

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Equity and Access Council Meeting

December 18<sup>th</sup>, 2014

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. EAC Roadmap	30 min
5. Development of Recommendations: Progress to Date and Next Steps	60 min
6. Meeting Logistics	10 min

**Appendix: Supplemental Material for Reference**

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. EAC Roadmap	30 min
5. Development of Recommendations: Progress to Date and Next Steps	60 min
6. Meeting Logistics	10 min

**Appendix: Supplemental Material for Reference**

# EAC Roadmap: Objectives for Today

---

Proposed objectives for today's discussion of a **roadmap for the EAC**:

1. Confirm the **high-level milestones** required of the EAC to carry out its charge
2. Review status and timeline of **activities underway outside of the EAC** that are related to the EAC's efforts
3. Establish a **timeline for completing EAC milestones**

# EAC Roadmap: Defining Our Work Products

## EAC Charter

This work group will [1] develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; [2] recommend a response to demonstrated patient selection and under-service; and [3] define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms.



***What we  
will  
accomplish***

The Council will [4] identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will [5] convene ad hoc design teams to resolve technical issues that arise in its work.



***How we  
will  
organize***

[6] Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. [7] Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. [8] A finding of failure shall not require proof of intentionality or a plan.



***How we  
will define  
key  
concepts***

# EAC Roadmap: Phases of Work

## EAC Charter *What we will accomplish*

The EAC charter splits its task into two phases

	Phase I	Phase II
Scope	<i>Focused</i>	<i>Broad</i>
Summary of Desired Outcomes	Issue recommendations for preventing, detecting, and responding to <b>under-service and patient selection</b>	Issue other recommendations that address <b>gaps or disparities in healthcare access</b> – those that currently exist and could be reduced through the SIM, or those that could arise as a byproduct of SIM reforms
Described in Charter as ...	<i>Required</i>	<i>Optional</i>
Key Language in Charter	“... what is the Council’s recommended approach for Connecticut’s public and private payers to monitor for and respond to under-service ... and patient selection?”	“1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?  2. Care variations and standardization, evidence-based standards?”

*Today’s focus*

# EAC Roadmap: Related Activities

The EAC will align its work with other activities that relate directly to the EAC's scope and objectives.

	Scope of CT Healthcare Reform Initiatives	Equity & Access Implications
<b>The SIM Initiative</b> ...	<ul style="list-style-type: none"><li>• Addresses care delivery and payment methods for <b>all of Connecticut's healthcare consumers</b></li><li>• Seeks to <b>align reforms across payers</b> in order to maximize the anticipated impact of the reforms.</li></ul>	 <ul style="list-style-type: none"><li>• Prevent, detect, and respond to under-service and patient selection <b>across payer populations</b></li></ul>
<b>Related Activities Are ...</b>	<ul style="list-style-type: none"><li>• Addressing care delivery and reimbursement for a <b>specific payer, population, or network</b></li></ul>	 <ul style="list-style-type: none"><li>• Prevent, detect, and respond to under-service and patient selection for a <b>single population</b></li></ul>

# EAC Roadmap: Related Activities

The EAC will align its work with other activities that relate directly to the EAC's scope and objectives.

	Scope of CT Healthcare Reform Initiatives	Equity & Access Implications
<b>The SIM Initiative</b> ...	<ul style="list-style-type: none"> <li>Addresses care delivery and payment methods for <b>all of Connecticut's healthcare consumers</b></li> <li>Seeks to <b>align reforms across payers</b> in order to maximize the anticipated impact of the reforms.</li> </ul>	<ul style="list-style-type: none"> <li>Prevent, detect, and respond to under-service and patient selection <b>across payer populations</b></li> </ul>
<b>Related Activities Are ...</b>	<ul style="list-style-type: none"> <li>Addressing care delivery and reimbursement for a <b>specific payer, population, or network</b></li> </ul>	<ul style="list-style-type: none"> <li>Prevent, detect, and respond to under-service and patient selection for a <b>single population</b></li> </ul>

*What is the universe of related activities that are relevant to the EAC's charge?*

