Connecticut State Innovation Model (SIM)

Ensuring Connecticut's Underserved and At-Risk Populations Benefit from SIM

Report of the Equity and Access Council on

Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements

DRAFT REPORT FOR EAC DISCUSSION

April 17, 2015

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Executive Summary

In December 2013 Connecticut published its State Healthcare Innovation Plan (SHIP) in which it articulated a vision to transform healthcare in the State. Connecticut seeks to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs. The State Innovation Model (SIM) is the organizing vehicle through which programs in pursuit of this vision are developed, coordinated, and implemented.

Changing how healthcare is paid for is one of SIM's core approaches for transforming the way healthcare is delivered. Specifically, SIM seeks to promote a shift from payment based on volume of services to payment based on the value of care delivered, and it seeks to promote multi-payer alignment around a common design framework for value-based payment.

The role of the Equity and Access Council (EAC) is to ensure that as SIM reforms are implemented, at-risk and underserved populations benefit. The EAC will evaluate and make recommendations about ways in which SIM reforms can be harnessed to increase health equity and reduce disparities in access to care and health outcomes. Within that broader role, the EAC has a specific charge to ensure that, as value-based payment becomes the prevailing way of financing healthcare in the state, appropriate safeguards are adopted to protect against under-service and patient selection. Under-service refers to the systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. This specific charge served as the scope for Phase I of the EAC's work and as the impetus for this report.

Shared savings programs have become an increasingly central feature of the U.S. healthcare landscape since the Centers for Medicare and Medicaid Services (CMS) launched the Medicare Shared Savings Program (MSSP) in 2012. Given their relative youth, there is scant evidence available that these types of payment arrangements do or do not lead to under-service or patient selection. However, the rapid growth in these programs' popularity and the possible potential for adverse responses to financial incentives has motivated Connecticut to proactively evaluate how these programs can be designed and monitored to ensure that all populations benefit.

In January 2015, the Council adopted a framework for organizing its Phase I work using two categories of safeguards that could be built into the proposed payment reforms. First, the EAC explored how the incentives inherent in shared savings **payment design features** can be structured, how they might impact an ACO's or a provider's behavior, and the extent and nature of the risk of under-service and patient selection associated with different design features. It then explored what **supplemental safeguards** might be layered on top of a program's internal incentive structure to further minimize the risks of under-service and patient selection.

The EAC is composed of twenty members appointed by the Healthcare Innovation Steering Committee (HISC) from four distinct stakeholder groups: government agencies, payers, consumers, and providers. Two of the twenty members were nominated by the Council on Medical Assistance Program Oversight (MAPOC) for the purpose of aligning planning between the EAC and the MAPOC.

The EAC established four design groups, populated by EAC members and others, to explore several sub-topics in more depth through a series of small group discussions from January through March.

- **Design Groups Related to Payment Design Features**
  - Design Group One: Patient Attribution and Cost Benchmark Calculation
  - Design Group Two: Payment Calculation and Distribution
- **Design Groups Related to Supplemental Safeguards**
  - Design Group Three: Rules, Communications and Enforcement
  - Design Group Four: Detection and Monitoring – Concurrent and Retrospective

Design Group discussions surfaced ideas that the Council reviewed, discussed, adapted, and endorsed in the form of twenty-nine recommendations. The EAC organized its recommendations for the purpose of this report into five sections that are structured similarly, but not identically, to the design group topics.

The EAC issued five recommendations related to <u>patient attribution</u>, on the following topics:

- Patients' ability to self-designate the provider to whom they are attributed via attestation
- Notification of patients that they have been attributed to a provider
- The settings of care in which a patient can be attributed to a provider
- The time at which a patient is attributed to a provider (prospectively or retrospectively)
- Use of an end-of-year reconciliation process to maximize accuracy of attribution

The EAC issued five recommendations related to <u>cost target calculation</u>, on the following topics:

- Designing cost targets in a way that rewards improvement
- Adjusting cost targets for unpredicted systemic costs
- Use of supplemental payments to manage complex patients
- Use of retrospective analyses to identify populations that may be inadequately risk-adjusted
- Truncating costs and/or carving out certain services to reduce the impact of outliers

The EAC issued seven recommendations related to <u>payment calculation and distribution</u>, on the following topics:

- Thresholds that must be met for ACOs to receive shared savings
- Use of quality incentive payments that are discrete from shared savings payments
- Designing quality targets in a way that rewards improvement
- Use of minimum savings rates (MSRs)
- Reinvestment of savings that are generated but not disbursed to an ACO
- Use of advanced payments to ACOs to invest in care management infrastructure
- Methods through which individual providers and provider groups share in savings generated

The EAC issued eight recommendations related to <u>rules, monitoring, and accountability</u>, on the following topics:

- Internal monitoring that ACOs conduct
- Accreditation of ACOs by independent professional organizations
- Parameters for retrospective monitoring conducted by payers

- Parameters for a nurse consultant or patient ombudsman role dedicated to issues that derive from the use of value-based contracts
- Parameters for mystery shopper programs to identify inappropriate patient selection
- Use of corrective action plans and other methods of accountability
- Independent retrospective analysis at a future point in time across payer populations to assess any impact of payment reform on under-service and patient selection
- Public reporting about the existence and results of monitoring

The EAC issued four recommendations related to communication with patients and providers, on the following topics:

- Scope of information to be communicated to consumers about shared savings programs
- Accessibility and consistency of communication with consumers
- Process for developing the content of consistent core messages for consumers
- Communicating with providers about shared savings programs

1. Connecticut State Innovation Model Background

The State Innovation Model (SIM) program, administered by the Center for Medicaid and Medicare Services (CMS), awards federal grants to states committed to developing and implementing multi-payer healthcare payment and service delivery model reforms that will improve health care system performance, increase the quality of care, and decrease costs.

In December 2013 Connecticut published its State Healthcare Innovation Plan (SHIP) in which it articulated a vision to transform healthcare in the State. Connecticut seeks to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs. SIM is the organizing vehicle through which programs in pursuit of this vision are developed and coordinated.

In December 2014 Connecticut was awarded a $45 million grant to begin working toward this vision over a four-year period (2015-2018) in the "Test Phase" of its model through a number of initiatives that include plans to improve population health, value-based payment and insurance design, quality measure alignment, health information technology, implementing a Medicaid Quality Improvement and Shared Savings Program, and primary care transformation.

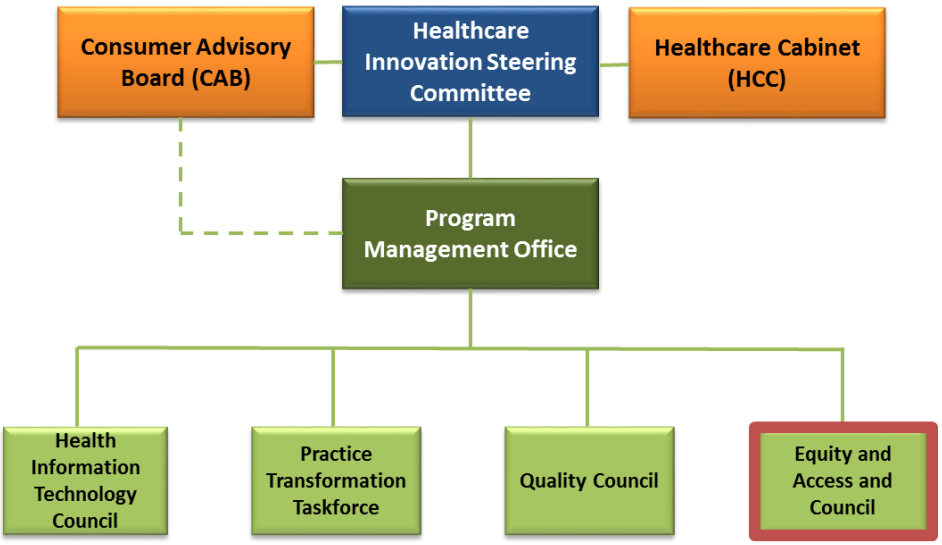
Definitions:

Value-Based Payment: *A form of payment for healthcare services that rewards providers for managing the cost and/or improving the quality of care they provide to patients. This differs from the more traditional fee-for-service payment method in which providers are paid based on the volume of services they render. The goal of value-based payments is to reduce unnecessary costs, improve the care experience, and improve health outcomes, by rewarding physicians, other healthcare professionals, and organizations for delivering value to patients.*

Shared Savings Program: *A form of a value based payment that incents networks of providers to manage healthcare spending for a defined patient population by sharing with those organizations a portion of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures, and then shared between payer and providers. Shared savings programs typically require providers to meet defined targets with respect to quality metrics in order to qualify for shared savings.*

Accountable Care Organization (ACO): *A healthcare provider–led organization or network designed to manage the full continuum of care and be responsible for the overall costs and quality of care for a defined population. ACOs exist in many forms, including large integrated delivery systems, physician–hospital organizations, primary care groups, multi–specialty practice groups, independent practice associations, and virtual interdependent networks of physician practices. In this report we use the term "ACO" to refer to provider networks or entities that enter into shared savings arrangement(s) with payer(s). In this use, the term is synonymous with the term "advanced networks" as employed elsewhere in SIM.*

SIM initiatives will be informed by the recommendations of four work groups, including the work group responsible for generating the recommendations included in this report, the Equity and Access Council (EAC). In addition to the EAC, there will be a Health Information Technology (HIT) Council, a Quality Council, and a Practice Transformation Task Force (PTTF). 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, as depicted below.



2. The Equity and Access Council's Role

Changing how healthcare is paid for is one of SIM's core approaches for transforming the way healthcare is delivered. Specifically, SIM seeks to promote a shift from payment based on volume of services to payment based on the value of care delivered, and it seeks to promote multi-payer alignment around a common design framework for value-based payment. The design framework it has chosen is the Medicare Shared Savings Program (MSSP). MSSP was introduced in 2012 as a key component of CMS's reform initiatives to facilitate coordination, improve the quality of care, and reduce unnecessary costs for Medicare beneficiaries. Of the estimated 750 ACOs in the U.S. as of March 2015, approximately half are participants in MSSP. The remainder participate in shared savings programs operated by commercial insurers or Medicaid programs. Many ACOs participate in multiple payers' shared savings programs (Gordon D. , 2014; Muhlestein, 2015).

Connecticut's SIM initiatives focus in particular on two payer populations: Medicaid beneficiaries and the commercially insured. For populations served by Medicaid, payment transformation will be accomplished by implementing the Medicaid Quality Improvement and Shared Savings Program (MQISSP). For the commercially insured population, while each payer will implement its own distinct programs, all of Connecticut's large commercial payers have endorsed broad alignment with MSSP. The introduction of shared savings programs to the market in Connecticut is well underway. At least fifteen organizations have existing shared savings contracts with Medicare and/or commercial payer(s).

The EAC's role is to ensure that as SIM reforms are implemented, and more patients begin to receive care through delivery systems that participate in shared savings programs, at-risk and underserved populations benefit from these reforms. Within that broader role, the EAC has a specific charge to ensure that, as value-based payment becomes the prevailing way of financing healthcare in the state, appropriate safeguards are adopted to protect against under-service and patient selection. The EAC's charter calls for it to develop recommendations for the PMO and the Healthcare Innovation Steering Committee (HISC) concerning:

I. Retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care;
II. A response to demonstrated patient selection and under-service; and,
III. The state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms

The EAC's charter further articulates two phases of work. The first phase of work, which is the focus of this report, concerns issuing recommendations to prevent, detect, and respond to under-service and patient selection. The second phase of the EAC's work will focus on developing recommendations that address gaps or disparities in healthcare access or outcomes that can be addressed through SIM.

To focus the topic of the council's recommendations in Phase I, the HISC developed definitions for under-service and patient selection:

Under-service: *Refers to the systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements.*

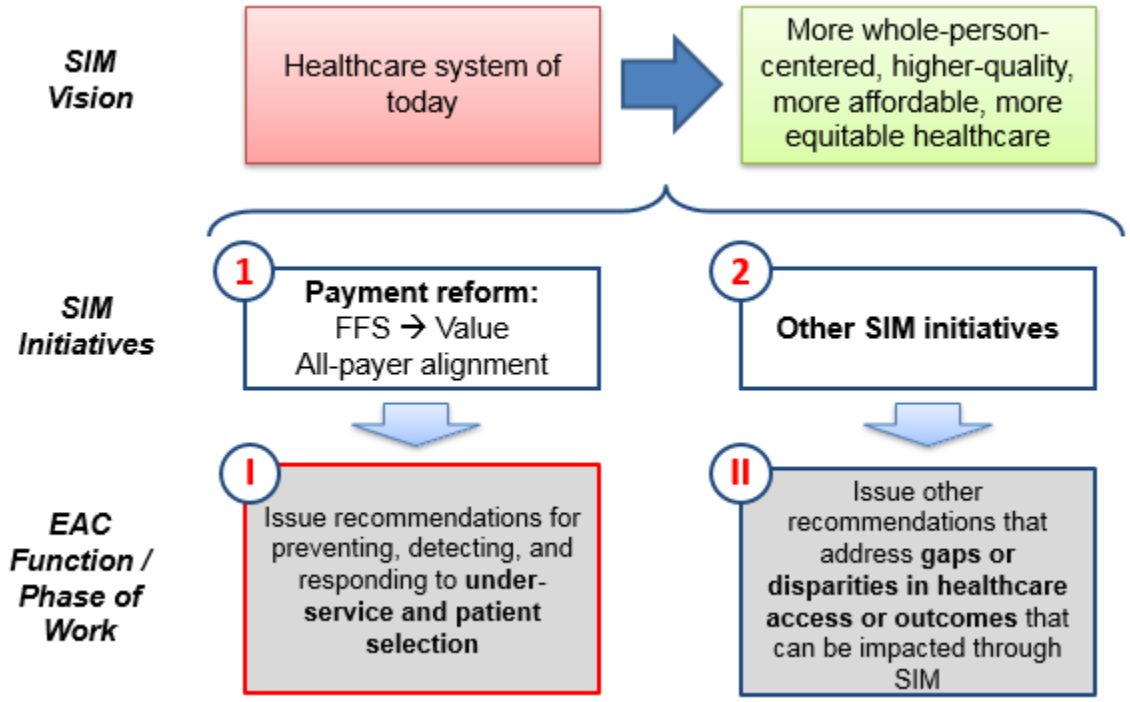
Patient Selection: *Refers to efforts to avoid serving patients who may comprise a provider's measured performance or earned savings*

These definitions, and the associated scope of work, are based on the hypothesis that, whereas the traditional fee-for-service payment model contains incentives that lead to unnecessary provision of services, a shared savings payment model may result in under-provision of services and/or reluctance to serve certain populations.

