

**EAC PHASE I REPORT – COMMENTS ON DRAFT REPORT DISTRIBUTED 4/17/15**

This document contains the following submitted by EAC members and other readers:

- (11) Edits to Passages in the Report Narrative for EAC Consideration
- (1) Comment for EAC Consideration Not Confined to Specific Recommendations or Narrative Sections

**Edits to Passages in the Report Narrative for EAC Consideration  
April 23, 2015**

<b>Edit Suggestion #:</b>	1
<b>Submitted By:</b>	Ellen Andrews
<b>Page # (s) Referenced:</b>	31-32
<b>DRAFT Report Language/Summary:</b>	Summary: If individual providers are not directly incentivized to manage the cost of care of their patients (i.e.; savings distribution is dependent on how much they saved on their patient panel), monitoring at the ACO level will be more important than monitoring at the provider level.
<b>Recommended Edit:</b>	<p>On pages 31 to 32 you suggest that if individual providers are not directly rewarded for achieving savings, we don't need to be concerned that they will under-serve or avoid costly patients, and consequently we don't need to monitor for under service at the provider level.</p> <p>It's always best to measure at the point closest to the behavior you are concerned about – and here that is at the level of the providers who authorize treatments, or don't. A very wise professor told me that you don't try to measure how fast your lawn is growing from a satellite – you take a ruler out to your yard.</p> <p>I also don't think the incentives are that straight forward. People who aren't directly paid based on shared savings could still be motivated to deny necessary care with other levers by the ACO that is at financial risk based on savings. Managers and others at ACOs have lots of ways to motivate providers (and other employees) to limit care. This isn't a perfect analogy, but associates at law firms, who are not paid based on the firm's profits, work very hard to increase their billable hours. Incentives to overbill may be strongest for associates near a partnership. And since not all associates are close to partner, overbilling may not show up at the larger firm level. I agree that considering incentives can help us avoid perverse ones that promote underservice, but it can happen in any system for all the messy reasons that drive human behavior, including even salaried employees with no apparent financial incentive. We should monitor everyone.</p> <p>Monitoring by provider should not be more of a burden than by ACO, just more rows in the spreadsheet. The hard part of monitoring is figuring out the columns/metrics to monitor and finding data sources and definitions everyone agrees</p>

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	<p>with. Crystal Run monitors for variation – over and under treatment – at the provider level very effectively. I would imagine most ACOs do.</p> <p>I don't disagree with the recommendation, but I am not sure it is as protective as your argument suggests. Can we consider moderating the language in that section?</p>
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<b>Edit Suggestion #:</b>	2
<b>Submitted By:</b>	Vicki Veltri
<b>Page # (s) Referenced:</b>	34
<b>DRAFT Report Language/Summary:</b>	The Office of the Healthcare Advocate (OHA) is an independent agency that helps commercially insured consumers access medically necessary services and educates consumers about their rights and responsibilities under health plans.
<b>Recommended Edit:</b>	OHA helps people in all plans, public and private, commercially insured and self-funded. So we help clients in Medicaid, Medicare and all types of private coverage.

<b>Edit Suggestion #:</b>	3
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	8
<b>DRAFT Report Language/Summary:</b>	The specific questions the council was tasked with answering are outlined in more detail in the EAC charter found in Appendix A of this report.
<b>Recommended Edit:</b>	I would recommend including the questions presented, as opposed to citing to Appendix A. They won't take up much space, and will inform the reader.

<b>Edit Suggestion #:</b>	4
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	12-13
<b>DRAFT Report Language/Summary:</b>	Summary: description of attribution methodologies and examples of payers that use them.
<b>Recommended Edit:</b>	I am requesting that you identify CT Medicaid as another example of a payer that uses the "plurality of visits" technique and retrospective approach in its attribution method.

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<b>Edit Suggestion #:</b>	5
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	14
<b>DRAFT Report Language/Summary:</b>	Prospective assignment allows providers to know in advance which patients they are managing, potentially improving their ability to proactively manage toward improved outcomes and lower costs in a manner that retrospective assignment does not allow. Many physicians prefer prospective assignment. However, CMS has been historically reticent to utilize prospective assignment because of its articulated concern about associated risks of under-service: "... we agree with the comment that while providing such information may be a benefit to both the beneficiary and the ACO, concerns remain that ACOs could use it to avoid at-risk beneficiaries or to stint on care." (CMS, CMS Medicare Shared Savings Program Final Rule, 2011).
<b>Recommended Edit:</b>	I am requesting that you indicate that another motivation for CMS using a retrospective approach in attribution was to support consumer choice.