• **Medicaid reforms and ongoing program elements:**

- DSS-led initiatives
- Oversight (MAPOC CMC)

• **Other reforms or programs**

- Other CT executive branch
- Medicare
- Private payer
- Provider-led
- Consumer-led

# EAC Roadmap: Process for SIM/Medicaid Alignment

## **STATEMENT OF INTENT TO ALIGN PLANNING:**

The PMO and DSS recognize the interrelationship of the Medicaid Quality Improvement and Shared Savings Program (QISSP) and the SIM initiative and agree that planning should be aligned.\*

## **PROCESS:**

### Oversight for Medicaid Reform & Safeguards

MAPOC

Care Mgmt. Committee

Quality Measures Workgroup

(Comment on all of QISSP)

DSS

Supp. Medicaid Quality Measures & Safeguards

Supp. Medicaid Quality Measures

Supp. Medicaid Safeguards

### Governance for All-Payer Reform & Safeguards

SIM PMO

Quality Council

EAC

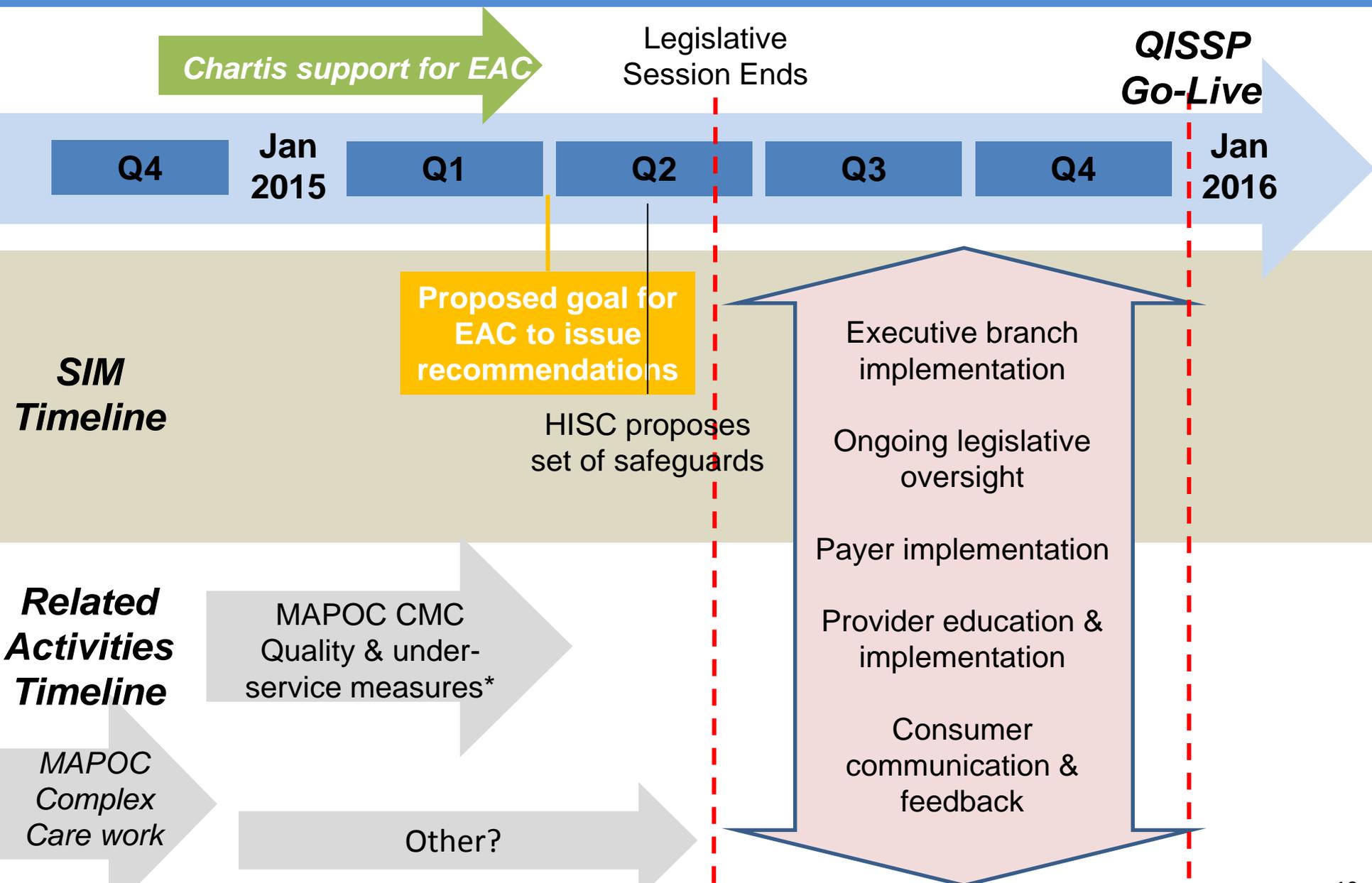
All-payer safeguards that could be adopted by Medicaid  
Medicaid safeguards that could be applicable to all payers

