

CONNECTICUT
HEALTHCARE
INNOVATION PLAN

Equity and Access Council Meeting

February 5, 2015



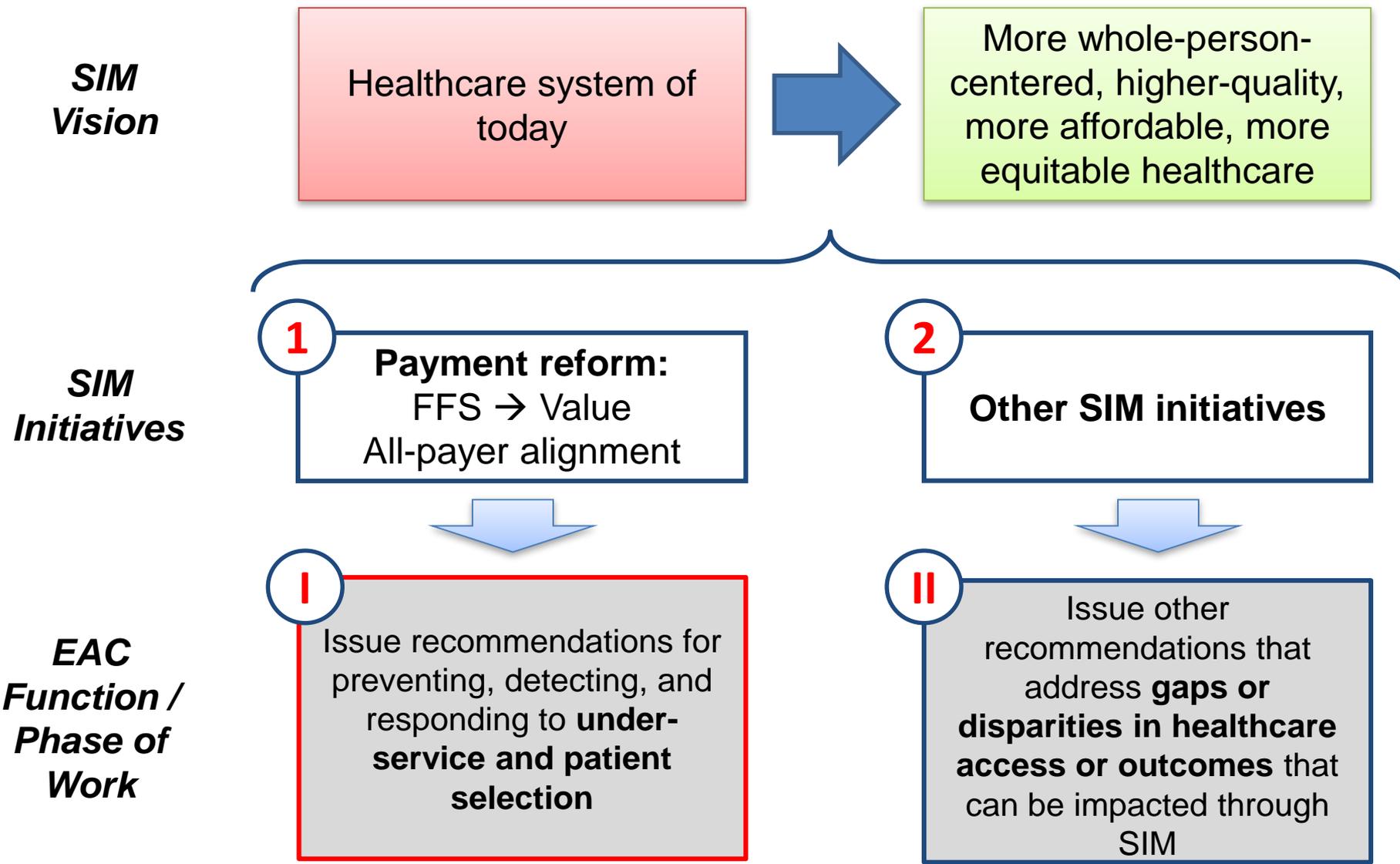
Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Guidelines for Participation of Alternates	5 min
4. Minutes	5 min
5. Design Groups: Review of Process and Orientation to “EAC Library”	15 min
6. Design Group 1: Patient Attribution & Cost Benchmark Calculation	65 min
7. Design Group 2: Incentive Payment Calculation and Distribution - Preview	15 min

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EAC Phases of Work in the Context of SIM



Our focus through early April

Design Groups: Built Around Types of Safeguards

CT's Process

1. **Evaluate evidence** for the hypothesized risks and options for preventive safeguards
2. **Establish safeguards** (incentives, policies, and processes) that prevent under-service and patient selection
3. **Implement** safeguards
4. **Monitor** and analyze results
5. **Adjust** safeguards based on lessons learned

What types of safeguards can be built into the proposed payment reforms?

