Advisory Committee and Task Force recommendations on costs, savings, and financing

PATIENT CENTERED MEDICAL HOME ADVISORY COMMITTEE

Patient Centered Medical Home

- The SustiNet law directs the committee to make recommendations for early implementation of PCMHs to prioritize enrolling patients "for whom cost savings appear most likely."
- However, the Committee learned that practices are unlikely to undergo the hard work of transformation to a PCMH for only a subset of patients. Providers made it clear that they will not treat their patients differently; everyone gets the best care possible. Practices typically change the way they practice medicine for their entire population.
- The committee was also advised by PCMH leaders from other states to pilot the program first with practices that are enthusiastic about the concept, are willing to do the hard work of practice transformation, and most eager to change.
- Risk adjustment methods that give providers information on likely future health care events and costs for each patient, such as event probability modeling, are important tools to target resources and care management, especially for new patients. It is critical to provide these tools to PCMHs after they have accepted patients into the practice to ensure they are not used to select patients.
- Many providers, especially in small groups, will need upfront financial assistance to implement a PCMH. The SustiNet law provides for low interest loans and availability of reduced price consultants to facilitate practice transformation. This gives practices the resources they need while fairly recognizing the investment already being made by others without outside support.

Federal and regional funding and technical assistance opportunities

- It is critical that Connecticut take advantage of momentum at the federal level to support PCMHs. Connecticut should consider taking advantage, at minimum, of 90% Medicaid matching rates on PCMH services for people with chronic conditions, as this does not require a competitive application but only a state plan amendment. Connecticut should also consider whether a more general "health home" application under the Patient Protection and Affordable Care Act is warranted and fits with the structure of developing PCMHs in Connecticut.
- Connecticut should join the other New England states in developing a Medicare waiver for a multi-payer PCMH pilot. Connecticut should also join other states in a learning and evaluation PCMH collaborative to share resources and best practices.
- A multi-payer initiative, to include Medicare, is critical to developing uniform standards, data elements, evaluation criteria, focused studies, disease management, compatible data formats, and compliance processes for practices and removing important barriers to PCMH transformation. This should include an all-payer claims database for accurate evaluation of costs, practice trends, and provider performance.
- A multi-payer PCMH initiative allows for aligned incentives reducing efficiencies due to cost shifting between payers. Standardizing data collection and incentives across payers allows seamless tracking and ensures that quality incentives will be large enough to be salient to providers.

    - While PCMH evaluations must include cost effectiveness, it is critical to include benefits and costs across the health care system and should include avoidance of costs including impact on medical error rates, reductions in duplication of services, and administrative efficiencies. Baseline utilization measures, by individual, are important controls for cost effectiveness analysis and the impact of pent up demand for patients with historically low access, including the uninsured and Medicaid consumers, must be accounted for. Evaluations must include not only historical utilization before PCMH implementation, but likely

increases in costs in the alternative traditional medical model. It is important to include estimates for long term impact on health costs such as changes in rates of smoking or obesity and overweight.

- Cost effectiveness of the PCMH model must include impact on patients' and families' costs of care.
- Typical evaluation measures include hospital admissions, including readmissions and avoidable hospitalizations, appropriate use of medications, wellness and screening rates, and emergency room use. The committee urges caution in relying too heavily on one or a few metrics, such as emergency room use, which are ambitious goals and may require several rounds of system adjustment and time for patients to learn to trust the new system of care to see improvement. Evaluations should separate performance on processes practices control, such as completeness of wellness visits, in-office screening rates, from performance on health care processes not directly controlled by PCMH providers, such as hospital transition planning, referral compliance, and patients filling prescriptions.

QUALITY AND PROVIDER ADVISORY COMMITTEE

Goals for cost control

- Reduce and control growth in costs while maintaining quality through appropriate care

Principles for cost control

- Cost control must be achieved through a combination of price control and system redesign
- For cost control to be effective at reducing potential overtreatment and inappropriate utilization, providers must have liability protection if standards of care are met
- Cost control is the responsibility of all stakeholders, including providers, patients, payers and government
- Stewardship of plan resources through cost control is essential to optimize access, service, quality, and safety for all plan participants

Recommendations regarding cost control

1. SustiNet should engage with coalitions of employers and other payment stakeholders aligned to reduce costs. Coalitions should examine best practice standards and cost-benefit studies as a decision factor in developing recommendations regarding specific cost control measures.
2. Cost-saving measures should be introduced into SustiNet from its inception.
3. SustiNet should identify and secure Federal funding to support at least initial efforts of this work.
4. SustiNet should develop a policy to disclose and minimize financial conflicts of interest.
5. Industry detailing should be countered with academic detailing,
6. SustiNet should promote the formation of provider organizations willing and able to be accountable for quality and financial outcomes of care provided.

