Concerns with OHS's Cost Cap/Benchmarking Project

Summary
Healthcare costs a lot in Connecticut, especially for middle and lower income residents. Primary care is the foundation of a healthy health system. Lowering costs and supporting primary care are important goals, however the Office of Health Strategy's (OHS) new plan to limit costs is ill-conceived and likely to create unintended harm. Despite the pandemic, OHS is rushing ahead on the cost cap with out-of-state consultants and without critical input.

OHS is following a model from Massachusetts, that would aggregate all healthcare costs for all populations and payers. If those costs exceed an economic marker chosen by OHS, the agency will choose provider organizations for corrective plans to lower costs. In addition, OHS plans to significantly expand primary care's share of spending while simultaneously reducing the size of the entire healthcare pie, cutting other critical care.

Concerns

- The plan threatens access to necessary care and could widen disparities
- The pandemic has had unprecedented impact on Connecticut healthcare delivery and spending – plans to use 2020 as the base year for the cost cap are risky
- OHS's plan does nothing to address the main drivers of rising health costs – prescription drug prices and mergers leading to higher service prices
- The rush to plan during the pandemic and secrecy in developing corrective plans undermines trust
- The plan implements cost caps a year before quality improvements, allowing erosion of quality to achieve savings
- A cost cap removes incentives for investment and innovations that could lower costs
- Aggregate cost cap removes incentives to lower costs
- Proposed economic benchmarks miss the impact of rising health costs on Connecticut middle and lower income residents who bear the highest burden
- Connecticut does not have either personnel or systems in place to do this work – outside consultants are not a good option
- An arbitrary primary care spending benchmark is the wrong place to start improving primary care and could have unintended consequences
- OHS's plan favors capitation, a payment model that failed Connecticut
- The Plan ignores the unique features of Medicaid that could undermine cost reductions and expansions of access in the program, while enabling further cost increases in commercial plans

Advocates, primary care providers and other stakeholders have offered dozens of better, safer options to improve health outcomes and control costs in Connecticut.

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Although the trend has moderated in recent years, healthcare costs are rising for Connecticut as for the rest of the nation, mainly driven by prescription drug prices and mergers driving up prices for services. Consumers bear the burden of escalating costs through increasing premiums, taxes, lost wages, and out-of-pocket costs. Primary care is the foundation of the health system and there is evidence that strong primary care networks are associated with better health outcomes. Intentions behind the Office of Health Strategy's new efforts to cap rising costs through benchmarking and support primary care by increasing the proportion of spending are admirable. However, OHS's plan includes nothing to address rising drug and service prices. **Advocates and other stakeholders have serious concerns about the process, timing and content of these efforts both that it is unlikely to be successful and because the plan risks significant unintended consequences that will harm consumers**. We end with better options.

Unintended consequences

1. **Connecticut does not have a tradition or capacity to monitor for unintended harm or accountability.** Identifying problems has largely been the responsibility of advocates, media, and watchdogs. In too many cases, agencies with that responsibility have aligned with troubled interests to perpetuate the problems. Agencies are not immune from promoting initiatives that cause problems, making it especially difficult to reverse course.
2. **There must be robust, fiercely independent evaluation and monitoring** of the cost cap's impact including health outcomes, quality of care, gaps in care, access to care, preventive and maintenance care, and impact on community services.
3. **The cost cap could generate savings at the expense of quality.** Quality improvements are scheduled for implementation a year after the cost cap.
4. **Plans to use 2020's health spending as the cost cap base year will distort any benchmark.** COVID-19 has had an extraordinary and unprecedented impact on Connecticut's health spending. Insurer profits are up, hospital and other provider revenues are down, and much necessary care has been delayed. It is likely that healthcare delivery and costs will be different post-pandemic. We won't know the final impact of these competing trends for years. Despite assurances, without explanation, from OHS's consultants that they can adjust for this, it is a very bad idea.
5. **The cost cap may threaten equal access** to care regardless of payer/uninsured/self-pay, race/ethnicity, language spoken, income, urban/rural residence, disability, health condition, sexual orientation, age, health status, and pre-existing conditions, among other health disparities.
6. **Secrecy in OHS's proposal is deeply troubling**, especially secret negotiations with providers identified as overspending and resulting corrective action plans. Consumers' interests must be a priority. All evaluations and monitoring results must be made public as soon as they are collected, regardless of whether there is a corrective action plan in place or negotiations have begun. People have a right to know the details as soon as OHS does. All evaluations and monitoring must be de-identified by patient but not by provider or health system/practice.

