

CONNECTICUT
HEALTHCARE
INNOVATION PLAN

Equity and Access Council Meeting

March 26, 2015



Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 1: Cost Target Calculation	15 min
5. Design Group 2: Payment Calculation & Distribution	40 min
6. Design Group 4: Retrospective and Concurrent Monitoring & Detection	40 min
7. Closing Comments	5 min
Appendix	

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EAC: Milestones and Timing

The agenda of upcoming EAC meetings will be organized around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January		February			March				April				May				
		Week of:		Week of:			Week of:				Week of:				Week of:				
		19	26	2	9	16	23	2	9	16	23	30	6	13	20	27	4	11	18
1	Healthcare Innovation Steering Committee (HISC)			5				12				9					14		
2	Equity and Access Council Meetings	22		5		26		12		26		9		23					28
4	Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking		M1	R1	M2		R2	M3	R3										
5	Group 2 - 1C-D: Performance-based payment calculation & distribution					M1				M2	R1/R2								
6	Group 3 - 2A-B-C: Rules, communication, enforcement					M1						M2	R1/R2						
7	Group 4 - 2D-E: Retrospective & concurrent monitoring				M1			M2		R1			R2						
8	EAC deliberate on draft report, adopt full slate of recommendations																		
9	HISC review, feedback on EAC report																		
10	MAPOC Care Management Committee (CMC) Meetings					20						8							13

↑
Today

M1 Design milestone/workshop 1

M2 Design milestone/workshop 2

M2 Design milestone/workshop 3
(if needed)

R1 EAC initial review/input

R2 EAC final review/input

R3 EAC final review/input – continuation
(if needed)



4. Design Group 1: Cost Target Calculation

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues.

Status of Recommendations After 3/12/15 EAC Meeting

Recommendation	Status After 3/12/15	Action for 3/26/15
1 <i>Rewarding Improvement</i>	Adopt as presented	
2 <i>Benchmark Adjustment for New Treatments</i>	Adopt with changes discussed [focus more narrowly on adjusting for newly approved treatments rather than on a general need to adjust benchmarks retrospectively]	Review new language
3 <i>Supplemental Payments for Complex Patients</i>	Edit and table for further consideration	Review new language, complete discussion
4 <i>Retrospective Assessment of Risk Adjustment</i>	Adopt as presented	
5 <i>Cost Truncation and Service Carve-outs</i>	Adopt with changes discussed [cost truncation is not the only method of accounting for catastrophic events]	Review new language



4. Design Group 1: Cost Target Calculation

The following set of recommendations emerged from Design Group 1 when asked to consider how the cost target calculation methodology might bear on patient selection or underservice.

1

Rewarding Improvement

Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.

2

Benchmark Adjustment for New Treatments

An end of year assessment should be conducted to evaluate the need to adjust for any systemic factors (e.g. the advent of new treatments) that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year. An adjustment can be made to the historic cost benchmark or the identified treatment can be temporarily carved out of the cost benchmark calculation.



4. Design Group 1: Cost Target Calculation

The following set of recommendations emerged from Design Group 1 when asked to consider how the cost target calculation methodology might bear on patient selection or underservice.

3

Supplemental Payments for Complex Populations

An imperfect risk adjustment that does not account for hidden expenses associated with caring for socioeconomically complex patients may put some of the most vulnerable patients at greater risk for under-service and patient selection. To date, there is not a commonly accepted payment mechanism within shared savings programs to account for this, but payers should consider ways to financially incent provider organizations to care for the most vulnerable individuals.

4

Retrospective Assessment of Risk Adjustment

In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors.

5

Cost Truncation and Service Carve-outs

Truncating costs based on a percentile cutoff, and/or carving out select services, will eliminate any incentive to withhold required care after a catastrophic event or diagnosis in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.



4. Design Group 1: Cost Target Calculation

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues.

