

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN

# Equity and Access Council Meeting

March 12, 2015



# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Design Group 1: Patient Attribution & Cost Target Calculation	60 min
5. Design Group 4: Retrospective & Concurrent Monitoring and Detection	35 min
6. Closing Comments	5 min
Appendix	

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# 4. Design Group 1: Patient Attribution

The following set of recommendations emerged from Design Group 1 when asked to consider how a patient attribution methodology might bear on patient selection or underservice.

1

## ***Attestation***

Patients should be able 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.

2

## ***Notification***

Patients should be made aware that when they are attributed to a physician who is participating in a shared savings program. They should also be made aware of the program's goals and the role of the patient and the provider in achieving those goals.

3

## ***Settings of Care***

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). Payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage a provider to take accountability for their care.

4

## ***Timing***

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.

5

## ***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.



# 4. Design Group 1: Patient Attribution

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues.

Recommendation	Under-Service	Patient Selection	Other E&A implication
<b>1</b> <i>Timing</i>			
<b>2</b> <i>Notification</i>			
<b>3</b> <i>Attestation</i>			
<b>4</b> <i>Reconciliation</i>			
<b>5</b> <i>Settings of Care</i>			



# 4. Design Group 1: Cost Target Calculation

The following set of recommendations emerged from Design Group 1 when asked to consider how the cost target calculation methodology might bear on patient selection or underservice.

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

## ***Control Group Adjustment***

When a historical methodology is used to set a cost benchmark, a concurrent control group benchmark should also be calculated to evaluate the need to adjust for any systemic factors that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year.

3

## ***Supplemental Payments for Complex Populations***

Use of a PMPM payment should be considered for patients who have socioeconomic attributes that are demonstrated to increase resource-intensiveness of providing care but that are not well-captured by purely clinical risk adjustment methods.

4

## ***Retrospective Assessment of 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.

5

## ***Cost Truncation***

Truncating costs based on a percentile cutoff will eliminate any incentive to withhold required care after a catastrophic event 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.



# 4. Design Group 1: Cost Target Calculation

The recommendations articulated in the design group address under-service, patient selection as well as have implications on other equity and access issues.

Recommendation	Under-Service	Patient Selection	Other E&A implication
<b>1</b> <i>Rewarding Improvement</i>			
<b>2</b> <i>Control Group Adjustment</i>			
<b>3</b> <i>Supplemental Payments for Complex Patients</i>			
<b>4</b> <i>Retrospective Assessment of Risk Adjustment</i>			
<b>5</b> <i>Cost Truncation</i>			

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# 5. Design Group 4: Monitoring & Detection

The EAC charter poses a number of questions for the council to answer that are related to monitoring for under-service and patient selection.

<i>Guarding Against Under-Service and Patient Selection:</i>		Assigned to...
Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language		Design Group
A	What are the current <b>methods utilized by private and public payers</b> for detection/monitoring?	4
B	Can <b>standard measures and metrics be applied</b> for detection/monitoring?	4
C	What are the <b>program integrity methods in use today by Medicare / Medicaid</b> and how might such methods be applied here?	4
D	What <b>other methods</b> might be available to monitor for patient selection (e.g., mystery shopper)?	4
E	<b>Who will monitor, investigate, and report</b> suspected under-service and <b>what steps should be taken</b> if under-service is suspected?	3 & 4
F	What are the <b>criteria and processes that a payer might use</b> to disqualify a clinician from receipt of shared savings	3
G	What are the <b>mechanisms for consumer complaints</b> of suspected under-service?	4



# 5. Design Group 4: Monitoring & Detection

The EAC charter poses a number of questions for the council to answer that are related to monitoring for under-service and patient selection.

## Guarding Against Under-Service and Patient Selection:

Assigned to...

Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language		Design Group
A	What are the current <b>methods utilized by private and public payers</b> for detection/monitoring?	4
B	Can <b>standard measures and metrics be applied</b> for detection/monitoring?	4

**A**

*Shared savings payments are still in a nascent stage and therefore so are the current monitoring and detection methods. However, some payers and providers, like Crystal Run, which focuses on monitoring over/under utilization by cost offer a good place to start...*

**B**

**A potential standard approach to measurement:**  
 Conduct utilization comparisons over time and between groups (i.e.; between different ACOs and between ACOs and FFS populations)

Examination can be twofold:

1. Assess variation in total cost of care for populations or sub-populations (adjusted for payer mix to provide on par comparisons)
2. Assess variation in utilization (i.e.; of different interventions) by diagnosis where there is a specific under-service concern and well-understood intervention guidelines

**Benefits**

- Allows for more robust understanding of care patterns than either method alone can provide.
- Specific under-service measures for universal adoption may not be a good idea - more effective deterrent if specific measures are not known in advance by providers; monitoring may differ by payer.
- Serves as an initial filter for under-service, but will require additional investigation to assess the root cause of the variation and determine if it is truly related to under-service.



# 5. Design Group 4: Monitoring & Detection

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## ***Guarding Against Under-Service and Patient Selection:***

Assigned to...  
Design Group

### Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language

D	What <b>other methods</b> might be available to monitor for patient selection (e.g., mystery shopper)?	4
G	What are the <b>mechanisms for consumer complaints</b> of suspected under-service?	4



### **OHA Nurse Consultant (Ombudsman) Potential Job**

#### **Description**

- Dedicated** to addressing under-service and patient selection.
- Proactively **monitors and analyzes utilization data** produced from standard monitoring activities and **patient grievances** to identify trends that point to equity and access concerns and merit further investigation.
- Plays a role as a **patient educator**, in particular as it relates to under-service, and to promote role as a trusted patient resource.
- Plays role as a community **health worker educator** to promote under-service education in day to day interactions.
- Communicates back to providers** when patients voice grievances, even when there is no evidence of provider mistreatment.
- Responds** and further investigates under-service and patient selection concerns as they are flagged.



### **Mystery Shopper**

- ✓ Consensus that this **role provides helpful insight into the occurrence of unwanted behavior**, in particular patient selection.
- ✓ Consensus that this role **should exist for all payer populations.**

#### *Additional Considerations:*

- Should this role be a centralized function run by the state?
  - Could the existing Administrative Services Organization contract under which DSS obtains mystery shopper data for the Medicaid population be expanded on a contributory basis to cover all payers?
  - Could the role be housed within OHA and paired with the Nurse Consultant?
- Should payers that engage in shared savings contracts be required to conduct mystery shopping and publicly report results?



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## ***Guarding Against Under-Service and Patient Selection:***

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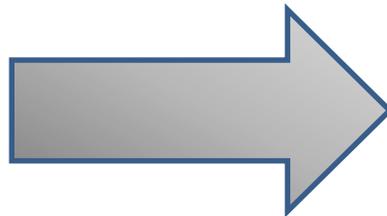
### Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language

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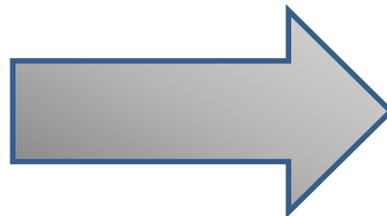
E **Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?**

3 & 4

***What are the council's thoughts on using the Consumer Report Card and the APCD to generate insight into any trends related to under-service and patient selection?***



*Possibility to include new statistics (i.e. utilization-based) related to impact of value-based contracts, including under-service indicators, in annual Consumer Report Card on Health Insurance Carriers in Connecticut developed by the CID. This would require that payers analyze claims data for under-service and patient selection.*



*Possibility to use all payer claims database to do monitoring.\**

\*Note: DSS has not been able to determine how to satisfy federal and state statutory standards for disclosure of Medicaid data to APCD.