7. **The cost cap could increase barriers** to prenatal, pregnancy and postpartum care, and family planning services including abortions. As this is a long-term plan; it must protect the rights of all Connecticut residents, regardless of changes in administrations.
8. **Aggregate benchmarks may allow hard won efficiencies in one area to enable cost escalation in others punishing investments that could improve care and lower costs.**
    a. The key to sustainable cost control is investing in one area, (i.e. prevention) that reduces costs in another area (i.e. hospitalizations) while improving health outcomes.
    b. **In a rigid cost cap system that depends on aggregate spending, efficient systems would cover losses by poor performers.** Historic savings in Medicaid should not allow for increases in private insurance premiums, public investments in affordable housing that lower hospitalization and ED costs should not drive skyrocketing increases in drug prices, and efficiencies created by innovations in one ACO, often competing in the same market, should not enable price increases by a competitor health system that is less efficient.
    c. **It is critical to encourage beneficial investment effects and innovation/investment and to discourage profit-taking.** The first leads to dissemination of best practices, the second to corrective action. This is a difficult, and possibly subjective, analysis that is beyond the current capability of OHS and should not be at the discretion of only one or more state agencies.
9. **Choosing a single rigid economic benchmark for acceptable increases in health care spending could have significant unintended consequences.** The choice requires a consensus on values that doesn't exist in Connecticut.
    a. We believe any benchmark should consider the economic impact on the state's highest-need, least-resourced residents. Connecticut is among the worst states in economic inequality. Choosing only average per capita/household economic measures misses the experience and capacity of lower income state residents to pay those bills. It assumes that all state residents have an equivalent ability to accommodate increasing costs.
    b. Including median rather than average income mitigates distortions as incomes of Connecticut's wealthiest residents rises faster than others. As a reported metric among many, GDP could be valuable, but it is a less robust indicator that largely reflects personal income. The cost cap should reflect the volatility in working and low-income family incomes – not the historical disproportionately rising fortunes of Connecticut's wealthy.
    c. OHS should report on performance against many benchmarks. Differences could give important clues to identify problems, craft better, more targeted solutions, and avoid unintended consequences we can't foresee now.
    d. OHS's plan doesn't include assessing the impact of allowable increases, and how they are structured (worker vs. employee share, rising deductibles, etc.), on households with the highest healthcare care and cost burdens.
    e. It is critical to use independent, non-conflicted sources of data and information for decisions. Those sources don't exist now.
10. In addition to current consulting fees, **consider carefully the future costs of fully implementing the cost cap project**. There are better uses of these funds, especially as Connecticut recovers from the COVID-19 pandemic, a recession, and significant reduction in state revenues.

a. New resources must include time and analytic capacity to evaluate state health costs proposals in detail, by provider and industry, every year, and to determine what the cap allows. The majority of plans will be approved with no modification. The few cases where costs are rising too fast, will require sophisticated analysis to parse what is driving the rise, if it is justified, and, if necessary, develop and negotiate a corrective action plan. It will then require even more extensive resources to track compliance and negotiate adjustments.
b. Massachusetts has a long history of successful, stepwise reforms. The Massachusetts Health Policy Commission is well-trusted and seen as balanced. The Commission's budget this year is $8.5 million. Even given the advantages, there are serious questions about whether the Commission's cost cap project is responsible for the reductions in spending that pre-dated its implementation.
c. To be successful, the cost cap project will require adding significant capacity to OHS, which is not in a position currently to do the work.
d. This escalation in state costs provides questionable value to residents and taxpayers. It will further burden the state's budget crisis, forcing cuts to clearly valuable services such as education, healthcare and community resources – potentially deepening the recession.
e. Consider other, more pressing uses for those scarce public funds.

11. The recession, state budget constraints, and political shifts, because of and beyond COVID-19, could increase the rates of uninsured/self-pay patients, raise prices for critical treatments, expand political and/or fiscal undermining of the ACA and its protections, and erode/overwhelm the safety net. The cost cap project and government efforts to cut healthcare costs, even if unintended, cannot be allowed to add to these problems. **Recommending deep cuts that impact the health of Connecticut residents can significantly harm physical, emotional, and economic recovery.**

