

**STATE OF CONNECTICUT**  
**State Innovation Model**  
***Equity and Access Council***

**Meeting Summary**  
**April 23, 2015**  
**6:00-8:00p.m.**

**Location:** Connecticut Behavioral Health Partnership, Hartford Room (Suite 3D), 500 Enterprise Drive, Rocky Hill, CT

**Members Present:** Ellen Andrews; Linda Barry; Johanna Bell; Peter Bowers; Christopher Borgstrom; Alice Ferguson; Margaret Hynes; Gaye Hyre; Robert Russo; Donald Stangler; Victoria Veltri; Robert Willig; Katherine Yacavone

**Members Absent:** Maritza Bond; Arnold DoRosario; Bonita Grubbs; Kristen Hatcher; Roy Lee; Kate McEvoy; Keith vom Eigen

**Other Participants:** Arlene Murphy; Mark Schaefer; Katie Sklarsky; Adam Stolz; Sheldon Toubman for Kristen Hatcher

The meeting was called to order at 6:05pm.

**1. Introductions**

Adam Stolz of The Chartis Group facilitated the meeting. Council members announced themselves.

**2. Public Comment**

Supriyo Chatterjee gave [public comment](#).

Sheldon Toubman [remarked](#) on the draft report's language. Mr. Stolz proposed Mr. Toubman's third and fourth language modifications be adopted and the first and second be tabled for further discussion. The Council agreed by consensus.

**3. Minutes**

Alice Ferguson motioned to approve the April 9<sup>th</sup> meeting minutes. The motion was seconded by Robert Russo and the minutes were adopted.

**4. Review Process and Timeline for Issuing Phase I Report**

Mr. Stolz reviewed the proposed steps and timeline for EAC and MAPOC CMC to conduct SIM-MQISSP planning alignment and for the EAC to submit its report to Healthcare Innovation Steering Committee (HISC). Ellen Andrews said she felt Kate McEvoy needed to be present in order for the EAC to endorse the proposed plan. Ms. Andrews said that regardless of what response the Council receives from CMC and the Steering Committee, it is still the Council's report and they retain autonomy over its content.

Mr. Stolz discussed the EAC's outstanding items and the proposed course of action. Kathy Yacavone suggested the Council delay its presentation to the HISC until the Council reaches consensus on the recommendations and produces a final draft of the report. The Council discussed funding related to shared savings implementation. Mr. Stolz suggested the

Council submit recommendations to the HISC without annotation regarding implementation and consider their comments to generate the next part of the report. The Council agreed on this approach.

## **5. Comments and Discussion on Structure of Draft Report**

Mr. Stolz reviewed the structure of the draft report and solicited comments and recommendations for revision.

Mr. Stolz reviewed pages seven and eight in the [draft report](#) which describes the EAC's role and scope. Additionally, pages seven and eight define patient selection and under-service. Ms. Andrews endorsed the EAC's exploration of under-service in the broader healthcare system. Dr. Russo remarked that evaluation is an important aspect of monitoring for patient selection and underservice and questioned whether there would be sufficient data given the roadblocks to the All-Payer Claims Database (APCD). Mark Schaefer gave a quick overview of the proposed data solutions and the funding allocated for Health Information Technology from SIM and other sources.

Mr. Stolz facilitated a discussion about [proposed edits to passages in the report narrative](#), submitted by Council members prior to the meeting. Mr. Stolz suggested a few proposed revisions be surfaced for the Council to discuss and then move to adopt these revisions by consensus.

Edit suggestion number one submitted by Ellen Andrews was reviewed. Ms. Andrews and Kathy Yacavone discussed shared savings incentives at the provider level. Gaye Hyre remarked that given the technological advances large medical groups have, they may benefit disproportionately and thus receive shared savings incentives payment more often than less advanced community health organizations. Mr. Stolz suggested the group table the point for a longer discussion.