The initial objectives of the EAC were to explore the risks of under-service and patient selection within the context of shared savings arrangements in order to inform the Council's understanding of the extent and type of need for safeguards to prevent, detect and respond to under-service and patient selection. The Council was asked to answer a set of questions to determine existing best practices for methods used to detect unwanted behaviors, who monitors for this behavior, and what responses are employed when unwanted behavior is detected.

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.

The EAC's role within SIM, and its two phases of work, can be depicted as follows:



3. The EAC's Approach to Developing Recommendations

The EAC's task for Phase I of its work is to issue recommendations to prevent, detect, and respond to under-service and patient selection that occurs within total cost of care payment arrangements[1]. To do this, the EAC sought to identify the most effective monitoring methods and other approaches employed today. However, a literature review and exploration of evidence from CMS, other states, think tanks, and members of Connecticut's payer, ACO, consumer, and regulatory committees revealed that it may be too early to assess how shared savings payment arrangements impact equity and access, and also too early to identify proven safeguards against under-service or patient selection. Additional information from CMS is forthcoming and will be reflected in a future draft of this report.

Despite the absence of evidence to date that shared savings programs lead to instances of under-service or patient selection, the rapid growth in these programs' popularity and the possible potential for adverse responses to financial incentives has motivated Connecticut to proactively evaluate how these programs can be designed to ensure that all populations benefit. As a foundational step in this analysis, the EAC explored how the incentives inherent in the design of a shared savings program are typically structured, how they might impact an ACO's or a provider's behavior, and the extent and nature of the risk of under-service and patient selection associated with different design features.

In January 2015, the Council adopted a framework for organizing its Phase I work using two categories of safeguards that could be built into the proposed payment reforms:

- **Payment Design Features:** Recommendations about design features of new payment models that, taken together, do not create incentives for under-service or patient selection.

- **Supplemental Safeguards:** Recommendations about rules and processes that will deter and detect patient selection and under-service.

To explore how payment design could potentially impact under-service and patient selection, the topic was broken into four areas:

1A. Patient Attribution: The method by which patients are assigned to a provider

1B. Cost Target Calculation: The method by which a patient's benchmark (expected) cost of care is determined and adjusted for clinical and other risk factors

1C. Incentive Payment Calculation: The method that defines the amount of incentive payments generated for a given patient population

1D. Payment Distribution: The method by which individual providers share in achieved savings

To explore how supplemental safeguards could protect against under-service and patient selection, the topic was broken into five areas:

2A. Rules: Rules for who can participate in a value-based contract and what activity is allowed and prohibited

[1] For the purpose of this report the methods that will be recommended to protect against under-service and patient selection will be referred to as safeguards.

2B. Communication: Methods of informing consumers and providers about the definition and consequences of prohibited activities

2C. Accountability: Consequences for violating rules and methods for enforcing those consequences

2D. Monitoring & Detection – Retrospective: Methods of detecting under-service and patient selection by observing it using data produced after a period of performance is over

2E. Monitoring & Detection – Concurrent: Methods of detecting under-service and patient selection in real-time or near-real-time

For the purpose of conducting further research and evaluation, and exploring solutions, the Council established four design groups organized around these nine areas of inquiry, as follows:

Design Group	Design Area	Principle Question to Answer
1	Patient Attribution (1A) and Cost Target Calculation (1B)	How to minimize improper patient selection by appropriately defining expected outcomes and accountabilities
2	Incentive Payment Calculation (1D) and Payment Distribution (1D)	How to balance financial incentives to promote appropriate, efficient, patient-centric care decisions
3	Rules (2A), Communication (2B), and Accountability (2C)	How to set appropriate rules, communicate them, and enforce them
4	Monitoring & Detection: Retrospective (2D) and Concurrent (2E)	How to evaluate for under-service and patient selection – as both an accountability tool and an evaluation tool- after the performance period and/or in near real-time

The design groups were tasked with evaluating current practices, research, theories, and evidence in each design area, and establishing hypotheses about the impact of safeguards on patient selection and under-service. EAC members were asked to pick one or two design groups in which to consistently participate. All design groups were open to all EAC members, individuals named by EAC members, and members of the public. Each design group held two or three facilitated discussions from January through March via webex and conference-bridge. The EAC's schedule from January through April 2015 was as follows:

		January		February				March					April				May			
		Week of:		Week of:				Week of:					Week of:				Week of:			
	WORKSTREAM/ACTIVITY	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																			

The points of view articulated in the design groups were shared with the broader council for discussion and endorsement in the form of recommendations on which the full Council deliberated. In turn, the recommendations contained in this report were adopted by the Council.

[NOTE FOR 4/17/15 DRAFT: This draft of the report includes recommendations in the form they were last considered by the EAC or modified to reflect EAC feedback. Not all recommendations contained here have been endorsed. All recommendations, and potentially supplemental recommendations, are subject to further deliberation at the 4/23/15 EAC meeting. Each recommendation in this draft report is annotated to indicate its status. Note that "Adopt with Changes" means that the EAC endorsed the recommendation's premise but suggested changes; the language reflected in this report reflects subsequent revisions made by the EAC's facilitators to address those suggestions].

As the design groups progressed in their discussions, the organizing principles used to group topics into each design group evolved. In some cases, inter-relationships between different design group topics became apparent, while in other cases topics were sufficiently discrete to merit an independent discussion. Accordingly, we have organized this report using a structure related to, but not identical to, the original design group structure, as follows:

Design Group	Solution Area
1	(1A) Patient attribution (1B) Cost target calculation (cost benchmarks & risk adjustment)
2	(1C) Incentive payment calculation (1D) distribution
3	(2A) Rules (2B) Communication (2C) Accountability
4	(2D) Retrospective detection (2E) Concurrent detection

Organization of Recommendations in this Report	
1	(1A) Patient attribution
2	(1B) Cost target calculation (cost benchmarks & risk adjustment)
3	(1C) Incentive payment calculation & (1D) distribution
4	(2A) Rules (2D) Retrospective & (2E) Concurrent detection (2C) Accountability
5	(2B) Communication

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.

4. Under-Service and Patient Selection Safeguards: Background, Discussion, and Recommendations

Payment Design Features: Patient Attribution

Background

Implicit in a shared savings program is that a group of providers manages the quality and cost of care for a defined population. The twin goals of such a program are to improve efficiency (typically through methods that improve utilization management) and to improve quality (typically through more effective, consistent clinical performance and through care management and care coordination). When providers achieve these goals they are eligible for incentive payments that supplement their fee-for-service revenue. Often a provider's ability to actually share in any savings achieved is dependent on meeting the quality targets agreed to at the outset of the contract period. The process of defining the population that a given group of providers is responsible for managing under a shared savings contract is called patient attribution. The clinical participants in the shared savings contract, which can include providers, provider groups, hospitals, and other care supplier entities, collectively agree to be responsible for the cost and quality of the patients assigned to them under the contract. We refer here to the organizations or groups of organizations that enter into shared savings contracts as Accountable Care Organizations (ACOs).

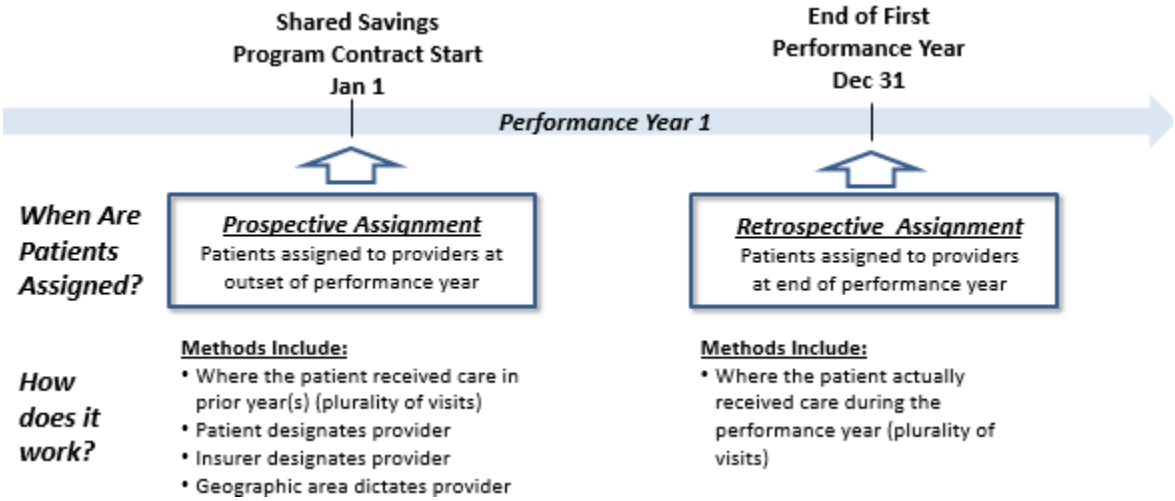
Insurance plans have developed a range of methods for attributing patients to provider organizations. Every attribution methodology involves at least three main design decisions:

1) ***How*** the patient is assigned to a provider (i.e. the technique or "rule" used to assign a patient)
2) To ***whom*** the patient is assigned (i.e. the type of provider to whom a patient can be assigned)
3) ***When*** during the contract period the patient is assigned

There are several techniques used to assign a patient to a provider in a shared savings program. A plurality of visits technique is used by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Shared Savings Program (MSSP) (CMS, CMS Medicare Shared Savings Program Final Rule, 2011), which makes up the majority of shared savings programs in the market today (CMS, Medicare Shared Savings Program ACO Fast Facts, 2014; Gordon D. , 2014) . This technique assigns a patient to the provider that the patient saw most frequently within a defined period of time (i.e. the year prior to the performance year or during the performance year). In patient-selected attribution patients designate their primary care provider when they enroll in their insurance plan. This technique, known as "patient attestation" is used by Blue Cross Blue Shield of Massachusetts for their Alternative Quality Contracts (Chernew, Mechanic, Landon, & Safran, 2011), among others. Insurer-selected attribution relies on the insurer to designate the patient's primary care provider when the patient selects the insurance plan (Cromwell, 2011). A geography-based (or "population-based") technique assigns patients to a provider based on where the patients live. This technique was used for the Medicaid patients in New Jersey in combination with a plurality of visits technique (Houston & McGinnis, 2013). The technique was intended to attribute patients who did not regularly see a physician. Attribution techniques are not necessarily mutually exclusive; in some instances using more than one can be useful, as was the case in New Jersey.

The type of provider to whom a patient can be assigned is another aspect of patient attribution. The objective is to assign patients to the providers who are predominately responsible for managing their primary care needs (Cromwell, 2011). While a primary care provider (e.g. internist, family practitioner, general pediatrician) is generally the provider type that would be the most responsible for managing the primary care needs of a patient, in practice that is not always the case. For example, patients who have chronic conditions (e.g. heart disease or diabetes) that require intensive management from a specialist will often see the specialist provider as their primary care provider. For this reason CMS, in its most recent proposed rule for MSSP, proposes changes to the current patient attribution methodology to exclude specialists in the attribution process whose services are "not likely to be indicative of primary care services" (CMS, Fact Sheets: Proposed Changes to the Medicare Shared Savings Program Regulations, 2014) Many states have followed CMS's lead in designing their shared savings programs for Medicaid and in some cases taken it a step further. In Minnesota attributing patients to an Emergency Department (ED) was considered if that was the location of the plurality of their visits (Houston & McGinnis, 2013).

A final design consideration concerns the timing of patient assignment to a shared savings program. A patient can be assigned to a shared savings program either retrospectively or prospectively. Retrospective assignment assigns a patient to a provider at the *end* of the first performance year of the shared savings contract. In a retrospective model, providers do not know which patients they will be responsible for at the beginning of the shared savings contract period. Conversely, prospective assignment assigns a patient to a provider at the *outset* of the shared savings contract period. Prospective assignment allows providers to enter into the contract period aware of the population for whom they are managing cost and quality (see figure below).



The MSSP program currently uses retrospective assignment, but is recommending prospective assignment for some of its participating ACOs[2] (CMS, Fact Sheets: Proposed Changes to the Medicare

[2] In the 2014 CMS proposed rule a third track is proposed that will use retrospective assignment and require that the ACO take on down-side risk.

Shared Savings Program Regulations, 2014). 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). Unlike CMS, commercial insurers more commonly use prospective assignment for a range of value-based contract types, including upside-only and two-sided shared savings programs (Bailit, Christine, & Burns, Shared-Savings Payment Arrangements in Health Care: Six Case Studies, 2012).

Discussion

The three design decisions outlined in the background section may bear on provider behavior, and in turn have the potential to impact the degree to which patient selection or under-service emerge as unintended byproducts of a shared savings program. In addition, these design decisions have other consequences that have the potential to impact other outcomes – wanted or unwanted – of shared savings programs. For a shared savings program to achieve its objectives of lowering costs and improving the quality of care, the design choices about areas like attribution must yield a healthcare financing method in which all stakeholders (i.e. patients, providers, and insurers) are willing to participate.