Primary care

12. We are concerned that **significantly expanding the share of Connecticut's healthcare spending on one sector while also capping total costs will result in serious reductions in care in other critical areas.** This double cut will hit high-need and at-risk Connecticut residents, their providers, and payers hardest.
13. **A 10% primary care spending benchmark is the wrong place to start.** Start with practice supports and re-orienting the health care system toward primary care. It is likely that spending on primary care will rise with more effective reforms, but so will health outcomes. Throwing money into the current system will not solve the problem.
    a. A review of the literature finds that **the critical factors in promoting better health outcomes are 1) supporting providers in providing primary care functions, for instance with care coordinators and EHRs, and 2) restructuring the health system** to focus on primary care delivery, e.g. expanding access to primary care, no consumer cost sharing for all primary care, encouraging a usual source of care. Supporting primary care medical providers gave mixed results, e.g. studies of outcomes for patients cared for by primary care providers compared with specialists found no difference in outcomes.

b. **Most reforms cited by Connecticut primary care providers and other stakeholders as necessary to improve practice and health outcomes do not relate to payment** but are changes in policy and process such as lowering administrative burdens, improving practice and patient care tools, standards of practice, expanding consumer choice, care coordination, effective community/social service connections, workflow improvements, getting better data to providers on their patients, patient communication, and access to specialty care. The last could be seriously harmed by the benchmark in OHS's plan.
c. There is **an unsupported assumption** underlying this proposal that raising rates or overall primary care spending will improve health or even expand access and utilization of primary care – but that is far from proven.
    i. Healthcare markets are not like others. Basic economic theories about the impact of blanket increases in spending improving consumption often do not work in healthcare and often backfire.
d. **Correlation is not causation** – While studies have found higher primary care spending associated with better health outcomes, that does not prove or even suggest, that artificially raising payment rates to primary care physicians will expand access and lower overall healthcare costs.
    i. Other features of effective health systems are more likely to improve outcomes, such as public health investments, monitoring population health (protecting patients privacy and security), effective monitoring for best practices, targeting interventions to just where they are needed and evaluating the impact, addressing social determinants of health, personal safety, and effective interventions to promote health such as quitting smoking cessation and prevention, access to healthy food, and exercise.
    ii. Raising physician primary care rates is the easiest (therefore most likely) way to increase spending. However paying more to the people providing primary care now will not improve the quality of care or re-orient the healthcare system.

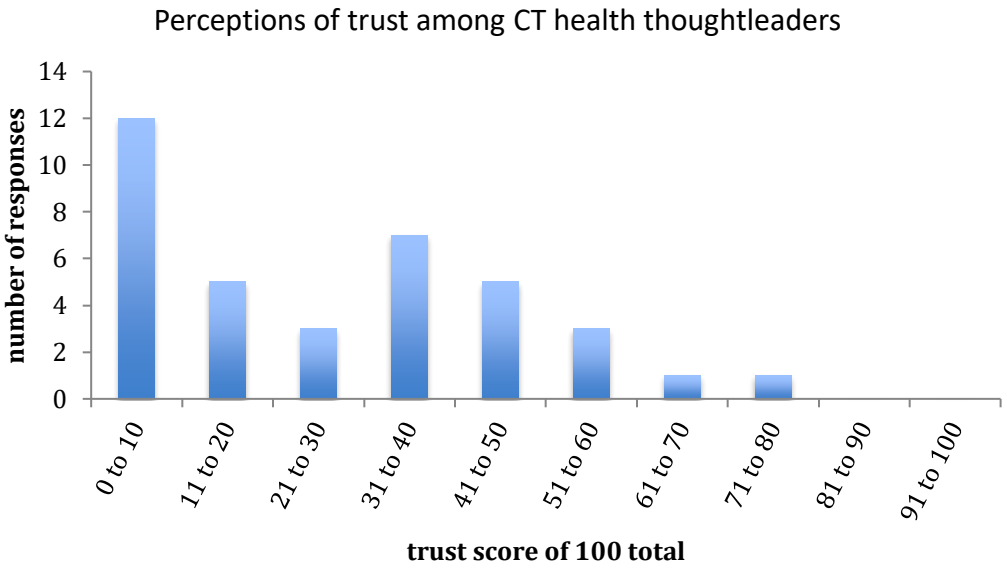
14. **OHS should use a broad definition of primary care that recognizes functions and the value of non-physician providers as the reference for tracking primary care spending.**
    a. Connecticut has the lowest percent primary care spending (CT 3.5% vs. 5.6% US) when only including care delivered by some physicians, as refenced in OHS's RFP[1] to hire the consultants for this project. When using the more reasonable definition, included in the referenced paper, that includes primary care provided by other qualified providers working within their scope of practice (such as NPs, PAs, and OB/GYNs), **Connecticut already spends more than OHS's 10% mandate** (CT 10.6% vs. US 10.2%) and more than the US average.
    b. A large and growing proportion of primary care delivery is not provided by physicians. Team-based care is a best practice and shouldn't be undermined. Emphasizing only physician capacity would increase overall health costs.

