

CONNECTICUT
HEALTHCARE
INNOVATION PLAN

Equity and Access Council Meeting

February 26, 2015



Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Report Out On EAC Member Survey	10 min
5. EAC Phase I Roadmap: Progress & Approach to Next Steps	20 min
6. Design Group 1: Patient Attribution & Cost Benchmark Calculation	40 min
7. Design Group 4: Retrospective and Concurrent Monitoring & Detection	25 min
8. Closing Comments	5 min

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4. Report Out of Survey Results

7 out of 20 EAC Members Completed The Survey from 1/27/15 through 2/17/15

Highest Ranked Barriers to Participation

Response

Logistically difficult to make meetings

Conference line available for those who cannot make it in person on a given date

Need to be equipped with more information prior to Council meeting in order to participate effectively

- Materials sent prior to the meeting with supplemental reading materials
- Pre-meeting Q&A sessions held

Other Survey Highlights:

- Across all payer populations, **lack of familiarity with the healthcare system** was identified as the most significant barrier to patients receiving care
- Among payer populations, **Medicaid beneficiaries** are perceived to have the greatest barriers to obtaining healthcare
- **Patient selection** is the greatest concern about moving from fee for service to shared savings programs
- **Monitoring mechanisms** are likely to be the most important safeguard
- Among the actors involved in payment reform, **Providers/ACOs** have the greatest ability to affect equity and access

A more complete synthesis of the survey is available on healthreform.ct.gov

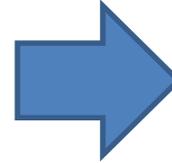
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5. EAC Phases of Work in the Context of SIM

**SIM
Vision**

Healthcare system of
today



More whole-person-
centered, higher-quality,
more affordable, more
equitable healthcare

**SIM
Initiatives**

1

Payment reform:
FFS → Value
All-payer alignment

2

Other SIM initiatives

**EAC
Function /
Phase of
Work**

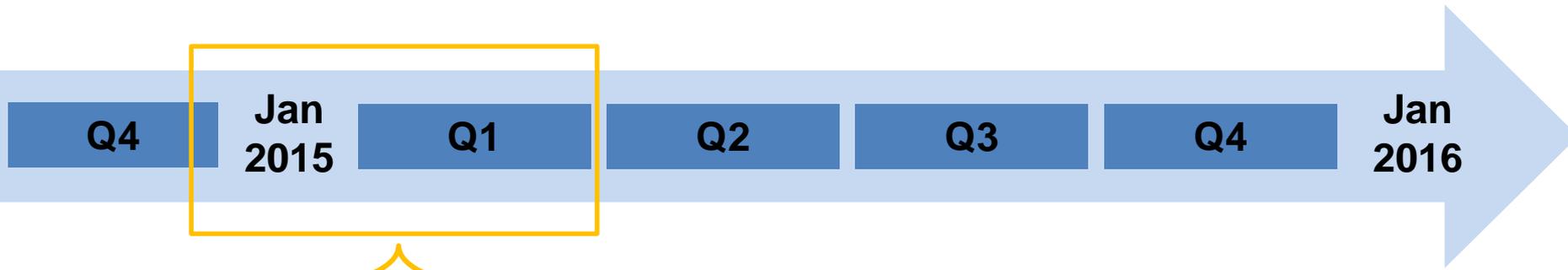
I

Issue recommendations for
preventing, detecting, and
responding to **under-
service and patient
selection**

II

Issue other
recommendations that
address **gaps or
disparities in healthcare
access or outcomes** that
can be impacted through
SIM

5. EAC Roadmap: Phase I Timeline – Updated



EAC Roadmap for 2015 Q1

	Dec	Jan	Feb	Mar	Apr
EAC Meetings	12/18	1/22	2/5 2/26	3/12 3/26	4/9 4/23
Key Activities	<p>EAC “Reboot”: Adopt roadmap, approach, schedule, priorities</p>	<p>Research, evidence review</p> <p>EAC articulation of options and preferences</p> <p>Design groups for identified safeguards</p> <p>Communication with MAPOC CMC</p> <p>Draft & edit report</p> <p>Public input</p>			<p>Report revisions, additional coordination with MAPOC CMC as needed</p>

5. Research and Evidence Review

Research & evidence review

We have pursued two ways of understanding the nature and likely extent of risks posed by contracts that incent providers to manage total cost and quality of care:

1

Review any findings about under-service or patient selection that may have resulted from existing contracts of this type.

