Connecticut Health Policy Project

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Fifteen ways to save money in Connecticut's health care budget
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With the state facing significant budget deficits and a new Governor preparing to take office, we have updated our list of policy proposals to save money in Connecticut's health care budget. Across-the-board cuts are counter-productive and unnecessary. There are not only areas of the budget where significant savings can be achieved, but initiatives that could also improve the delivery and quality of health care. These are not experimental -- most of these ideas have been tested and are being used successfully in other states and by other payers. There is no shortage of innovative ideas and willing partners to improve our state's health care system and save money.

It is important to note that significant savings to the state budget, as well as Connecticut employers and households, are likely due to SustiNet reforms.[i] Some of the savings outlined below are likely to be incorporated within SustiNet estimates and some are independent. Information on projected savings from SustiNet is expected soon.

1. Implement patient-centered medical homes for every member of state coverage plans. Medical homes coordinate fragmented services and give patients the tools and support they need to improve and maintain their own health status. Medical homes reduce the need for specialty care, improve access, reduce duplicate tests, reduce unnecessary and conflicting medications, keep patients out of emergency rooms, and improve patient safety by strengthening the patient-provider relationship and by emphasizing primary care and prevention.[ii] National health reform includes several funding opportunities for states to implement and support patient-centered medical homes.[iii] Under the leadership of the Comptroller's Office, Connecticut has applied for federal approval of a patient-centered medical home pilot to include Medicaid, Medicare and state employees, potentially reaching over 1 million state residents.[iv]
Potential savings: $71 to $530 per person per year[v]

2. Implement Primary Care Case Management statewide for the HUSKY program. Committing attention and resources to ensure a robust program that attracts providers and consumers, is accountable for outcomes, serves as honest competition to the HUSKY HMOs (motivating them to perform) would provide Connecticut taxpayers with significant savings. An alternative to troubled HMOs and based on the patient-centered medical home model, Primary Care Case Management (PCCM) is built on delivering care through a team of providers and giving patients the tools and support they need to keep themselves healthy. PCCM not only saves money but invests in primary care and care coordination, sorely needed capacity in Connecticut. PCCM has been implemented and is saving money in thirty other states. Oklahoma saved $86 million in the first year after transitioning from HMOs to PCCM[vi], North Carolina saved between $150 and 170 million with PCCM in 2006[vii] and Illinois saved $320 million last year after their transition to PCCM.[viii] Families in these states have experienced improved

quality of care, higher provider participation rates and reductions in emergency room visits in addition to reductions in state spending. To date, Connecticut has implemented this important program in only a limited number of communities. The state has also set several artificial barriers to participation for both consumers and providers, including a failure to devote resources equal to those committed to HUSKY HMO, and administrative barriers to provider and consumer participation.[ix] National health reform includes a provision allowing a state plan amendment providing 90% matching funds for care management services for Medicaid recipients with chronic illnesses.[x]
Potential savings: $40 to 50 million[xi]

3. Recover overpayments to HUSKY HMOs. $50 million in HUSKY HMO rate overpayments were identified last year in an independent audit by the Comptroller's Office.[xii] In a program that totaled over $787 million last year, this is a significant source of savings. The savings were included in the FY 2010 and 2011 state budgets but DSS has yet to reduce HMO capitation rates. Authorizing the Comptroller's Office to regularly repeat this audit would ensure the state is paying a fair price for services.
Potential savings: $50 million or more

4. Move HUSKY to self-insurance. Last year's state budget included over $76 million in savings by moving HUSKY from the current fully insured arrangement to an Administrative Services Organization model.[xiii] However DSS has not implemented this change and has no plans to do so, leaving HUSKY in the capitated health system that has been blamed for restricting care to families and driving up state health costs. Most large health care purchasing groups are self-funded, including the state employee plan, allowing more transparency and levers for cost control. In 2009 HUSKY's three HMOs made $19 million in profits;[xiv] if the program had been self-funded last year, the state would have captured those savings.
Potential savings: $76 million in first year, $19 million each year after[xv]