Patient selection is the predominant equity and access concern related to choice of patient attribution methodology. However, it is not the only concern. Several implications of attribution design choices are described below:

Techniques	Patient Selection Implication	Other Implications
Geographic	Eliminates the possibility of patient selection since attribution is solely based on where a person lives.	Removes patient choice in the process of selecting a physician and exposes the provider to greater financial risk.
Patient-Selected	May reduce providers' ability to avoid patients; however, providers can close their panels.	Active selection of a physician promotes patients taking an active role in their care. If used as a primary attribution method, it also incents physicians to proactively manage patients' care even if the patient does not schedule a visit.
Insurer-Selected	While this reduces providers' ability to avoid patients, an insurer could inappropriately influence which patients are attributed to which providers.	Removes patient choice in the process of selecting a physician.
Plurality of Visits	This method used retrospectively might incent avoidance of difficult patients in the performance year.	Serves as a good proxy for patient choice since it is based on historical patient decisions about where to obtain care.

Given the above implications, the geographic approach arguably provides for the greatest protection against patient selection. However, the geographic approach also puts a heavy burden on providers to do patient outreach in order to assume responsibility for cost and quality. This pressure could result in providers trying to dissuade patients from seeking care elsewhere, which may make the patient feel as though their choice in provider is limited. It also provides little distinct incentive for the patients to engage in their care and puts the providers at greater financial risk. While this technique may be effective when used in a targeted manner to reach specific populations that are not frequently interacting with the health care system (Houston & McGinnis, 2013), it is unlikely to be the most effective primary attribution technique on a broad scale. Similarly, the insurer-selected method will not allow for patient choice and will minimize provider control, giving rise to the same concerns as the geographic technique.

Patient engagement is paramount in a shared savings program to improve proactive patient care-management and coordination. A primary attribution technique that does not involve patient choice in assigning them to a provider will diminish the level of patient engagement. Allowing patients to choose their providers allows for the greatest amount of patient choice, but unless it is made a requirement will not capture patients who choose not to designate a primary care provider. The patient-selected technique allows for direct patient choice, whereas the plurality of visits method represents a patient's historical choices The Council believes that allowing for direct patient choice when possible is preferable, and that, in absence of this, the plurality of visits methodology is preferable.

> ***Recommendation #1.1: Patient Attestation.*** ***Patients should be able, though not required, to identify their primary care provider through an attestation (designation) process as a primary attribution technique. 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 choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits. [Status as of Initial EAC Review: Adopt with Changes]***

Regardless of whether patients designate their primary care provider or are assigned to a provider through a plurality of visits method, making patients aware of the fact that they are seeing a provider who is participating in a shared savings program will also support transparency and patient engagement in the process of managing and coordinating their care.

> ***Recommendation #1.2: Patient Notification.*** ***Patients should be made aware when they are attributed to a physician who is participating in a shared savings program. Notification should be in a manner that is accessible and understandable by all patients. [Status as of Initial EAC Review: Adopt with Changes]***

In addition to its equity and access implications, patient attestation also provides an opportunity to embed value-based insurance design features that promote patient engagement. Value-based insurance design refers to structuring insurance plans in a way that incents patients to engage in healthy behavior, participate in their healthcare decisions, and make intelligent use of healthcare resources. For example, patients could be rewarded in some manner for declaring a primary care provider.

While the geographic attribution technique is not broadly desirable as a method of primary attribution, it surfaces an important point: the most common attribution methods used today will not capture patients who do not interact with the healthcare system in a provider office setting. Another manner in which this issue has been addressed in other states is by more broadly defining the type of provider to which a patient can be assigned, such as allowing for attribution to an emergency department if that is where patients are receiving the bulk of their care (Houston & McGinnis, 2013). Secondary attribution, in the context of the recommendations made thus far, would mean that a patient who has not chosen a primary care provider and is not seeing another provider with enough frequency to be attributed through the plurality of visits technique, could be attributed to the ACO based on their visits to an emergency department. In a vertically integrated ACO that includes a hospital with an emergency department, the benefit of secondary attribution through an emergency department is twofold:

- By placing patients who are inappropriately using an ED into an ACO's attributed population, the ACO will have a financial incentive to coordinate their care such that they begin to receive care in more appropriate, efficient settings; and
- It will render futile any attempt at patient selection, since patients may end up attributed via the emergency department even if excluded from physician panels.

Recommendation #1.3: Settings of Care for Attribution. ***Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or urgent care center). For integrated ACOs (i.e.; an ACO that includes a hospital), payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage an organization to take accountability for their care. The use of a non-traditional setting of care to assign a patient to an organization will only be used if a patient does not have any visits with a primary care provider in the last year and/or did not designate a provider at the outset of the contract period. This recommendation is meant to provide an incentive at the macro level for an organization to develop the required care coordination structure and primary care access to improve care for the most difficult patients.*** ***[Status as of Initial EAC Review: Table for Further Discussion]***

The use of the plurality of visits method, and to a lesser extent the patient attestation method, in turn affect the way in which timing of patient attribution could come to bear on both patient selection and under-service. In retrospective attribution providers are unaware of who they will be caring for at the outset of a shared savings program. Retrospective assignment in conjunction with the plurality of visits technique could incent providers to avoid patients who are perceived to be riskier in an effort to establish more manageable cost targets. In contrast, prospective attribution will supply the provider with information at the outset of the contract about which patients are part of their shared savings program and therefore whose costs will be attributed to their overall cost and quality targets. This knowledge presents a potential risk that the provider will stint on the care provided in order to meet the identified cost target. While prospective attribution may protect against patient selection, it could also incent under-service. Conversely, while retrospective attribution may protect against under-service, it could incent patient selection.

Prospective assignment helps to prevent patient selection and has the added benefit of promoting transparency by providing information up front to both the patient and provider about who is attributed

to whom. This information provides a better platform to achieve a core goal of a shared savings program (i.e. appropriately lowering costs while improving outcomes). Additionally, the prospective assignment methodology financially ties a patient to a provider at the outset, making the provider financially responsible for the patient regardless of where that patient seeks out care. This has the potential to protect against unreasonable patient discontinuation as well as creates the incentive for providers to closely manage and coordinate their patient's care. A potential drawback to prospective assignment (i.e. as articulated by CMS) is the risk for under-service which in theory retrospective assignment eliminates by virtue of blinding providers from seeing who will be attributed to them in advance. However, in practice providers are still aware of their participation in a given shared savings program, and they are aware of patients' insurance status, which together give them a basic understanding that a patient for whom they provide frequent care will likely be attributed to them. Accordingly, any benefit with respect to protecting against under-service of retrospective assignment, as compared to prospective assignment, is likely to be minimal.

After evaluation of the sum of all benefits and risks, the Council believes that the benefits of a prospective attribution method generally outweigh the risks and as a whole provide more benefits than the retrospective method:

> ***Recommendation #1.4: Timing of Attribution. Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment. [Status as of Initial EAC Review: Adopt as Presented]***

While the Council believes that the benefits of prospective assignment outweigh the risks, the Council recognizes the concern that providers may be assigned a patient at the outset of the shared savings contract who ultimately does not receive care from that provider in the upcoming year. It is important that the provider-patient assignment is as accurate as possible, but there is not one approach that will get it right every time. This makes an end-of-year reconciliation process a potentially important tool. The Council considered reasons for which it might be appropriate or inappropriate to "re-attribute" a patient during a year-end reconciliation. An "unlimited" reconciliation process that removes any patient who at the end of the performance year would no longer be attributed to their original provider opens the opportunity for inappropriate discontinuation of patients. But there are instances in which a patient decides to seek care from another provider that are reasonable and do not present a concern (e.g. moving to another town). To help prevent inappropriate discontinuation it may be useful to evaluate data about patients who are re-attributed during a reconciliation to determine if they are appropriate or if they may represent an instance of inappropriate discontinuation from a provider panel.

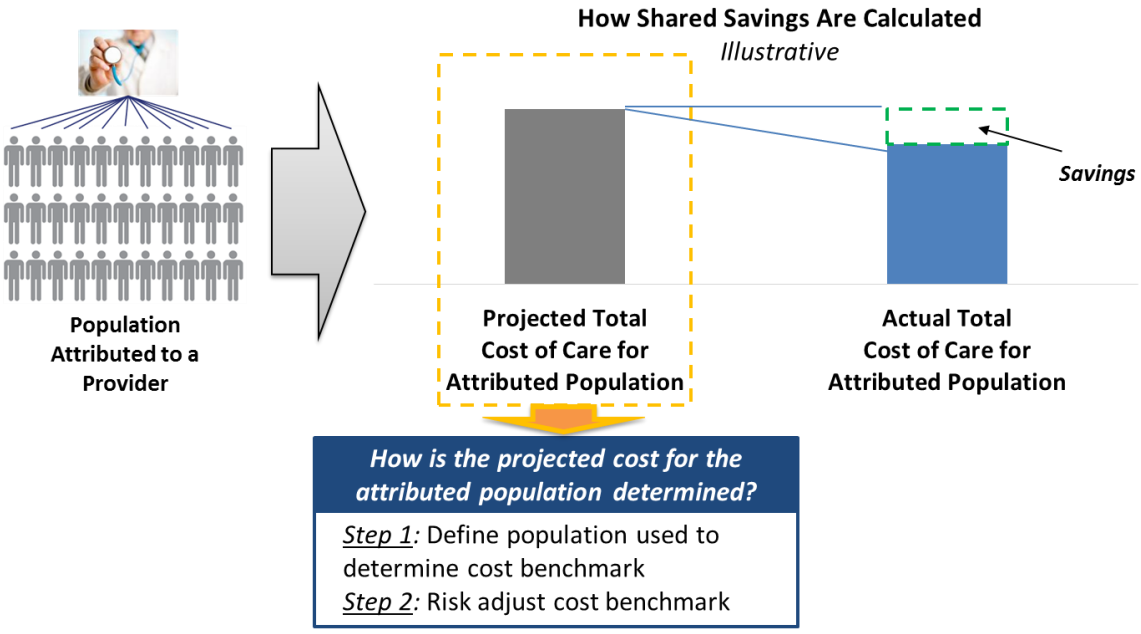
> ***Recommendation #1.5: Attribution Reconciliation. An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year. In instances in which the retrospective reconciliation process determines that a patient should be un-attributed, that patient will not be re-attributed to another ACO. [Status as of Initial EAC Review: Adopt with Changes]***

In considering the Council's recommendations on the topic of patient attribution, it merits repetition that though the CMS MSSP does not use prospective assignment today, it likely will in the future, in part in response to experienced ACOs' feedback on what would make the program more effective. In a letter to CMS in response to the MSSP 2014 proposed rule, the National Association of Accountable Care Organizations (NAACOS) supported the use of prospective assignment for track three and it is suggested that prospective assignment will allow ACOs the ability to "….employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible" (Gaus, CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations, 2015).

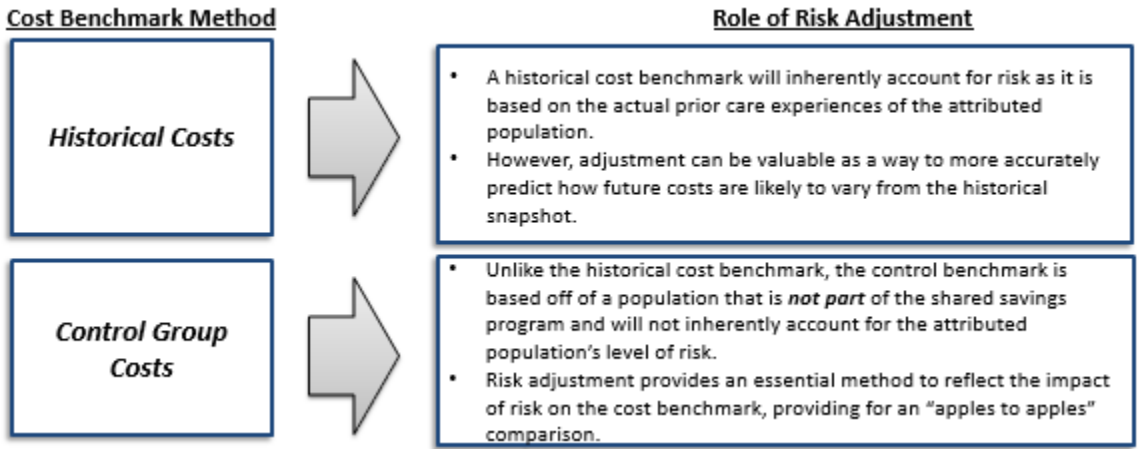
Payment Design Features: Cost Target Calculation

Background

To determine if an ACO achieves savings during a shared savings program contract period, the expected (or targeted) cost of caring for the population attributed to the ACO first needs to be defined. This is known as the cost benchmark. The determinants of the cost of a population include many factors, some of which allow for a level of predictability and others that do not. Some of the more predictable factors include: current diagnoses, age, socioeconomic status, and other social determinants of health (e.g., housing, access to transportation, etc.). Less predictable factors include: new and unexpected diagnoses, catastrophic events, and unpredictable general health trends (e.g., a bad flu season). In combination, all of these factors influence how complex and potentially costly a patient is to care for and should be considered when determining a cost benchmark. The choice of population used to set a benchmark, and the risk adjustment methodology used to adjust those costs, relate to the more predictable factors associated with cost benchmarking. The risk adjustment methodology adjusts future cost projections to account for the variation in resources required to care for different populations. The risk adjustment takes into consideration demographics and the diagnoses of the population to allow for an "apples to apples" comparison in costs between populations with different risk profiles. Additional contract features relate to the less predictable factors associated with benchmarking.