We propose two categories of safeguards:



1. Payment design features

Concept:

Design new payment methods in a way that, taken together, do not create incentives for under-service and patient selection



2. Supplemental safeguards

Concept:

Establish additional rules and processes to deter and detect under-service and patient selection

Design Groups: Elements of Safeguards Defined



1. Payment design features

Concept:

Design new payment methods in a way that, taken together, do not create incentives for under-service and patient selection

1. Payment Design Features

- A Patient Attribution
- B Cost Benchmark Calculation
- C Incentive Payment Calculation
- D Incentive Payment Distribution



2. Supplemental safeguards

Concept:

Establish additional rules and processes to deter and detect under-service and patient selection

2. Supplemental Safeguards

- A Rules
- B Communication
- C Enforcement
- D Detection: Retrospective
- E Detection: Concurrent

Design Groups: Structure of Work

For the purpose of further research, evaluation, and solution design, the safeguard types have been organized into four design groups tasked with proposing answers to the key questions below

Solution Areas

Solution Areas
(1A) Attribution (1B) Cost target calculation (cost benchmarks & risk adjustments)
(1C) Incentive payment calculation (1D) distribution
(2A) Rules (2B) Communication (2C) Accountability/enforcement
(2D) Retrospective detection (2E) Concurrent detection

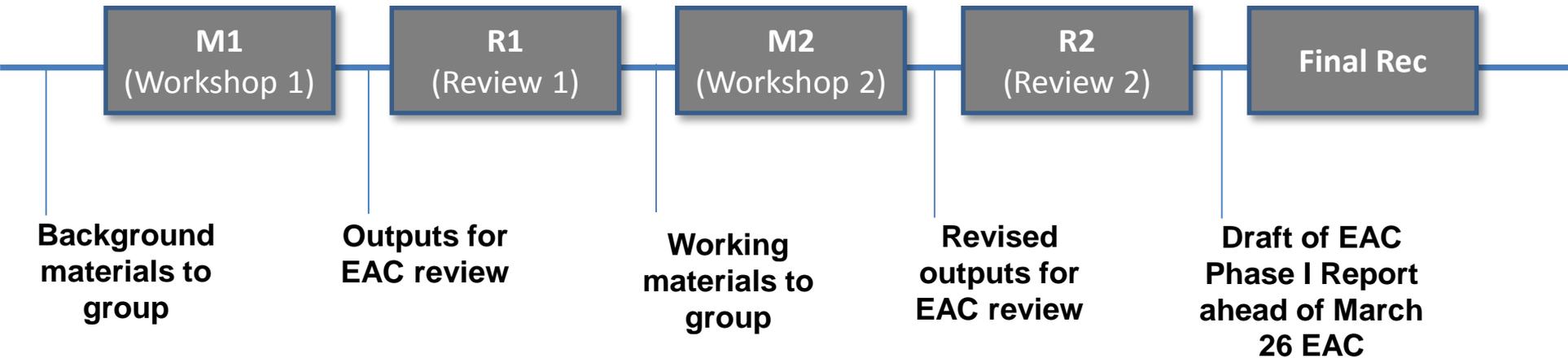


4 Design Groups

Design Groups	Principal Questions to Answer:
1	How to minimize improper patient selection by appropriately defining expected outcomes and accountabilities
2	How to balance incentives to promote medically appropriate, efficient, patient-centric care decisions
3	How to set appropriate rules, communicate them, and enforce them
4	How to evaluate for under-service and patient selection – as both an enforcement/deterrence tool and an evaluation tool – after the performance period and/or in near-real-time

Design Groups: Process

EAC Design Group Process



Offline information/input gather from EAC participants and experts

Consolidation of recommendations from work groups and testing draft reports with EAC