5. Rebid HUSKY and all state health care purchasing on a regular basis. After creating the program in 1996, the state did not re-bid the HUSKY program until 2008, and then only to create the joint HUSKY-Charter Oak program. The state employee plan, like most large purchasing pools, is rebid every three years to ensure the state is getting the best possible price for services. DSS should rebid services for the HUSKY program on a regular basis. The state needs to strengthen its position in negotiations for HUSKY services. When HUSKY briefly moved to self-insured status in 2008, HMOs were paid $18.18 per member per month (pmpm) for minimal administrative functions; in 2009, when administrative costs come out of their capitated rates, the same HMOs managed to provide a larger array of administrative services for only $13.24 pmpm on average.[xvi]
Potential savings: potential significant state savings

6. Build robust wellness programs for state coverage plans. A new study of wellness programs found that every dollar spent returned $3.27 on the investment in reduced medical costs and $2.73 in reduced absenteeism.[xvii] Successful programs emphasize consumer incentives over penalties. The new administration should allow consumer rewards for risk assessments and healthy behaviors into state wellness programs.
Potential savings: $43 million for state employees alone[xviii]

7. Create a shared-savings plan for all state coverage plans to engage consumers in both identifying and reporting fraud, waste and abuse and in generating ideas for innovation. The successful Medicare Senior Patrol program developed by the US Administration on Aging provides an important guide.[xix] Use the "wisdom of crowds" and the network of hundreds of thousands of consumers to drive improvement.
Potential savings: difficult to estimate, possibly $40 million or more[xx]

8. Expand urgent care center and retail clinic capacity. A recent study found that between 14 and 27 percent of all emergency department visits could be safely provided at urgent care centers or retail health centers[xxi] costing less than half or one third than at emergency departments for the same service.[xxii] Connecticut hospital emergency departments are increasingly overcrowded, particularly with Medicaid patients, driving state budget costs. It is critical to ensure safe, quality care at urgent care centers and retail clinics by requiring certification by national accrediting bodies. It is also critical to coordinate care with appropriate primary care in patient centered medical homes. Electronic linkages to area primary care providers should be required of all clinics and centers, including the ability to make appointments, and incentives to divert patients back to appropriate care. To save money in the state's growing Medicaid budget, urgent care clinics and retail clinics should be rewarded for building capacity in underserved areas.
Potential savings: $10.5 million in HUSKY alone[xxiii]

9. Implement payment reform for all state health care purchasing and support all-payer initiatives to reduce overutilization and pay for quality. This includes a variety of initiatives implemented in other states such as pay-for performance for both providers and managed care plans, paying for episodes, or bundles, of care in one payment across the care continuum rather than paying fees for each individual service, and eventually making global care payments for individuals, risk adjusted to account for varying levels of need. The state should incorporate Value Based Insurance Design into coverage programs providing consumers with personalized incentives to improve their health. While preserving competition and recognizing anti-trust concerns, the state should take a lead role among payers in developing Accountable Care Organization arrangements in our state to align incentives for efficiency among providers across the care continuum. Maine and Minnesota have led states in bringing together employers with government payers to align standards and incentives, share oversight resources, improve the quality of care and reduce rising costs.[xxiv] National health reform includes several funding opportunities for implementation of payment reform models.[xxv]
Potential savings: $126 million in Medicaid[xxvi]

10. Promote and require the use of health information technology tools, including provider electronic medical records and consumer personal health records, for all state coverage programs. Support the development of a secure, private, user-friendly health information exchange for all state residents. Strong privacy protections, including opt-in consumer consent policies, are critical to the integrity of health information exchange and a viable statewide system.[xxvii] Competence in health information technology is gaining interest as a component of physician licensure and renewal standards.[xxviii] The pilot health information exchange being developed by eHealthConnecticut for Medicaid recipients could serve as a template for the state.
Potential savings: $100 million in Medicaid[xxix]

11. Use transparency and market forces to improve cost effectiveness of care by providing consumers with comparative quality and cost data. Maine, Pennsylvania and Minnesota have led states in developing publicly available comparisons among providers based on quality and cost data. Public quality reporting gives consumers the tools to choose the best health care value and comparisons with colleagues has been very effective in motivating providers to improve.[xxx]
Potential savings: potential significant state savings

