

Submission 1

Ellen Andrews
Concerns re: EAC draft narrative ver 1.2
Recommendation 3.5
Narrative

Thank you for your acknowledgement that the funds for health care come from enrollees and taxpayers.

In the cases we are discussing, enrollees paid for a low-value product. Returning the funds to improve value, benefits them and honors the original intent of the spending – in direct contrast to your assertion #7. Payers should never expect to get double the savings payments – this is found money that should not be a part of or a consideration in their business case (#6). So it should not be a disincentive that they don't get funds they never expected (#8). The spending was always intended to improve value (or at least that what insurers claim) in contrast to your assertion in #7.

I think you misunderstood the intention of the recommendation (#5). No one is suggesting that the denied savings would ever go back to the ACO that underserved or cherry picked patients. The expectation is that it would go to an independent entity, presumably the payer's quality consultants, to support quality improvement activities. It could and should be very carefully controlled to ensure that the funding does not displace current funding by the ACO. I would expect a maintenance of effort provision to be included in contracts specifying quality improvement efforts and spending not decrease. It could even require that, in addition, the ACO match the denied savings payment reinvestment in quality improvement. It could also be structured that the quality improvement payment (even though not to the ACO) is a loan against expected future shared savings payments – which they should start receiving if the problems are fixed.

Ensuring that the denied savings do not benefit the bottom line of the ACO is far easier to enforce than your last recommendation – that payers use the double payment to reduce premiums. It is a huge leap of faith (and a bit naïve) to suggest or assume that “the funds are more likely to return to consumers in the form of lower premiums”. (#9) There is no evidence that unexpected savings or rebates are returned to consumers in lower premiums, rather than higher profits to shareholders, to executives in even higher compensation, etc.

I am disappointed that you cite four reasons for the recommendation and five against. Especially as #5 and #6 are essentially the same (or could be easily

combined). I believe it also distorts the sense of the committee about the recommendation. Counting votes that night, I believe the recommendation would have passed if we hadn't chosen a consensus model of decision making. (I know that was my idea – I won't make that mistake again.) It was only the payers and one ACO that opposed the recommendation. (Keith had questions but was clear that he didn't think the money should be returned to the payers.) The advocates and provider members were strongly in support of the recommendation. It would be good if your narrative noted that dynamic – that consumers and providers largely supported and payers opposed. (This makes clear the incentives at play.)

Also, in answer to your assertion (that I did not hear from any committee members) in #8 that ACOs will leave the program if they don't get savings, so investing in quality is pointless. I disagree – those are exactly the networks we need to target to improve value – they may leave the program, but they will still be providing care (we need primary care capacity) so investing in those providers will improve the quality and hence the value of care in CT, exactly where it is most needed. And an offer of quality improvement support may be just what is needed to keep them in the program. How exactly are under-performing ACOs expected to improve without any resources – shared savings payments could provide that. I would imagine that learning that all their hard work to reduce the total cost of care was only going to benefit insurers would be a much bigger reason for an ACO to leave the program.

I hope you are right (#8) that this will be rare. Now, while accountable care is new and insurers need ACOs, they are keeping the standards low (as one insurer admitted on the phone). That was also true in the early days of managed care, when insurers needed providers and consumers to sign up. But as managed care penetration rose, insurers became less generous toward both providers and consumers. We are writing recommendations that should last into the future.

In recommendation #3, you should more explicitly describe the information asymmetry – that insurers know what to target with prior authorization and other means to reduce utilization, but ACOs and consumers have no idea what they are. As accountable care grows (before it fails like managed care), insurers will have more tools to ensure that they get double savings.

Submission 2

Vicki Veltri
(Transcribed from hand-written notes)

- P2. Formatting – use bullets to set off definitions.
- General: Check for consistent use of either ACO or “advanced network” terminology, and explain at the outset the meaning and use of the term.

- P19, last paragraph re: Recommendation 1.3. Change “EAC agreed by consensus not to adopt a recommendation ...” to “EAC did not reach consensus on a recommendation.”
-

Submission 3

Donald Stangler

This is in response to your email of last Friday. I have 3 areas of comments and concerns. The 1st is on the Draft Narrative About Recommendation 3.5 in the Points For section #3 last sentence beginning with, “Prior authorization is already used by payers to save money in this fashion, often inappropriately.....” I think the wording “often inappropriately” is negative and inflammatory and not appropriate for this type of document.

The 2nd comment is the use of the word Consensus which I brought up at the last meeting. Someone reading this report for the 1st time would think that the use of “Consensus” means almost everyone is in agreement, and I think that may be misleading. As an example, I was against the Attribution Recommendation and stated so during the discussion (and I believe there were others), however, the “Consensus” was that the recommendation would go forward that the member would choose their physician. While I understand that may have been the majority opinion, it would be helpful if “Consensus” was defined somewhere in this document so that the reader/reviewer will understand that not all members of the council were in complete agreement.

And the 3rd point is that several of the payers, or at least UnitedHealthcare may not be able to operationalize some or all of the final recommendations. I think there needs to be acknowledgement that while this document reflects tremendous work on your part and many of the members of the Council, the ACO processes in place for some of the payers might not be adaptable to these recommendations; and while I understand this is a non-binding document, I get concerned that once it leaves our control, there will be an expectation that the payers will implement the recommendations. Without full disclosure I would not want the SIM leadership to be surprised if items cannot be implemented by the payers. I would also be concerned about the impact it may have on the overall program. Therefore, I would like to see acknowledgement of the capacity of the payers to adopt these recommendations.

In full transparency, my comments above were written prior to your email that was sent out last evening concerning implementation options, so some of my concerns will probably be or get addressed at our next meeting.

Submission 4

Bonita Grubbs

Concerning Recommendation 3.5 Reinvestment of Non-Retained Savings

To restate something in a much clearer fashion, I would say that when a provider does show savings but it comes at the expense of patient care, there should be some way to document this but redirect the savings to organizations that can improve service delivery writ large.

Submission 5

Adam Stolz

Concerning CMS Methods for Monitoring Under-Service and Patient Selection

CMS recently shared a template that it uses to compare the clinical and utilization profile of an individual ACO's patient population to all-ACO averages and to averages for the non-ACO Medicare fee-for-service population. While this tool is not designed specifically to capture data about under-service or patient selection, its design and selection of metrics could be informative to the EAC. We still have not received information from CMS about any monitoring methods related specifically to under-service or patient selection or about any results to date of that monitoring.

We propose editing the following passages of the report to better reflect the status of information CMS has shared to date:

- P10 paragraph one
- P38 second to last paragraph
- P39 last paragraph
- P58 multiple locations
- P60 multiple locations