Payers generally use one of two data sources to establish a cost benchmark for a given population: historical costs or control group costs. A historic benchmark sets the expected costs of a population based on the past experience of that population. A control group benchmark uses a comparator population (e.g. all enrollees in a health plan throughout a broad regional area) to determine expected costs. Importantly, the historic benchmark inherently accounts for the clinical and cost profile of a given ACO's population, while the control group does not. For this reason, risk adjustment is an especially important dimension of a benchmarking method that relies upon a control group.



Another difference between these two methods is how accurately the benchmark reflects the utilization of a population that is desirable (i.e. represents best clinical practice). A historic benchmark utilizes the historical experience of an ACO's population, which may or may not represent best practice, whereas a control benchmark is based on performance against market-wide medians, targets, or trends. If a historic benchmark is used and historically the population has experienced unnecessary over-utilization, the benchmark will not account for excessive and unnecessary costs that a shared savings program attempts to minimize. Over time this will be addressed as the cost benchmark is adjusted over the subsequent years, but getting to best practice may take longer than it would if the control group methodology were to be used. Regardless of which population is used to determine the cost, risk adjustment will also be necessary. Even when a historical benchmark is used, additional factors need to be considered, such as the increased age of the population or new diagnoses. CMS currently uses the historical cost methodology for MSSP and applies a risk adjustment factor (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011). The CMS risk adjustment takes into account acuity of diagnoses and basic demographics such as age, but does not account for any social determinants of health. In addition, as the CMS MSSPs function today, risk is adjusted annually for patient age and decreases in patient acuity are reflected to adjust cost benchmarks downward, but CMS does not adjust the benchmark upward if there is an increase in acuity (Gaus, CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations, 2015). In the healthcare market there are additional proprietary risk adjustment methodologies used by various commercial payers (Bailit, Christine, & Burns, Shared-Savings Payment Arrangements in Health Care: Six Case Studies, 2012). However, given their proprietary nature there is not an abundance of publicly available information and it is unclear which factors are adjusted for in their methodology.

To account for the less predictable factors that affect a population's cost of care, shared savings programs often include additional contract features to help minimize ACOs' financial risk. Common examples of these additional contract features and examples of payers that use them are outlined in the table below:

Additional Contract Feature	Payers That Utilize
Truncation of High Cost Claimants – exclusion of patients with costs above the a certain percentile (commonly 99th percentile)	• CMS • Vermont Medicaid Shared Savings Program
Exclusion of high cost procedures or services – plans will exclude high cost procedures such as transplant and/or less predictable services to such as behavioral health	• Commercial payers and CMS (Bailit, Christine, & Burns, Shared-Savings Payment Arrangements in Health Care: Six Case Studies, 2012)
Enhanced Per Member Per Month (PMPM) Payment for patients with chronic conditions – payment intended to support enhanced care management needs	• BCBS of Michigan (Share & Mason, 2012)
Socioeconomic payment adjustment factor – enhanced payment to account for non-health factors that impact the complexity of caring for an individual	• Providers are working with payers to develop in Oregon

Discussion

From the perspective of a provider, the greatest financial opportunity in a shared savings program can only be achieved if costs are effectively managed and quality targets are met. The cost benchmark chosen for the population of patients cared for through a shared savings contract plays a fundamental role in determining whether or not an ACO receives a financial reward for adequately controlling costs. A cost benchmark should provide an incentive to reduce medically unnecessary expenditures through better utilization management and attainment of a healthier population, without creating perverse incentives to stint on necessary care or to avoid particularly complex patients in order to meet the defined cost targets. A cost benchmark that accurately reflects the expected cost of a population and is realistic with respect to the prior cost profile for the population will minimize any incentive for providers to stint on care or to avoid more complicated patients. An accurate and realistic cost benchmark will also likely incent providers to take on more complex patients. Complex patients have the greatest utilization management opportunity and therefore also represent the greatest savings opportunity. Clinically complex patients are likely already diagnosed with the illnesses that make them complex, which makes their costs more predictable. With the stated goals of the cost benchmark in mind, the following design considerations for setting a cost benchmark will be explored here: the basic methodology (data source) employed, how the benchmark is risk adjusted, and what additional contract features are included to account for less predictable risks.

A cost benchmark should promote appropriate cost management but should not set unattainable targets or incent under-service or patient selection. Both the historical and control group methodologies can be used to meet these goals, but each has distinct advantages with respect to the subjects of this report. A historical benchmark inherently accounts for year over year improvement. Providers are being measured against prior year performance for their own population, and so they are rewarded for improvement against their own performance.

Conversely, a control group methodology may pose challenges for an ACO whose population's historical costs far exceed the best practice or market average in a region. Such an ACO will likely not be able to drive their costs down to the benchmark in one year using clinically appropriate methods. In some cases the cause of an ACO's relatively high cost profile may be unnecessary over-utilization and selection of more expensive sites of care; in this case, a control group benchmark may be useful to stimulate a change in provider behavior. But in other cases an ACO's high cost profile may be due to complexities in its population that justifiably cause their care to be more costly than what risk-adjusted market-based benchmarks would suggest. If a control group benchmark is unrealistic it may generate incentives to stint on care or avoid patients with certain profiles in order to meet the cost target. To guard against that possibility, in instances where a control group methodology is utilized, it may help to reward providers for improving upon prior performance (as measured against a market-based benchmark) in addition to rewarding them for absolute performance against the benchmark in a given year.

> ***Recommendation #2.1: Rewarding Improvement.*** ***Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group. [Status as of Initial EAC Review: Adopt as Presented]***

An inherent benefit of the control group methodology that is similarly absent in the historic methodology is the ability to account for any one-time unpredictable costs that can be incurred throughout the year. A bad flu season or the introduction of a new, expensive drug to the market can cause an unexpected spike in healthcare costs, which may or may not be localized to specific clinical populations. Even though this is not inherent in the historic cost methodology, it could be incorporated as an adjustment method to achieve a similar effect.

> ***Recommendation #2.2: Adjustment for Unpredicted Systemic Costs.*** ***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, severe flu season) 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 an identified treatment can be temporarily carved out of the cost benchmark calculation. [Status as of Initial EAC Review: Adopt with Changes]***

Another important consideration related to cost targets, and one that is particularly relevant to this report's scope, is accounting for healthcare expenses that result from non-clinical complexities of certain patient populations. These types of complexities are generally referred to as social determinants of health and include factors such as socioeconomic status, cultural and linguistic barriers to obtaining care, and an individual's social support structure.

Traditional risk adjustment methodologies are diagnosis-based and do not directly account for non-clinical risks. For example, clinical evidence suggests that, on average, a patient who is diabetic will need a certain number of billable procedures or tests that are above and beyond what a healthy patient

will need. There is sufficient evidence to estimate what the cost of providing this care should be. However, the costs incurred caring for patients who are more resource-intensive due to social determinants of health may be less predictable and also may not be billable on a fee for service basis.

In a shared savings program that uses a control group to establish cost benchmarks, an ACO that cares for a patient population with a relatively high prevalence of socioeconomic risk factors may find that, absent some supplemental non-clinical risk adjustment, the expected cost to care for its population does not accurately reflect the population's true cost. This may create some incentives to under-serve these populations or to select them out of provider panels. To the extent that socioeconomic factors in fact lead to clinical conditions that can be measured using a traditional risk-adjustment, this incentive is intrinsically limited. However, there may be populations for which resource-intensiveness is relatively high but for which clinical acuity is not – in which case a supplemental adjustment or method of compensating for this added cost should be employed.

Chronic disease management poses similar reimbursement challenges as social complexities and has demonstrated success with improving quality and lowering overall costs of care by providing a per member per month (PMPM) care management fee to care for patients with chronic disease. Among others, Blue Cross Blue Shield of Michigan used this approach in 2011 as part of a broader value based care initiative that was focused on managing the quality and costs of patients with chronic conditions and demonstrated success (Share & Mason, 2012), (CMS, MLN Connects (TM) National Provider Calls, 2015).

As with chronic disease management, providing adequate care to patients who face socioeconomic barriers will require a number of resources in the form of increased visit times, more robust education and potentially more proactive care management. The additional resources are often not reimbursable and represent an opportunity cost for the provider. Given the similarities from a resource perspective between managing chronic conditions and social complexities, using a PMPM approach to financially support providers who are caring for patients with social complexities could minimize the incentive to stint on care or to avoid patients who are socially complex. While there are parallels between chronic disease management and social complexities, payments in any form that reimburse for costs incurred due to socioeconomic barriers is relatively unchartered territory. Determining which socioeconomic complexities are the most appropriate to address in this manner will likely require additional research over time through the monitoring of the shared savings program after its inception.

> ***Recommendation #2.3: Supplemental Payments for Complex Patients.*** ***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. [Status as of Initial EAC Review: Adopt with Changes]***

As value-based contracting becomes more prevalent, retrospective analysis of utilization and other trends can help to identify gaps in care for certain populations. This will provide the insight necessary to identify any populations that are not benefiting from existing risk adjustment methods and provide insight into how to adjust them going forward.

Recommendation #2.4: Retrospective Assessment for Risk Adjustment. ***In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors. [Status as of Initial EAC Review: Adopt as Presented]***

Amongst all populations there will be unpredictable and costly risks for which a risk adjustment or a supplemental PMPM cannot account. These types of risks are often referred to as catastrophic events and could pose a risk for under-service after the event occurs. This could be an accident (i.e. trauma) or a newly diagnosed medical condition that involves unusually high costs. To avoid any incentive for withholding care, and to create more predictable financial outcomes for providers, it is common to truncate high-cost claimants as a percentile of costs. Incorporating this as a shared savings contract feature will likely reduce any incentive a provider might have to stint on the care for a patient who experiences a catastrophic event.

Recommendation #2.5: 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. [Status as of Initial EAC Review: Adopt with Changes]***

Payment Design Features: Incentive Payment Calculation and Distribution

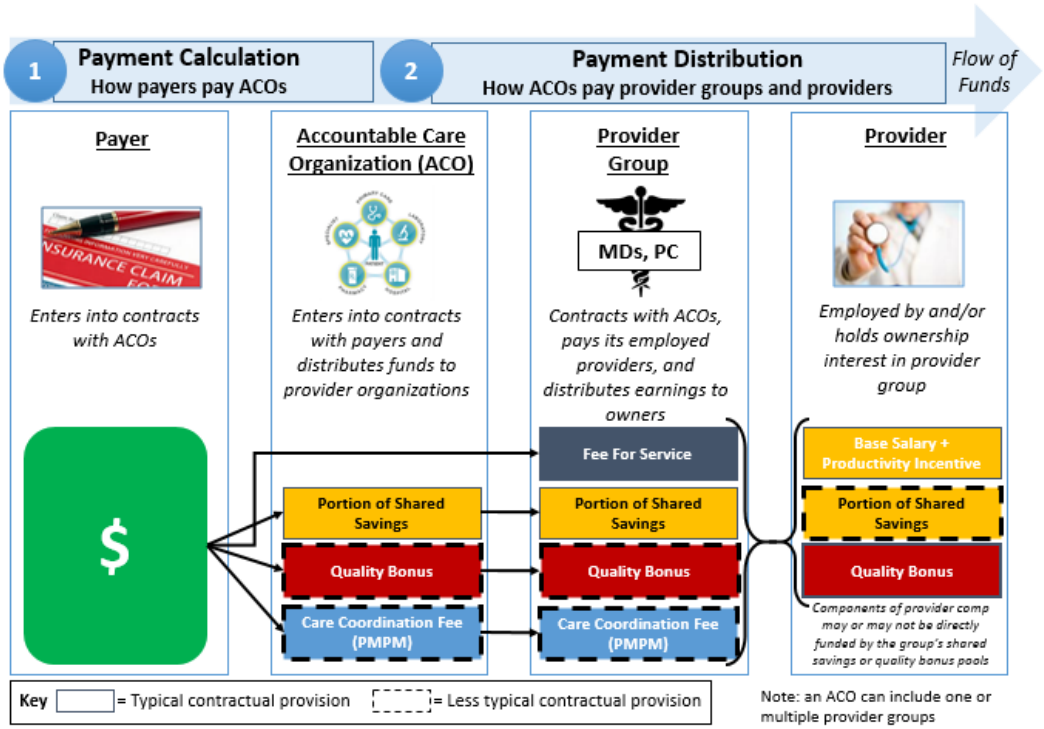
Background

When an ACO signs a shared savings contract with an insurer, the ACO becomes eligible to earn payments that represent a share of savings it achieves on medical spending for a defined population. The ACO, in turn, may distribute the savings to the ACO's member organizations such as provider groups or hospitals, which provide services for the ACO's attributed population. The ACO may also retain a portion of shared savings to invest in shared infrastructure used to care for the attributed population. Provider organizations that receive shared savings payments from an ACO may in turn pass these along to providers, either in whole or in part, according to formulas they devise to reward provider performance. The shared savings paid to an ACO by a payer and in turn to the ACO's providers is known as an incentive payment, because it is incremental to what a provider will receive on a fee for service basis. In most shared savings payment arrangements, the savings generated are split between the provider and the payer.

The process used to determine the portion of cost savings that an ACO receives is referred to as an incentive payment calculation. How the ACO distributes those savings among providers and/or provider groups, or otherwise compensates service providers within the ACO, is referred to as payment distribution.

The diagram below depicts common ways in which funds flow from a payer to providers participating in a shared savings contract.