1 RFP: STATE OF CONNECTICUT OFFICE OF HEALTH STRATEGY REQUEST FOR PROPOSALS (RFP), Health Care Cost Growth and Quality Benchmarks and Primary Care Spend Target Consulting Services, RFP Number 20OHS170, February 7, 2020

c. If the goal is to expand access to and utilization of primary care, expanding physician capacity is not the most effective option. It is not easy and takes a great deal of time to train new doctors, this leaves out building capacity with all potentially valuable providers and will divert scarce resources.
d. Emphasizing only physician capacity could undermine efforts to improve the diversity of Connecticut's health care and primary care workforce.

15. **Equalize payments rates for primary care services and functions with other care**, across payers. This can be accomplished without increasing healthcare costs by fairly apportioning current funding. Quality and patient experience is what matters and should be rewarded. Payment should match the service and the quality of care, not the payer or the provider type.
16. **An emphasis on an arbitrary benchmark for spending on primary care favors primary care capitation.**
    a. Primary care capitation is **very controversial** in Connecticut and has not been widely adopted for a variety of reasons. Capitation has a long history of failure and harm to patients in Connecticut and across the US, failing at improving access, quality, and sustainably lowering costs.
    b. **Capitation inherently includes incentives to underserve and cherry-pick more lucrative patients.** This will leave many without access to care, particularly people with disabilities, patients with social service needs, and patients with less-lucrative or less-easily treated conditions, such as behavioral health issues.
    c. Unfortunately, Connecticut has not adopted the recommendations of SIM's Equity and Access Committee to **lower the risks and mitigate the harms of underservice and adverse selection**.
    d. **Responsible imposition of capitation requires robust monitoring, evaluation and the political will to make modifications that may be unpopular with special interests.** Connecticut does not have the capacity or culture to do this and it would be strongly resisted. Even simple processes to identify quality measure reporting in Connecticut have been bogged down and delayed by interests for years.
    e. **Once implemented, capitation took over a decade to remove from Connecticut Medicaid**, even as overwhelming evidence emerged that it was costing Connecticut more than fee-for-service, reducing access, and lowering provider participation in the program. For years, powerful interests successfully fought any efforts to hold managed care companies accountable under their contracts. Since that time, nothing has changed significantly in either Connecticut's culture or capability to hold entities accountable. Since rejecting capitation in favor of a care coordination-based system, Connecticut Medicaid saved taxpayers $2.25 billion by last year.
    f. There are at least 38 better, safer options to support primary care in Connecticut, none of which involve capitating primary care.

Mistrust



Source: Mistrust in Connecticut Health Policymaking, CTHPP April 2017

Trust has been a linchpin for many successfully developed and implemented state cost containment agendas. A common theme across all of the six states is a general sense of trust among key public and private stakeholders.

Bailit report to Connecticut Health Care Cabinet on states with successful reforms, 2017

1. Advocates have concerns that only some parts of any plan will be implemented. In the past, protective proposals for consumers included in potentially harmful initiatives will not be implemented. **Advocates are concerned that when the cost cap is launched, any moderating, consumer-centered safeguards included in the proposal to gain support will not be.**
    a. In 2016, OHS's plans for Connecticut healthcare reform, also led by Bailit consultants, violated a promise by current OHS and DSS leadership that there would be no downside risk in Medicaid.
2. Because Connecticut has a very troubled history in this area, **strong conflict of interest protections are key to success.** In addition to mistrust, self-interested plans are never successful. While it is important to get input from Connecticut's industries, provider groups and others with a financial interest in the cost cap's outcomes, they cannot drive the group's recommendations. This has been a serious and ongoing problem in Connecticut and OHS health policymaking. Committees should be re-constituted to remove even the appearance of conflicted interests, rather than to affirmatively include them and focus on trying to balance them, as now.

Medicaid

1. **Medicaid is unique**
    a. Per person **costs in Connecticut Medicaid are under control, unlike private coverage.**
    b. As a safety net program, **Medicaid cares for Connecticut's most fragile and costly members.** If their needs are not met because resources are reduced inappropriately, costs will rise across the entire healthcare system, the state budget, and for Connecticut families.

c. As a safety net program, one of the ways to qualify for Medicaid coverage is having high medical bills. **Tripling primary care spending (absent increases in healthcare budgets in a recession) will mean cuts to other, equally critical lifesaving care.**
d. **Aggregate spending benchmarks are inappropriate and counterproductive** in primary care as for total costs of care. For instance, from Slide 8 Meeting #2 of the Technical Team meeting, the second objective of the Cost Cap project is "Recommend primary care spending targets **across all payers and populations** as a share of total health care expenditures for CYs 2021-2025 to reach a target of 10% by 2025" (bold added for emphasis).

