Equity and Access Council Meeting

April 9, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 3: Communication	20 min
5. Design Groups 3 & 4: Rules, Monitoring & Accountability	75 min
6. Closing Comments	5 min

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 3: Communication	20 min
5. Design Groups 3 & 4: Rules, Monitoring & Accountability	75 min
6. Closing Comments	5 min

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	25
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)**

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 3: Communication	20 min
5. Design Groups 3 & 4: Rules, Monitoring & Accountability	75 min
6. Closing Comments	5 min

4. Design Group 3: Communication

The following recommendations relate to the charge of Design Group 3, which was asked in part to consider how communication about shared savings might act as a safeguard against patient selection or underservice.

1

Consumer Communications: Scope

Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to efficiently manage the total cost of care and definitions of under-service and patient selection. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.

4. Design Group 3: Communication

The following recommendations relate to the charge of Design Group 3, which was asked in part to consider how communication about shared savings might act as a safeguard against patient selection or underservice.

2

Consumer Communications: Accessibility and Consistency

The type of information described in Recommendation #1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (i.e. at the time of insurance enrollment) and at the point of care (i.e. in the provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told.

3

Consumer Communications: Content Development

A work group should be convened to advise state agencies and payers on the content to be contained in the core messages described in Recommendation #2. This work group should recommend specific language to be incorporated in messages. The work group should be composed predominately of consumers, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

4. Design Group 3: Communication

The following recommendations relate to the charge of Design Group 3, which was asked in part to consider how communication about shared savings might act as a safeguard against patient selection or underservice.

4 ***Provider Communications***

Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to lower the total cost of care and definitions of under-service and patient selection. This latter information should be communicated in a consistent manner to all providers.

4. Design Group 3: Communication

The recommendations related to communications safeguard against under-service and patient selection, and also have other equity and access implications.

Recommendation	Under-Service	Patient Selection	Other E&A implication
1 *Consumer Communications: Scope*	✓	✓	✓
2 *Consumer Communications: Accessibility & Consistency*	✓	✓	✓
3 *Consumer Communications: Content Development*	✓	✓	✓
4 *Provider Communications*	✓	✓	✓

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 3: Communication	20 min
5. Design Groups 3 & 4: Rules, Monitoring & Accountability	75 min
6. Closing Comments	5 min

5. Design Groups 3&4: Rules, Monitoring & Accountability

A Layered Approach to Rules, Monitoring, and Accountability – DRAFT for Discussion

Payers

- Establish rules in contracts with ACOs
- Use claims data analysis, audits to monitor for compliance
- Rely on contract provisions for enforcement

ACOs

- Establish rules for participating groups or individual providers
- Embed robust performance management and care variations analysis in ACO governance

Provider Groups

MDs, PC

- Utilize peer review process to identify and correct any aberrant practices
- Structure individual provider compensation in a way that rewards clinical excellence and patient satisfaction

