

Testimony to the Health Care Cabinet

Presented by: Timothy M. Elwell, Ph.D., M.B.A.

Affiliations: President & CEO, Qualidigm; Member of the Connecticut Partners for Health (CPH); Vice President of the Connecticut Partnership for Patient Safety (CPPS); Co-Chair of the Connecticut Choosing Wisely Collaborative (CCWC); and a Board Member, eHealthConnecticut (State Regional Extension Center)

Date: November 15, 2016

Amended Date: December 8, 2016

Regarding: Comments in support of the Connecticut Health Care Cabinet's recommendations.

Hello, I am Dr. Tim Elwell, President and CEO of Qualidigm, a not-for-profit, mission-driven, healthcare consulting organization with headquarters in Wethersfield, CT and offices in Rhode Island, Vermont, and New Hampshire. I represent a regional Quality Improvement Organization whose focus has been on supporting the interest of Medicare beneficiaries for 35 years. We have created a brand based on trust that has established many successful collaborations at the community as well as at the organizational level throughout Connecticut. Qualidigm is also the state's technical assistance consultant and practice transformation content expert who has led over 200 PCMH NCQA certifications in the state, more than any other organization, in support of the State Innovation Model's Advanced Practice Model.

First, I congratulate the Health Cabinet for its leadership and courage in setting forth a number of bold agenda items. Second, I come to you today to speak in support of strategy 1A, 1B, 1C, 2A, 3B, 5A, 6 and 7. In particular, I am supporting the Cabinet's desire to shift from volume to value and its desire to move to risk-based contracting, in accordance with the rest of the United States and the direction set by the Secretary of Health and Human Services. I believe, which I will submit as part of an addendum to my testimony, the presumption that our fee-for-service payment construct for our Medicaid program is efficient and has saved money may be overstated when compared with our New England neighbors. I also believe the longer that we delay in moving aggressively toward value-based payments, we, as a state, will fall further behind the rest of the healthcare market, which will create an undesirable payment environment for our providers. If we continue on our present trajectory, the result of these delays will lead to the continued loss of providers, which will have negative consequences on access to care for our citizens. Furthermore, I strongly support the need to implement integration strategies that will improve transparency, including the implementation of the All Payer Claims Database, and the installation of a working health information exchange (HIE) for the state that will assist us in the evaluation of provider performance and align cost and outcomes so that patients may make informed decisions. Also, I support the need for improved accountability so that state programs

are evaluated regularly for effectiveness and competition is introduced so that innovation is encouraged. Lastly, I applaud the Cabinet's support for improved collaboration across departments with the hope that valuable social determinants of health information may be made available and combined with both medical and behavioral provider-held clinical information, with a focus on health equity, so that the best outcomes for our citizens, regardless of socio-economic or racial status, may be achieved. Qualidigm and our partners stand ready to support these initiatives. Thank you.

Addendum

Support for Testimony

Amended Support for the Qualidigm Testimony:

Based on feedback received from the Department of Social Services Commissioner Roderick Bremby, and comments made by a consumer advocate, I am submitting this amended support document as my intent was not to offend any department or group. Qualidigm has enjoyed a good working relationship with DSS on all levels and it is our desire that this relationship may continue, despite our differences. However, as a concerned citizen, who runs a business with headquarters in Connecticut, and who is committed to making investments in Connecticut, I remain concerned about the direction the state is headed relative to controlling our healthcare costs in the Medicaid program. These concerns have only been heightened with the results of the November elections and the current discussions concerning potential new Federal mandates including block grants. My comments are not meant to alienate, but to promote support for a number of the Bailit recommendations, which are centered on the need to lower costs while improving outcomes. It is my sincere hope that any discrepancies in understanding may be examined and explained so that we all have a better understanding of the alternatives and the consequences concerning changes in direction. Lastly, while we may not all agree on the specifics, I am hopeful that we all may agree on the goal of equitable treatment of all our citizens in the most cost effective manner that yields the best outcomes.

