Connecticut State Innovation Model (CT SIM) – Equity and Access Council (EAC)

Summary of Draft Recommendations for EAC Consideration on April 9, 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 April 9, 2015 the EAC will consider adopting recommendations in three 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 3 (Area 3): Communication

Background

As shared savings arrangements and other forms of value-based payment become increasingly prevalent in Connecticut, it is important that those who provide and receive care have an understanding of how healthcare financing is changing, and what it means for them. Communicating directly to consumers about value-based payment reform provides an opportunity to engage them in their health and healthcare decisions, and to support their capacity for effective self-advocacy. In addition, alerting consumers to provider financial incentives and the associated potential for under-service or patient selection will promote detection and reporting of any such activities. However, depending on the context and content of such messages, they could also lead consumers to misinterpret provider decisions, undermine patient-provider relationships, or dissuade providers from participating in shared savings arrangements. The EAC sought to find a balance between these competing public interests.

Recommendations

Recommendation #1: 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.

Recommendation #2: 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.

Recommendation #3: 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.

Recommendation #4: 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.

Design Group 3 (Areas 1 & 2) / Design Group 4: Rules, Monitoring, and Accountability

Background

Adopting supplemental safeguards, complementary to those embedded in value-based payment design features, will enhance the extent to which under-served populations benefit from payment reforms. These supplemental safeguards can be described using a framework within which rules are articulated, care delivery is monitored, and accountability is exercised. To propose potential parameters for such a framework, the EAC drew on the rules that govern healthcare delivery today, in particular those related to ACOs; the approach to concurrent and retrospective monitoring employed by CMS, other payers, and providers; and common methods used to promote accountability in healthcare.

Recommendations

Recommendation #1: 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.

Recommendation #2: 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.

Recommendation #3: 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.

Recommendation #4: 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).

Recommendation #5: 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.

Recommendation #6: 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.

Recommendation #7: 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.

Recommendation #8: 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.