Shared Savings Payment Terminology and Structure



Note a few key features associated with the flow of funds:

- Provider groups still earn a fee-for-service payment directly from the payer
- Providers' compensation is generally composed of a combination of guaranteed salary, productivity payments, and a portion of shared savings and/or separate quality-based bonuses
- In shared savings arrangements quality metrics are often used to establish eligibility for some or all of an ACO's potential shared savings, but are not generally used to pay separate quality bonuses if no savings are achieved
- Note that "quality" in this construct typically includes clinical processes and outcomes as well as other measures of provider performance such as patient satisfaction surveys

In most shared savings arrangements a Minimum Savings Rate (MSR) establishes the degree of savings an ACO must achieve in order to be eligible to earn any amount of savings. An MSR is used to ensure that ACOs only share in savings that are statistically significant and don't result from random variation in expenditures. For example, an MSR of 1% would require that the ACO's actual costs at the end of the performance year are at least 1% lower than the expected cost benchmark in order for the ACO to share in the savings.

The MSR set in a contract often depends on the size of the ACO (i.e. the number of lives the ACO manages) and the contract type (i.e. upside vs. two-sided risk). Random variation is less likely in a larger population and thus will usually be accompanied by a lower MSR (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011). The MSR used by CMS ranges from 2.0% to 3.9% depending on the size of the beneficiary population. A 2.0% MSR is used for ACOs with greater than 60,000 patients. 3.9% is the highest MSR and is applied to ACOs with 5,000 patients, the minimum population required for participation in a CMS MSSP (CMS, Proposed Changes to Medicare Shared Savings Program Regulations, 2014). Some payers believe that random variation will occur in both directions (i.e. result in savings and losses) and even out over the contract period. For this reason some payers do not utilize an MSR and others utilize a very low MSR regardless of population size. A lower MSR generally makes a shared savings contract more appealing to an ACO.

Upside vs Two-Sided Risk:

A shared savings contract can have *only* an upside or can have an upside *and* a downside. In an upside-only contract the ACO will have the opportunity to share in savings if actual costs are below the expected cost benchmark, but will *not* be at financial risk if costs are in excess of the cost benchmark. In a contract that has upside and downside risk (also known as two-sided risk) the ACO will continue to have an opportunity for savings, but will also incur a loss if spending is higher than the expected cost benchmark. The loss will occur in the form of a payment back to the payer for costs that exceed what was expected. Similar to an MSR, in a downside arrangement there is a threshold of excessive expenditures that has to be met before the ACO incurs a loss. This is known as a Minimum Loss Rate (MLR). ACO expenditures must be in excess of the MLR for the ACO to be required to owe the payer for the costs beyond what was expected. In both the MSR and the MLR the amount of` savings and/or losses are capped at a maximum amount. It is worth noting that even in an upside risk arrangement with payers that are perceived to underpay, such as Medicaid, the investment required by providers to

be successful in a shared savings arrangement leaves the provider at financial risk for losses even though not in the form of a two-sides arrangement.

CMS is considering the use of a deferred reconciliation for MSRs. In this scenario the MSR would be applied over an entire contract period, so if the ACO achieves consistently small savings each year that cumulatively reach the MSR, those savings will be shared at the end of the contract period (Gaus, CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations, 2015).

Three contract design features figured in the EAC's discussions about the potential for payment calculation to impact under-service or patient selection:

Contract Design Feature	Common Design Options
Does the contract type use downside risk, or upside risk only?	• In a downside risk arrangement the maximum share of savings an ACO can earn is usually set at a higher percentage to make participation in a downside risk arrangement more appealing; greater risk, greater reward.
Does quality performance affect the ACO's opportunity to earn savings?	• The majority of programs define a quality threshold that must be met to receive any savings. • In a varied arrangement the percentage of savings given to the ACO correlates with quality performance. Better quality performance relative to peers or over the prior year will result in a higher percentage of savings earned by the ACO. • In a fixed arrangement the amount of savings shared with an ACO remains the same as long as the minimum threshold for quality performance is met.
How is quality performance measured?	• Quality performance of an ACO can be evaluated as it compares to the performance of other ACOs. This is commonly called a benchmark method. • Quality performance can also be measured based on an ACO's improvement over the prior year. • Some arrangements use a combination of the benchmark and the improvement methods • The improvement method helps to engage lower performers and likely will account for any risks inherent in the ACO's population that might make achievement of a benchmark difficult • A benchmark method can be useful for high performers for which demonstrating further improvement may be difficult.

References for table: (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011) (CMS, Fact Sheets: Proposed Changes to the Medicare Shared Savings Program Regulations, 2014)

Most shared savings contracts require that an ACO meet minimum thresholds on a set of quality measures in order to be eligible to receive a portion of the savings achieved. However, other payment arrangements also exist that will provide incentive payments independent of one another; one incentive

payment for the achievement of quality targets and another incentive payment for the achievement of savings (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011) (McGinnis, Riley, Zimmerman, & Sahni, 2013).

Example: CMS Medicare Shared Savings Program (MSSP) Payment Calculation

The maximum shared savings payment for ACOs ranges from 50% to 75% of total savings achieved. The opportunity varies depending on the type of contract. Upside contracts have a maximum savings opportunity of 50% while downside risk contracts have a maximum savings opportunity from 60% to 75%. The ACO's maximum share is greater for contracts that require greater downside risk. Similarly, in a two-sided risk arrangement the ACO is responsible for a percentage of the losses. The percentage of losses the ACO is responsible for is equivalent to the total savings opportunity (i.e. 60% - 75% depending on the type of two-sided risk contract).

CMS assesses MSSP ACOs' quality using a benchmark. An ACO's performance is ranked against all other Medicare providers' performance based on a percentile ranking. The ACO is required to meet a baseline level of performance on a select set of quality measures to receive any share of savings it generates. The share of savings given to the ACO is based on a sliding scale using a point system. Points are assigned to an ACO for each quality measure based on its percentile performance. An ACO that earns the maximum number of points will receive the maximum amount of savings (i.e. 50% for an upside only contract).

Reference: (CMS, Fact Sheets: Proposed Changes to the Medicare Shared Savings Program Regulations, 2014; CMS, Methodology for Determining Shared Savings and Losses Under the Medicare Shared Savings Program, 2014)

Once the savings are received by the ACO, the ACO is responsible for distributing the savings to the provider participants in the ACO. Most ACOs consider at least three questions when deciding how to distribute savings amongst participants:

1. Should the ACO retain a portion of the savings?
2. How should money be distributed among ACO participating organizations?
3. What factors should play a role in how savings are distributed to individual providers?

Often an ACO retains a portion of the savings to support the infrastructure needed to run the ACO. ACOs that are in a downside risk arrangement or are considering moving to a downside arrangement from an upside only arrangement will take a portion of the savings to build a reserve fund. The composition of ACOs varies greatly, from having primary care providers only to having primary care providers, specialists, hospitals, and providers of other services along the care continuum (e.g. skilled nursing facilities). How the savings are distributed between these groups usually takes into consideration the centrality of the role each provider type plays in managing the quality and cost of care for attributed patients.

Lastly, individual providers may receive a portion of the savings – but the savings may be pooled by the provider group and distributed in any number of ways. Individual providers' shares can be based on how many attributed patients they cared for, their individual quality performance, or their individual

contribution to achieving the savings. A common method for determining an individual provider's share of the savings involves using quality performance and weighting by the number of patients attributed to that provider (The Chartis Group, 2014).

Discussion

The way in which payments are calculated and distributed will affect the nature and mix of financial incentives that ACOs and individual providers face. Unlike other aspects of shared savings payment design (e.g. attribution, cost benchmarking), payment calculation and distribution design are heavily related to performance on quality. The incentive to improve quality in these types of arrangements serves as an important complement and counterbalance to incentives to lower costs. While in many cases, delivering higher-quality care will inherently reduce total medical expenditures – especially over a long period of time – in other clinical scenarios higher-quality care may be higher-cost care. Accordingly, incorporating a strong financial incentive to maintain and improve quality is generally recognized as an important safeguard against under-service in total cost of care payment arrangements.

Financial incentives to improve quality can be established through the use of a quality threshold. A quality threshold will require that baseline quality performance is achieved, either as compared to others or to one's own performance, in order to be eligible for any savings (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011).

> ***Recommendation #3.1: Eligibility Thresholds.*** ***ACOs should only be able to share in savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or patient selection (as defined in the EAC charter and incorporated in payer-ACO contracts). [Status as of Initial EAC Review: Adopt with Changes]***

Though the use of a quality threshold provides a built-in under-service safeguard, there are shared savings programs that make cost management incentives distinct from quality incentives. In these models an ACO can receive shared savings without improving quality and, conversely, can be rewarded for quality without achieving savings. In the former scenario, to protect against ignoring quality, the amount of savings received is usually correlated with quality performance, despite the absence of a threshold (McGinnis, Riley, Zimmerman, & Sahni, 2013). In the latter scenario, ACOs will be rewarded for quality regardless of savings achieved, which may reduce the incentive to stint on care in order to hit cost benchmarks and earn savings.

> ***Recommendation #3.2: 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. [Status as of Initial EAC Review: Adopt as Presented]***

The manner in which quality performance is measured and used to calculate an ACO's shared savings opportunity are additional factors that impact the incentive to improve quality. Assessing quality performance in a manner that is perceived as fair, and scaling the opportunity for savings with improved performance, will provide greater incentive for providers to focus on quality improvement.

To assess quality performance fairly, payers should consider methods to control for clinical and socioeconomic factors that may impact quality performance. Assessing quality performance based on an ACO's improvement over the prior year inherently accounts for the clinical and socioeconomic

factors associated with that ACO's patient population. In contrast, comparing an ACO to its peers to assess performance, absent any adjustment, may not account for the relative complexity of their patients and may put an ACO with more complex patients at a disadvantage.

Within the context of a method that rewards improvement, quality goals that are unique to each ACO can be established with the intent of providing a greater reward for greater improvement. Providing individual ACOs with threshold, target, and stretch goals, with performance between these goals scaled to correlate with increased savings opportunity, will encourage continual quality performance improvement. The combination of assessing quality performance based on improvement, with varied improvement targets that are unique to the ACO, will encourage ACOs with quality performance across the spectrum (i.e. both high and low performers) to participate in shared savings arrangements and continually strive toward better quality performance.

> ***Recommendation #3.3: 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. To ensure that ACOs are not penalized for accepting new patients who may be more challenging to care for, year over year changes in ACO quality performance should be calculated using patients who have been continuously attributed to the ACO during the prior year and the performance year. [Status as of Initial EAC Review: Adopt with Changes]***

Successful ACOs generally make investments to build the infrastructure that supports the care management and clinical decision-making required to become more cost-efficient and improve quality (Lewis, Larson, & McClurg, 2012). CMS recognized that this can be a challenge, especially for smaller organizations, and led to the development of two different ACO models that provide funding at the start of the ACO contract: the ACO Investment model and the Advance Payment ACO model (CMS, Innovation Models, 2015).

Because of the degree of investment required to be a successful ACO, these organizations may experience financial pressure to recoup the cost of these investments through new revenue streams, including shared savings. In this sense, even upside-only contracts may generate "risk" for ACOs in the form of pre-paid investments. This type of financial incentive is a potential driver for the sort of potential activities – under-service and patient selection – that the EAC has been asked to assess. Accordingly, the EAC considered ways in which pressure to hit financial targets could be minimized without undermining the incentives to manage costs in appropriate ways.

The MSR is one design feature that can be adapted to this end. As mentioned above, some ACOs have ceased to use an MSR or are considering deferring MSR reconciliation to eliminate and/or diminish the hurdle it presents to achieving savings (Bailit & Hughes, Key Design Elements of Shared-Savings Payment Arrangements, 2011) (Gaus, CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations, 2015).

> ***Recommendation #3.4: 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. [Status as of Initial EAC Review: Adopt as Presented]

The EAC considered additional design features related to the use of savings not traditionally retained by ACOs that might promote equity and access. An ACO that is struggling to meet quality targets, and therefore will not receive any share of savings that it generates, might be struggling to meet targets in part due to gaps in its infrastructure. Using a portion of the savings an ACO achieves – but does not retain – to invest in infrastructure that promotes quality of care could help lift under-performing ACOs and ensure that they continue on an improvement path rather than exit the shared savings program.

Recommendation #3.5: 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). [Status as of Initial EAC Review: Table for Further Consideration]

Lastly, the EAC considered design features related to the sufficiency of payment rates and timing to induce provider organizations to participate in shared savings arrangements. Given the investments required to effectively manage care for defined populations, and the potential for additional investments to coordinate care for particularly vulnerable populations, some organizations may require supplemental, up-front payments in order to finance the needed outlays or to participate in a shared savings program at all.

Recommendation #3.6: Advance Payments. Providing ACOs with up-front funding dedicated to infrastructure will allow them to invest in the resources required to effectively manage care for defined populations. This incentive is especially important for smaller organizations or networks that are considering participating in MQISSP as ACOs. In addition, by improving ACOs' ability to lower costs through effective utilization management, this type of investment will reduce any incentives to lower costs through inappropriate methods that involve stinting on care or discontinuing patients. [Status as of Initial EAC Review: Not Yet Considered]

Thus far, this report's discussion has concerned payment design incentives faced by ACOs. It has not discussed incentives faced by provider groups or individual providers. Payment distribution is the sole design feature related to shared savings arrangements that has a direct financial impact on a provider group (assuming it is not the sole participant in an ACO) or on an individual provider (i.e. it will affect the provider's take-home pay).

Choices about payment distribution will affect whether and how any of the incentives faced by an ACO are passed through to successively lower, more disparate levels of the delivery system. Accordingly, those choices will have implications for the necessity and appropriateness of various other safeguards. For example, if any financial incentives to stint on care or select against high-risk patients begin and end

at the ACO level, then arguably that is the level of activity at which monitoring activities should be focused. Conversely, if provider groups or individual providers are rewarded for managing their own patients' cost of care – rather than for the ACO's overall cost performance – then monitoring arguably needs to extend equally to the provider group or individual provider level.

