STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
March 26, 2015
6:00-8:00p.m.

Location: Connecticut State Medical Society, 127 Washington Avenue, East Building, 3rd Floor North Haven, CT

Members Present: Ellen Andrews; Johanna Bell; Christopher Borgstrom; Peter Bowers; Alice Ferguson; Kristen Hatcher; Margaret Hynes; Gaye Hyre; Donald Stangler; Vicki Veltri; Robert Willig; Katherine Yacavone

Members Absent: Linda Barry, Maritza Bond, Arnold DoRosario, Roy Lee, Kate McEvoy, Robert Russo

Other Participants: Mark Schaefer; Adam Stolz; Sheldon Toubman

The meeting was called to order at 6:04pm.

1. Introductions

2. Public Comment
There was no public comment.

3. Minutes
Adam Stolz asked for a motion to adopt the March 12th EAC meeting minutes, which was made and seconded. The minutes were approved.

4. Design Group 1: Cost Target Calculation – EAC Consideration of Recommendations for Adoption (Continued from Prior Meeting)

Mr. Stolz facilitated a discussion about recommendations related to Design Group 1 that the EAC previously considered.

1. *Rewarding Improvement* – This recommendation was previously considered and adopted.

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."*

This recommendation was previously considered, and revised as written above to more narrowly focus on the advent of new treatments rather than atypical occurrences of any kind that affect total medical spending.

Ellen Andrews expressed concern that events other than introduction of new treatments (e.g. abnormally bad flu season) could result in providers not earning shared savings, which could potentially lead those providers to stop participating in a shared savings program or stop taking a payer population (e.g. Medicaid) altogether. She remarked that even upside-only risk is in a sense downside risk because currently, many providers feel they are undercompensated by Medicaid and

are therefore restricting the amount of Medicaid patients in their panel. From the perspective of the provider, shared-savings offers an opportunity to decrease the financial loss associated with caring for Medicaid patients. Chris Borgstrom remarked that this is also reflected in the opportunity cost. Sheldon Toubman suggested draft recommendation number two include new treatments and unusual public health occurrences such as a flu epidemic. Robert Willig said Aetna does not pay less than the prevailing commercial rate and that downside rates are a long ways off. Dr. Willig noted that there is a capability to exclude expensive treatments if the need arises.

Mark Schaefer asked why the recommendation was initially narrowed to focus on new treatments. Dr. Schaefer added that a flu epidemic would increase the benchmark for the following year, evening out the initial loss. Kathy Yacavone clarified Ms. Andrews's point that an epidemic would affect regular performance and incur unusual costs that shared-savings would not account for, such as additional staffing to meet demand. Donald Stangler suggested adding a risk target to provide protection against any unusual events that could increase the cost trend.

Gaye Hyre asked what would happen if unusual events become the norm for a number of years, citing the HIV outbreak in Indiana as an example. Mr. Stolz explained that these costs would be captured in the benchmark for the next performance year. Ms. Yacavone suggested the draft recommendation language be broadened to include a broader set of atypical cost-inflating events. Dr. Willig explained that commercial payers look at the population year over year and the ACO takes into account some variation in new therapies and costs. Commercial payers will sometimes remove an outlier patient from the cost calculation. Peter Bowers added that there are outlier protections and that the cost targets and performance measures quickly align when using the prospective model. Dr. Willig added that a new drug expense, such as Sovaldi, will affect ACOs across the board and is not related to geography. Mr. Stolz summarized the sense of the group to revert to language used in earlier version of the draft recommendation.

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."*

This recommendation was previously considered and tabled for further discussions. Bonita Grubbs endorsed language that prevented exclusion based on income and asked for some clarification. Mr. Stolz explained that total cost of care may not be reflected in purely clinical risk adjustment. For example, a homeless population with a clinical risk-adjustment equivalent to a non-homeless population may cost more to care for. Mr. Borgstrom said an issue may arise around the way supplemental payments can be used. Ms. Yacavone reasserted a point from earlier EAC meetings that the rural areas of Connecticut have additional access barriers. Ms. Andrews and Keith vom Eigen expressed concern that paying a practice extra to care for certain groups of people may label those groups, and suggested that practices perhaps be reimbursed for actual support services utilized such as a translator. Mr. Borgstrom suggested a patient navigator funded by an upfront incentive payment based on the provider's Medicaid roster.