Governance structures cross-populated

**AND:** No matter what the result of the above process, DSS will retain authority to implement the measures that it determines to be in the best interest of the Medicaid program.\*

# EAC Roadmap: High-Level Context

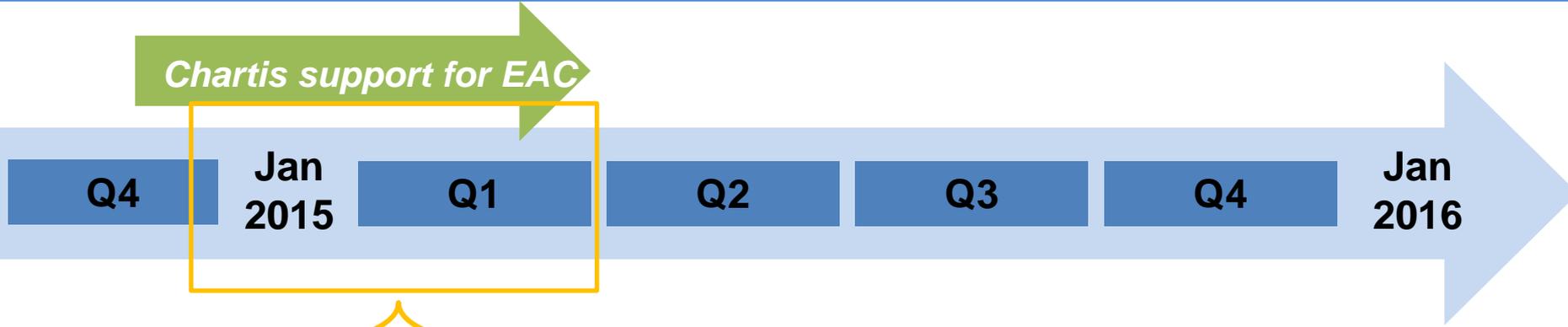
*Draft for discussion*



\*Timeline for completing review and adoption will be decided by MAPOC and DSS 10

# EAC Roadmap: Near-Term Timeline

*Draft for discussion*



## EAC Roadmap for 2015 Q1 Draft Proposal for EAC Discussion

	Dec	Jan	Feb	Mar	Apr
<b>EAC Meetings</b>	12/18	1/22	2/12 2/26	3/12 3/26	4/9 4/23
<b>Key Activities</b>	EAC "Reboot": Adopt roadmap, approach, schedule, priorities	Research, evidence review	EAC articulation of options and preferences Ad hoc design team(s) for identified safeguards Communication with MAPOC CMC	Draft report	Report revisions, additional coordination with MAPOC CMC as needed
	Public input				

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. EAC Roadmap	30 min
5. Development of Recommendations: Progress to Date and Next Steps	60 min
6. Meeting Logistics	10 min

**Appendix: Supplemental Material for Reference**

# Development of Recommendations: Objectives for Today

---

Proposed objectives for today's discussion of the EAC's **process for developing its recommendations**:

1. Review questions contained in **EAC charter**
2. Review a **synthesis of information presented** to the EAC to date
3. For each question in the charter, identify additional **topics to research** and potential **sources of information**

# Questions Contained in EAC Charter Phase I: Summary

- Assessing Risk:**
1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
  2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

## Guarding Against Under-Service and Patient Selection:

Applies to...

Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language		Under-Service	Patient Selection
A	What are the current <b>methods utilized by private and public payers</b> for detection/monitoring?		
B	Can <b>standard measures and metrics be applied</b> for detection/monitoring?		
C	What are the <b>program integrity methods in use today by Medicare / Medicaid</b> and how might such methods be applied here?		
D	What <b>other methods</b> might be available to monitor for patient selection (e.g., mystery shopper)?		
E	<b>Who will monitor, investigate, and report</b> suspected under-service and <b>what steps should be taken</b> if under-service is suspected?		
F	What are the <b>criteria and processes that a payer might use</b> to disqualify a clinician from receipt of shared savings		
G	What are the <b>mechanisms for consumer complaints</b> of suspected under-service?		

**Conclusions:** Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service and patient selection? 14

# Summary of Information Reviewed to Date

Presentation	Content Included ...
<p><b>CT Health Neighborhoods -- Building an underservice monitoring system</b>                      Ellen Andrews, CT Health Policy Project                      9/18/14</p>	<ul style="list-style-type: none"> <li>• Summary of work performed through MAPOC Complex Care Committee for “Health Neighborhoods” dual eligibles initiative</li> <li>• Compilation of research previously collected or performed</li> <li>• Lessons learned for problem definition and evaluation process</li> <li>• Summary of recommendations</li> </ul>
<p><b>Gaps in Care</b>                      Peter Bowers, Anthem                      9/18/14</p>	<ul style="list-style-type: none"> <li>• Methodology for identifying “care opportunities”</li> <li>• Dashboard for use by provider/care manager</li> </ul>
<p><b>Consumer Advocacy Overview</b>                      Demian Fontanella, OHA                      9/18/14</p>	<ul style="list-style-type: none"> <li>• Overview of OHA activities and capabilities</li> <li>• Case studies on how the denial appeals process works</li> <li>• Medical necessity definition</li> </ul>
<p><b>Measuring Under-Utilization of Services</b>                      Sylvia Kelly, CHNCT                      11/13/14</p>	<ul style="list-style-type: none"> <li>• Methodology and tool for detection of under-service in Medicaid population</li> </ul>
<p><b>Crystal Run Webinar/Slides</b>                      Scott Hines, Crystal Run Healthcare                      4/22/14 (EAC homework for 11/13/14)</p>	<ul style="list-style-type: none"> <li>• Detailed discussion of rationale, methodology, and results related to reducing variation in care within a physician-group-led ACO</li> <li>• Impact of reducing wasteful utilization on access to providers</li> </ul>

**How far did these examples get the group toward solutions for each area of deliberation outlined in the EAC charter?**

**What follow-up questions did the presentations leave the group wanting to explore?**

# Questions Contained in EAC Charter Phase I: Discussion

## *Assessing Risk:*

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

## EAC Activities Implied

 Literature Review

## *Guarding Against Under-Service and Patient Selection:*

### Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language

A	What are the current <b>methods utilized by private and public payers</b> for detection/monitoring?		Research
B	Can <b>standard measures and metrics be applied</b> for detection/monitoring?		Research, Assessment
C	What are the <b>program integrity methods in use today by Medicare / Medicaid</b> and how might such methods be applied here?		Research, Assessment
D	What <b>other methods</b> might be available to monitor for patient selection (e.g., mystery shopper)?		Research, Assessment
E	<b>Who will monitor, investigate, and report</b> suspected under-service and <b>what steps should be taken</b> if under-service is suspected?		Assessment, Solution Devt
F	What are the <b>criteria and processes that a payer might use</b> to disqualify a clinician from receipt of shared savings		Research/ Solution Devt?
G	What are the <b>mechanisms for consumer complaints</b> of suspected under-service?		Research/ Solution Devt?