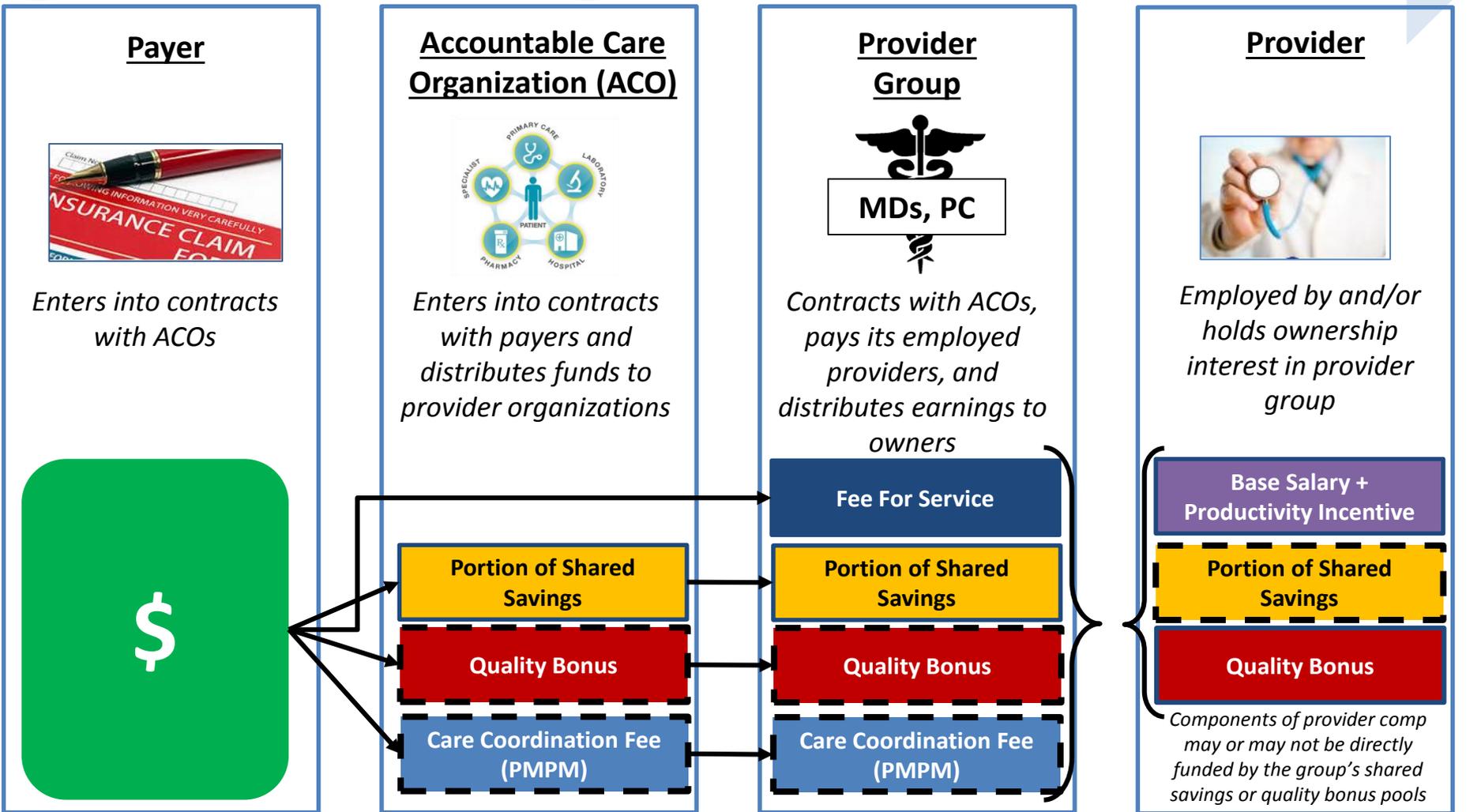
Recommendation	Under-Service	Patient Selection	Other E&A implication
1 <i>Rewarding Improvement</i>			
2 <i>Benchmark Adjustment for New Treatments</i>			
3 <i>Supplemental Payments for Complex Patients</i>			
4 <i>Retrospective Assessment of Risk Adjustment</i>			
5 <i>Cost Truncation and Service Carve-outs</i>			

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5. Design Group 2: Payment Calculation & Distribution



Key = Typical contractual provision = Less typical contractual provision

Note: an ACO can include one or multiple provider groups 10

5. Design Group 2: Payment Calculation & Distribution

The following ideas emerged from Design Group 2 when asked to consider how payment calculation and distribution methodology might bear on patient selection or underservice.