Who is Qualidigm?

The Connecticut Peer Review Organization, Inc. d/b/a Qualidigm has been a Connecticut-based, not-for-profit, mission-driven organization for nearly four decades. Our mission is to improve the quality, safety, and cost-effectiveness of healthcare through transformational change. While our focus is on Connecticut and New England, we perform services across the United States. Qualidigm has earned an excellent reputation and developed a strong brand through its work as the quality improvement organization (QIO) for Connecticut. Central to our values are transparency, integrity, and the development of trust. Anything that we do or say that places that position of trust at risk is of great concern to me.

Because we perform work across the nation and are apprised of the healthcare landscape, we are concerned that Connecticut is falling further behind other states in its ability to provide innovative healthcare solutions that will reduce cost and improve patient outcomes. Bailit was commissioned to perform its study because others feel that it is appropriate to explore alternative models. Thankfully, the Bailit recommendations made a number of excellent points worth serious consideration, which were supported in my testimony. After being asked to provide testimony, I felt compelled to voice my concerns about the direction Connecticut is headed, with the hope that alternative views might be invited and heard without reprisal.

Why are things different now?

Accountable care organizations (ACOs) under the Medicare Shared Savings Plan (MSSP) represent a recycled attempt to rebuild the integrated delivery systems of the 1990s (Mulvany, 2010). Previous integrated delivery systems sought to encourage collaboration between various stakeholders but failed to achieve their desired outcomes of lowered costs and improved patient healthcare outcomes. Unlike previous healthcare delivery models, the government's MSSP initiative provides legislated funding to improve the likelihood for success. Other attempts to rein in costs included the institution of health maintenance organizations through the Health Maintenance Act of 1973, pay-for-performance, and preferred provider organizations in the 1990s in which capitated arrangements with providers were established and episodic payments were based on historical fee-for-service data (Numerof, 2011). Unlike earlier managed care efforts that limited one's choice of providers, the ACO is not designed to constrain which provider the beneficiary chooses to visit (Berwick, 2011). However, ACO opponents fear that the construct has introduced an untested new organizational structure that will advantage larger provider organizations and reduce competition, which may be counter-productive to its goal of cost effectiveness and improved quality (Numerof, 2011). The question that the Cabinet needs to address is whether this fear is warranted.

Providers are already accepting risk!

Some might argue that providers are not yet accepting risk. In fact, as of April 2015, 99% of the ACOs participating in the Medicare Shared Savings Program (MSSP) participated in the one-sided payment plan (CMS, 2015). However, in a review of what ACOs under the MSSP must do, Moore and Coddington (2011) identified that to meet the CMS requirement of managing the health of a defined population and to manage risk adequately for their populations and drive anticipated savings, ACOs needed to make major investments. For instance, in two hospital-based examples, Moore and Coddington indicated that ACO organizers needed to: develop networks of appropriate providers; create a supporting infrastructure including technology investment such as electronic health records, connectivity, data analysis, and quality reporting; invest in management; and create a culture that was motivated to meet the financial incentives that the shared savings plan outlined. The authors also indicated that the ACO needed to work as a unified, coordinated organization. In their two prototype organizational examples, Prototype A was a 200-bed hospital system-based ACO with 80 primary care providers and 150 specialists; Prototype B represented a 1,200-bed, five-hospital system with 250 primary care providers and 500 specialists (Moore & Coddington, 2011). The anticipated first year costs for Prototype A included a start-up estimate of \$5,315,000 with ongoing annual costs of \$6,300,000. Prototype B start-up costs were anticipated at \$12,000,000 with ongoing annual costs of \$14,090,000. In both cases, although both ACOs were not engaged in downside risk associated with payments, they were both at financial risk relative to offsetting their IT investment. Already, we have heard from Kurt Barwis, one CT-based hospital CEO, and a member of the Healthcare Cabinet, who remarked in your meeting on November 1, 2016 that in actuality, his hospital is engaged in risk-

based arrangements because of the high investment costs that they must recoup. Accepting this assumption that many in CT are engaged in risk-based models, a case may be posited that providers are currently engaged in risk and the fears of moving to a risk-based model are unwarranted.