# 5. Design Group 4: Monitoring & Detection

Below is a summary of the existing research and ideas that have been generated in response to questions posed in the charter.

Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language	Existing Research and Evidence Considered to Date
A What are the current methods utilized by private and public payers for detection/monitoring?	<ul style="list-style-type: none"> <li>• Public: CHN on behalf of DSS*, robust quality metrics – including utilization metrics (VT Medicaid), CMS metrics pending</li> <li>• Private: Anthem gaps in care</li> </ul>
B Can standard measures and metrics be applied for detection/monitoring?	<ul style="list-style-type: none"> <li>• Comparison of an ACO population over time (i.e.; utilization and risk adjustment) – CMS MSSP, VT Medicaid</li> <li>• Scale of savings – CMS</li> <li>• Measures/metrics will only serve as an initial flag that a problem may exist, but will likely need to be followed up with further data analysis or an audit to confirm</li> </ul>
C What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied here?	<ul style="list-style-type: none"> <li>• Request made to CMS for details about their monitoring activities and results</li> </ul>
D What other methods might be available to monitor for patient selection (e.g., mystery shopper)?	<ul style="list-style-type: none"> <li>• Mystery shopper (DSS)</li> <li>• Ombudsman/Nurse Consultant (CMS)</li> <li>• More robust nurse consultant role (EAC design group feedback)</li> </ul>
E Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?	<ul style="list-style-type: none"> <li>• Payer (CMS, VT Medicaid)</li> <li>• Payers, ACOs, and/or centralized state function (EAC design group feedback)</li> </ul>
G What are the mechanisms for consumer complaints of suspected under-service?	<ul style="list-style-type: none"> <li>• Dedicated Ombudsman for patients in an ACO (CMS)</li> <li>• Dedicated, proactive OHA nurse consultant monitoring role to help consumers identify and address potential cases of under-service or patient selection (EAC design group feedback)</li> </ul>

\*Note: CHN on behalf of DSS also 1) reviews PCMH practices based on a range of HEDIS and measures (on an annual, as well as year-over-year improvement basis), as well as comparing PCMH practices and non-PCMH practices; and 2) Performs some population-based inquiries (e.g.; regarding women with high risk pregnancies)

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# Recommendation Adoption Vehicles

For each of the EAC's recommendations, the Council will characterize the nature of the recommendation and the vehicle through which we expect it will achieve its impact.

***What is the recommendation about?***



- Patient selection
- Under-service
- Other equity and access issue

***Through what vehicle will the recommendation's impact be realized?***



- Voluntary** adoption of standard by payer or provider – **minimum essential component** of a total cost of care payment arrangement
- Voluntary** adoption of standard by payer or provider – **additional consideration** for a total cost of care payment arrangement
- Creation of **mandatory standard** via regulation/legislation
- Other state action** (e.g. monitoring or enforcement programs)



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## Research/Evidence to Date



**Medicaid**

**Shared Savings**

- Robust quality targets with savings achievement dependent on meeting targets



**Medicare**

**Shared Savings**

- Stated that it would monitor for avoidance of at-risk patients and for stinting on care.
- Methods mentioned include comparing risk of population across years and flagging providers with very large savings



**DSS**

- CHN on behalf of DSS has utilizes tool to review claims and examine provider behavior



- Gaps in care tool
- Provider care management solution

***Other methods CT payers use?***

## Design Group 4 Initial Perspectives & Ideas

- Relying on patient-reported grievances and/or patient experience data (e.g.; CAHPS) alone is an insufficient monitoring mechanism.
- Crystal Run used total spend as a first-order filter to identify over/under utilization across providers.



