied, monitored and evaluated for effectiveness and cost efficiency.
- **Strengthen primary care capacity.** Areas with adequate access to primary care enjoy lower emergency room use for non-urgent care, improved outcomes for patients with chronic illness, and lower levels of overall health spending.[31] Connecticut is facing a shortage of primary care capacity; reduced access to primary care has been linked to higher health costs.[32] Massachusetts has included expansions of physician assistant and nurse practitioner roles, loan forgiveness guarantees, and primary care residency programs in their cost control law.[33] Reforms go beyond the need for

[25] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012
[26] W Hunter et. al., What Strategies do Physicians and Patients Discuss to Reduce Out of Pocket Costs?, Medical Decision Making, Jan. 19, 2016
[27] Connecticut residents worried about high drug costs – Express bipartisan support for a range of government solutions, Universal Healthcare Foundation of CT, April 2018
[28] Sluggish economy forces Americans to cut corners to pay for medications, Consumer Reports, Sept. 2012
[29] A Gawande, The Cost Conundrum, New Yorker, June 1, 2009; Hospital and Physician Capacity, Dartmouth Atlas
[30] Connecticut Healthcare Workforce Assessment, CT Office of Workforce Competitiveness and CT Employment and Training Commission, August 2011
[31] Flattening the Trajectory of Health Care Spending: Foster Efficient and Accountable Providers, RAND, 2012
[32] Assessment of Primary Care Capacity in Connecticut, Center for Public Health and Health Policy, UConn, Dec. 2008
[33] The Next Phase of Massachusetts Health Care Reform, MA General Court, 2012

more practitioners to include support for new skills, team based care, expectations that every provider work at the top of their license, and reforming payment policies to maximize the effectiveness of all team members.

- **Ease provider administrative burdens.** US physicians average 43 minutes each day on health plan administrative functions; their staff spends far more time on administration. Administrative simplification could reduce these costs by as much as $29,000 per physician. Reforms include streamlining electronic transactions, a common provider enrollment and credentialing system, and standardized reporting requirements.[34] Administrative hassles are a crucial barrier to Medicaid participation for Connecticut physicians.[35]
- **Support family caregivers** It is estimated that 40 million Americans provided 37 billion hours of care to a disabled or elderly family member or friend without pay. Not only do they provide unpaid care, family caregivers also incur out of pocket cost to care averaging $7,000 each. Without family care, healthcare costs in the US would be substantially higher.[36] Connecticut needs to take a comprehensive analysis of challenges facing family caregivers and policies that could help including financial, legal, and health barriers.

Engage consumers in the fix

- **Create a public campaign about smart healthcare consumption** Connecticut consumers ultimately pay for all healthcare, but much of the costs are hidden. A comprehensive, effective state consumer education campaign could harness the power of state residents to make better decisions about their own health and spending while also generating savings for the state. An effective campaign would use diverse messengers, multi-media, and engage diverse audiences. Themes to include:
    - Patients should **ask prescribers about the costs of drugs**, side effects, how likely they are to be effective and, if necessary, ask for less expensive and non-pharmacy options. Providers should help consumers set priorities for spending on pharmaceuticals.
    - **Over and under treatment** In the absence of balanced information on the effectiveness of treatments, too often patients assume more care is better care. Current incentives in well-resourced health plans such as the state employee plan can act to increase utilization of less valuable care. In programs with lower payment rates like Medicaid however, underservice is a danger. All consumers should ask their doctor about the full range of treatment options, side effects and alternatives. Reducing low-value overtreatment isn't rationing – it's better care.
    - Consumers should understand accessing care in the most appropriate setting and how to access resources to know the difference. Going to the ED for small problems that could be handled in a doctor's office involves long waits

[34] D Cutler, et. al., Reducing Administrative Costs and Improving the Health Care System, New Eng J Med 367:1875-1878, November 2012
[35] Fixing Medicaid: Healing Connecticut's Largest Health Care Program, CT Health Policy Project, May 2011
[36] Valuing the Invaluable, AARP, July 2015

and costs more. They can call their primary care provider or health plan if they aren't sure.

- **Engage consumers in identifying and reporting fraud, waste and abuse in all state programs** and in generating ideas for innovation. The successful Medicare Senior Patrol program developed by the US Administration on Aging provides an important guide.[37] Use the wisdom of crowds and the network of a million consumers covered by state programs to drive improvement.
- **Quality/cost rankings for consumers** Over half of Connecticut residents have high deductible insurance plans and that number is rising.[38] As more consumers have to shop for value in healthcare, opening up the APCD as a tool to find the best price for care will help lower costs for both consumers and payers. Adding information about the quality of care will help ensure they get their money's worth.
- **Outreach to the uninsured** Almost two in three uninsured Connecticut residents qualifies for either Medicaid or ACA tax credits through Access Health CT.[39] Covering the uninsured will reduce uncompensated care provider costs, lowering prices and cost shifting onto payers, including state government.

Support Medicaid

While Connecticut Medicaid is a national model of cost control, it does consume a large part of the state budget. There is room to continue and build on progress lowering costs while improving access to quality care.

- **Continue to focus on high cost, high need patients** Medicaid's current Intensive Care Management (ICM) program is a success in lowering the costs of care for members with complex health and social needs while improving health outcomes.[40] Ensure that with the shift to PCMH Plus, no one loses access to this critical program but that health systems do not receive half the savings from the state's investment in ICM.
- **P4P smart incentives** Build on the success of previous P4P initiatives such as reducing early elective deliveries. Assessing quality and costs challenges and targeting P4P incentives to address them could increase savings and quality improvement. A good choice to start would be the lower quality levels, particularly high ED visit rates, for patients of community health centers despite their much higher reimbursement rates.
- **Monitor access to care** It is critical to monitor members' access to care, particularly primary care, that could reverse lowered ED visit or hospital utilization rates.
- **Monitor spending** This is especially important with large policy shifts. To date, there has been no analysis of the cost of shifting hospital primary care clinics to community health centers control across the state.

[37] http://www.aoa.gov/AoAroot/AoA_Programs/Elder_Rights/SMP/index.aspx
[38] MEPS, AHRQ, 2016
[39] Estimates of eligibility for ACA coverage among the uninsured in 2016, Kaiser Family Foundation, June 19, 2018
[40] Intensive Care Management, DSS

Learn from every initiative, big and small

It is critical to monitor, evaluate, and adjust or abandon initiatives, without fear or favor, if they do not meet the goals of improving access and quality while controlling costs.

Bottom line: There is no shortage of realistic, tested opportunities to control Connecticut's health care costs that do not harm our health. Improving quality doesn't have to cost more.