1

Quality Thresholds

ACOs should only be able to share in savings if they meet threshold performance on quality measures.

2

Discrete Quality Payments

Providing discrete incentive payments based on quality performance, irrespective of whether savings are achieved, will promote the provision of appropriate care and serve as a counter-balance against any incentive to inappropriately reduce costs.

3

Rewarding Quality Improvement

ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement.

4

Minimum Savings Rates (MSRs)

MSRs should not be utilized, or should be structured in a way that allows for deferred recoupment of savings. In the former case, any savings achieved should be shared with providers (assuming quality thresholds are met), thereby reducing the "all or nothing" aspect of reaching or not reaching an MSR. In the latter case, if an ACO demonstrates savings over a multi-year period which failed to meet an MSR in individual years, but which in combination are statistically significant, the ACO should be retroactively eligible to share in those savings.

5. Design Group 2: Payment Calculation & Distribution

The following ideas emerged from Design Group 2 when asked to consider how payment calculation and distribution methodology might bear on patient selection or underservice.

5

Reinvestment of Non-Retained Savings

When an ACO demonstrates cost savings, but is not eligible to receive the savings (either because the MSR was not met or because quality/performance targets were not met), the funds should be reinvested either (a) into the community's delivery system as a whole or (b) into the ACO (subject to a set of guidelines to ensure that funds are earmarked to support the ACO's future ability to deliver high performance, and are not used to finance incremental growth or compensation)

6

Payment Distribution Methods

To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel.



5. Design Group 2: Payment Calculation & Distribution

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues.

Recommendation	Under-Service	Patient Selection	Other E&A implication
1 <i>Quality Thresholds</i>			
2 <i>Discrete Quality Payments</i>			
3 <i>Rewarding Quality Improvement</i>			
4 <i>Minimum Savings Rates (MSRs)</i>			
5 <i>Reinvestment of Non-Retained Savings</i>			
6 <i>Payment Distribution Methods</i>			

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6. Design Group 4: Monitoring & Detection

The EAC charter poses a number of questions for the council to answer that are related to monitoring for under-service and patient selection.

Guarding Against Under-Service and Patient Selection:

Assigned to...

Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language		Design Group
A	What are the current methods utilized by private and public payers for detection/monitoring?	4
B	Can standard measures and metrics be applied for detection/monitoring?	4
C	What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied here?	4
D	What other methods might be available to monitor for patient selection (e.g., mystery shopper)?	4
E	Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?	3 & 4
F	What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings	3
G	What are the mechanisms for consumer complaints of suspected under-service?	4



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B	Can standard measures and metrics be applied for detection/monitoring?	4

A

Shared savings payments are still in a nascent stage and therefore so are the current monitoring and detection methods. However, some payers and providers, like Crystal Run, which focuses on monitoring over/under utilization by cost offer a good place to start...

B

A potential standard approach to measurement:
Conduct utilization comparisons over time and between groups (i.e.; between different ACOs and between ACOs and FFS populations)

Examination can be twofold:

1. Assess variation in total cost of care for populations or sub-populations (adjusted for payer mix to provide on par comparisons)
2. Assess variation in utilization (i.e.; of different interventions) by diagnosis where there is a specific under-service concern and well-understood intervention guidelines

Benefits

- Allows for more robust understanding of care patterns than either method alone can provide.
- Specific under-service measures for universal adoption may not be a good idea - more effective deterrent if specific measures are not known in advance by providers; monitoring may differ by payer.
- Serves as an initial filter for under-service, but will require additional investigation to assess the root cause of the variation and determine if it is truly related to under-service.



