

STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
April 9, 2015
6:00-8:00p.m.

Location: Connecticut State Medical Society, 127 Washington Avenue, East Building, 3rd Floor North Haven, CT

Members Present: Ellen Andrews; Johanna Bell; Peter Bowers; Christopher Borgstrom; Bonita Grubbs; Margret Hynes; Gaye Hyre; Roy Lee; Kate McEvoy; Donald Stangler; Victoria Veltri; Keith vom Eigen; Robert Willig; Katherine Yacavone

Members Absent: Linda Barry; Maritza Bond; Arnold DoRosario; Alice Ferguson; Kristen Hatcher; Robert Russo

Other Participants: Mark Schaefer; Katie Sklarsky; Adam Stolz; Sheldon Toubman (sitting in for Kristen Hatcher)

The meeting was called to order at 6:06pm.

1. Introductions

2. Public Comment

[Supriyo Chatterjee gave public comment.](#) Council members responded.

Kate McEvoy thanked Mr. Chatterjee for his comments and asked him to provide context for his remarks. Mr. Chatterjee said he believes SIM is a tremendous opportunity to acknowledge health equity issues and disparities. He illustrated the SIM initiative's relevance by referencing a CMS publication that indicated a lack of change in national health disparities. Ellen Andrews thanked Mr. Chatterjee and commented that the SIM process has not been subject to sufficient ethics standards, which has cast a shadow over the process.

Mr. Toubman remarked that Alice Ferguson could not attend the meeting due to the location, which has not rotated in some time.

3. Minutes

Kathy Yacavone motioned to adopt the March 26th meeting minutes. The motion was seconded by Gaye Hyre and the minutes were approved.

4. Design Group 3: Communication – EAC Review and Consideration of Recommendations for Adoption

Adam Stolz presented draft recommendations concerning Design Group 3's charge regarding the use of consumer communication and the role it could play as a tool to safeguard against patient selection or underservice.

1. *Consumer Communications: Scope – “Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information*

about incentives to efficiently manage the total cost of care and definitions of under-service and patient selection. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's providers, 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."

Mr. Toubman remarked that, during the Design Group's discussion, there was only one person who disagreed with the idea of discretely informing patients about the risks of under-service. He asserted the importance of disclosing a shared savings model that could unintentionally encourage providers to stint on care. Mr. Toubman suggested the word "efficiently" be removed or changed to a more descriptive term, and asked that language about under-service risks be explicitly included in this recommendation. Mark Schaefer agreed that the word "efficiently" can be interpreted multiple ways. In response to Vicki Veltri's request for clarification on the dissenting view from the Design Group, Mr. Toubman relayed two dissenting points: 1) The Design Group participant expressed concern about what the impact would be of informing a patient about a doctor's financial motives on the patient-provider relationship; and, 2) The concern that a patient's definition of under-service may be different than under-service of medically necessary care. For example, a patient who requests a medication based from a television advertisement that the physician determines is not medically necessary. Ms. Hyre referenced a JAMA study that found patient requests for medical treatments were often not inappropriate and did not significantly increase costs. Ellen Andrews agreed. Dr. Schaefer also suggested the communication focus on the benefits of the payment model to provide a balanced perspective. Kathy Yacavone commented on the difficulty of crafting an informative message that was also easy to comprehend by a large scale audience. Ms. Veltri stated that the SIM Project Management Office has experience crafting straightforward and understandable language given their experience with the [SIM Innovation Plan](#).

Mr. Toubman remarked that the Council's charge is to look at underservice, in contrast to the overarching goal of shared savings to address over-service. Peter Bowers remarked that the general public does not have a full understanding of the issues associated with over service and under-service, and may not easily contextualize a message about just one without the other. Dr. Bowers asked if there is anything the Council could harness from Medicare's approach. Mr. Stolz responded that Medicare's patient education literature about ACO's is uniformly positive and does not mention the possibility of under-service. Ms. Yacavone remarked that Southwest Community Health Center has a placard stating patient rights and consumer responsibility in the forefront of their establishment. Their group represents the patient's right to access and the consumer responsibility to ask appropriate questions. The subcommittee looking at language could use Southwest as a very basic model of communication upon patient registration. Mr. Toubman said that each organization is different and the patient should know the providers payment model upfront. Rev. Grubbs endorsed the use of basic language, noting that the concept could be misinterpreted easily. She also expressed the importance of using multiple avenues and means of communication to account for different learning styles and comprehension. She also reminded the Council that constructing this communication is not in their charge. Ms. McEvoy shared the Medicaid over-service example of dental providers ordering imaging for children that is not medically necessary.

Mr. Stolz recapped by suggesting that he would add explicit language about underservice, and additional language about other, positive, potential effects of shared savings contracts, to recommendation number one.