Mr. Stolz reviewed [Vicki Veltri's suggested revisions](#). The Council discussed Ms. Veltri's proposed revision number 18. Ms. Veltri stated that there are participants in self-funded health plans in Connecticut that are not technically enrolled in insurance products, and therefore not included in the current language. Ms. Andrews suggested the term "coverage" be used in lieu of "insurance." Dr. Willig remarked that some large health systems offer coverage as well.

Mr. Stolz suggested Council members submit proposed revisions via email for incorporation in the draft report. Ms. Sklarsky and Mr. Stolz will highlight revisions in the draft for the Council's consideration. The Council agreed and the draft language was tabled for adoption after revision.

## **6. Review and Act on Slate of Recommendations**

Mr. Stolz reviewed [the summary of EAC recommendations](#) that had been annotated to indicate recommendations the council reached consensus on and those that were tabled for further discussion.

Mr. Stolz reviewed the recommendations on which the Council previously reached consensus and proposed that they be adopted as a slate. Ellen Andrews motioned to adopt recommendations on which the Council previously came to consensus. Ms. Yacavone seconded the motion and the following items were approved by consent:

- 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.”*
- 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.”*
- 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.”*
- 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.”*
- 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.”*
- 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).”*
- 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.”*

- 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.”*
- 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.”*
- 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.”*
- 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.”*
- 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.”*

Recommendations 1.1, “Patient Attestation” and 1.2, “Patient Notification,” were removed from the consent agenda for further discussion.

*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.”*

*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.”*

Donald Stangler expressed concerns regarding methodology of recommendation 1.1, “Patient Attestation.” Dr. Russo suggested the recommendation explicitly affirm patients’ right to select their providers. Ms. Andrews agreed and suggested an additional sentence be added that endorsed a patient’s ability to stay with their provider if they so choose. Dr. Stangler endorsed attribution based on plurality of visits rather than patient attestation. Ms. Veltri said plurality does indicate patient choice. Mr. Stolz said the recommendation was meant to promote equity and access by creating a safeguard against patient discontinuation and an incentive for providers to proactively engage patients who may not be coming to the office for visits. Dr. Russo remarked that there would be negative feedback if patient choice was omitted. Ms. Yacavone said patient choice is the most important. Dr. Stangler asked that his dissenting view with respect to the use of patient attestation be recorded but did not object to inclusion of the recommendation in the report. The Council agreed to include recommendation 1.1 in the report.

Arlene Murphy of the Consumer Advisory Board suggested language be included in recommendations 1.1, 1.2, or 5.1 that communicated to patients that they retain choice of providers. Mr. Toubman remarked that patient choice is already mandated in Medicaid law. Ms. Murphy said language should include all patients including Medicaid. Ms. Yacavone suggested an overarching statement to that effect be added to the report. The Council decided by consensus to add that language to recommendation number 1.2, “Patient Notification.”

*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.”*

Mr. Stolz summarized the Council’s deliberation to date about recommendation 1.3, “Settings of Care for Attribution.” Ms. Andrews expressed concern that Emergency Department (ED) attribution would result in reduced ED access as organizations screen difficult patients upon arrival to decrease financial risk. Additionally, it is an enormous undertaking for the provider organizations to coordinate care for frequent ED visitors. Chris Borgstrom agreed that the risk is too high for providers. The Council decided to not endorse the 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.”*

*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.”*

Mr. Stolz reviewed recommendations 1.4, “Timing of Attribution,” and 1.5, “Attribution Reconciliation.” Mr. Stolz and Ms. Sklarsky suggested the two recommendations be merged and the language be changed to be more consistent with that of other recommendations. After some discussion, the Council asked The Chartis Group to work the changes and to include the merged recommendation in the report.