# Questions Contained in EAC Charter Phase I: Discussion

## ***Assessing Risk:***

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

## ***Guarding Against Under-Service and Patient Selection:***

### **Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language**

- A What are the current **methods utilized by private and public payers** for detection/monitoring?
- B Can **standard measures and metrics be applied** for detection/monitoring?
- C What are the **program integrity methods in use today by Medicare / Medicaid** and how might such methods be applied here?
- D What **other methods** might be available to monitor for patient selection (e.g., mystery shopper)?
- E **Who will monitor, investigate, and report** suspected under-service and **what steps should be taken** if under-service is suspected?
- F What are the **criteria and processes that a payer might use** to disqualify a clinician from receipt of shared savings
- G What are the **mechanisms for consumer complaints** of suspected under-service?

***To what degree has each question been answered to date?***

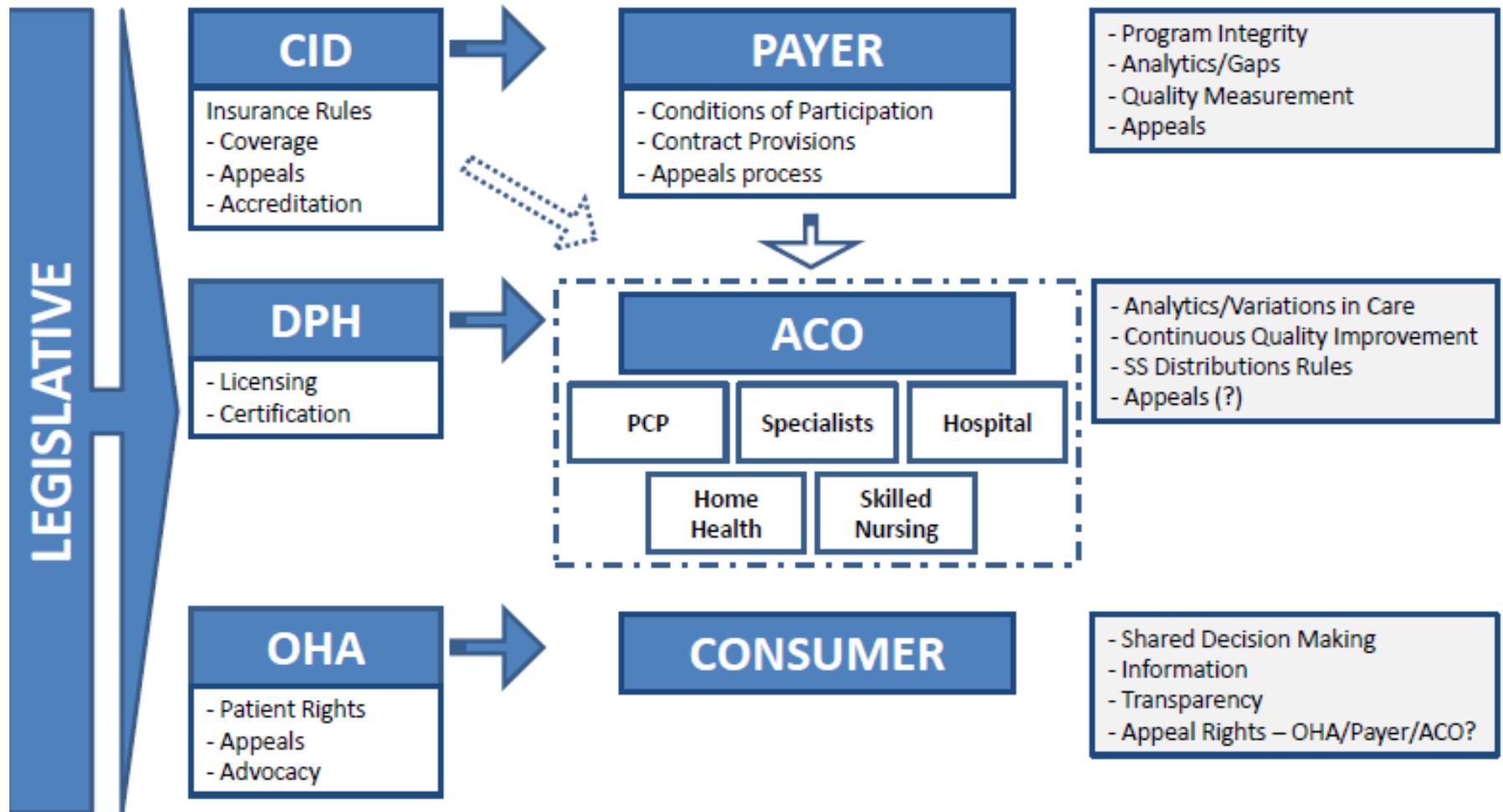
***What decisions have already been made (in the SIM plan, in the EAC, in the HISC)? e.g. that the consequence of under-service will be forfeiture of shared savings payments***