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Guarding Against Under-Service and Patient Selection:

Assigned to...
Design Group

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

D	What other methods might be available to monitor for patient selection (e.g., mystery shopper)?	4
G	What are the mechanisms for consumer complaints of suspected under-service?	4



OHA Nurse Consultant (Ombudsman) Potential Job

Description

- Dedicated** to addressing under-service and patient selection.
- Proactively **monitors and analyzes utilization data** produced from standard monitoring activities and **patient grievances** to identify trends that point to equity and access concerns and merit further investigation.
- Plays a role as a **patient educator**, in particular as it relates to under-service, and to promote role as a trusted patient resource.
- Plays role as a community **health worker educator** to promote under-service education in day to day interactions.
- Communicates back to providers** when patients voice grievances, even when there is no evidence of provider mistreatment.
- Responds** and further investigates under-service and patient selection concerns as they are flagged.



Mystery Shopper

- ✓ Consensus that this **role provides helpful insight into the occurrence of unwanted behavior**, in particular patient selection.
- ✓ Consensus that this role **should exist for all payer populations.**

Additional Considerations:

- Should this role be a centralized function run by the state?
 - Could the existing Administrative Services Organization contract under which DSS obtains mystery shopper data for the Medicaid population be expanded on a contributory basis to cover all payers?
 - Could the role be housed within OHA and paired with the Nurse Consultant?
- Should payers that engage in shared savings contracts be required to conduct mystery shopping and publicly report results?



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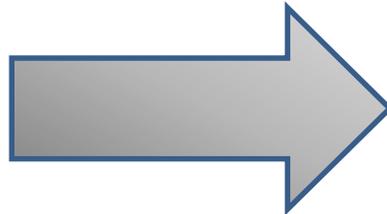
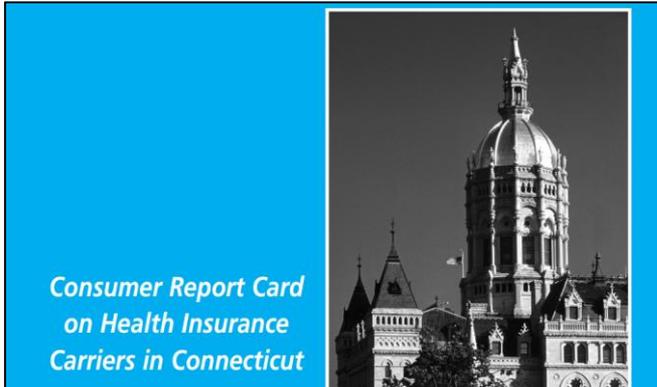
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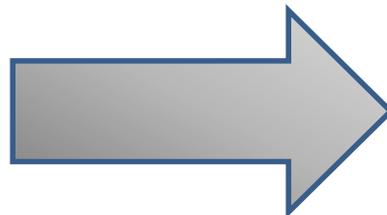
E **Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?**

3 & 4

What are the council's thoughts on using the Consumer Report Card and the APCD to generate insight into any trends related to under-service and patient selection?



Possibility to include new statistics (i.e. utilization-based) related to impact of value-based contracts, including under-service indicators, in annual Consumer Report Card on Health Insurance Carriers in Connecticut developed by the CID. This would require that payers analyze claims data for under-service and patient selection.



*Possibility to use all payer claims database to do monitoring.**

*Note: DSS has not been able to determine how to satisfy federal and state statutory standards for disclosure of Medicaid data to APCD.



6. Design Group 4: Monitoring & Detection

Below is a summary of the existing research and ideas that have been generated in response to questions posed in the charter.

Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language	Existing Research and Evidence Considered to Date
A What are the current methods utilized by private and public payers for detection/monitoring?	<ul style="list-style-type: none"> Public: CHN on behalf of DSS*, robust quality metrics – including utilization metrics (VT Medicaid), CMS metrics pending Private: Anthem gaps in care
B Can standard measures and metrics be applied for detection/monitoring?	<ul style="list-style-type: none"> Comparison of an ACO population over time (i.e.; utilization and risk adjustment) – CMS MSSP, VT Medicaid Scale of savings – CMS Measures/metrics will only serve as an initial flag that a problem may exist, but will likely need to be followed up with further data analysis or an audit to confirm
C What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied here?	<ul style="list-style-type: none"> Request made to CMS for details about their monitoring activities and results
D What other methods might be available to monitor for patient selection (e.g., mystery shopper)?	<ul style="list-style-type: none"> Mystery shopper (DSS) Ombudsman/Nurse Consultant (CMS) More robust nurse consultant role (EAC design group feedback)
E Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?	<ul style="list-style-type: none"> Payer (CMS, VT Medicaid) Payers, ACOs, and/or centralized state function (EAC design group feedback)
G What are the mechanisms for consumer complaints of suspected under-service?	<ul style="list-style-type: none"> Dedicated Ombudsman for patients in an ACO (CMS) Dedicated, proactive OHA nurse consultant monitoring role to help consumers identify and address potential cases of under-service or patient selection (EAC design group feedback)

*Note: CHN on behalf of DSS also 1) reviews PCMH practices based on a range of HEDIS and measures (on an annual, as well as year-over-year improvement basis), as well as comparing PCMH practices and non-PCMH practices; and 2) Performs some population-based inquiries (e.g.; regarding women with high risk pregnancies)

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Recommendation Adoption Vehicles

For each of the EAC's recommendations, the Council will characterize the nature of the recommendation and the vehicle through which we expect it will achieve its impact.

What is the recommendation about?



- Patient selection
- Under-service
- Other equity and access issue

Through what vehicle will the recommendation's impact be realized?



- Voluntary** adoption of standard by payer or provider – **minimum essential component** of a total cost of care payment arrangement
- Voluntary** adoption of standard by payer or provider – **additional consideration** for a total cost of care payment arrangement
- Creation of **mandatory standard** via regulation/legislation
- Other state action** (e.g. monitoring or enforcement programs)



Design Group 4: Monitoring & Detection

The EAC charter poses a number of questions for the council to answer that are related to monitoring for under-service and patient selection.

Guarding Against Under-Service and Patient Selection:

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

Design Group

A What are the current **methods utilized by private and public payers** for detection/monitoring?

4

Research/Evidence to Date



Medicaid

Shared Savings

- Robust quality targets with savings achievement dependent on meeting targets



Medicare

Shared Savings

- Stated that it would monitor for avoidance of at-risk patients and for stinting on care.
- Methods mentioned include comparing risk of population across years and flagging providers with very large savings



DSS

- CHN on behalf of DSS utilizes tool to review claims and examine provider behavior



- Gaps in care tool
- Provider care management solution

Other methods CT payers use?

Design Group 4 Initial Perspectives & Ideas

- Relying on patient-reported grievances and/or patient experience data (e.g.; CAHPS) alone is an insufficient monitoring mechanism.
- Crystal Run used total spend as a first-order filter to identify over/under utilization across providers.



Design Group 4: Monitoring & Detection

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Design Group

B Can **standard measures and metrics be applied** for detection/monitoring?

4

Research/Evidence to Date



Medicaid Shared Savings

- Both use metrics that require comparisons of ACO population/performance over time (i.e.; risk of population between years and analysis of changes in utilization patterns)
- CMS suggests that it will examine the scale of savings



Medicare Shared Savings

Analyzing claims data against defined metrics can serve as a way to identify patterns that merit further inquiry. It will likely not be sufficient on its own to confirm that under-service and/or patient selection has occurred.