A discussion ensued about where the money would come from for these resources to take care of complex populations. Mr. Stolz suggested source of funding be left off the table as the draft recommendations from the EAC have not addressed financing to date. Mr. Stolz said as long as the need for funding does not adversely affect other equity and access issues, those who finance healthcare in the state will have to make those decisions. Within the context of leaving financing off the table, there was agreement to include the recommendation.

4. *Retrospective Assessment of Risk Adjustment* – This recommendation was previously considered and adopted.

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."*

Mr. Stolz explained that based on the March 12 discussion, service carve outs were added to cost truncation in draft recommendation number five, "Cost Truncation and Service Carve-outs." A service carve out could include things transplants and may include drugs like Sovaldi which were discussed earlier in the context of outliers. The group agreed to include the recommendation as now written.

5. Design Group 2: Payment Calculation and Distribution – EAC Review & Consideration of Recommendations for Adoption

Mr. Stolz reviewed a schematic depicting how funds typically flow from payers to ACOs to provider groups and providers. Ms. Yacavone asked for clarification about ACO verse provider eligibility criteria for shared-savings. Mr. Stolz said payers can create terms and rules of contracts while an ACO can choose how to compensate their providers. Dr. Bowers pointed out that variation will occur across ACO organizations. Ms. Andrews suggested distinguishing between providers with an ownership interest in their group and those with a salary because those with an interest benefit financially by denying expensive patients care in a shared-savings model.

Mr. Stolz facilitated a discussion about recommendations related to Design Group 2.

1. *Quality Thresholds – "ACOs should only be able to share in savings if they meet threshold performance on quality measures."*

There was a discussion about whether it is appropriate for the EAC to be specific about quality measures, or whether the EAC should allude to the work of the Quality Council. Dr. Schaefer and Ms. Yacavone discussed the quality benchmarks being developed by the Quality Council. Mr. Stolz said that in light of the Quality Council's health equity design group, does the recommendation need to be more specific or should the EAC defer to the equity design group's findings? Dr. Schaefer said the issue is best addressed by including health equity gaps in the scorecard and rewarding measures that address these gaps. The payer's perspective was reiterated that low performance on quality measures would disqualify an ACO from participating in shared savings. Currently, if the ACO is poorest performer of a group of ACOs they do not receive any shared savings. Dr. Stangler said United Healthcare uses a baseline with targets of one, two, and three years.

Ms. Andrews asserted quality measures that serve as a qualifier to a shared-savings programs should include a robust number of under-service measures. Dr. Willig said there are about 60 different measures. These include basic measures unless the provider is already at 100 percent on those measures. Other factors such as providing better care by adding medication or controlling heart failure through additional medications are also included in the basic measures – these serve to disincent under-service.

Mr. Toubman reminded the Council that its charge is to develop underservice measures as a prerequisite for providers earning shared savings. Mr. Stolz clarified that the Council is charged with recommending methods – this could take the form of specific measures or of other methods like proactive monitoring and investigation – and that payers committed more broadly to the notion that any ACO that demonstrates systematic or repeated underservice won't be eligible for shared-savings. Dr. vom Eigen said that quality performance is important to track to see if certain groups are continuously missing targets. Quality may also include access e.g. how long does it take to get an appointment? Were you able to get a translator? It is worthwhile to have a separate indicator or qualifier that relates equity and access. Mr. Stolz said additional language could be placed in the

recommendation to explicitly state the "lack of under-service or patient selection" gate that an ACO has to pass through to earn shared savings. The group agreed to employ language from the Charter in the recommendation; with that change the group agreed to include the recommendation.

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."*

Dr. Bowers noted that pay for performance has not historically been very successful as moving the needle on performance, absent a total cost of care incentive. Ms. Andrews said it differs with Medicaid where providers already feel underpaid. If they have discrete quality payments, providers know they will receive some sort of compensation. Ms. Yacavone said she would not want discrete quality payments to be optional. Dr. Schaefer felt that it is an important concept that shouldn't be lost. Mr. Toubman said he thought the group was articulating a desire to not interfere with the Medicaid PCMH quality payment reward system. The group decided to preserve the recommendation in its current form.