Design Groups: Milestones and Proposed Timing

We propose to organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April						
		Week of:				Week of:				Week of:					Week of:						
		5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27			
3. Equity and Access Council (EAC)																					
1	Healthcare Innovation Steering Committee (HISC)	8				5								12				9			
2	Equity and Access Council Meetings			22		5			26					12		26		9		23	
3	Equity and Access Council Exec Team Meetings		15					19						19					16		
4	1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2												
5	1C-D: Performance-based payment calculation & distribution								M1					R1	M2	R2					
6	2A-B-C: Rules, communication, enforcement								M1					R1	M2	R2					
7	2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2										

- M1** Design milestone/workshop 1 **R1** EAC initial review/input
- M2** Design milestone/workshop 2 **R2** EAC final review/input


**Report containing
Phase I
recommendations**

Design Groups: Participation

To further research, evaluate and design solutions we have asked Council members to participate in one or two design groups (or more if desired).

If you are interested in participating in a “design group” we would ask for the following commitment:

- Review of pre-design session reading materials (provided in advance of meeting)
- Attend 2 workshops conducted by conference call, with participation open to all EAC members, and to the public
- Provide input on design features and recommendations to bring back to EAC



If you have not signed up yet, we would encourage you to pick one or two groups you would like to join and participate in on a regular basis.

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Design Group 1: Patient Attribution Overview

1A. Patient Attribution



Method used to assign a patient to a provider in a shared savings model

Is the timing of patient attribution likely to have an impact on patient selection and under-service? If so, how?

Shared Savings
Program Contract Start
Jan 1

End of First
Performance Year
Dec 31

Performance Year 1

When Are Patients Assigned?

Prospective Assignment
Patients assigned to providers at outset of performance year

Retrospective Assignment
Patients assigned to providers at end of performance year

How does it work?

- Methods Include:**
- Where the patient received care in prior year(s) (plurality of visits)
 - Patient designates provider
 - Insurer designates provider
 - Geographic area dictates provider

- Methods Include:**
- Where the patient actually received care during the performance year (plurality of visits)



Design Group 1: Patient Attribution Overview

1A. Patient Attribution



Method used to assign a patient to a provider in a shared savings model

Will the provider type a patient can be assigned to in a shared savings program impact under-service or patient selection?



For a **physician group ACO**, the use of access points other than physician practices for attribution may not have a material impact on patient selection



Primary Care Providers



Specialists



Urgent Care / Retail Providers



Emergency Departments



For a **vertically integrated network ACO**, including “mandatory” access points like the ED in an attribution methodology may obviate any hypothesized incentive to select against patients perceived to be high utilizers – since these patients can end up attributed in any event through their use of the ED

Design Group 1: Report Out from Workshop Held 1/30

In its first workshop, Design Group 1 surfaced several ideas for further discussion.

Ideas Surfaced in Design Group

1 Choice of attribution methodology is **unlikely to have a significant, predictable impact**, positive or negative, on patient selection or under-service. It may, however, have other implications for the quality and type of care delivered.

2 The **prospective attribution methodology may have benefits** for equity and access because it will allow for:

- Patient to play a more active role in their care management
- Buy in from providers
- Less opportunity for “cherry picking” as compared to retrospective attribution

3 **Attributing patients to a group** rather than to an individual provider might dissuade or otherwise reduce patient selection.

4 There will **not be a one size fits all approach** for attribution across all payers, nor does there need to be.

Discussion Questions

1. While the design group articulated benefits of a prospective attribution method, do we believe that prospective attribution creates any significant **risk of inviting under-service** by virtue of the provider’s advance knowledge of which patients are in a shared savings program?
2. Beyond the timing of when patients are attributed to a shared savings program, will the **method of how patients are attributed** (e.g.; plurality of visits vs patient-designated) have an impact on patient selection or under-service?
3. Does **all-payer alignment** on attribution methodology, or lack thereof, have implications for the likelihood of under-service or patient selection?
4. Will the **provider type** to which a patient is attributed impact under-service or patient selection? Will it depend on the participants in the shared savings program (e.g.; ED)?