By keeping the incentive to become more cost efficient at the level of the ACO or the provider group, rather than extending it to the individual provider, it is more likely that cost efficiencies will come from providers working together to manage utilization effectively, and not from inappropriate under-service. In addition, this arrangement potentially makes the task of monitoring substantially more efficient and effective by permitting it to focus on a relatively small number of ACOs, or even provider groups, rather than on a relatively large number of individual providers. In this scenario, provider groups and individual providers will still have an incentive to manage costs efficiently, since the total savings available to distribute are based on the ACO's overall cost performance. But if the portion of the ACO's savings that a group or a provider earns is based on something other than its own patient panel's cost savings (i.e. on a combination of quality and number of attributed lives), then the financial benefit of inappropriately reducing costs will be distributed and diluted across the group, while the risk of inappropriately reducing costs (i.e. from oversight by the group, the ACO, the payer, and licensing bodies) will remain squarely on the provider. This type of structure is a potentially powerful counter-incentive to under-service and patient selection.

> ***Recommendation #3.7: 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. [Status as of Initial EAC Review: Adopt as Presented]***

Supplemental Safeguards: Rules, Monitoring, and Accountability

Background

As discussed in preceding sections, a distinct feature of shared savings programs as compared to some other total cost of care payment methods (e.g. earlier forms of pure capitation) is the use of a balanced mix of incentives for providers. This mix includes continued use of fee-for-service payments and strong incentives to improve quality, along with incentives to manage total cost of care. Still, despite the balancing incentives inherent in these contracts, and even with the payment design safeguards recommended in this report above, Connecticut believes that supplemental safeguards are essential to ensure that these new contracting methods broadly benefit consumers and do not adversely affect at-risk groups.

While shared savings contracts have been rapidly adopted over the last three years, they are still relatively new. There is not yet a well-defined set of safeguards against under-service or patient selection that are considered to be best practice. However, payers and ACOs have adopted a number of approaches that provide relevant examples of safeguards that might be useful for the Equity and Access Council to consider. Any set of safeguards will contain three key elements:

I. **Rules**: The guidelines that govern participation in a contract for all participants (e.g. payers, providers, ACOs)
II. **Monitoring**: Methods for evaluating performance and/or identifying unwanted behaviors through the use of data and observation (i.e. claims data, clinical data, and patient feedback)
III. **Accountability**: Methods through which results, including prevalence of non-compliance with rules, are made known to appropriate audiences; and an appropriate response occurs when undesired outcomes are identified

A framework for instituting safeguards along these lines requires some articulation of which entities will perform what functions. By way of background, a number of entities have historically played key roles in the delivery, financing, and oversight of high-quality healthcare in Connecticut:

- **Healthcare consumers, consumer advocates, researchers, and other members of the public** play a role in assessing the way that healthcare is delivered, highlighting barriers to access and high-quality care, and evaluating the impact on services due to changes in financing or regulatory methods.
- **Individual providers** are responsible for delivering the best patient care by following standards for the practice of medicine and their own clinical judgment.
- **Provider groups** create standards for member providers and measure and reward performance.
- **Health systems, hospitals, and other service delivery organizations** have an array of responsibilities under federal and state statute to maintain, monitor, and report on quality and other standards.
- **ACOs** establish governance and performance evaluation structures to drive high performance among their participating organizations and providers.
- **Payers** utilize contracts with providers and ACOs to establish rules for distribution of incentive payments, rules for obtaining reimbursement for valid services, and processes for handling disputes that may arise.

- **Employers** that use payers to administer self-insured plans play a role in determining features of payer-provider and payer-ACO contracts.
- **The State of Connecticut** plays several relevant roles:
    - **The Department of Health (DPH)** licenses providers, hospitals, and other organizations that deliver healthcare services. It also establishes and enforces rules about these entities' performance, and collects and publishes information for public consumption.
    - **The Connecticut Insurance Department (CID)** regulates several aspects of health insurance policies that are issued for sale in the state. It also licenses and sets rules related to companies that issue those policies.
    - **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.
    - **Access Health CT** is Connecticut's health insurance marketplace. It approves insurance plans for participation on the exchange and engages consumers to encourage enrollment.
    - **The Connecticut All-Payer Claims Database (APCD)** is intended to be a consolidated repository of health insurance claims data that will allow for analysis in the interest of improving the way healthcare is delivered, utilized, and financed. It is established by law and overseen by Access Health CT. It is not operational as of this report's writing.
    - **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

CMS has created a basic framework for monitoring for under-service and patient selection in the MSSP, and holding ACOs accountable. An ACO that wants to participate in CMS MSSP agrees to follow the guidelines set forth in the final rule. Though the rule does not require ACOs to be certified or accredited to participate, it does establish limited guidelines for governance and legal structure that require ACOs to exercise oversight over its participating providers. The ACO governing body must have the "….authority to execute the functions of the ACO as defined in this final rule, including but not limited to, the definition of processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinating care" (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). MSSP ACOs are required to report on quality, but not on other measures.

While MSSP does not require ACO accreditation, other CMS innovation demonstrations (e.g. CMS FQHC Advanced Primary Care Practice Demonstration, which required Level 3 Patient Centered Medical Home accreditation) do (CMS, Innovation Models, 2015). Accreditation standards often include detailed guidelines about reporting capabilities. In addition, accreditation for ACOs does exist. The National Council on Quality Assurance (NCQA) and URAC (formerly known as the Utilization Review Accreditation Commission) confer ACO accreditation that requires numerous capabilities that promote quality of care, of which several directly or indirectly support equitable and accessible care for patients. Among others, the requirements include: conducting performance monitoring geared toward population health management, requiring technology capabilities to report on performance results, enforcing clinical guidelines and protocols, and implementing advanced population management strategies. In addition,

the accreditation standards require ACOs to establish mechanisms to monitor for utilization – though, notably, they do not prescribe a specific method for doing so (NCQA, 2015; URAC, 2013).

Several concurrent (i.e. method of monitoring in real-time or near-real-time) and retrospective (i.e. method of monitoring using data produced after a period of performance is over) methods used to monitor performance within the healthcare delivery system today – both within and outside the confines of shared savings programs – could be relevant for monitoring under-service and patient selection. A common method used to identify problems with the care experience or the provision of care is patient feedback, as demonstrated by the reliance on survey-generated measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for hospitals and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for healthcare providers more broadly (CMS, HCAHPS: Patients' Perspectives of Care Survey, 2015; AHRQ, 2015). Another manner of capturing patient feedback is through the use of patient advocacy services. CMS has done this through the creation of an Ombudsman Center. This center is responsible for assisting beneficiaries with grievances, taking ownership of the related casework, and conducting robust analyses on the complaints received in order to pinpoint systemic problems and recommend solutions (Ombudsman, 2013). In Connecticut, the Office of the Healthcare Advocate (OHA) serves a similar function as the CMS Ombudsman office.

When CMS began the MSSP initiative, resources within the Ombudsman office were dedicated specifically to respond to the needs of beneficiaries enrolled in an MSSP- ACO (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). Mystery shopping is another method of evaluating service that is commonly used in healthcare and could help to identify instances of patient selection. Mystery shopping is when the shopper, in this case a patient, is secretly evaluating the entity from which they are receiving services, in this case the provider. In healthcare mystery shopping is often conducted at the point of entry to healthcare system. An individual posing as a patient will call to make an appointment and take notes about their experience and/or ask specific questions to obtain specific information. DSS runs a mystery shopper program study annually that assesses access to care by visit type (i.e., urgent visit, routine care, etc.) and the impact of insurance type on access to appointments.

Retrospective monitoring methods for under-service and patient selection predominately rely on analysis of claims data. The CMS MSSP final rule states that monitoring for potential instances of stinting on care or avoidance of at risk beneficiaries will be conducted and flagged for further investigation (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). CMS has not publicized the methods used to monitor under-service or patient selection nor the outcomes to date, but the final rule suggests that changes in utilization could serve to identify stinting on care and the risk profile of an ACO over time could suggest avoidance of at risk beneficiaries. Even though to date there is very little outcomes data on whether or not monitoring utilization is in fact the best way to detect under-service, other providers and payers use utilization variation to detect both under and over service (Maheras & Cooper, 2015; Kelly, 2014; Hines, 2013). While CMS does not publicize measures, they have agreed to share their monitoring methods and outcomes pertaining to under-service and patient selection with Connecticut. Upon receipt of this information, the detail of these methods will be incorporated into this report.

CMS holds MSSP ACOs accountable for unwanted behaviors, which includes stinting on care and avoidance of at-risk beneficiaries. Violation of guidelines are addressed primarily through the use of a

corrective action plan (CAP) and/or termination if the unwanted behaviors are not resolved or violations continue (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). The Vermont Medicaid ACO program responds to the discovery of unwanted behaviors by engaging the ACO in a collaborative learning process with other high-performing ACOs (Maheras & Cooper, 2015). Another way to promote accountability is through transparency. While CMS has not made metrics related to under-service or patient selection available publicly, quality performance and financial performance are made public. Transparency concerning quality in healthcare has played a large role in the movement to hold providers accountable for outcomes.

Discussion

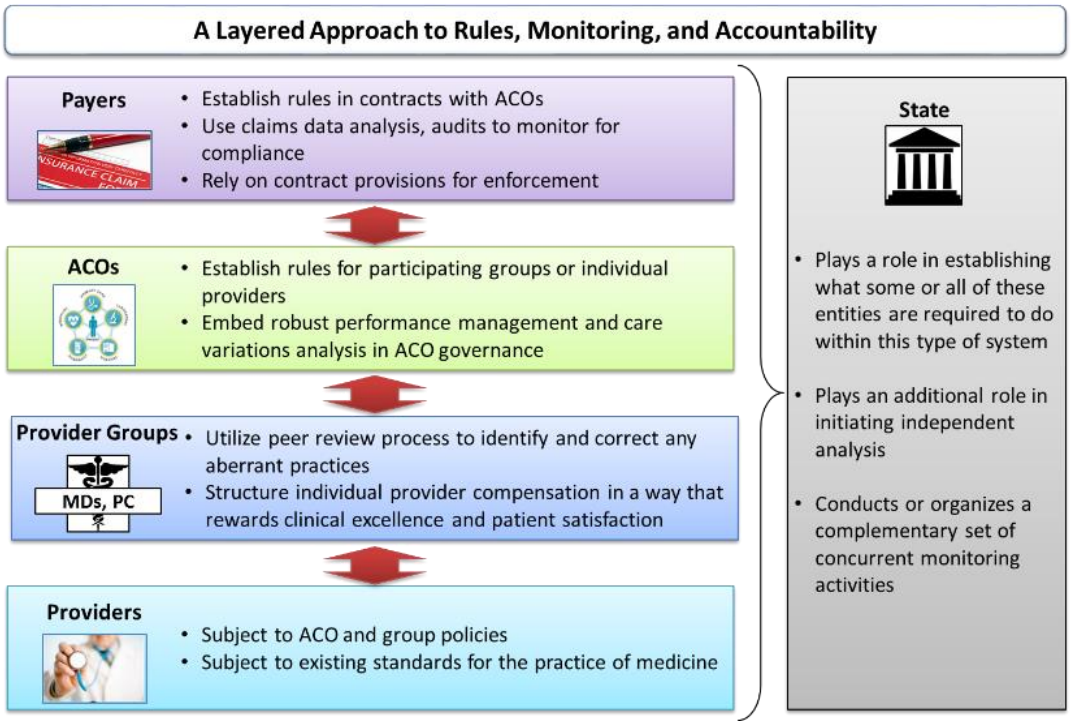
The Equity and Access Council's charter includes three charges that motivate the recommendations contained in this report:

I. Recommend "retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care"
II. "…recommend a response to demonstrated patient selection and under-service"; and
III. "…define the state's plan to ensure that that at-risk and underserved populations benefit from the proposed reforms"

This report focuses in particular on items (I) and (II), and on safeguards other than analytic methods that might similarly limit patient selection and under-service. The recommendations above concerning shared savings payment design will enhance the extent to which Connecticut's under-served populations benefit from payment reforms, but alone they are not sufficient to safeguard against under-service and patient selection. Recommendations for monitoring and accountability will complement the recommendations concerning payment design.

At this early stage in the adoption of shared savings contracts, their full impact – positive or negative – on under-service and patient selection is unknown. Accordingly, to ensure that the residents of Connecticut benefit from payment reform it will be imperative that new payment models are monitored for unwanted effects, and that the results of this monitoring are used in a way that holds ACOs and providers accountable if systemic or repeated under-service and/or patient selection are identified.

The EAC recommends a multi-layered approach to supplemental safeguards in which ACOs, payers, and state agencies each play a role in promoting continuous performance improvement and accountability for delivering high-quality care to Connecticut's most at-risk and historically underserved groups.



The first layer of safeguards should be established at the ACO level. These safeguards can be initiated and memorialized via ACO agreements with participating groups and individual providers, and/or via ACO contracts with payers.

> ***Recommendation #4.1: 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. [Status as of Initial EAC Review: Adopt as Presented]***

> ***Recommendation #4.2: 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. [Status as of Initial EAC Review: Adopt as Presented]***

A second layer of safeguards should be established by payers in the form of monitoring claims data. As is the case with the CMS MSSP and Vermont's Medicaid ACOs, the payer can play a central role in monitoring for under-service and patient selection as it would monitor for over-service and fraud and abuse. Some monitoring methods can be employed by all payers across all populations. In other cases, understanding variations in utilization that are disease specific for diagnoses that raise particular under-service concerns will also be necessary.

> ***Recommendation #4.3: 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 by assessing utilization and total cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation.

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.