- Given how new these payment mechanisms are, there is little or no direct evidence widely available to support or reject the hypothesized risks of under-service or patient selection.
- We have sought out evidence from CMS, other states, think tanks, and members of CT's payer, ACO, consumer, and regulatory communities.
- Extrapolating from evidence about the impact of capitated contracts is a fraught proposition in light of structural differences between pure capitation and the value-based contracts presently emerging in CT.

2

Assess the components of value-based contracts in order to identify whether and how contract provisions are likely to induce under-service or patient selection.

- In design groups 1 and 2 we have evaluated the elements of a value-based contract which could potentially create financial incentives for providers to under-serve patients or avoid certain patients.
- We have also studied the safeguards inherent in these contracts, including incentives to provide the most medically appropriate care and to care for the sickest, most complex patients.
- Aetna will be speaking more about this during today's meeting.

5. Research and Evidence Review

The Charter poses two questions about the nature of the risks the EAC is addressing.

- 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?



Medicare Shared Savings Program

- CMS “... proposed to use a variety of methods ... to identify trends and patterns suggestive of avoidance of at-risk beneficiaries” (CMS Final Rule 2011).
- Extensive experience monitoring for compliance provides CMS with necessary tools to “...assess whether ACO provider/suppliers have been stinting on care provided to beneficiaries assigned to the ACO in an effort to artificially create savings...” (CMS Final Rule 2011).



Medicaid Shared Savings Programs

- VT expressed concerns about under-service and patient selection similar to those found in CT's SIM grant application.
- According to VT, first year results in its Medicaid shared savings model do not suggest any evidence of under-service or patient selection. We are awaiting the availability of data to assess in greater depth.
- Initial cost and utilization claims based metrics do not suggest dramatic differences compared to 2013 baseline year.



Safety Net ACOs

- Robert Wood Johnson Foundation works with a collaborative of Medicaid and safety net ACOs; its experience to date is that historically vulnerable patients have benefited from these arrangements.
- RWJF notes that payment reform has incented better care management for “super-utilizers”.

5. Research and Evidence Review

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Capitation

- Capitated contracts – in which providers received a flat fee to care for a patient population – became increasingly prevalent for a period in the 1990s.
- These contracts were criticized for several reasons including the creation of financial incentives for providers to stint on care or avoid costly patients.

Capitation Prevalent in the 1990s:

- Placed full financial risk on providers.
- Eliminated fee for service payments.
- Lacked quality requirements, providing no direct financial incentive to ensure that quality of care was not sacrificed in the process of managing costs.

VS

Current and Emerging Shared Savings Models:

- Exposes providers to a capped amount of financial risk (in particular for upside risk arrangement).
- Retains fee for service payments for care rendered.
- Requires achievement of quality measures to be eligible for a share of savings.

5. EAC Milestones: Accomplished and Forthcoming

The EAC's development of recommendations, communication with MAPOC, and drafting of a report are each moving forward as described below.

EAC articulation of options and preferences

- Design groups have been stood up; 5 of 8 calls initially planned have taken place; remainder have been scheduled
- Development of recommendations is underway; first set to be considered today for preliminary adoption
- More discussion of design process on the following pages

Communication with MAPOC CMC

- DSS and the SIM PMO expressed an intent to align planning activities related to payment reform to the extent appropriate and useful.
- The EAC's recommendations may be useful to the MAPOC Care Management Committee (CMC) as it considers similar issues in the context of Medicaid payment reform (i.e. MQISSP). Reciprocally, recommendations made by the CMC will be incorporated within the set of recommendations made by the EAC.
- Communication and collaboration between the EAC and the MAPOC CMC will be facilitated by the Medicaid Director and an individual who holds membership on both the CMC and the EAC.

Draft & edit report

- A draft outline of the report will be circulated prior to the 3/12 EAC meeting.
- The outline will be populated with draft recommendations and other content as they emerge.
- In addition to the outline of the draft report, a framework will be created to capture all of the EAC's recommendations on a standing basis as they are developed. This framework will be made available to the council on the healthreform.ct.gov website.
- A completed draft of the report will be prepared for the EAC's consideration at its 4/9 meeting.

5. 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

5. Organizing the Design Process

To support further research, evaluation, and solution design, the EAC has organized its safeguard solution areas into four design groups.