Design Group 1: Projected Cost Calculation Overview

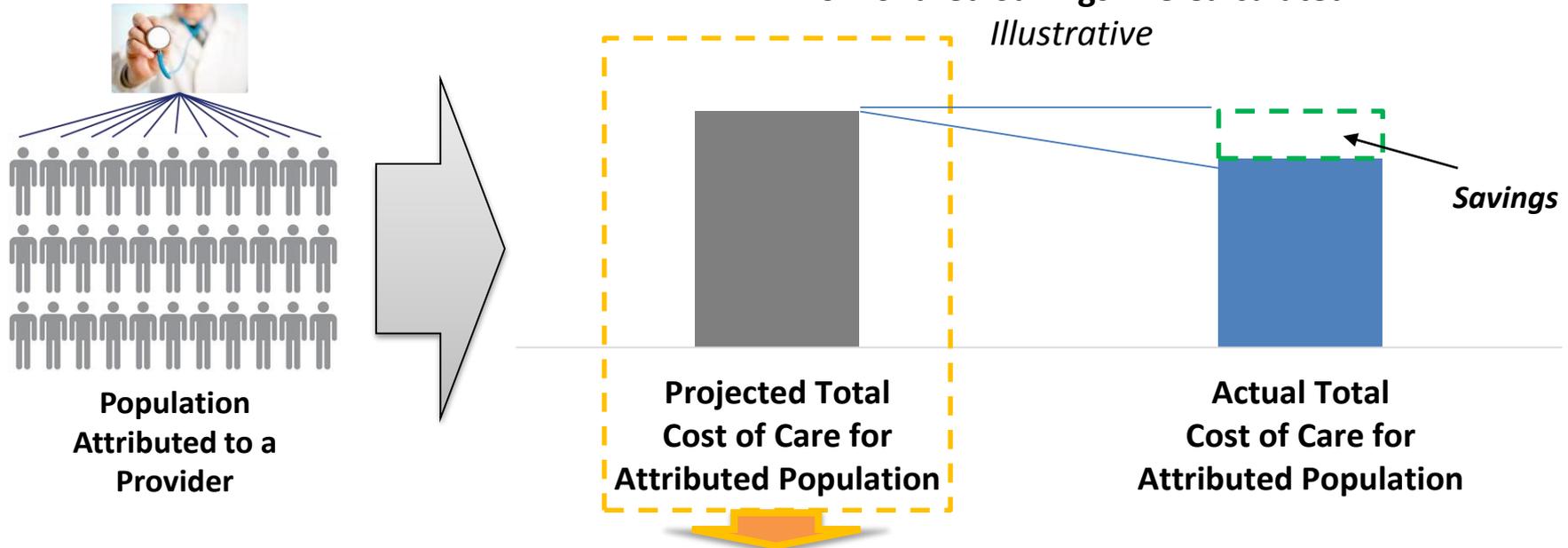
1B. Cost Calculation (cost benchmark & risk adjustment)



Future cost estimation for population of patients attributed to a provider, from which shared savings calculations are determined

How Shared Savings Are Calculated

Illustrative



How is the projected cost for the attributed population determined?

Step 1: Define population used to determine cost benchmark

Step 2: Risk adjust cost benchmark



Design Group 1: Cost Benchmark Overview

1B. Cost Calculation (cost benchmark)



Population of patients used to determine cost benchmark for shared savings program

Step 1: Define population used to determine cost benchmark

1 Historical Costs:

Uses past patient experiences of population attributed a provider to project future expenses for that population.

2 Control Group Costs:

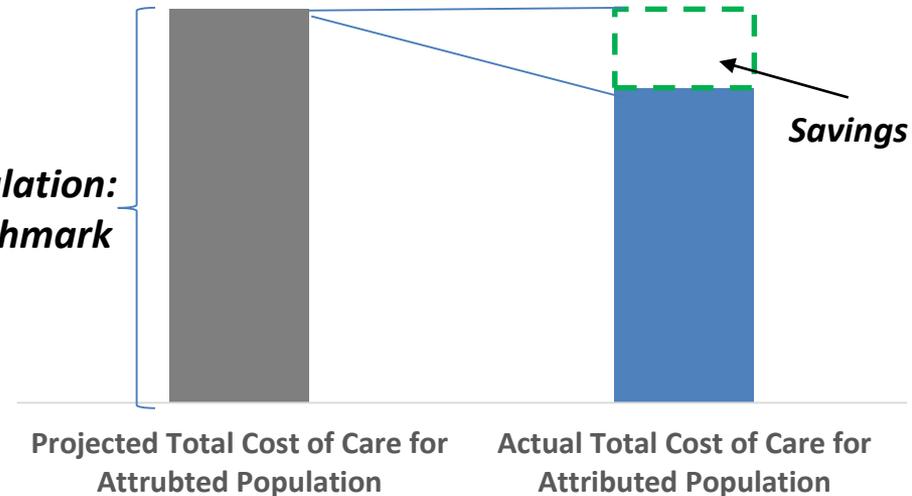
A comparator group that *is not* based on the past experiences of the patients in the shared savings program. Control groups can be based on:

- What is considered to be best practice in the region
- The broader regional provider network, or
- A comparator group that is deemed to be similar

How Shared Savings Are Calculated

Illustrative

**Cost Calculation:
Cost Benchmark**





Design Group 1: Risk Adjustment Overview



1B. Cost Calculation
(risk adjustment)

Additional method used to adjust future shared savings cost projections that accounts for the overall risk of the population as part of the cost projection. Risk adjustment takes into consideration demographics and the diagnoses of the population.