[Status as of Initial EAC Review: Adopt with Changes]

The use of concurrent monitoring will also serve an important role in detecting potential instances of under-service and patient selection. The SIM model test grant award explicitly describes and allocates funding for a "nurse consultant" to play a key role in Connecticut's concurrent monitoring framework (Administrators, 2014). Connecticut currently employs ombudsmen (nurse consultants) in the Office of the Healthcare Advocate (OHA) to respond to patient complaints and requests for assistance related to health insurance coverage. The work OHA does today to field complaints is not specific to patients enrolled in shared savings programs nor does it have a focus on detecting under-service or patient selection. While gathering and responding to patient concerns is undoubtedly beneficial, using this type of approach to detect under-service and patient selection will likely be difficult. Specifically, patients who have experienced under-service or patient selection will likely not be able to identify what they experienced as such, and without specific training a nurse consultant may not be able to recognize under-service or patient selection either.

For a nurse consultant role to contribute effectively to monitoring for under-service and patient selection, the role will require training and education and should be dedicated to fielding, responding, and analyzing concerns arising from patients who are receiving care through an ACO that is participating in a shared savings program as well as providing patients with education about what under-service and patient selection is.

Recommendation #4.4: 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). [Status as of Initial EAC Review: Table for Further Consideration]

A set of recommended elements of the nurse consultant's job description is contained in Appendix F.

Mystery shopping can serve as a more proactive approach to identifying instances of patient selection. Conducting mystery shopping in a similar manner to what CHNCT does on behalf of DSS today, assessing access to care by visit type and the impact of insurance type on appointment availability, would bring to light variations in access that are due to insurance, particular diagnoses, or socioeconomic factors. This activity has the potential to identify instances in which patient selection might be occurring at the point of entry into a medical practice and expanding it more broadly across payers will support the identification of patient selection.

Recommendation #4.5: 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. [Status as of Initial EAC Review: Table for Further Consideration]

When instances of under-service or patient selection are detected and verified – via payer analysis, an ACO's own analysis, consumer reporting to the State, or a combination of the above – a thorough, fair, and constructive process should be undertaken to correct the problems identified.

Recommendation #4.6: 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. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern. [Status as of Initial EAC Review: Adopt with Changes]

The rules and monitoring recommended above are intended for implementation within a relatively short timeframe. However, in light of the relative paucity of accumulated experience to date with respect to outcomes of shared savings programs, in particular among certain patient populations, additional monitoring and evaluation should occur in the long-term. A more in depth assessment of shared savings programs after several years of experience will help to identify the extent to which these programs are ameliorating or aggravating equity and access problems, including under-service and patient selection.

Recommendation #4.7: 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. [Status as of Initial EAC Review: Adopt as Presented]

For the framework of safeguards above to be effective, a degree of transparency must be embedded at the appropriate places in the system. At a minimum, the public should have access to information about the rules under which shared savings contracts are being implemented, the monitoring for under-service and patient selection that is taking place, and the results of that monitoring. This will promote public confidence that contracting methods of this type are broadly benefiting Connecticut's residents and are not having undesired effects.

Recommendation #4.8: 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.

[Status as of Initial EAC Review: Table for Further Consideration]

Supplemental Safeguards: Communications

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 information directly to patients and providers is foundational to promoting this understanding. Such communications might include information about:

- The objectives of shared savings arrangements and the payment components utilized to achieve those objectives
- The ways in which shared savings arrangements are different than fee-for-service contracts
- The role of patients and providers in achieving the objectives of value-based payment

In addition, such communications might include, separately or in combination with other topics, information about issues the EAC has explicitly sought to address in this report, such as:

- The mix of financial incentives that providers, provider groups, and other ACO member service delivery organizations have under a shared savings arrangement
- The existence in some scenarios of a financial incentive to stint on care or inappropriately restrict patient panels
- How to understand if appropriate medical care has been provided
- What patients should do if they believe they have been denied medically necessary care

A number of entities historically communicate with healthcare consumers in Connecticut. These entities could play various roles in informing consumers about the above topics. For example:

- Payers could provide information at the time of patient enrollment
- Payers could provide information annually or on a standing basis
- Providers could post information at the point of care
- State agencie(s) could provide information annually, on a standing basis, or upon certain qualifying events

For the MSSP, CMS requires providers to post signs in facilities notifying beneficiaries that the provider participates in the MSSP, and to provide written notices upon request. Failure to notify beneficiaries of participation in an ACO constitutes grounds for termination from the MSSP. (CMS, 2014) CMS also publishes a beneficiary Q&A guide entitled "Accountable Care Organizations and You." These materials focus on data privacy, beneficiary retention of provider choice, and benefits of being served by an ACO; they do not discuss financial incentives associated with providers' participation in an ACO. (CMS, 2014)

Discussion

Choices about the content and medium employed to inform patients and providers about the nature of shared savings arrangements have implications for equity and access, and also for the success of payment reform more broadly. These choices include:

- Who should determine the content of communications?
- What should be the focus and scope of communications?

- Who should write and distribute communications?
- When should communications be issued, in what venues, and using what media?
- What messages should be consistent across all populations or multiple populations, and which messages should be tailored to specific populations?
- What should be done to ensure that the communications are accessible and understood by all of the intended audiences?

Communicating to consumers about shared savings contracts presents a number of opportunities and challenges. At a foundational level, consumers should have access to accurate, complete, usable information how their healthcare services are paid for. In addition, giving clear information to patients about shared savings contracts creates an opportunity to enlist them as participants in the goals of these contracts – improving the quality and coordination of their care, and utilizing healthcare resources efficiently. It also provides an opportunity to generate understanding among patients about how payment reform is intended to affect the way care is delivered, and about how it could unintentionally affect care delivery decisions in other, unwanted ways.

Armed with this understanding, consumers may be able to advocate for themselves more effectively and discern any instances in which medically appropriate services are not ordered for them, or in which they are excluded from a provider's panel for inappropriate reasons. These latter opportunities are particularly important to the context in which the EAC is evaluating this topic. To the extent that informing consumers about the potential for under-service and patient selection helps both to prevent and identify those activities, it will complement other safeguards that the EAC recommends.

At the same time, the complexity and variety of financial incentives associated with shared savings contracts make it inherently challenging to convey them to consumers in a succinct and universally applicable manner. Within an ACO, individual providers and provider groups may or may not be exposed to financial incentives associated with efficiency or quality. Given that fact, and given the mix of potentially countervailing short- and long-term incentives associated with ordering or not ordering a particular procedure or treatment, it may be difficult to characterize with great specificity the financial incentive associated with a provider's decisions.

And, while informing consumers about the potential incentive to stint on care will make them more alert to any actual instances of under-service, it is also likely to induce false positives – instances in which consumers perceive their care to be inappropriate or insufficient, when it is in fact consistent with standards of care and with the provider's clinical judgment. This concern is heightened by the fact that, even absent any prompting, consumers in some instances may already perceive that they are being under-served if a provider fails to order a commercially publicized treatment, even if that treatment is not indicated. If information provided to consumers about payment reform focuses exclusively or unduly on potentially adverse incentives, it may harm patient-provider relationships – which are fundamental to achieving individual and population-wide health goals. In turn, if providers perceive that communications are likely to adversely affect their relationship with patients – or, more generally, that the communications lack context or balance – they may elect to abstain from new payment arrangements or from accepting certain insurance products altogether.

Given the combination of opportunities and challenges described above, it is important that information communicated to patients on this topic be accurate, complete, balanced, and presented in a manner and context that makes it comprehensible and actionable.

> ***Recommendation #5.1: 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 manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. 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. [Status as of Initial EAC Review: Adopt with Changes]***
>
> ***Recommendation #5.2: 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. [Status as of Initial EAC Review: Adopt as Presented]***
>
> ***Recommendation #5.3: 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. [Status as of Initial EAC Review: Adopt as Presented]***

Providers also need to be informed generally about the impact of payment reform, and specifically about the potential for under-service or patient selection to occur. These concepts need to be defined in an explicit, consistent way and within their proper context. Messaging to providers should communicate that incentives for quality improvement and cost efficiency operate within the confines of existing, independently established standards for the provision of medically appropriate and necessary care. To the extent that contracts between payers and ACOs stipulate conditions under which an ACO will forfeit eligibility for some or all shared savings that it generates (i.e. demonstrated under-service or patient selection), these conditions – and the process for finding their existence, including appeals – should be made transparent to providers.

Recommendation #5.4: 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. [Status as of Initial EAC Review: Adopt as Presented]***

5. Consolidated List of Recommendations

Patient Attribution

Recommendation #1.1: Patient Attestation. Patients should be able, though not required, to identify their primary care provider through an attestation (designation) process as a primary attribution technique. 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 choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #1.2: Patient Notification. Patients should be made aware when they are attributed to a physician who is participating in a shared savings program. Notification should be in a manner that is accessible and understandable by all patients. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #1.3: Settings of Care for Attribution. Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or urgent care center). For integrated ACOs (i.e.; an ACO that includes a hospital), payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage an organization to take accountability for their care. The use of a non-traditional setting of care to assign a patient to an organization will only be used if a patient does not have any visits with a primary care provider in the last year and/or did not designate a provider at the outset of the contract period. This recommendation is meant to provide an incentive at the macro level for an organization to develop the required care coordination structure and primary care access to improve care for the most difficult patients. [Status as of Initial EAC Review: Table for Further Discussion]

Recommendation #1.4: Timing of Attribution. Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #1.5: Attribution Reconciliation. An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year. In instances in which the retrospective reconciliation process determines that a patient should be un-attributed, that patient will not be re-attributed to another ACO. [Status as of Initial EAC Review: Adopt with Changes]

Cost Target Calculation

Recommendation #2.1: Rewarding Improvement. Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost

improvement over the prior year, in addition to their performance against the group. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #2.2: Adjustment for Unpredicted Systemic Costs. 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, severe flu season) 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 an identified treatment can be temporarily carved out of the cost benchmark calculation. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #2.3: Supplemental Payments for Complex Patients. 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. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #2.4: Retrospective Assessment for Risk Adjustment. In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #2.5: 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. [Status as of Initial EAC Review: Adopt with Changes]

Incentive Payment Calculation and Distribution

Recommendation #3.1: Eligibility Thresholds. ACOs should only be able to share in savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or patient selection (as defined in the EAC charter and incorporated in payer-ACO contracts). [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #3.2: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #3.3: 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. To ensure that ACOs are not penalized for accepting new patients who may be more challenging to care for, year over year changes in ACO quality performance should be calculated using patients who have

been continuously attributed to the ACO during the prior year and the performance year. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #3.4: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #3.5: 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). [Status as of Initial EAC Review: Table for Further Consideration]

Recommendation #3.6: Advance Payments. Providing ACOs with up-front funding dedicated to infrastructure will allow them to invest in the resources required to effectively manage care for defined populations. This incentive is especially important for smaller organizations or networks that are considering participating in MQISSP as ACOs. In addition, by improving ACOs' ability to lower costs through effective utilization management, this type of investment will reduce any incentives to lower costs through inappropriate methods that involve stinting on care or discontinuing patients. [Status as of Initial EAC Review: Not Yet Considered]

Recommendation #3.7: 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. [Status as of Initial EAC Review: Adopt as Presented]

Supplemental Safeguards: Rules, Monitoring, and Accountability

Recommendation #4.1: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #4.2: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #4.3: 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 by assessing utilization and total cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation.
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.
[Status as of Initial EAC Review: Adopt with Changes]

Recommendation #4.4: 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). [Status as of Initial EAC Review: Table for Further Consideration]

Recommendation #4.5: 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. [Status as of Initial EAC Review: Table for Further Consideration]

Recommendation #4.6: 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. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #4.7: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #4.8: 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.
c) Recommendation #5.1: 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 manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. 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. [Status as of Initial EAC Review: Table for Further Consideration]

Supplemental Safeguard: Communication

Recommendation #5.1: 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 manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. 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. [Status as of Initial EAC Review: Adopt with Changes]

Recommendation #5.2: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #5.3: 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. [Status as of Initial EAC Review: Adopt as Presented]

Recommendation #5.4: 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. [Status as of Initial EAC Review: Adopt as Presented]

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Appendices

Appendix A: Equity and Access Council Charter

EQUITY AND ACCESS COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; recommend a response to demonstrated patient selection and under-service; and define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work. Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. A finding of failure shall not require proof of intentionality or a plan.

Key questions this work group needs to answer – Phase I – Design & Implementation

Setting Context

1. Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council.

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?

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?
5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?
5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to patient selection?

Questions this work group may opt to consider – Phase II

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?

Appendix B: Equity and Access Council Assessment and Recommendations Mapped to Charter Questions

Below is a summary of all the questions posed in the charter with excerpts from the report that answer those questions and the accompanying recommendations. The excerpts from the report are in italics.

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)?

   The EAC sought to identify the most effective monitoring methods and other approaches employed today. However, a literature review and exploration of evidence from CMS, other states, think tanks, and members of Connecticut's payer, ACO, consumer, and regulatory committees revealed that it may be too early to assess how shared savings payment arrangements impact equity and access, and also too early to identify proven safeguards against under-service or patient selection. Information from CMS on under-service and patient selection monitoring methods and the associated outcomes have been requested from CMS and are forthcoming. The information on monitoring mechanisms and any evidence of under-service or patient selection occurring in the MSSP will be incorporated into this report when it is received.

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?

   The EAC did not find evidence of studies commissioned by private payers that specifically examined the risks of patient selection or under-service. CMS has been monitoring under-service and patient selection and will share that information with Connecticut to support and inform the work of this council.

Guarding Against Under-Service and Patient Selection

1. What are the current methods utilized by private and public payers for detecting under-service and patient selection?

   Retrospective monitoring methods for under-service and patient selection predominately rely on analysis of claims data. The CMS MSSP final rule states that monitoring for potential instances of stinting on care or avoidance of at risk beneficiaries will be conducted and flagged for further investigation (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). *CMS has not publicized the methods used to monitor under-service or patient selection nor the outcomes to date, but the final rule suggests that changes in utilization could serve to identify stinting on care and the risk profile of an ACO over time could suggest avoidance of at risk beneficiaries. Even though to date there is very little outcomes data on whether or not monitoring utilization is in fact the best way to detect under-service, other providers and payers use utilization variation to detect both under and over service* (Maheras & Cooper, 2015; Kelly, 2014; Hines, 2013).