Solution Areas

4 Design Groups

Design Groups	Design Groups	Principal Questions to Answer:
(1A) Attribution (1B) Cost target calculation (cost benchmarks & risk adjustments)	1	How to minimize improper patient selection by appropriately defining expected outcomes and accountabilities
(1C) Incentive payment calculation (1D) distribution	2	How to balance incentives to promote medically appropriate, efficient, patient-centric care decisions
(2A) Rules (2B) Communication (2C) Accountability/enforcement	3	How to set appropriate rules, communicate them, and enforce them
(2D) Retrospective detection (2E) Concurrent detection	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

5. EAC Milestones: Accomplished and Forthcoming

We are organizing the agenda for 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
Healthcare Innovation Steering Committee (HISC)	8				5					12				9			
Equity and Access Council Meetings			22		5			26		12		26		9		23	
Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2									
Group 2 - 1C-D: Performance-based payment calculation & distribution							M1			R1	M2	R2					
Group 3 - 2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
Group 4 - 2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

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



Design Group Workshop Participation to Date

DG1 M1 1/26	DG1 M2 2/13	DG2 M1 2/17	DG3 M1 2/19	DG4 M1 2/12
3 Consumer	2 Consumer	4 Consumer	2 Consumer	4 Consumer
4 Provider	3 Provider	2 Provider	2 Provider	4 Provider
2 Payer	1 Payer	1 Payer	0 Payer	0 Payer
1 Government	0 Government	1 Government	6 Government	0 Government
10 Participants	6 Participants	8 Participants	10 Participants	8 Participants

5. EAC Milestones: Accomplished and Forthcoming

All design groups have completed an initial milestone conference call (M1). Group 1 has also completed its initial EAC review (R1) and a second conference call (M2).

Design Group		M1	R1	M2	R2	Status
1	(1A) Attribution (1B) Cost target calculation (cost benchmarks & risk adjustments)	1/26	2/2	2/13	2/26	<ul style="list-style-type: none"> Attribution recommendations drafted, for consideration today Consideration of cost target recommendations will likely need to be carried over to 3/12 EAC
2	(1C) Incentive payment calculation (1D) distribution	2/17	3/12	3/19	3/26	<ul style="list-style-type: none"> Initial perspectives articulated on both topics; for discussion at 3/12 EAC
3	(2A) Rules (2B) Communication (2C) Accountability/enforcement	2/19	3/12	3/17	3/26	<ul style="list-style-type: none"> Initial perspectives articulated on all three topics; for discussion at 3/12 EAC
4	(2D) Retrospective detection (2E) Concurrent detection	2/12	2/26	3/5	3/12	<ul style="list-style-type: none"> Initial perspectives articulated on both topics; for discussion today

Completed

M1 Design milestone/workshop 1

R1 EAC initial review/input

On Today's Agenda

M2 Design milestone/workshop 2

R2 EAC final review/input

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6. Design Group 1: Cost Benchmark Calculation

Council and Design Group discussions on this topic have largely focused on how to appropriately risk adjust the cost benchmark, and on additional contract elements that exist today that are used to account for patient risk.

<p><i>What do most risk adjustment methodologies tend to adjust for today?</i></p>	 <p><i>CMS accounts for basic demographics (i.e.; age) and the acuity of diagnoses, but does not account for social determinants of health.</i></p>	 	<p><i>There are several proprietary methods used by various commercial payers to adjust for risk. However, all elements accounted for are not publicly available.</i></p>
<p><i>How are risk adjustment methods applied?</i></p>	 <p><i>CMS uses patient age to annually adjust the risk adjustment factor. It uses decreases in beneficiary acuity to adjust cost benchmarks downward, but it does not adjust benchmarks upward in response to increases in acuity.</i></p>		
<p><i>What supplemental methods are in use today?</i></p>	  <p><i>VT Medicaid ACOs and CMS truncate high cost claimants at the 99th percentile.</i></p>	 	<p><i>BCBS of Michigan rewarded providers for care management for patients with chronic conditions. This resulted in <u>improved quality and lower cost.</u></i></p> <p><i>Oregon providers are working toward developing a socioeconomic adjustment factor as a rationale for enhanced payments.</i></p>



6. Design Group 1: Cost Benchmark Calculation

How will the cost benchmark used to determine shared savings impact the risk for patient selection and under-service?

A proposed hypothesis is....

Providers who feel adequately reimbursed for caring for more complex and high risk patients will have no incentive to avoid complicated patients and will have no incentive to stint on care for those patients.