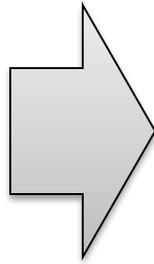
Step 2: Risk adjust the cost benchmark

Will the need for risk adjustment vary depending on the cost benchmark method?

Cost Benchmark Method

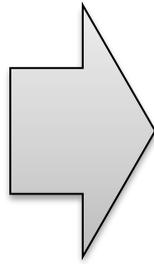
Role of Risk Adjustment

Historical Costs



- A historical cost benchmark will inherently account for risk as it is based on the actual prior care experiences of the attributed population.
- However, adjustment can be valuable as a way to more accurately predict how future costs are likely to vary from the historical snapshot.

Control Group Costs



- Unlike the historical cost benchmark, the control benchmark is based off of a population that is **not part** of the shared savings program and will not inherently account for the attributed population’s level of risk.
- Risk adjustment provides an essential method to reflect the impact of risk on the cost benchmark, providing for an “apples to apples” comparison.

Beyond the risk adjustment method used, the timing of the adjustment (i.e.; concurrent vs prospective) and supplemental methods (e.g.; cost outlier adjustments, enhanced payments and service exclusions) should be considered



Discussion Questions

1. **How important** is the cost benchmark methodology on influencing the opportunity or incentive for patient selection and under-service? The risk adjustment methods?
2. Would the cost benchmark alone ever be enough to protect against under-service and patient selection or **is risk adjustment always necessary**?
3. **What impact will the different methodologies** for cost benchmark definition have on patient selection and under-service? The impact of the risk adjustment methodologies?
4. Which methods (cost benchmark and risk adjustment) will create the **highest level of provider confidence** that the projected costs reflect the actual costs? How much confidence do providers and payers have in the methods in use today?
5. **Which additional methods** (i.e.; cost outliers, enhanced payments and service exclusions) should be considered? How will they impact under-service and patient selection?
6. Will the same cost benchmarking and risk adjustment methodologies be **applicable across all payers**?



Design Group 1: Cost Projection Impact

1B. Cost Calculation (cost benchmark) 	Potential Hypothesis About Impact on Equity and Access	
	Under-Service	 A cost benchmark that is perceived to be appropriately adjusted for the complexity of the patients will help prevent under-service
Patient Selection	 Does not address directly	

	Potential Equity & Access Risks/Benefits	All-Payer Applicability
1 Historical Costs	<ul style="list-style-type: none">  Does not predict for uncontrollable/unexpected factors (e.g.; bad flu season or poor economy); does not adjust for practices that had higher than average costs at outset  Less sensitivity around risk assessment 	<p>More applicable to population likely to have few variations in cost/care patterns (e.g.; SCHIP)</p>
2 Control Group	<ul style="list-style-type: none">  Difficult to accurately account for the risk of the population, which may lead to unintended under-service  Adjusts for providers who are starting with higher than average costs 	<p>Applicable to any plan that wants to control for over-service or large variations in care</p>



Design Group 1: Risk Adjustment Impact

1B. Cost Calculation (risk adjustment) 	Potential Hypotheses About Impact on Equity and Access	
	Under-Service	 A cost benchmark that is perceived to be appropriately adjusted for risk will minimize incentives for under-service
	Patient Selection	 Higher-risk patients will provide greater opportunity for savings if risk adjustment is done appropriately