2. *Consumer Communications: Accessibility and Consistency – "The type of information described in Recommendation #1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (i.e. at the time of insurance enrollment) and at the point of care (i.e. in the*

provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told."

- 3. Consumer Communications: Content Development – "A work group should be convened to advise state agencies and payers on the content to be contained in the core messages described in Recommendations #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."*

Bonita Grubbs asked how the committee plans to craft the document into everyday language. Rev. Grubbs remarked that given the changing nature of healthcare it is important that the provider be able to communicate clearly to the patient and understand the patient's point of view. Mr. Stolz relayed a Design Group member's concern with representing negative aspects of the program absent other information. Mr. Toubman added that there was a concern of scaring off patients. Ms. Andrews commented that the communication should be balanced in its representation of both sides. Ms. Veltri agreed. Dr. Schaefer remarked that there are many competitors for a patient's attention in the doctor's office.

Ms. Yacavone requested clarification on the communication delivery method. Mr. Stolz said there are two points of delivery, at the point of care and in advance of receiving care. Ms. Hyre commented on the lack of relationship between the provider and patient in today's healthcare environment, and suggested that providers could host a regular meeting for clients to provide a form for patients to ask questions and get to know their providers better in a stress free environment. Ms. Veltri remarked that the communication should not be like the privacy statements patients get at point of care that are rarely read and digested. Mr. Stolz said the program would benefit from placing this information in a broader context to induce patient participation in their healthcare and maximize the extent to which these messages are actually read and understood.

Ms. Andrews suggested the patient know about attribution up front to help them navigate to their provider instead of the emergency room. Communication provided could function as a pre-orientation. Keith vom Eigen remarked that some patients may not attend the pre-orientation and providers may not be able to track who attended. The variety of plans providers interact with could provide further confusion when the plans have different means of orientation. Ms. Andrews remarked that although the group will not be able to solve for those problems, this should not deter us from recommending that patients be informed about how the program works. Mr. Toubman remarked that there are different structures of providers that result in different incentives and risks and asked how to account for this in the communication. Mr. Toubman asked if the group wanted the message to be uniform or catered to the different types of provider structures and arrangements. Mr. Stolz remarked that the design group expressed a preference for uniform messaging. The group agreed that a separate work group should devise specific messages. Dr. vom Eigen suggested the group set up a list of guidelines that structure what the communication should address.

- 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."*

Christopher Borgstrom commented on the recommendation's functionality, referencing the different levels of health care policy literacy and comprehension. Ms. Yacavone commented that the language would be represented to providers in the standard value based contract and that larger organizations need to inform their individual providers, which may be challenging.

The Council agreed to add draft recommendations one, two, three, and four to the slate for consideration at the April 23rd meeting.

5. Combined Elements of Design Groups 3 and 4: Rules, Monitoring and Accountability/Enforcement – EAC Review and Consideration of Recommendations for Adoption

Mr. Stolz reviewed the draft recommendations that resulted from the discussions of Design Group 3, which was asked in part to consider rules and accountability, and Design Group 4, which was asked to consider monitoring that will safeguard against patient selection or under-service.

1. *ACO Internal Monitoring – “ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.*
2. *ACO Accreditation – “Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.*

Ms. Andrews remarked that under-service would be hard to capture at the ACO level of monitoring – one would need to monitor down to the provider level. Dr. Bowers suggested the Council keep in mind the distinction between payer populations (i.e. self-insured vs fully-insured), the Connecticut Insurance Department's rules and regulation, and key stakeholders. Ms. Andrews endorsed draft recommendation number two citing the use of an outside body to tackle accreditation criteria. Ms. Andrews said that accreditation may incent ACOs to monitor for under-service which is otherwise a costly endeavor. Ms. McEvoy suggested that we identify the origin point for additional standards that a payer might require of an ACO. Ms. McEvoy asked if recommendation one would be obligatory and the second discretionary. Mr. Stolz suggested that recommendation one represents requirements short of accreditation. Ms. McEvoy suggested standardized and centralized enforcement. Mr. Stolz asked the payers if they currently require anything of an ACO beyond the number of lives or providers. Robert Willig described current practices. Dr. Bowers commented that Anthem contracts with St. Vincent's, which is an accredited ACO. Ms. Andrews suggested the recommendation suggest identifying gaps in care and distributing shared savings based on the progress providers make on those gaps. Dr. Bowers suggested it be tied to quality. Dr. Bowers said at Anthem they are not telling providers and others how to do it, they are helping them figure it out.