<b>Edit Suggestion #:</b>	6
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	26
<b>DRAFT Report Language/Summary:</b>	Summary: Blue box describing the difference between upside vs two-sided risk shared savings program contracts.
<b>Recommended Edit:</b>	I believe that it would be helpful to indicate within the blue text that the Medicare SSP started with an expectation of upside-only risk in year 1, then migrated to downside risk.

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<b>Edit Suggestion #:</b>	7
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	34
<b>DRAFT Report Language/Summary:</b>	The Department of Social Services (DSS) is the single state agency for Medicaid in Connecticut. It contracts with Community Health Network of Connecticut, Inc. (CHNCT), a not-for-profit corporation, to provide administrative services for the Medicaid program. In this section of the report, the term “payers” is meant to include DSS and CHNCT acting on behalf of DSS
<b>Recommended Edit:</b>	Could you amend the reference to DSS on p. 34 to indicate that CHN is the medical ASO (we have three other ASO arrangements) and also indicate that it performs data analytics for the entire Medicaid program?

<b>Edit Suggestion #:</b>	8
<b>Submitted By:</b>	Kate McEvoy
<b>Page # (s) Referenced:</b>	35
<b>DRAFT Report Language/Summary:</b>	Summary: Discussion of use of CAHPS to assess patient satisfaction; reference to DSS mystery shopper program
<b>Recommended Edit:</b>	I recommend adding in reference to the PCMH CAHPS. Also, please indicate that CHN performs the mystery shopper function on behalf of DSS.

<b>Edit Suggestion #:</b>	9
<b>Submitted By:</b>	Adam Stolz/Katie Sklarsky (Chartis)
<b>Page # (s) Referenced:</b>	6
<b>DRAFT Report Language/Summary:</b>	The work groups will be overseen by the SIM Project Management Office (PMO) with additional oversight from the Health Innovation Steering Committee and the Consumer Advisory Board...
<b>Recommended Edit:</b>	The work groups will provide policy and programmatic advice to the SIM Project Management Office (PMO) and the Healthcare Innovation Steering Committee (HISC). A Consumer Advisory Board (CAB) will ensure significant consumer participation in the planning and implementation process.

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<b>Edit Suggestion #:</b>	10
<b>Submitted By:</b>	Adam Stolz/Katie Sklarsky (Chartis)
<b>Page # (s) Referenced:</b>	11
<b>DRAFT Report Language/Summary:</b>	n/a
<b>Recommended Edit:</b>	<p>Based on feedback throughout from both EAC members and other audiences, we believe it is important to provide additional context about the scope of the EAC’s work. Specifically, to emphasize that the EAC’s intent in issuing recommendations on payment design is NOT to prescribe an “ideal shared savings contract” for all-payer adoption. Though the report as currently written makes no such assertion, the depth in which the topic is covered and the breadth of recommendations about payment design may lead some readers to draw improper inferences about the report’s intended application. This issue will be partly abated if and when the EAC adopts language concerning implementation with which to annotate each recommendation. In addition to doing that, we suggest that language along the following lines be incorporated toward the bottom of p11:</p> <p>“It is important to note that the EAC’s intent in articulating a perspective about payment design features was not to prescribe a single standard shared savings contract model for all-payer adoption. As mentioned above [on p7], Connecticut recognizes that commercial payers will continue to develop and offer distinct provider contracting models, and believes that variety and experimentation are important to refining these relatively new models. Connecticut expects that all payers will align broadly around shared savings programs, though they will not adopt a uniform approach to many of the design choices addressed in solution areas 1A-D as listed above. Still, the EAC believes that all payers should consider the equity and access implications that it has identified related to these design choices; that it will be informative to evaluate actual contracting methods that gain prevalence during the SIM model test period against these recommendations; and that a subset of the contract design features identified do in fact constitute essential safeguards.”</p>

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#	Submitted By	Comments
1	K. McEvoy	My overarching concern is that the report does not include much indication of how strand III of the EAC charge ("the State's plan to ensure that at-risk and underserved populations benefit from the proposed reforms") will be addressed. Strand III is referenced on pages 7 and 36, but there is little discussion of process or potential decision points (e.g. whether to pursue enabling legislation to require common standards, say, around publication of the details of ACO arrangements or other; whether, instead, to pursue voluntary adherence to standards; whether, instead, to regard the recommendations as only aspirational in nature). I would recommend adding more detail on this topic.