Potential Equity & Access Risks/Benefits		All-Payer Applicability
1 Risk-Assessment Methodology	<ul style="list-style-type: none"> If the risk assessment methodology is not perceived to reflect the risk of a clinically and/or socially complex patient population, providers may be prone to underservice An appropriate risk assessment methodology should account for social factors and other demographics that are not directly related to, but impact, an individual's health and health behavior 	Will be of particular importance for patients who are relatively difficult to manage (e.g. low-income with chronic conditions)
2 Cost Outlier Threshold	<ul style="list-style-type: none"> The size of the shared savings program (# of beneficiaries) and the threshold for excluding high cost claimants will impact a provider's willingness to take on high-risk patients. Cost outlier adjustment should strike a balance between encouraging providers to take on high-risk/high-cost patients and the concern that the savings pool will be skewed. 	Applicable for all payers, but threshold level-setting will be more sensitive for higher-risk patient populations
3 Additional Payment for High Risk Patients	<ul style="list-style-type: none"> An additional payment for high-risk groups beyond what can be earned through shared savings will encourage providers to accept complex patients There is an added expense to coordinating complex patients; an enhanced FFS payment or a separate PMPM will lower the cost barrier for providers 	Applicable for all payers, but would be most impactful for complex patients

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Incentive Design: Payment Design Features



1C. Payment Calculation

Elements of the incentive design that determine the amount of savings achieved for a given patient population for which a provider is eligible

Design Options/Considerations

Who Uses the Method (e.g.)?

1 Performance Incentives/Thresholds – amount of savings paid out is dependent on reporting on and/or hitting performance targets.

- MA Medicaid Demonstration
- ME Medicaid Demonstration
- MSSP
- BCBS of Illinois - Advocate

2 Medical Savings Rate (MSR)– minimum amount of savings that need to be achieved to receive a shared savings payment. There can also be a cap on the savings percent that can be distributed as shared savings (e.g. any savings above 6% will not be shared)

- Harvard Pilgrim Health (2%)
- MSSP (2%-3.9%, dependent on size)
- NJ Medicaid (none)

3 Upside/Downside Risk – providers share in savings and losses. Many shared savings programs phase in downside risk over time. There is also often a cap on losses for providers who accept downside risk

- Pioneer ACOs (downside)
- MSSP (two tracks: upside and downside)
- MN Medicaid (phased in downside)



Incentive Design: Payment Design Features

1D. Payment Distribution



The method by which providers share in the savings received

Design Options/Considerations

- 1 Who is shared savings payment made to?** To the provider network/ACO? Directly to individual providers?
- 2 When is the payment made?** Annually? Biannually? Will impact quality and cost reporting and impact lag between services provided and full payments.
- 3 Are any savings retained** by the network, rather than distributed to providers? Can help to cover operating expenses or build reserves if program takes on risk in future
- 4 How are out of network providers** paid? By the ACO or by the payer?
- 5 What are the distribution pools with in the shared savings program? And how do you distribute among these pools?** Hospitals vs physicians; PCPs vs specialists; practice level or individual level?
- 6 What role do performance metrics play?** Relative quality/cost of individuals or practices taken into account? Number of lives managed? Relative risk of patients seen by one practice or provider vs. others taken into consideration?

APPENDIX



2. Patient Attribution: Equity & Access Impact

<p>1A. Patient Attribution</p> 	<p>Potential Hypotheses About Impact on Equity and Access</p>	
<p>Underservice</p>		<p>Blinding providers from who is attributed to their shared savings panels would make intentional under-service difficult</p>
<p>Patient-Selection</p>		<p>Preventing providers from determining who is in their shared savings programs will minimize patient selection</p>

Design	Potential Equity & Access Risks/Benefits	All-Payer Applicability
<p>1 Plurality of Visits: Retrospective</p>	<ul style="list-style-type: none"> — Providers may be reluctant to take patients in value-based contracts without full transparency up front + Limits provider's ability to selectively withhold care 	<p>Focus on complex patients where under-service is more of a concern</p>
<p>1 Plurality of Visits: Prospective</p>	<ul style="list-style-type: none"> — Advance knowledge of all patients assigned to an ACO could be used to selectively lower costs + Providers have actively chosen to accept responsibility for group of patients 	<p>Applicable to all payers, may be attractive to providers who are "on the fence" about shared savings</p>
<p>2 Patient-Selected</p>	<ul style="list-style-type: none"> — Providers can close panels to avoid being selected + Supports patients being an active participant in their care 	<p>More applicable for an HMO model where patient has to designate a PCP</p>
<p>3 Population-Based</p>	<ul style="list-style-type: none"> — Provider may take on many patients with whom there is no established relationship + Potential to attribute high-risk patients who otherwise would not be served through contracts that rely on attribution 	<p>More applicable for high-risk, underserved patients (eg Medicaid and uninsured) for which one provider organization provides all or most of the care in a given area</p>