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 established. At a minimum, the standard under-service and patient selection monitoring performed by payers should include:*
 - a. *Under-service should be monitored through utilization comparisons over time and between groups (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to assess total cost of care variations.*
 - b. *Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time.*

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

Ms. Yacavone suggested that risk adjustment and population management be proactively monitored at every level. She also suggested that monitoring occur globally and not just at the payer level. Ms. Andrews suggested the state monitor the state. Mr. Borgstrom asked about who is responsible, once you get past claims data, for assessing the root causes, given the diversity in technical sophistication across providers? Dr. Bowers added that some providers have that capability but many do not. Ms. Andrews asked where the savings that an organization who did not meet their goals went. Perhaps they could be reinvested in the organization to help them meet their goals, a topic that originated from prior EAC discussions. Dr. Bowers said self-funded employers will disapprove of this concept. Dr. vom Eigen suggested an independent authority conduct claims analysis to compare like items rather than the payers. Dr. vom Eigen asked if reinvestment of shared savings would burden organizations that are saving money. Ms. Andrews said the reinvestment would be in technical assistance rather than financial help. Dr. vom Eigen suggested the group use the All Payer Claims Database (APCD) for claims data analysis. Ms. Veltri said the APCD does not have that oversight authority. Additionally, there is a statutory limitation on Medicaid data sharing that has not been overcome to date.

4. *Concurrent Monitoring: Nurse Consultant – “A nurse consultant (i.e. ombudsman) will play a key role as a ‘hub’ of information related to under-service and patient selection and act as a one-stop source of information for consumers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based contracting programs. This role will be funded by the SIM initiative and be overseen by the Office of the Healthcare Advocate (OHA).”*
5. *Concurrent Monitoring: Mystery Shopping – “Mystery shopping programs should be implemented by all payers to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to each payer population.”*

Ms. Andrews reinforced Dr. vom Eigen’s point that monitoring by multiple payers may require duplicate efforts for providers. A hub that facilitates higher level monitoring may be a more effective method. Ms. Yacavone said it would be impossible for just one person to perform the job described by draft recommendation number four. Ms. Veltri explained that the term Nurse Consultant came about due to the current staffing composition of the Office of the Healthcare Advocate (OHA). The role does not necessarily have to be filled by a Nurse Consultant. Ms. Andrews suggested the person have analytic skills. Dr. Schaefer remarked that OHA does not have the analytic skill set nor are they equipped to take on analytic functions. Ms. Veltri said the monitoring cannot be facilitated by a regular state entity. Ms. McEvoy remarked that the monitoring entity needs to have neutrality.

Rev. Grubbs commented that the idea contains multiple layers. What do you do when the information is analyzed? Where is it located? Rev. Grubbs also said OHA is a natural place to start but the Council

also needs to think further. Dr. Schaefer said that kind of administrative tracking is within the OHA realm. Rev. Grubbs asked who would move the process forward past the reporting phase.

Dr. Schaefer asked how the mystery shopper would function in terms of identifying patient selection. He cited a previous mystery shopping study conducted by Medicaid. Ms. Andrews expressed concern on the amount of underservice that would need to occur before it was able to be detected. She suggested a control group be established and organized by levels. The mystery shopping would take place at the practice level. Mr. Toubman explained the Medicaid mystery shopping program. Ms. McEvoy asked if enough information would be available through this approach to assess underservice of Medicaid patients. She was unconvinced that patient conditions would arise in a scheduling call, in which case mystery shopping will not lend itself to detecting patient selection in the EAC's context. Mr. Stolz remarked that once the monitoring is tested the Council may find underservice in scheduling and new patient acceptance is not an issue. Ms. Andrews said a cancer survivor is an example of a patient that could be denied service at the time of scheduling.

Dr. vom Eigen said there are multiple ways a provider could screen their patients based on referral source rather than clinical condition per se. For example, patients coming out of nursing homes, psychiatric hospitals, and rehab facilities may be more difficult and risky to treat than others, and therefore denied an appointment. He also expressed concern about the type of patient selection that results when an ACO eliminates a less lucrative service. Roy Lee asked if there was a way to construct a solution that helped providers avoid having to underserve in the first place.

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

Dr. vom Eigen suggested the payer do the analysis described in draft recommendation number six. Dr. Schaefer asked if the corrective action would result in the provider's loss of shared savings. Mr. Stolz said it may depend on the ACO's payer contract. Ms. Andrews endorsed corrective action. Mr. Toubman remarked that the assumption is all payers are equally engaged but in reality this is not always the case.

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.”*

Mr. Stolz reviewed draft recommendation number eight, “Accountability: Public Reporting.” Dr. vom Eigen remarked that a patient may have the right to know which providers are saving more than others. Due to the time, Mr. Stolz suggested Council members submit closing comments via email. Council members suggested the recommendations and comments be compiled and circulated before the next meeting. Ms. Yacavone suggested the Council focus on the recommendations that did not reach consensus at the next meeting.

6. Closing Comments

Rev. Grubbs motioned to adjourn. The motion was seconded by Ms. Andrews and the meeting was adjourned at 8:00pm.