12. Reduce prescription drug costs with a provider education (counter detailing) campaign, on the relative costs and effectiveness of medications; limit gifts to providers from drug companies; require disclosure of all financial ties between providers and suppliers; prohibit direct industry funding of provider Continuing Medical Education training. All these measures have been adopted by Massachusetts in their health care cost containment reforms.[xxxi] Much can be done to encourage generic drug use and mail order delivery savings among Medicaid consumers.
Potential savings: $35 million in Medicaid[xxxii]

13. Expand public health programs that give patients tools to take responsibility for their health including care coordination, disease management, risk assessments, disease screenings and immunizations on a community level to prevent disease and manage chronic illness. Connecticut's program providing free nicotine replacement therapies was overwhelmed and had to be shut down early because demand outstripped the budget. Vermont's Blue Print for Health can serve as a template for Connecticut.[xxxiii]
Potential savings: potential significant state savings

14. Assess areas of over and under capacity in Connecticut's health care workforce. The nursing shortage has been a significant driver of hospital costs, in particular, while there is evidence that an over-abundance of physicians in an area can increase costs.[xxxiv] As our population ages, chronic diseases multiply, and the practice of medicine changes, it is critical that Connecticut monitor and regulate its health care workforce. The federal WISH grant secured by the Connecticut Employment and Training Commission and the Allied Health Workforce Policy Board will provide a roadmap to thoughtful health care workforce development keeping labor costs in check, preserving quality care and growing jobs as well as creating an opportunity for Connecticut to access further workforce development funding.
Potential savings: potential significant state savings

15. Develop a public education campaign about appropriate health care treatment. Consumers facing an increasingly complex health care environment can be misled by industry interests threatened by reductions in profits. A coordinated, thoughtful campaign to educate consumers about the dangers of overtreatment and mistreatment,[xxxv] that more care is not always better, the important new lessons of comparative effectiveness research to improve the effectiveness of care, to counter misinformation about "rationing" and gatekeeping, and the benefits of coordinating health care through a patient-centered medical home will engage consumers in improving the effectiveness and value of health care.
Potential savings: potential significant state savings