2. Payment Design Features: Patient Attribution

<p>1A. Patient Attribution</p> 	<p>Potential Hypotheses About Impact on Equity and Access</p>	
<p>Under-Service</p>		<p>A provider with fewer care management capabilities may have more incentive to under-serve to reach cost targets</p>
<p>Patient Selection</p>		<p>Having a comprehensive network (i.e.; includes hospitals, physicians, and other care sites) will provide a disincentive to patient-select</p>

Potential Equity & Access Risks/Benefits		All-Payer Applicability
Provider Type		
<p><i>PCP</i></p>	<ul style="list-style-type: none">  Not all patients have an established relationship with a PCP  PCP practice model is likely to have a more robust care management infrastructure 	<p>May be more helpful for complex patients who could benefit from PCMH type model</p>
<p><i>Specialist</i></p>	<ul style="list-style-type: none">  Specialty care model does not lend itself to care coordination  Some specialists function as primary care providers for patients (e.g.; OB/GYN) or play a critical role in their care management (e.g.; Endocrinologist) and assignment of the patient to that provider will provide a more accurate assessment of utilization 	<p>More applicable to commercial where many patients may see a specialist for primary care as well as patient's with chronic conditions</p>
<p><i>ED</i></p>	<ul style="list-style-type: none">  May be a challenge in a non-vertically integrated shared savings program – would not be ideal to make ED long-term care plan  Manner to capture and manage underserved/under insured patients who have historically used ED as primary source of care 	<p>More applicable to newly insured Medicaid and uninsured</p>
<p><i>Combination</i></p>	<ul style="list-style-type: none">  May be more difficult to coordinate, and different provider types may be more/less amenable to different incentive structures  Patient will be attributed to the provider who takes more active role in managing their care 	<p>Applicable to all</p>



Incentive Design: Payment Design Features

 1C. Payment Calculation	Hypothesis About Impact on Equity and Access	
	Underservice 	Tying quality performance to the ability to receive shared savings will incentivize providers to provide all necessary care.
Patient-Selection 	Quality incentives that reflect improvements with underserved and/or complex patients will allow for greater provider opportunity for savings.	

Potential Equity & Access Risks/Benefits	All-Payer Applicability
<ul style="list-style-type: none"> • If the quality payment is not tied to achieving savings, the incentive to lower costs through better care coordination may suffer • The pressure of having to lower costs to earn savings may provide an incentive to underserve, underscoring the importance of quality measures to adequately reflect care for particularly vulnerable patients 	Will be of particular importance for patients who are relatively difficult to manage (e.g. low-income with chronic conditions)
<ul style="list-style-type: none"> • The size of the shared savings program and infrastructure the provider organization has in place to do care management will impact how an MSR influences provider behavior. • Larger shared savings programs will have less variation due to chance, so even small savings (e.g.; <2%) are likely due to real changes in care provision • Providers with few care management capabilities will need time to build out capabilities, making large cost savings less likely in the first year 	Applicable for all payers
<ul style="list-style-type: none"> • Particularly high-cost patients could lead to provider fear of downside risk, incentivizing providers to skimp on care to achieve cost savings and/or only want to care for healthier patients • With the “right” set of performance measurements, downside risk is necessary for the provider to truly assume responsibility for managing costs 	Applicable for all payers, but fear of downside risk may be greater for Medicaid



Incentive Design: Payment Design Features

1D. Payment Distribution	Hypothesis About Impact on Equity and Access	
	Underservice	✓ Appropriate distribution of shared savings will incent physicians to provide the most appropriate care while controlling costs, and to emphasize teamwork within the ACO
	Patient-Selection	✗ Does not address directly

Potential Equity & Access Risks/Benefits	All-Payer Applicability
<ul style="list-style-type: none"> The portion of shared savings distributed to the provider must provide a sufficient incentive to manage care without tipping too far toward incenting the withholding of care 	<p>Payers with higher infrastructure costs and/or for profit payers may be less willing to implement a higher sharing percentage</p>
<ul style="list-style-type: none"> Rewarding providers based on ACO performance, rather than individual performance, will minimize any incentive for a provider to withhold appropriate services, while facilitating monitoring for improper behavior 	<p>May be difficult to address in practices with providers seeing different numbers of shared saving beneficiaries</p>