PREVENTIVE HEALTH CARE ADVISORY COMMITTEE

Cost-effectiveness

- Cost-Effectiveness: The preventive health care advisory committee should incorporate cost-effectiveness assessments into its decision-making on covered benefits whenever possible.
- Cost-effectiveness and cost-saving analyses provide an assessment of how much gain in "health" each preventive service will deliver for a unit of cost and should be reviewed and considered as a component of coverage decisions. These analyses can determine which services are likely to have the greatest return on investment and thus should be strongly encouraged, with reduced barriers to delivery and use.

- Cost effectiveness modeling should include projections of the actual dollar reductions to overall health care spending expected from specific prevention activities so that return on investment (ROI) analyses can be performed. The time horizon for these analyses should be appropriate to each prevention activity, often 3 years or more. Cost-effectiveness modeling should incorporate evidence-based research on behavioral responses to prevention initiatives. The committee should also consider recognizing social benefits in its cost-effectiveness modeling, such as improving school performance and reducing days missed from work.

Preventing the need for expensive tertiary care
SustiNet should address cost-effective tertiary prevention strategies by including quality and safety performance measures that promote improvements, such as:

- Reducing hospital readmissions within 30 days,
- Reducing preventable hospitalizations and emergency department visits,
- Reducing hospital acquired infections,
- Reducing the incidence of "serious reportable events" as defined by the National Quality Forum,
- Reducing adverse drug events, and
- Improving care transitions.

Note that in evaluating these measures, SustiNet must also evaluate the cause of reductions in service, for example, if emergency room visits decline, but there is increased use of other inappropriate and costly settings.

Health care providers require a wide range of resources and supports in order to provide preventive care services effectively. These resources and supports include, but are not limited to sufficient payment, HIT technical support, a medical home coordination team, and after-hours call support.

Government's Opportunities as an Employer: As employers, state and local governmental entities have an opportunity to drive a prevention strategy for their employees, the families of their employees, and retirees. In addition to providing a value-based health plan, such as SustiNet, government entities have three broad levers for driving a prevention agenda with the objectives of improving health, improving productivity, and containing health care costs:

(1) Creating a healthy and supportive work environment for employees that drives healthy behaviors at the workplace; private companies, such as Pitney Bowes and General Electric, have demonstrated significant return on these investments.
(2) Delivering preventive clinical services at or near the workplace; partnering with community clinicians to provide preventive services in or near the workplace increases the likelihood that employees will take advantage of these services.
(3) Giving employees, their families and retirees tools for more effective self-management of their health; for example, a patient-controlled, portable, electronic medical record.

HEALTH DISPARITIES AND EQUITY ADVISORY COMMITTEE

- The Committee believes that, in the long term, reducing disparities, increasing equity, and promoting better coordinated and culturally competent care for everyone will help to slow rising health care costs. Addressing the health needs of chronically ill patients through integrated care models will be particularly important in this regard. However, the Committee also acknowledges that treatment of widespread, unaddressed health care needs among vulnerable and disadvantaged people will require significant up-front investment from the State and federal government.
- The SustiNet Plan should establish a Pay for Performance (P4P) system to reward providers for reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes. The P4P system should reward providers for improvement as well as for meeting benchmarks. The P4P system should reward providers for having an effective plan in place for preventing illness, as well as improving health status.

- The SustiNet payment system should specifically reward providers for caring for patients with the most complex and least well-controlled conditions.

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE

Financial Considerations

1. Leverage federal ARRA grants to promote EHR adoption SustiNet should join efforts to leverage ARRA funds for health information technology and exchange in Connecticut:

- $5 million to community health centers for capital/operating support/HIT;
- $7 million for strategic and operational planning with implementation of selected projects by the State RHIO (DPH),
- $5.7 million to e-Health CT, Inc for physician training in meaningful use.