Foot in two canoes!

The frequent analogy used to describe today's healthcare reimbursement model pictures a provider with one foot in a "*fee-for-service*" canoe and another foot in a "*value-based*" canoe. The problem with this picture is that the provider will ultimately get wet, which is the direction that Connecticut is headed by delaying its move toward risk-based value contracting. While some initiatives, such as the Advanced Medical Home (AMH) model and the Community and Clinical Integration Program (CCIP) which fall under the State Innovation Model (SIM) program, and PCMH+ are assisting providers to accept risk by helping them to align quality and outcomes with payments, concern has been voiced related to moving from a fee-for-service model to a risk-based model. Fee-for-service represents a broken model that provides incentives for volume over value. In fact, at a time that HHS Secretary Burwell has set aggressive goals for the Medicare program to move to 50% value-based payments by 2018, CT continues to be only one of three states in the United States that has not accepted a risk-based managed care or primary care case management construct and continues to pay providers 100% on a fee-for-service basis (Kaiser Commission, 2015). However, statements have been made that our current fee-for-service approach has been successful in reining in costs and is a model for the United States. The concern with these statements relates to the mix of the patients that is included in the measures, compared with years past and how we, as a state compare with our New England neighbors.

Swimming in the opposite direction

According to the October 2015 Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by the Health Management Associates report that I referenced in my testimony, Connecticut, Alaska and Wyoming are the only three states in the United States paying claims based on a 100% fee-for-service (FFS) model. (Please see the attached Table 5 from the report). As the Bailet report recommends, we need to look at ways to move toward risk-based payment contracts. Admittedly, our State's move toward APM via the PCMH+ program is a great step forward; however, our current payment structure remains as a FFS-based payment system. Today, 94% of the states, including the District of Columbia, have made the move to some type of managed care, which includes inherent risk or to a primary care case management-based system. I remain concerned that unless we can demonstrate dramatic improvements in cost reductions and outcomes compared with our neighbors, Connecticut appears to be moving in the wrong direction. Therefore, while I applaud the PCMH work that that has been completed throughout the state which will help providers prepare to take on risk,

current acceptance of risk has not occurred. The Bailit recommendations recommend a move toward risk, which we support.

An argument that could be made is that it does not matter that Connecticut has moved in a different direction because our outcomes are better or our costs are better than others. However empirical evidence casts doubt on this assertion. For instance, below, **Table 1** lists the Medicaid budgets from each New England state and calculates the average cost per beneficiary by state. The approach we have used is necessary in an attempt to normalize the costs, so that meaningful comparisons may be made. As indicated in my reference, this information is taken from the CMS Form 64, a publically available document for all states.

Table 1 – Spend per Medicaid Recipient by New England State

New England State	2015 Total Dollars Spent ¹	Average Number of Medicaid Recipients for 2015 ²	Total Dollars Spent Per Medicaid Recipient	Variance Compared with CT
Maine	\$2,580,219,327	275,819	\$9,355	-2.6%
New Hampshire	\$1,731,859,115	182,570	\$9,486	-1.3%
Massachusetts	\$15,564,425,180	1,832,725	\$8,493	-11.6%
Connecticut	\$7,853,582,804	817,506	\$9,607	0.0%
Rhode Island	\$2,598,444,116	275,763	\$9,423	-1.9%
Vermont	\$1,634,622,218	202,352	\$8,078	-15.9%

Notes:

¹ www.kff.org/medicaid/state-indicator (Urban Institute estimates based on data from CMS (Form 64), as of September 2016)

² CMS Form 64 Reports for 2015

The results from **Table 1** indicate that the cost per Medicaid beneficiary in the other New England states ranges from 1.3% to 15.9% less than the cost per Medicaid beneficiary in Connecticut. Each of our New England neighbors has instituted some form of risk-based managed care or primary care case management-based system into their Medicaid program. It should also be noted that in the recent fiscal accountability reports issued by the Office of Policy and Management and the Office of Fiscal Analysis, Medicaid spending has been identified as one of the top four fixed-cost drivers producing the budget deficit for FY18.