*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.”*

Mr. Stolz reviewed recommendation 3.2, “Discrete Quality Payments.” The group discussed the need for and impact of discrete quality payments separate from shared savings payments. Dr. Schaefer noted the potential for discrete payments to dilute the effectiveness of shared savings models on reducing unnecessary spending, and the related, negative impact on affordability. Ms. Andrews argued that there is not necessarily a direct relationship between cost savings and premium prices for consumers. The Council also discussed what “quality performance” means in this context; members expressed concern that if this only represents traditional “P4P” metrics, it will not provide a sufficiently strong set of incentives to improve care delivery practices. The group agreed that the recommendation should be retained but asked that the language be clarified to distinguish the proposed quality metrics from those typically used to pay P4P quality bonuses.

*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."*

*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)."*

*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 participation 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 patient."*

Mr. Stolz reviewed recommendation numbers 3.4, "Minimum Savings Rates," 3.5, "Reinvestment of Non-Retained Savings," and 3.6, "Advanced Payments." With respect to 3.5, in response to a comment submitted by Ms. McEvoy, Ms. Andrews stated that state designated accounts aren't necessary for implementation. Ms. Yacavone pointed out that upfront investing in care management and process improvement may be necessary. Mr. Borgstrom stated that incentivizing providers to sign on with an ACO is important. Ms. Andrews endorsed an upfront investment in providers by the payers.

Dr. Schaefer remarked that recommendation 3.5 would occur rarely enough to not create an access problem. Dr. Willig and Dr. Stangler discussed the language in recommendation 3.6 and expressed disagreement with the notion that advance payments would eliminate incentives to cut costs through inappropriate practices. Ms. Veltri endorsed an initial investment to bring smaller provider organizations into shared savings with larger groups. Ms. Andrews pointed out that if a practice does not receive advance payments, and is currently underpaid for Medicaid patients, it will need to make up the investment within a short time, which poses risks to patients. Mr. Toubman agreed. The Council agreed to adopt recommendation 3.6 with some revisions to the language.

The Council returned to recommendation 3.5 and raised questions about its link to under-service. Mr. Stolz suggested the recommendation's scope be narrowed to refer to savings that are not retained solely because of a finding of under-service. It was also pointed out that 80% of commercial members are self-insured and are not interested in redirecting their funds to ACOs that don't perform according to contract. Ms. Andrews said that the money is not the employer's but the consumers' lost wages. Dr. Willig stated that employers would disagree and would not support the recommendation. Ms. Andrews stated that by not following the recommendation, the payer is incentivized to deny shared savings. Dr.

Willig disagreed with the prescriptive wording of the recommendation. Dr. Stangler said that ACOs will elect not to participate in ACO under this definition.

Mr. Stolz agreed that the language is more prescriptive than that found in some other recommendations, and should be rewritten to more directly address under-service and/or patient selection. Dr. Schaefer stated that the ACOs should be required to use the funds to specifically address problems. Ms. Andrews responded that the ACO should be the one to decide how to fix the problem. Mr. Stolz proposed that without consensus among the group, he will not include the recommendation in the draft report for the Steering Committee; rather, the Council can table the recommendation and consider over the next month if there is greater consensus or a way to amend the recommendation such that it could garner consensus.

The Council returned to recommendation 3.6. Ms. Yacavone stated that the investment language should be reflected somewhere else. Dr. Barry commented that the recommendation can be reworded to inspire consensus; Chartis agreed to reword a portion of the recommendation using positive rather than negative language.

The Council returned to recommendation 3.4. Mr. Toubman stated that Minimum savings rates were discussed by the Care Management Committee. The Council expressed its desire to include the recommendation in the report by consensus.

Consideration of the remaining recommendations was tabled.

The Council discussed the previously articulated plan to submit its report to the HISC for its 5/14 meeting. Given that the Council still needs to deliberate on some of its recommendations, it decided to table the EAC report presentation. Dr. Russo suggested an additional meeting be held to finish work on the report. The Council agreed to complete the draft report in May and present to the HISC in June.

## **7. Closing Comments**

The Council meeting adjourned at 8:39pm.