[i] http://www.ct.gov/sustinet/site/default.asp
[ii] Patient Centered Medical Homes: The Fix for Our Health Care System?, CT Health Policy Project, June 2009, http://www.cthealthpolicy.org/medicalhome/patient_centered.pdf
[iii] Patient Centered Medical Homes in the Patient Protection and Affordable Care Act, CT Health Policy Project, May 2010, http://www.cthealthpolicy.org/medicalhome/20100516_pcmh_and_federal.pdf
[iv] Connecticut's Patient Centered Medical Home Medicare Application, CT Health Policy Project Policymaker Issue Brief No. 54, September 2010, http://www.cthealthpolicy.org/briefs/issue_brief_54.pdf.
[v] D. Fields et. al., Driving Quality Gains and Cost Savings through Adoption of Medical Homes, Health Affairs 29:819-826, 2010.
[vi] SoonerCare Choice – Oklahoma's PCCM Program, presentation to New England Medicaid Directors Meeting, January 2008.
[vii] Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid, Kaiser Commission on Medicaid and the Uninsured, May 2009, http://www.kff.org/medicaid/upload/7899.pdf.
[viii] Success Stories and "Lessons Learned" from PCMH Initiatives in the Field: Report on the Nation's Largest Medical Home, IL Academy of Family Physicians, October 2010.
[ix] CT Health Notes Blog, Medicaid Managed Care Council PCCM Subcommittee.
[x] Patient Centered Medical Homes in the Patient Protection and Affordable Care Act, CT Health Policy Project, May 2010, http://www.cthealthpolicy.org/medicalhome/20100516_pcmh_and_federal.pdf
[xi] Based on conservative estimate savings $100/year (see D. Fields above) for 400,000 (current) to 500,000 (conservative after health reform) enrollees
[xii] HUSKY Capitation Rate Review, SFY2009 Final, Milliman, Office of State Comptroller, May 2009, http://www.osc.state.ct.us/reports/health/dssaudit.pdf
[xiii] Connecticut State Budget 2010-2011 Revisions, Office of Fiscal Analysis.
[xiv] DSS report to Medicaid Care Management Oversight Council, October 8, 2010.
[xv] Connecticut State Budget 2010-2011 Revisions, Office of Fiscal Analysis, $19 million HUSKY HMO profits 2009 (see xii above).
[xvi] DSS reports to Medicaid Care Management Oversight Council.
[xvii] K Baicker, et. al., Workplace Wellness Programs Generate Savings, Health Affairs 29:1-8, 2010.
[xviii] $214 per person annual savings medical costs (see xv above) X 200,000 state employee plan members.
[xix] http://www.aoa.gov/AoAroot/AoA_Programs/Elder_Rights/SMP/index.aspx
[xx] Medicaid fraud estimates are very difficult to quantify but potential is significant (Medicaid Fraud and Abuse, GAO June 28, 2005, http://www.gao.gov/new.items/d05855t.pdf); it has been estimated that up to 10% of Medicaid billing is fraudulent, if 10% of that could be reduced through consumer education and incentives, it would total $40 million for CT's budget.
[xxi] R. Weinick et. al., Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics, Health Affairs 29:1630-1636, September 2010.
[xxii] M Thygeson et. al., Use and Costs of Care in Retail Clinics Versus Traditional Care Sites, Health Affairs 27:1283-1292, September/October 2008.
[xxiii] 38% of HUSKY children visited an ER at least once during 2007 (Emergency Care for Children in HUSKY A:2007, CT Voices for Children, April 2009), assuming an equal rate across the 400,000 population and assuming only one visit/year (conservative estimate), savings using clinics/centers over ED average $345/visit, estimate 20% reduction in ED use (based on xix above)
[xxiv] Value over Volume, Council of State Governments/Eastern Regional Conference, February 2010, www.valueovervolume.org.
[xxv] Patient Protection and Affordable Care Act, (P.L. 111-148) Title II, Subtitle I.
[xxvi] $300 to 400 savings estimate per Medicare enrollee (E. Fisher, et. al., Fostering Accountable Health Care: Moving Forward in Medicare, Health Affairs 28:w219-231, January 2009), 90% proportional pmpm spending Medicare to Medicaid for CT (Kaiser State Health Facts), 400,000 estimated enrollment current

[xxvii] Public comment submitted to the CT Health Information Technology and Exchange, CT Health Policy Project, June 23, 2010, http://www.cthealthpolicy.org/pdfs/20100623_eHealth_DPH_plan_testimony.pdf

[xxviii] H Chaudry, Federation of State Medical Boards: Maintenance of Licensure and Health IT, Health Affairs Blog, August 5, 2010, http://healthaffairs.org/blog/2010/08/05/fed-of-state-medical-boards-maintenance-of-licensure-and-health-it, K Weiss and S. Horowitz, American Board of Medical Specialties: Aligning Maintenance of Certification and Meaningful Use, Health Affairs Blog, August 5, 2010, http://healthaffairs.org/blog/2010/08/05/amer-board-of-med-specialties-aligning-maintenance-of-certification-and-meaningful-use

[xxix] 2.5% savings estimate (R Hillestad, et al, Savings in Electronic Medicaid Record Systems? Do it for the Quality, Health Affairs 24:1103, 2005) X $4 billion CT Medicaid budget.

[xxx] Value over Volume, Council of State Governments/Eastern Regional Conference, February 2010, www.valueovervolume.org.

[xxxi] http://www.mass.gov/?pageID=gov3pressrelease&L=1&L0=Home&sid=Agov3&b=pressrelease&f=080811_dr_gifts&csid=Agov3

[xxxii] CT's Medicaid program spent $356 million on drugs in 2004 (National Health Accounts), appropriate education and incentives could reduce spending by 10%.

[xxxiii] http://healthvermont.gov/blueprint.aspx

[xxxiv] Dartmouth Atlas project, www.dartmouthatlas.org

[xxxv] R Gibson and JP Singh, The Treatment Trap: How the Overuse of Medical Care is Wrecking your Health and What You Can Do To Prevent It, Ivan R. Dee, Chicago, 2010.