For each percentage point that Connecticut can reduce its Medicaid spend, the state stands to save \$78.5 million. By simple extrapolation, it would appear that Connecticut has an opportunity to reduce its Medicaid spend by over \$100 million if we were able to come in line with our

closest New England neighbor. When the State is looking at a \$1.2 billion budget deficit in 2018, one might argue that we must be looking at alternatives.

At a time when the HHS secretary is setting aggressive targets at moving to value-based payments, we do not feel that it is in CT's best interest to row in the opposite direction. CT is working hard to help prepare providers for value-based reimbursement, which will require accepting risk. Options such as consumer surveys, secret shoppers, and closely monitoring quality and outcome measures are examples of approaches that may ensure that all beneficiaries are being served appropriately. Additionally, periodic external evaluations of our programs by third-party, unbiased groups are needed to determine if progress is being made.

MACRA is coming...

While CT continues to be slow in adopting or accepting risk-based contracts, MACRA reform is underway. Since MACRA was the Republican's response to eliminate the Sustained Growth Rate and had received bipartisan support, we believe that this will be a program that will remain. Already, benchmarking has begun in long term care and home healthcare. In January 2017, baseline measurements for physician practice will begin, and based on our experience, many of the providers are not prepared. Unless the state helps providers to prepare for the MACRA change, which will be based on upside and downside risk, our providers will be penalized. As our providers fall further and further behind, the Connecticut market will become less attractive and we will see a further exodus of skilled providers as they move to more supportive markets. With nearly 30% of our providers 60 years or older (AMA Physician Masterfile, 2012), Connecticut can ill afford to create a provider environment that cannot support practices. When beneficiaries lack sufficient access to adequate providers, regardless of insurance type, the healthcare system in Connecticut will be disadvantaged. We can no longer ignore these trends. In fact, we believe the Bailit Health report has begun to create a healthy dialog around this very issue.

Social Determinants, CBOs and Funding moving forward

Additionally, at a time when one's zip code has a higher predictive value on one's healthcare outcomes than the medical therapy or prescription one receives from a provider, we believe it is now time to invest in the integration of public health and healthcare. However, to invest in this integration, funding sources must be established and tapped. Such an effort will require that DSS, DPH, OHA, DDS, DHMAS, and others, including knowledgeable partners such as the Qualidigm-led Connecticut Partners for Health, to work together to make this integration possible. This combination of valuable data, combined with real-time clinical information and predictive analytics, will help to identify the most vulnerable in our communities. By doing so, safeguards may be placed in our healthcare delivery system, including improved behavioral health and social worker access, to improve outcomes. To achieve this goal, we recommend a pilot focused on the dual eligible population. Lessons learned from this pilot will help lay the

foundation for the development of community-based organizations, similar to the Health Communities Model that was never funded.

Final Comment:

Qualidigm, like many Federal and state healthcare departments, is not unique in supporting the *Triple Aim* as put forward by the nationally-recognized quality improvement expert and Connecticut native Dr. Donald Berwick. As a result, while we may have some disagreements relating to the path forward, I believe most of us and our organizations agree on much more than we disagree. For instance, in the State of Connecticut, we fully support the DSS commitment of encouraging practices to become PCMH recognized. DSS has been courageous in the creation of its enhanced payment program in support of this need. The alignment of incentives by coupling financial rewards with milestone development is critical in achieving meaningful behavioral change. However, until we see improved outcomes at lower costs, these process improvements are not sufficient.