Design Group 4 Initial Perspectives & Ideas

None of the following were recommended as “standard measures,” but they were discussed by the design group

- Mine claims data to **identify variance** in the rate of interventions per patient with a particular diagnosis. Comparing ACOs to each other, or comparing the ACO-served population with the purely FFS population. All differences should be further probed to determine if they are **beneficial** or **inappropriate**.
- Monitoring should include identifying any patterns of **selection for patients with clinical conditions that afford especially large opportunities** to earn shared savings. This suggestion arose out of a concern about “crowding out” patients where the incentive is not prevalent, potentially leading to a narrowing of access if primary care providers begin to specialize in treating patients with certain diagnoses.



Design Group 4: Monitoring & Detection

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D What other methods might be available to monitor for patient selection (e.g., mystery shopper)?	4
G What are the mechanisms for consumer complaints of suspected under-service?	4

Research/Evidence to Date



Medicare Shared Savings

- Uses already existing Ombudsman function
- Dedicated monitoring function for grievances filed by beneficiaries assigned to an ACO



DSS

- Mystery shopper program in existence today
- Annual Mystery shopper study that assesses access to care by visit type (i.e.; urgent care, routine visit, etc.) and the impact of insurance type on appointment availability
- Mystery shopper also assesses if callers are treated with respect - Medicaid beneficiaries regularly report lack of respect as an unfavorable aspect of their care experience

Design Group 4 Initial Perspectives & Ideas

- Prior **mystery shopper** efforts by DSS have been effective and provide a good model. This role could **dovetail with the nurse consultant role**, who could apply a clinical lens when patient selection or under-service is identified.
- Other concurrent (real-time) monitoring methods could include:
 - **Peer review** of provider performance/panel composition
 - Reviewing access to different services by **geographic area**
 - Reviewing **insurance plans** to identify ways benefit structure may affect coverage and inclusion in ACOs of patients with certain clinical conditions
- Several suggestions were made about what **responsibilities the OHA nurse consultant** should have:
 - **Dedicated** to addressing instances of under-service and patient selection
 - Play a **proactive role**, taking intelligence gleaned from monitoring activities to conduct investigations
 - **Monitor outcome and utilization data** to understand if interventions being used are successfully addressing equity and access concerns
 - Part of larger group that **identifies “seminal events”** for which special investigations should be conducted to evaluate potential issues
 - Monitor **gaps in care transitions** (e.g.; readmissions) to identify patterns of complex patients who are not getting sufficient care management services



Design Group 4: Monitoring & Detection

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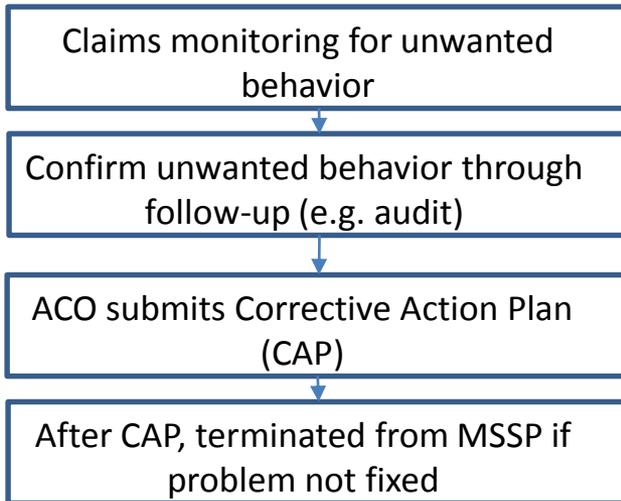
3 & 4

Research/Evidence to Date



Medicare Shared Savings

ACO will not receive savings nor be eligible for savings during CAP



Medicaid Shared Savings

- Emphasized constructive learning framework approach
- Take instances of unwanted behaviors and learn from peers how to improve

Design Group 4 Initial Perspectives & Ideas

- No matter what type of monitoring is performed, **the state will have a prominent role to play** unless a clear business case for payers or providers to do monitoring is established.
- The group that worked on the Health Neighborhoods program recommendations identified in greater detail **what** they wanted to monitor before determining who should do the monitoring and what the source of the data should be.