2. **In the past Connecticut has made broad, sweeping recommendations for all healthcare, but only applying them to Medicaid** – which did not suffer from the original problem -- because Medicaid is the only program the state can unilaterally control.

Delivery reform/Better options

1. **Thirty eight recommendations to support primary care in our state were collected** from primary care and other providers, payers, healthcare administrators, community health organizations, advocates, and consumers. Recommendations include connections to population health, care coordination, communications for both patients and providers, to lighten operations and administrative burdens, finances and incentives, services, workforce and practice, and policy. Only six of the 38 recommendations would raise on primary care spending, but all would make primary care better and improve health outcomes in our state.
2. **Provide full transparency in everything**, including decision making, background materials, and consultants' role and performance.
3. **Re-start the cost cap project with diverse committees** with broad representation to ensure diverse viewpoints, avoid cronyism, build trust and engage everyone in solutions that can succeed.
    a. Use Connecticut's time-tested method of choosing members by public official bipartisan appointments, nominations from the public and stakeholder groups, and objective qualifications.
    b. Make all documents, deliberations and votes public and on-the-record. Post all in timely fashion without requiring Freedom of Information requests, which are moving very slowly currently at OHS.
    c. Engage group members based on qualifications and lack of conflicting interests.
4. **Evidence-based social and associated clinical services have great potential to improve the quality of life, prevent and manage disease while controlling health costs.** Increase spending directly on social determinants of health to lower healthcare costs. Do not rely on donations or run funding through insurers, employers, ACOs/large health systems, or provider practices and hope it will trickle down to where it's needed. These organizations aren't qualified or equipped to identify best/most effective use of resources in communities. Large entities and payers are often distant from direct community voices who are in the best position to identify needs and opportunities. They are too often financially, personally, or operationally conflicted – for instance choosing to fund (or purchasing) corporate partners, favoring personal, or charitable connections, choosing options that are operationally easiest for their organization to fund,

favor groups they've historically had contracts or financial relationships with, or groups with the most sophisticated and robust development and marketing programs.

5. The state should **suspend and begin reversing healthcare mergers and acquisitions.** There is strong evidence that consolidated markets raise prices for care, do nothing to improve the quality of care, and erode consumer choice.
6. Go beyond simple Return on Investment calculations and **consider improvements in healthcare** infrastructure for both ongoing needs and the next crisis. Prioritize building community strength, support for novel innovations with potential to generate more constructive reforms and supporting health equity.
7. **Things we can cut now to save money**
    a. **PCMH Plus** – It's not working, costs are up and quality of care is not improving. It's time to end this experiment and move onto things that could work.
    b. Cease any **planning to expand PCMH Plus to more fragile, costly populations** especially seniors and people with disabilities. There are far better options to improve care for this population that have been developed by diverse Connecticut stakeholder groups.
    c. Institute **risk adjusted per member per month payments for care coordination rather** than through attenuated, indirect value-based payments that may not be directed to improving patient services as intended.
    d. **Cut all funding for OHS's Health Information Exchange** – It isn't needed, and raises serious concerns about selling data to payers that could use it to deny care and cherry-pick patients. Current OHS development, with out of state consultants, is deeply flawed and has drawn criticism from hospitals required to connect to it by law.
    e. **Immediately suspend and reverse shifts in care that take advantage of increased reimbursements**, especially Medicaid, with no improvement in access to care or quality. Reverse OHS approval of Yale-New Haven's primary care clinic shift patients to community health center (CHC) payments that receive significantly higher Medicaid rates but the same YNHH staff providing the same care at a distant site owned by YNHH and rented to the CHCs. CHC Medicaid patients are far more likely to have to seek care at an ED than other Medicaid patients
8. **Connecticut is unique**. Trust is extremely low here, especially in healthcare. We must learn from other states' experiences but **do not copy-and-paste from other states' cost cap projects.** To be successful, engage, listen to, hear, and incorporate input from all stakeholders, especially Connecticut's consumers who ultimately bear all healthcare costs through our taxes, out-of-pocket costs, and lost wages. Decision-making must be based on Connecticut's environment, history, culture, healthcare structures, and demographics. Direct consultants to start with a clean slate.