Providers

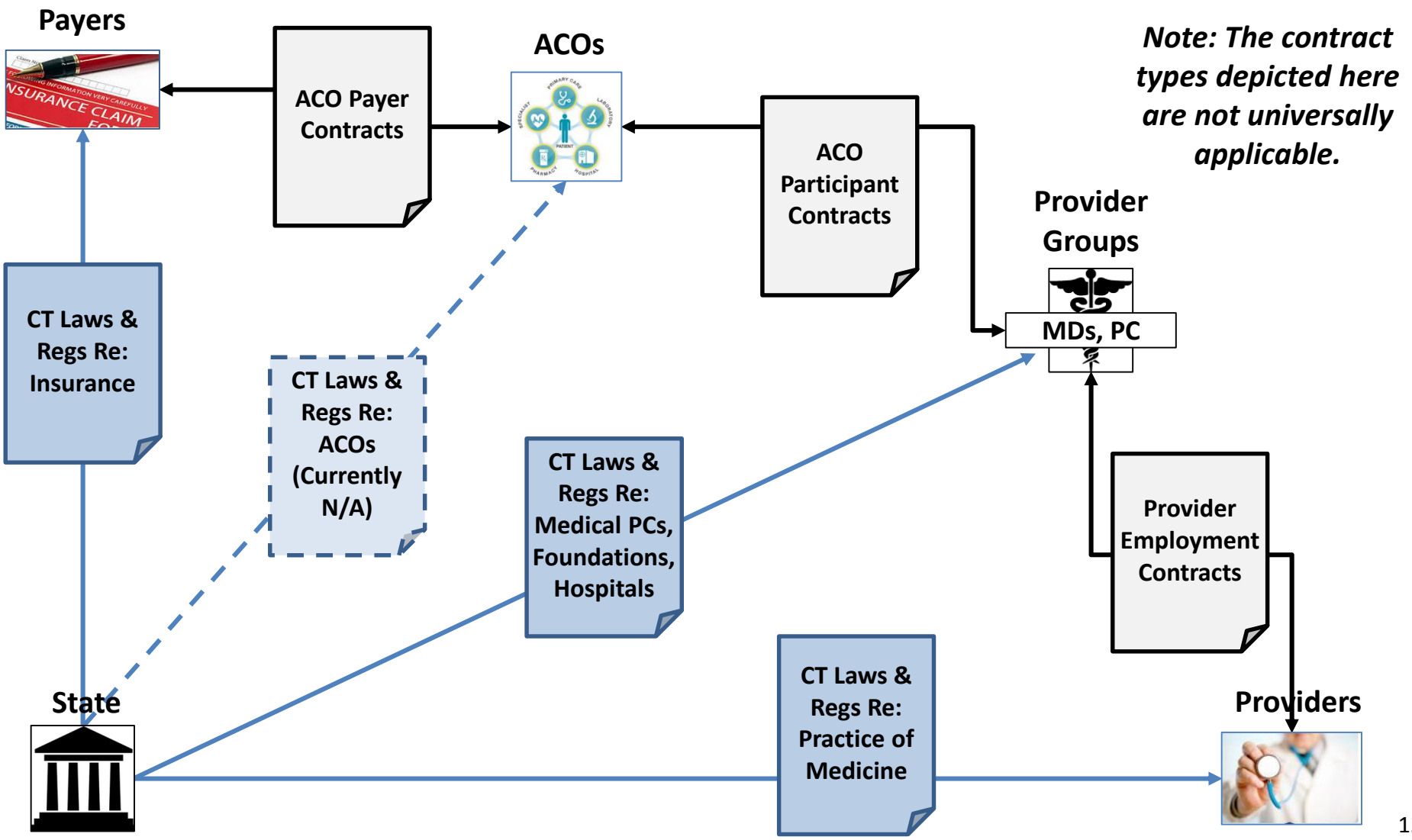
- Subject to ACO and group policies
- Subject to existing standards for the practice of medicine

State

- Plays a role in establishing what some or all of these entities are required to do within this type of system
- Plays an additional role in initiating independent analysis
- Conducts or organizes a complementary set of concurrent monitoring activities

5. Design Groups 3&4: Rules, Monitoring & Accountability

Potential Vehicles Through Which Rules, Monitoring & Accountability Mechanisms Could Be Expressed– DRAFT for Discussion



5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

1

ACO Internal Monitoring

ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.

2

ACO Accreditation

Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.

5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

3

Retrospective Monitoring Guidelines

Each payer that enters into shared savings contracts should monitor for under-service and patient selection on an annual basis using a set of analytic methods that it establishes. At a minimum, the standard under-service and patient selection monitoring performed by payers should include:

a) Under-service should be monitored through utilization comparisons over time and between groups (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to assess total cost of care variations.

b) Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time.

c) For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under-service payers should not necessarily disclose to providers which diagnoses will be monitored.

d) Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.

5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

4

Concurrent Monitoring: Nurse Consultant

A nurse consultant (i.e. ombudsman) will play a key role as a "hub" of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA).

5

Concurrent Monitoring: Mystery Shopping

Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population.

5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

6

Accountability: Corrective Action

When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. A CAP should not be punitive, but rather supportive through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.

5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

7

Retrospective Monitoring: Long-Term Analysis

After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer analysis of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.

5. Design Groups 3&4: Rules, Monitoring & Accountability

The following ideas relate to the charges of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

8

Accountability: Public Reporting

Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include:

a) Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which shared savings were withheld from an ACO.

b) OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions.

5. Design Group 2: Payment Calculation & Distribution

The recommendations related to rules, monitoring, and accountability address under-service and patient selection and also have other equity and access implications.

Recommendation	Under-Service	Patient Selection	Other E&A implication
1 *ACO Internal Monitoring*	✓	✓	✓
2 *ACO Accreditation*	✓	✓	✓
3 *Retrospective Monitoring Guidelines*	✓	✓	
4 *Concurrent Monitoring: Nurse Consultant*	✓	✓	✓
5 *Concurrent Monitoring: Mystery Shopping*		✓	✓
6 *Accountability: Corrective Action*	✓	✓	
7 *Retrospective Monitoring: Long-Term Analysis*	✓	✓	✓
8 *Accountability: Public Reporting*	✓	✓	✓

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 3: Communication	20 min
5. Design Groups 3 & 4: Rules, Monitoring & Accountability	75 min
6. Closing Comments	5 min