

**Connecticut State Innovation Model (CT SIM) – Equity and Access Council (EAC)
Summary of Draft Recommendations for EAC Consideration on March 26, 2015**

Introduction

The CT Healthcare Innovation Steering Committee (HISC) has charged the EAC with evaluating the risk of, and recommending methods to safeguard against, under-service or patient selection that could occur as a byproduct of the transition from fee-for-service provider reimbursement to payment models that reward providers for managing total cost and quality of care.

The EAC has explored nine “solution areas” in which the state, payers, providers, or other entities could build such safeguards into the healthcare financing and delivery system in concert with other reforms. At its meeting on March 12, 2015 the EAC will consider adopting recommendations in two of these areas. Please see materials at www.healthreform.ct.gov for more background on these solution areas.

Recommendations that are adopted in EAC meetings will be placed in a draft report, which, once complete, will be subject to a review in which the EAC considers each recommendation again, this time in the context of the full slate. The report, once the EAC adopts it, will be submitted to the HISC for its consideration, feedback, and adoption.

The EAC, like other components of the SIM governance structure, exists to surface effective solutions and to create alignment among key stakeholders in support of the goals established in Connecticut’s State Healthcare Innovation Plan. Its recommendations are intended to inform the actions of policymakers as well as those who purchase, provide, insure, and utilize healthcare in Connecticut. They are not binding on the executive branch of government, on any of the EAC’s members, or on the organizations they represent.

Design Group 2 – Areas 3 & 4: Payment Calculation and Distribution

Background

The way in which payments from insurers to ACOs are calculated, and the way in which ACOs distribute payments to provider groups and individual providers, have implications for the risk of patient selection and under-service that could occur as a byproduct of shared savings contracts. The EAC explored a number of contract design features and payment distribution principles that might deter inappropriate withholding of services and ensure that quality improvement is an essential component of the effort to manage healthcare costs more effectively.

Recommendations

Recommendation # 1: ACOs should only be able to share in savings if they meet threshold performance on quality measures.

Recommendation # 2: 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.

Recommendation #3: 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.

Recommendation #4: 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.

Recommendation #5: 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)

Recommendation #6: 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.