***What work will be required of the EAC to answer each question?***

***What should be our priority and sequence?***

# Framework for Devising Safeguards (from 11/13/14 EAC)

## CONSUMER SAFEGUARD OPPORTUNITIES



# Phase I Recommendations: Choosing Organizing Principles

## Problem Definition

**1. Hypotheses** about likely effects of QISSP and all-payer shared savings programs in CT

**2. Evidence** about patient selection and under-service in total cost of care reimbursement environments

**3. Definition and prioritization** of desired program design elements and outcomes

## A. Identified Risks

**1. Risk of Patient Selection**

**2. Risk of Under-Service**

## B. Solution Areas

### 1. Prevention

#### Incentive Design

- Shared savings payments
- Quality & service payments
- Definition/barriers/consequences for proscribed behavior

### 2. Detection

#### Concurrent Monitoring

- Transparency
- Patient rights, appeals, advocacy
- Mystery shopper
- Peer review

#### Retrospective Analysis

- Outcomes measurement
- Care gaps analysis
- Practice variation analysis
- Payment distribution analysis

### 3. Response

#### Penalties, Education, Program Modifications

## C. Solution Sources

Existing CT Work

Other States

Other Payer Programs

Outside Experts

EAC Analysis

Other

## D. Actors

Payers

Regulatory/Licensing Bodies

Providers/ACOs

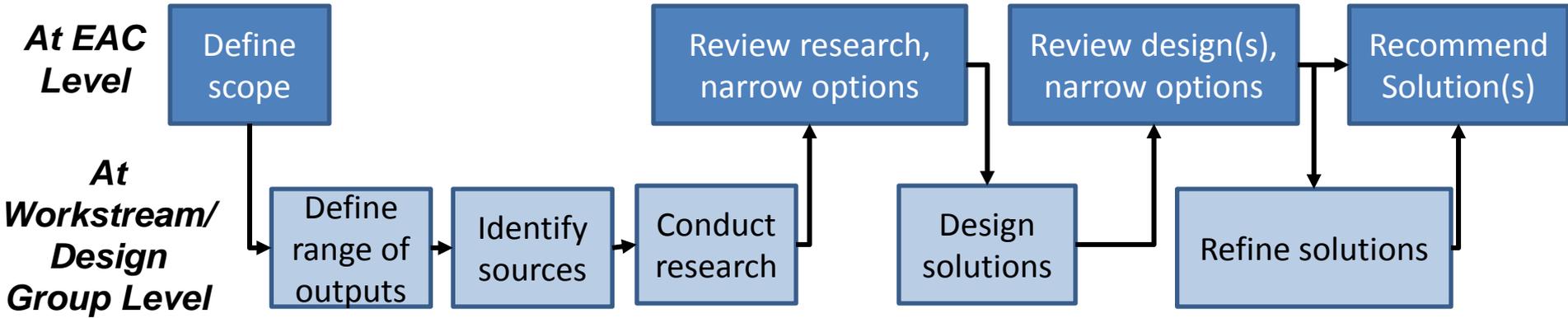
Consumers/Advocacy Bodies

Other 19

# Proposed Decision Framework

- 1** The EAC will establish a set of discrete workstreams or pathways using one or more organizing principles
  - A. Type of risk (patient selection vs under-service)
  - B. Solution area (prevention, detection, response)
  - C. Solution source (e.g. CT sources, other states, other payers, outside experts, original EAC analysis)
  - D. Actors (payers, regulatory/licensing bodies, providers/ACOs, consumers/advocacy bodies)