- 1** What elements must risk adjustment contain to meet the standard stated above?
- 2** What challenges might prevent a risk adjustment methodology from adequately adjusting for risk and the associated resources required to care for a patient population?
- 3** Which additional contract features that account for risk can help overcome the challenges of using inherently imperfect risk adjustment methodologies?

Examples of risk-related contract features include: truncation of high-cost claimants, provision of a supplemental care management per member per month fee and exclusion of high cost services/procedures



6. Design Group 1: Patient Attribution

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

1

Timing

Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and provide protection against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment.

2

Notification

Patients should be made aware when they are attributed to a physician who is participating in a shared savings program.

3

Attestation

Patients should be able to identify their primary care provider through an attestation (designation) process. In the event that the chosen provider's panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who do not pick a primary care provider through attestation will be assigned based on the plurality of their visits.

4

Reconciliation

An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year.

5

Settings of Care

Traditional attribution methodologies assume patients are actively seeking care from a physician. They will not attribute patients who seek care only in other settings (e.g. an ED or urgent care center). Payers should give strong consideration to using other settings of care for secondary attribution in order to attribute these patients and encourage a provider to take accountability for their care.



6. Design Group 1: Patient Attribution

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)



6. Design Group 1: Patient Attribution

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues. What adoption vehicle is most appropriate for each recommendation?

Recommendation	Under-Service	Patient Selection	Other E&A implication	Adoption Vehicle?
1 <i>Timing</i>				<input type="checkbox"/> Voluntary adoption of standard by payer or provider – minimum essential component of a total cost of care payment arrangement <input type="checkbox"/> Voluntary adoption of standard by payer or provider – additional consideration for a total cost of care payment arrangement <input type="checkbox"/> Creation of mandatory standard via regulation/legislation <input type="checkbox"/> Other state action (e.g. monitoring or enforcement programs)
2 <i>Notification</i>				
3 <i>Attestation</i>				
4 <i>Reconciliation</i>				
5 <i>Settings of Care</i>				

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7. 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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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

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

- CHNCT tool used 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.



7. Design Group 4: Monitoring & Detection

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Guarding Against Under-Service and Patient Selection:

Assigned to...

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

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.



7. 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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Design Group

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

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



7. Design Group 4: Monitoring & Detection

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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

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

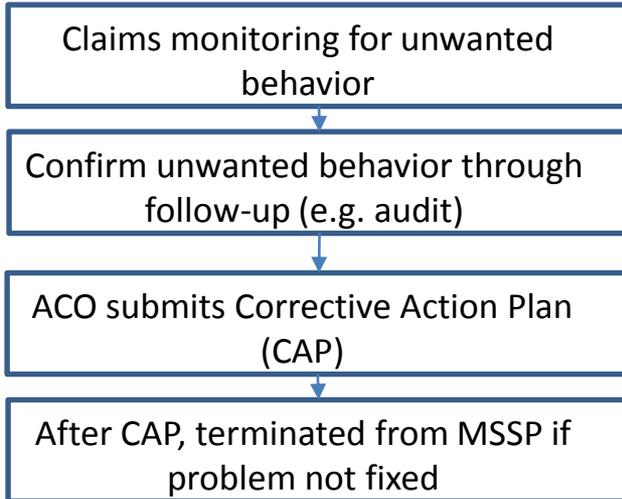
3 & 4

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.



7. 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
<p>A What are the current methods utilized by private and public payers for detection/monitoring?</p>	<ul style="list-style-type: none"> • Public: CHNCT (DSS), robust quality metrics – including utilization metrics (VT Medicaid), CMS metrics pending • Private: Anthem gaps in care
<p>B Can standard measures and metrics be applied for detection/monitoring?</p>	<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
<p>C What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied here?</p>	<ul style="list-style-type: none"> • Request made to CMS for details about their monitoring activities and results
<p>D What other methods might be available to monitor for patient selection (e.g., mystery shopper)?</p>	<ul style="list-style-type: none"> • Mystery shopper (DSS) • Ombudsman/Nurse Consultant (CMS) • More robust nurse consultant role (EAC design group feedback)
<p>E Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?</p>	<ul style="list-style-type: none"> • Payer (CMS, VT Medicaid) • Payers, ACOs, and/or centralized state function (EAC design group feedback)
<p>G What are the mechanisms for consumer complaints of suspected under-service?</p>	<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)

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