2. Develop a long term HIT/HIE funding stream

SustiNet, in conjunction with the work now underway at the state level, should participate in the consideration of a variety of business models for funding sources beyond the ARRA, including:

- User fees: HIE access fee; could be waived or pro-rated for those who contribute data
- Cost-avoidance: streamlined administrative/clinical processes yield savings to fund HIE
- Shared cost savings with health plans
- Medical claims tax/surcharge (e.g.,VT fee=2/10 of 1%/claim; PA tax=1/16 of 1%/claim).

TOBACCO CESSATION TASK FORCE

Savings from tobacco cessation

- Provide Medicaid coverage for tobacco use cessation (TUC) services. The American Legacy Foundation estimated that within five years, Connecticut would see annual savings of $91 million (2005 dollars) with a 50 percent decrease in smoking rates, and $18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking.
- Require all public and private health insurers to provide comprehensive tobacco usage cessation interventions, including counseling and all FDA-approved nicotine replacement therapies and pharmaceuticals. There are several business case studies that demonstrate significant cost savings to businesses that went smoke-free and provided smoking cessation benefits to their employees. Total excess cost of a smoking employee to a private employer is $4,279 per year.
- Integrate tobacco use cessation (TUC) interventions into medical encounters. The sooner a patient quits smoking, the more savings: tobacco dependence treatments cost savings **per life-year** saved is $3,539.

Advisory Committee and Task Force recommendations on public education

PATIENT CENTERED MEDICAL HOME ADVISORY COMMITTEE

- Despite strong public support for coordination of care, there is little public understanding of the PCMH model. A public education campaign to describe the model, its benefits to individuals, population health, and health care costs would support practices making this difficult transition as well as create momentum for other practices to consider the model.
- The public education campaign should emphasize information on the importance of showing up for appointments and the consequences of repeated no-shows.
- There is ample evidence that the US health care system often provides both too much and too little care to patients. While the public is acutely aware of the dangers of too little care, there is little understanding about the dangers of over-treatment. Unfortunately, public discussion about appropriate restraint in health care is often confused with emotional "rationing" arguments. One of the keys of PCMHs is providing appropriate care, which sometimes is "watchful waiting" or increased monitoring of a problem and delaying intensive treatment options to ensure they are indicated. PCMHs are built on a trusting patient-provider relationship which fosters a climate of more appropriate care. A public education campaign that includes information on over-treatment and its impact on health would support trust in those relationships and more effective treatment.

HEALTH DISPARITIES AND EQUITY ADVISORY COMMITTEE

- A financial and operational commitment to outreach among hard-to-reach populations will be crucial to bring as many people as possible into a more culturally competent health care system and realize the benefits of integrated and coordinated care delivery.

CHILDHOOD AND ADULT OBESITY TASK FORCE

- Create and maintain a database of treatment options throughout the state for use by health professionals and consumers. This can include educational tools (e.g., videos for families, toolkits for office providers), and a "hotline" for an initial family consultation with an expert on community resources who can connect the family with local programs and providers.
- Ensure that SustiNet adequately covers all empirically supported components of obesity treatment for children and adults, including nutritional counseling, parent education (especially for early childhood years), and long term support for bariatric surgery patients and others who have achieved weight loss. Coordinate efforts to obtain insurance coverage from other companies in the state.
- Fund a peer education network for pediatricians as a two-year pilot program at $130,000 per year. Assess impact on level of care received by patients and weight status of patients after two years.
- SustiNet should cover prenatal education services generally and ensure that service areas include motivational counseling about nutrition and prenatal exercise.

TOBACCO AND SMOKING CESSATION TASK FORCE

- Require age-appropriate life skill education in grades K-12 in Connecticut that address anti-tobacco education, drug and alcohol use prevention, nutrition, stress management and exercise.

WORKFORCE TASK FORCE

- The state should create a coordinated statewide outreach campaign with input from all stakeholders to encourage students to pursue shortage professions targeting minority students, with detailed information on shortage professions, resources, career counseling for parents and students, location and qualifications for shortage professions.