**2** The EAC will initiate and follow a process for each defined workstream:



# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. EAC Roadmap	30 min
5. Development of Recommendations: Progress to Date and Next Steps	60 min
6. Meeting Logistics	10 min

**Appendix: Supplemental Material for Reference**

# Meeting Logistics: Objectives for Today

---

Proposed objectives for determining **logistics for future meetings**:

1. Identify **barriers to member participation** and potential solutions
2. Confirm the **meeting schedule** going forward

# Potential Barriers to Participation and Solutions

## Potential Reasons for Lack of Participation to Date

- Lack of bandwidth
- Scheduling conflicts
- Unclear charge or scope
- Lack of confidence that meeting will be productive
- Perceived lack of relevant expertise/comprehension to contribute to the group

## Proposed Solutions

- EAC action: reaffirm (or revise) member expectations
- Survey tool for members (to address both participation and substantive questions)
- One on one interviews by Chartis with members to discuss:
  - Expectations
  - Member barriers to participation
  - Member objectives
  - Member suggestions for EAC focus/meeting topics
  - Specific areas where member would like to contribute his/her time/expertise
  - Member perspectives on substantive choices before the EAC

# Proposed Meeting Schedule

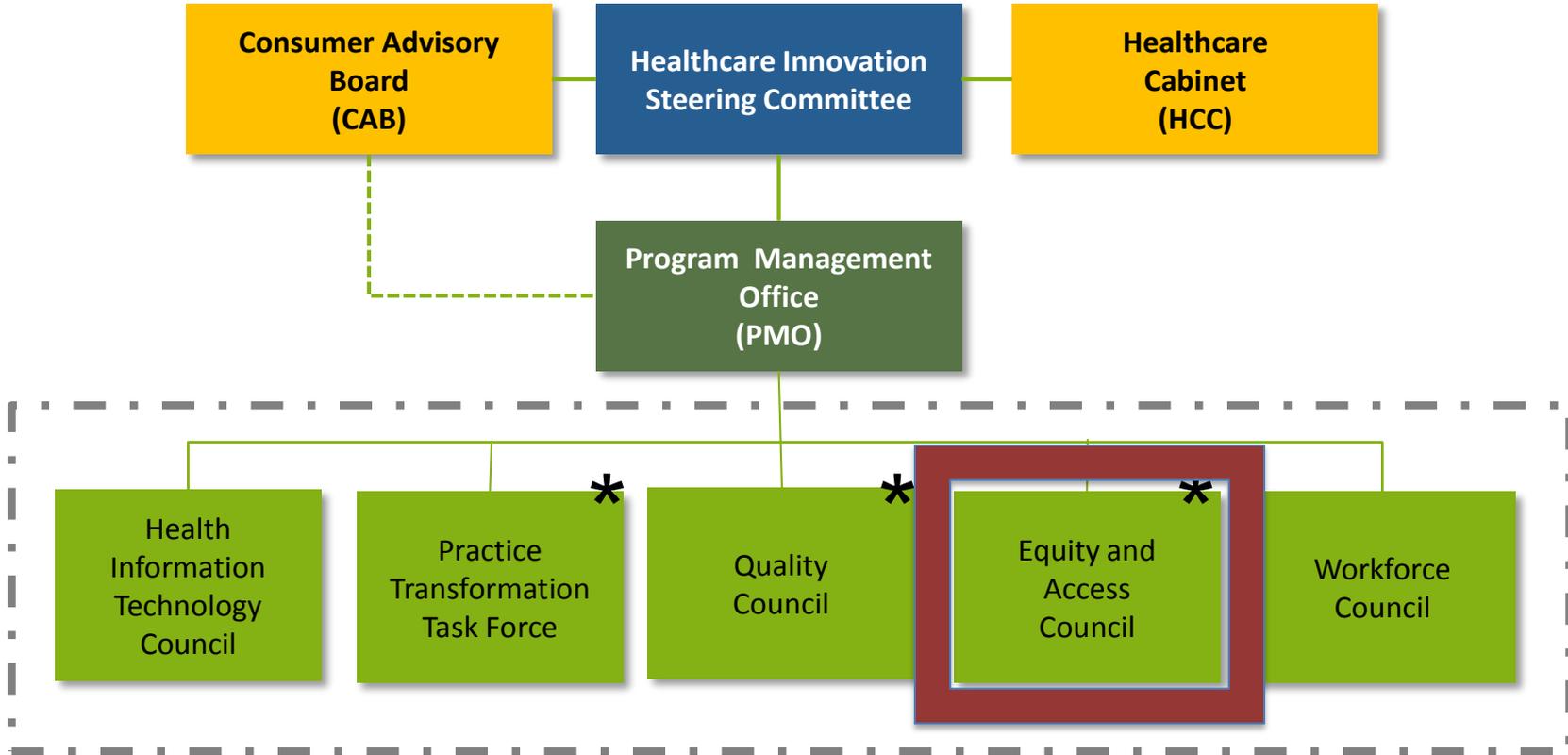
Month	EAC	MAPOC CMC	HISC
Jan	Thursday, January 22, 2015		Thursday, January 8
Feb	<b>Thursday, February 12, 2015</b> Thursday, February 26, 2015	<b>Wednesday, February 11</b>	Thursday, February 5
Mar	<b>Thursday, March 12, 2015</b> Thursday, March 26, 2015	<b>Wednesday, March 11</b>	Thursday, March 12
Apr	<b>Thursday, April 9, 2015</b> Thursday, April 23, 2015	<b>Wednesday, April 8</b>	Thursday, April 9
May	Thursday, May 28, 2015		Thursday, May 14
Jun	Thursday, June 25, 2015		Thursday, June 11