My sincere hope in the Health Care Cabinet process that solicits comments from the public is that the Cabinet can successfully pull together the many disparate voices across Connecticut and begin to identify where we all agree. Certainly, improved health care outcomes at a lower cost must be on that agenda. While debates are essential to the process, arguments in support of the status quo will not permit the needed transformational change to occur. We recognize that no one department or organization can take on this massive challenge alone. With a proven track record of being able to pull many various disparate groups together, we and our partners would like to assist in gathering talent from across the state to create plausible solutions predicated on reasonable approaches. We cannot continue to do things the same way and hope for a better outcome.

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Referenced Connecticut Companies and Collaborations



With its corporate headquarters in Wethersfield, Conn. and offices in Dover, NH; Barre, VT; and Providence, RI, Qualidigm's mission is to improve the quality, safety, and cost-effectiveness of healthcare through transformational change. Qualidigm provides consulting services to public and private sector clients nationwide and is the State of Connecticut's advanced transformational practice consultant partner in support of the State Innovation Model. In addition to consulting in quality improvement, health information technology, patient safety, and utilization review, we also perform data analysis and primary research. Qualidigm is part of a team that is serving as the Medicare Quality Innovation Network Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare and Medicaid Services for New England. Finally, Qualidigm is a Patient Safety Organization (PSO) as designated by the State of Connecticut.

www.Qualidigm.org



Founded in 2013, CT Partners for Health is a working group of over 30 Connecticut healthcare stakeholders representing healthcare providers and trade associations, consumer organizations, health plans and payers, community-based organizations, academic institutions, government agencies, quasi-government agencies, voluntary health organizations, the Regional Extension Center, and the business community. Qualidigm convenes the group regularly to identify and develop strategies for managing healthcare-related issues that present challenges to the consumer and provider communities in Connecticut. The CT Partners for Health's vision is to achieve the triple aim of the National Quality Strategy: Better Care, Healthy People/Healthy Communities and Affordable Care. Its mission is to align healthcare quality improvement and patient safety initiatives in Connecticut to assure efficient, cost-effective and coordinated efforts among its healthcare providers and stakeholders. Qualidigm serves as the chair of CPH.

www.ctpartnersforhealth.org/



Founded in 2014, The Connecticut Partnership for Patient Safety (CPPS) offers a patient safety-focused forum that is free of self-interests and that promotes transparency, inclusion, and debate towards the creation of an informed, and trusted and trusting organization. The organization strives to promote non-punitive policies that improve the culture of patient safety across the state of Connecticut. The mission of CPPS is to create a culture of patient safety across the healthcare continuum through a statewide collaboration that provides education and consultation. Qualidigm serves as the Vice President on the Executive Board of Directors.

www.safehealthcarect.org



Founded in 2014, the Mission of the Connecticut Choosing Wisely Collaborative (CCWC) is to raise awareness among groups in Connecticut about Choosing Wisely™ by creating a community made up of patients & consumer groups, employers & payers, practitioners and health systems, state government officials and policy makers. The group aims to accelerate the adoption of Choosing Wisely by sponsoring programs, facilitate and advocate for specific initiatives that address misuse and overuse. Additionally, CCWC actively creates avenues for local programs to get access to national and CT-based CW resources. Qualidigm serves as Vice Chair of the Leadership Council.

www.choosingwisely.org/partners/connecticut-choosing-wisely-collaborative



Founded in 2006, eHealthConnecticut is a not-for-profit entity that represents a collaborative approach to meeting the challenges of health information technology adoption and interoperability for the entire State. A Board of Directors representing physicians, providers, consumers, purchasers, payers, academia, and quality organizations governs eHealthConnecticut. eHealthConnecticut operates in a transparent fashion with the necessary privacy and security protections in place to earn trust from all entities and the general public. Qualidigm serves as the organization's fiscal agent and serves on its board.

www.ehealthconnecticut.org