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."*

Rev Grubbs expressed concern about the lack of encouragement for ACOs to take on complex populations. Ms. Andrews agreed, explaining that if you haven't treated populations in the past you may be penalized for taking on new patients who might be more challenging if you are penalized for performance against a historic standard. Dr. vom Eigen countered that if a provider does poorly one year, their benchmark would be lower the next. He said overall improvement over a number of years is a good thing. Ms. Grubbs asked how to incentivize people from an access standpoint. Dr. vom Eigen suggested that a newly served patient be excluded from an ACO's quality calculations. This would ensure that providers are not penalized for taking on more challenging patients that might imperial their ability to demonstrate improvement against prior performance. Ms. Yacavone added that it is retrospective analysis.

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."*

Ms. Andrews stated that the design group discussion reflected a preference that MSRs not be utilized, and that using certain types of MSRs is a secondary preference. Ms. Yacavone agreed.

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)."*

Dr. Bowers said that for the fully insured there are MLR rules and that ASO clients would not be supportive of this recommendation. Dr. Schaefer asserted that employers are interested in working to reduce premiums. The same thing may not apply to Medicaid. Dr. Willig agreed, stating that employers may view this as a tax and not a positive step. Ms. Andrews noted that by definition the savings in question here have been generated at the expense of quality or underservice and so isn't it appropriate that the money saved should go back into the community in some manner, rather than to the payer. After some discussion regarding the merit of this recommendation, the group decided to table the issue for further discussion.

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."*

Dr. vom Eigen endorsed the recommendation in the interest of preventing incentives for providers to limit the groups they serve. Mr. Toubman said the recommendation provides important consumer protection. The group discussed how this might be practically implemented. Dr. Willig said the ACOs have to be held to task and the EAC cannot prescribe how to distribute savings. The group would need to look at how recommendations were implemented. Dr. Schaefer said if a payer decided to adopt the recommendation, they could choose to enter into a contract for shared-savings only if the ACO agreed to terms like these. Dr. Willig said that some recommendations must be geared toward ACOs too.

Mr. Borgstrom asked if the group elected not to include a recommendation related to funding in the form of advanced payment for investment in ACO capabilities. Mr. Stolz acknowledged that he had not translated discussion of that topic into a recommendation and suggested he and Mr. Borgstrom confer in order to bring that back in the form of a recommendation for the EAC's consideration.

6. Design Group 4: Retrospective and Concurrent Monitoring and Detection – EAC First Review

Mr. Stolz reviewed ideas that emerged from the Design Group 4 discussions concerning monitoring. The group discussed the role of monitoring ACOs vs individual providers. Ms. Andrews suggested individual providers be looked at as well as ACOs, citing Crystal Run's experience where there were providers who fell above and below the bell curve. Dr. vom Eigen suggested the ACO work with the individual provider. Ms. Andrews suggested that underservice would have to be dramatic to detect it if it is only examined at the ACO level.

Dr. Bowers suggested monitoring look at both individual and cumulative instances in gaps of care. Dr. Willig noted that companies are starting to report gaps in care when they exist on a daily basis. For example, a diabetic with high cholesterol not on Statin is recognized through claims data and reported to the PCP. Dr. Bowers said this method is important when working with physician groups. Dr. Willig said each insurer has meetings with provider groups on a periodic basis.

Mr. Stolz said for the Council to get to a recommendation, they need to say in a systemic way what they expect payers will do with respect to monitoring ACO performance? How will instance of under-service or patient selection be found? How will the public know two years down the road whether this monitoring has occurred and what the results are? Dr. Bowers said responsibility usually lies with the ACO. It is a quality of care issue. If a quality of care issue is raised, a group will work to have a corrective plan. Dr. Stangler agreed and added that fraud and abuse tools are also potentially useful. He went on to say however, that there are a lot of false positives and the data may not get to the underservice measures easily.

Dr. vom Eigen expressed concerns from the provider perspective around gaps in care notifications. Dr. vom Eigen receives irrelevant or misinformed notices. He added that current practices, such as spending time on the phone with an insurance company over a patient refill, are not efficient. These duties could more effectively happen on an ACO level. He suggested in the future these responsibilities be integrated with the systems that are already in place. Vicki Veltri agreed that communication with the ACO is important and asked how they would ensure the ACO was notified when patients move from plan to plan. Ms. Andrews expressed that monitoring at some level should be done by an independent group. Dr. vom Eigen said it had to include more than just claims. Mr. Stolz suggested the group reconvene on the topic at the next meeting. Mr. Stolz asked for a motion to adjourn.

7. Closing Comments

There were no closing comments.

The meeting was adjourned at 8:05pm.