**Dates in red font are new – they were not on previously proposed EAC schedule**

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. EAC Roadmap	30 min
5. Development of Recommendations: Progress to Date and Next Steps	60 min
6. Meeting Logistics	10 min
Appendix: Supplemental Material for Reference	

# SIM Governance Structure



# House Rules

---

- Expectations of taskforce members:
  - Presence
    - Attend meetings
    - Prepare and participate between meetings as needed to move issues along
  - Outlook
    - Leave jobs and titles at the door; focus on best interest of CT citizens
    - Look for consensus to make recommendations to PMO
  - Action
    - Find solutions for proposed questions
    - Build ideas and be proponent of change and transformation
    - Be vocal and share the importance of our mission

## Value-based payment

- Broadly aligned around the Medicare SSP
- Responsible for overall cost of care for their patients
- Rewarded with a share of any savings if they meet quality and care experience targets
- Goal is to create a practice culture that is organized around increasing value

Value =

Quality + Care Experience

Cost

## Shared Savings Program

- Project how much it should cost for provider to serve their patients for one year
- Similar to establishing an annual budget--actually a *virtual* budget, because provider continues to be paid fee-for-service
- Projected budget higher for consumers with chronic illnesses
- This is called risk adjustment

## Shared Savings Program

- Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget
- Budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care.
- Provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer.

## Shared Savings Program

- In some arrangements, providers returns funds if their costs exceed the projected budget. This is called a risk arrangement
- Providers will typically try to achieve savings by providing high quality care and more efficient care
- For example, if they improve their ability to quickly find the right diagnoses for a patient, and to provide the right care the first time so as to avoid hospitalizations
- However, they may also achieve savings by eliminating wasteful and duplicative services

## Over- service

- Fee for service programs reward volume of services, even if those services are unnecessary or ineffective
- Sometimes these unnecessary services are costly or inconvenient or even harmful
- Most payers look at their claims data to identify providers who provide more services than are necessary
- They have program integrity or audit divisions that look for over-service

## Under-service

- Shared savings programs create an incentive to provide only those services that are necessary and effective
- However, there are concerns that they might also create incentives to provide *fewer* necessary services
- This concern about under-service is the primary reason that this Council was established

## Over- and Under-service

- Setting quality targets reduces the risk of under-service for target conditions
- However, they may not reduce the risk of under-service in the treatment of other conditions
- It could also lead to avoiding patients who are going to be harder than usual to treat...this is called “patient selection”