   The EAC made the following recommendation directly related to this topic:

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 by assessing utilization and total cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation.

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.

2. Can standard measures and metrics be applied for the detection of under-service and patient selection?

The monitoring recommended above is intended for implementation within a relatively short timeframe. However, in light of the relative paucity of accumulated experience to date with respect to outcomes of shared savings programs, in particular among certain patient populations, additional monitoring and evaluation should occur in the long-term. A more in depth assessment of shared savings programs after several years of experience will help to identify the extent to which these programs are ameliorating or aggravating equity and access problems, including under-service and patient selection.

The EAC made the following recommendation directly related to this topic:

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.

3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service and patient selection?

   The SIM PMO has asked CMS to provide information about methods that the CMS Center for Program Integrity or the CMMI Application, Compliance, Outreach Division may have adopted to detect under-service or patient selection. As of this writing, CMS has not provided any information about the nature, extent, or results of any such detection activities. DSS will define methods to monitor for under-service and patient selection as part of its MQISSP design process; this may include adapting existing program integrity methods.

4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service or patient selection is suspected?

   For the framework of safeguards above to be effective, a degree of transparency must be embedded at the appropriate places in the system. At a minimum, the public should have access to information about the rules under which shared savings contracts are being implemented, the monitoring for under-service and patient selection that is taking place, and the results of that monitoring. This will promote public confidence that contracting methods of this type are broadly benefiting Connecticut's residents and are not having undesired effects.

   The EAC made the following recommendation directly related to this topic:

   ***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.

5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?

   Methods for disqualifying ACOs from receipt of shared savings are likely to be more relevant to the EAC's charge than are methods for disqualifying individual clinicians. Most ACOs do not directly pass through shared savings payments to individual clinicians based on savings

associated with their own individual patient panels. Accordingly, individual clinicians have relatively little financial incentive to under-serve patients or exclude high-risk patients from their panels. Still, ACOs should monitor for this potential as part of their clinical performance management processes, and should initiate corrective actions in cases where patterns of under-service or patient selection are identified. In addition, any instances of under-service in which a clinician deliberately withheld medically necessary services for financial reasons, in contravention of accepted standards of care, should be handled through existing complaint and licensure review processes.

At the ACO level, payers should utilize claims data and follow-up analyses to establish the existence of any under-service or patient selection on the part of an ACO. CMS holds MSSP ACOs accountable for unwanted behaviors, which includes stinting on care and avoidance of at-risk beneficiaries. Violation of guidelines are addressed primarily through the use of a corrective action plan (CAP) and/or termination if the unwanted behaviors are not resolved or violations continue (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). *The Vermont Medicaid ACO program responds to the discovery of unwanted behaviors by engaging the ACO in a collaborative learning process with other high-performing ACOs* (Maheras & Cooper, 2015). *Another way to promote accountability is through transparency. While CMS has not made metrics related to under-service or patient selection available publicly, quality performance and financial performance are made public. Transparency concerning quality in healthcare has played a large role in the movement to hold providers accountable for outcomes.*

The EAC made the following recommendations directly related to this topic:

Recommendation #6: ***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.***

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 #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.

6. What are the mechanisms for consumer complaints of suspected under-service? What other methods might be available for patient selection (e.g., mystery shopper)?

   Several concurrent (i.e. monitoring that is meant to identify the problem when it happens) and retrospective (i.e. monitoring that uses data to identify a behavior after it has occurred) methods used to monitor performance within the healthcare delivery system today – both within and outside the confines of shared savings programs – could be relevant for monitoring under-service and patient selection. A common method used to identify problems with the care experience or the provision of care is patient feedback, as demonstrated by the reliance on survey-generated measures such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for hospitals and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for healthcare providers more broadly (CMS, HCAHPS: Patients' Perspectives of Care Survey, 2015; AHRQ, 2015). *Another manner of capturing patient feedback is through the use of patient advocacy services. CMS has done this through the creation of an Ombudsman Center. This center is responsible for assisting beneficiaries with grievances, taking ownership of the related casework, and conducting robust analyses on the complaints received in order to pinpoint systemic problems and recommend solutions* (Ombudsman, 2013). *In Connecticut, the Office of the Healthcare Advocate (OHA) serves a similar function as the CMS Ombudsman office. When CMS began the MSSP initiative, resources within the Ombudsman office were dedicated specifically to respond to the needs of beneficiaries enrolled in an MSSP- ACO* (CMS, CMS Medicare Shared Savings Program Final Rule, 2011).

   Mystery shopping is another method of evaluating service that is commonly used in healthcare and could help to identify instances of patient selection. Mystery shopping is when the shopper, in this case a patient, is secretly evaluating the entity from which they are receiving services, in this case the provider. In healthcare mystery shopping is often conducted at the point of entry to healthcare system. An individual posing as a patient will call to make an appointment and take notes about their experience and/or ask specific questions to obtain specific information. CHNCT runs an annual mystery shopper program on behalf of DSS that assesses access to care by visit type (i.e., urgent visit, routine care, etc.) and the impact of insurance type on access to appointments.

   The EAC made the following recommendations directly related to this topic:

   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.***

7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

   The EAC recommends a multi-layered approach to supplemental safeguards in which ACOs, payers, and state agencies each play a role in promoting continuous performance improvement and accountability for delivering high-quality care to Connecticut's most at-risk and historically underserved groups. The recommendations above speak to the role of each individual entity in achieving this outcome.

Appendix C: Equity and Access Council Roster

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Keith vom Eigen, MD
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Appendix D: List of Design Group Participants

Group One: Patient Attribution and Cost Benchmark Calculation

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Chris Borgstrom, Project Access
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Stephen Frayne, Connecticut Hospital Association
Deb Polun, Southwest Community Health Center, Inc.
Robert Russo, Robert D. Russo MD & Associates Radiology
Mark Schaefer, CT SIM PMO
Katie Sklarsky, The Chartis Group (Facilitator)
Adam Stolz, The Chartis Group
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Katherine Yacavone, Southwest Community Health Center, Inc.

Group Two: Payment Calculation and Distribution

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Group Three: Rules, Communications and Enforcement

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Mary Ellen Breault, Connecticut Insurance Department
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Group Four: Detection and Monitoring – Concurrent and Retrospective

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Appendix E: Glossary of Terms

Accountable Care Organizations (ACOs): A health provider–led organization designed to manage a patient's full continuum of care and be responsible for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician–hospital organizations, multi–specialty practice groups with or without hospital ownership, independent practice associations and virtual interdependent networks of physician practices.

ACO types cluster into three broad groups: those led by hospitals (Independent Hospital and Hospital Alliance), those led by physician groups (Independent Physician Group, Physician Group Alliance and Expanded Physician Group) and those led by integrated delivery systems (Full Spectrum Integrated).

Organization types include:

> **Full Spectrum Integrated ACOs:**
> Provide all aspects of healthcare directly to their patients, with a large, integrated delivery network.
>
> **Independent Physician Groups ACOs:**
> Are owned by a single physician group and do not contract with other providers for additional services.
>
> **Physician Group Alliances ACOs:**
> Similar to Independent Physician Groups ACOs but can be owned by multiple physician groups. They do not contract with other providers for further services.
>
> **Expanded Physician Groups ACOs:**
> Only offers outpatient services directly, but they do contract with other providers to offer hospital or advanced care services.
>
> **Independent Hospital ACOs:**
> ACOs with a single owner that provides direct inpatient services. Outpatient services can be provided directly by the ACO if the owner is an integrated health system or a physician-hospital organization.
>
> **Hospital Alliance ACOs:**
> ACOs with multiple owners with at least one owner directly providing inpatient services. Outpatient services can be provided either directly or by a contracted provider.

Accountability: Consequences for violating rules and methods for enforcing those consequences.

Communication: Methods of informing consumers and providers about the definition and consequences of prohibited activities.

Concurrent Monitoring & Detection: Methods of detecting under-service and patient selection in real-time or near-real-time.

Cost Target Calculation: The method by which a patient's benchmark (expected) cost of care is determined and adjusted for clinical and other risk factors.

Cost Benchmark: The expected (or targeted) cost of caring for the population attributed to the ACO.

Historic Benchmark: Sets the expected costs of a population based on the past experience of that population.

Control Group Benchmark: Uses a comparator population (e.g. all enrollees in a health plan throughout a broad regional area) to determine expected costs.

Risk Adjustment: Method to take into consideration demographics and the diagnoses of the population to allow for an "apples to apples" comparison in costs between populations with different risk profiles.

Incentive Payment Calculation: The method that defines the amount of incentive payments generated for a given patient population.

Fee for Service (FFS): A method of paying health care providers a fee for each medical service rendered.

Minimum Loss Rate (MLR): Similar to an MSR, in a downside arrangement there is a threshold of excessive expenditures that has to be met before the ACO incurs a loss.

Minimum Savings Rate (MSR): Establishes the degree of savings an ACO must achieve in order to be eligible to earn any amount of savings. An MSR is used to ensure that ACOs only share in savings that are statistically significant and don't result from random variation in expenditures.

Patient Attribution: The method by which patients are assigned to a provider.

Plurality of Visits Methodology: This technique assigns a patient to the provider that the patient saw most frequently within a defined period of time (i.e. the year prior to the performance year or during the performance year).

Patient-Selected: Patients designate their primary care provider when they enroll in their insurance plan.

Insurer-Selected: Attribution relies on the insurer to designate the patient's primary care provider when the patient selects the insurance plan.

Geography based: Also known as "population based", a technique assigns patients to a provider based on where the patients live.

Retrospective Assignment: Assigns a patient to a provider at the *end* of the first performance year of the shared savings contract.

Prospective Assignment: Assigns a patient to a provider at the *outset* of the shared savings contract period.

Patient Selection: Refers to efforts to avoid serving patients who may comprise a provider's measured performance or earned savings.

Pay for Performance (P4P): A method of paying health care providers differing amounts based on their performance on measures of quality and efficiency. While early P4P programs used quality and access measures to determine incentive awards, current models often include measures of physician practice efficiency, such as use of lower-cost generic pharmaceuticals. Payment incentives can be in the form of bonuses or financial penalties. Pay for performance is typically used in combination with fee for service payments to incentive improvement in quality of care and patient safety.

Payment Distribution: The method by which individual providers share in achieved savings.

Performance Measurement: Performance Measurement evaluates the impact on patients' care experience and quality of outcomes on their total health. Key goals of performance measurement are to ensure accountability for the quality of care and to identify and drive improvement in areas of substandard care.

Population Health: The health of a group of people such as those who live in a geographic region, belong to a worksite, or are members of minority groups.

Retrospective Monitoring & Detection: Methods of detecting under-service and patient selection by observing it using data produced after a period of performance is over.

Rules: Rules for who can participate in a value-based contract and what activity is allowed and prohibited.

Shared Savings Program: A form of a value based payment that offers incentives to provider entities to reduce healthcare spending for a defined patient population by offering physicians a percentage of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures and then shared between payer and providers. An accountable care organization (ACO) is a type of shared savings program.

> **Upside Risk:** An upside-only contract the ACO will have the opportunity to share in savings if actual costs are below the expected cost benchmark, but will *not* be at financial risk if costs are in excess of the cost benchmark.
>
> **Two-Sided Risk:** In this arrangement the ACO will continue to have an opportunity for savings, but will also incur a loss if spending is higher than the expected cost benchmark. The loss will occur in the form of a payment back to the payer for costs that exceed what was expected.

Triple aim in health care: A framework developed by the Institute for Healthcare Improvement that aims to optimize the U.S. health care system by enhancing the patient experience, improving the health of populations and reducing the per capita cost of health care.

Under-Service: Refers to the systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements.

Value Based Insurance Design: Insurance plans with structural components that incent patients to engage in healthy behavior, participate in their healthcare decisions, and make intelligent use of healthcare resources.

Value Based Payment Design: Form of payment that holds physicians accountable for the cost and quality of care they provide to patients. This differs from the more traditional fee for service payment method in which physicians are paid for volume. The goal of value based payments is to reduce inappropriate care and reward physicians, other healthcare professionals and organizations for delivering value to patients. Examples of value based payments include shared savings programs (SSPs).

Appendix F: Council on Medical Assistance Program Oversight (MAPOC)-Care Management Committee (CMC) Recommendations for Medicaid QISSP Under-Service Safeguards

This appendix will be populated with the MAPOC CMC's recommendations after they are issued.

Appendix G: Nurse Consultant Job Description

OHA Nurse Consultant Job Description -*DRAFT*

The individual in this role should:

- Be dedicated to addressing under-service and patient selection.
- Proactively monitor utilization data produced from standard monitoring activities and patient grievances to identify trends that point to equity and access concerns and merit further investigation.
- Play a role as a patient educator, in particular as it relates to under-service, and to promote role as a trusted patient resource. This includes education to help patients understand why a concern that they have may not actually represent inappropriate care.
- Play a role as an educator to community health workers who frequently interact with vulnerable populations, providing them with tools to promote under-service education in their day to day interactions.
- Be responsible for communicating back to providers when patients voice grievances, even when there is no evidence of provider mistreatment. This can provide useful information for a provider about potential communication gaps at the practice level.
- Identify process to respond and further investigate under-service and patient selection concerns as they are flagged.
- Be trained to identify/flag under-service and patient selection from patient grievances.
- Be trained to analyze patterns of grievances in relation to utilization monitoring to identify/flag under-service and patient selection.