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Questions for EAC – Excerpted from Charter with Minor Edits to Consolidate Language Design Group

B Can **standard measures and metrics be applied** for detection/monitoring? **4**

### Research/Evidence to Date



**Medicaid  
Shared Savings**



**Medicare  
Shared Savings**

- Both use metrics that require comparisons of ACO population/performance over time (i.e.; risk of population between years and analysis of changes in utilization patterns)
- CMS suggests that it will examine the scale of savings

***Analyzing claims data against defined metrics can serve as a way to identify patterns that merit further inquiry. It will likely not be sufficient on its own to confirm that under-service and/or patient selection has occurred.***

### Design Group 4 Initial Perspectives & Ideas

***None of the following were recommended as “standard measures,” but they were discussed by the design group***

- Mine claims data to **identify variance** in the rate of interventions per patient with a particular diagnosis. Comparing ACOs to each other, or comparing the ACO-served population with the purely FFS population. All differences should be further probed to determine if they are **beneficial** or **inappropriate**.
- Monitoring should include identifying any patterns of **selection for patients with clinical conditions that afford especially large opportunities** to earn shared savings. This suggestion arose out of a concern about “crowding out” patients where the incentive is not prevalent, potentially leading to a narrowing of access if primary care providers begin to specialize in treating patients with certain diagnoses.



# Design Group 4: Monitoring & Detection

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## Guarding Against Under-Service and Patient Selection:

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### Research/Evidence to Date



Medicare Shared Savings

- Uses already existing Ombudsman function
- Dedicated monitoring function for grievances filed by beneficiaries assigned to an ACO



DSS

- Mystery shopper program in existence today
- Annual Mystery shopper study that assesses access to care by visit type (i.e.; urgent care, routine visit, etc.) and the impact of insurance type on appointment availability
- Mystery shopper also assesses if callers are treated with respect - Medicaid beneficiaries regularly report lack of respect as an unfavorable aspect of their care experience

### Design Group 4 Initial Perspectives & Ideas

- Prior **mystery shopper** efforts by DSS have been effective and provide a good model. This role could **dovetail with the nurse consultant role**, who could apply a clinical lens when patient selection or under-service is identified.
- Other concurrent (real-time) monitoring methods could include:
  - **Peer review** of provider performance/panel composition
  - Reviewing access to different services by **geographic area**
  - Reviewing **insurance plans** to identify ways benefit structure may affect coverage and inclusion in ACOs of patients with certain clinical conditions
- Several suggestions were made about what **responsibilities the OHA nurse consultant** should have:
  - **Dedicated** to addressing instances of under-service and patient selection
  - Play a **proactive role**, taking intelligence gleaned from monitoring activities to conduct investigations
  - **Monitor outcome and utilization data** to understand if interventions being used are successfully addressing equity and access concerns
  - Part of larger group that **identifies “seminal events”** for which special investigations should be conducted to evaluate potential issues
  - Monitor **gaps in care transitions** (e.g.; readmissions) to identify patterns of complex patients who are not getting sufficient care management services



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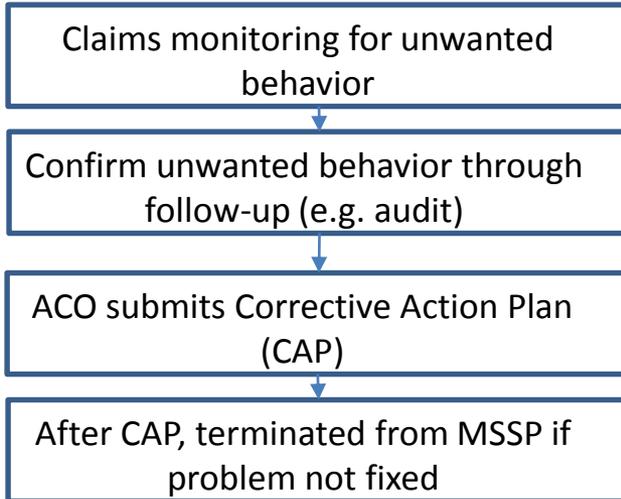
3 & 4

### Research/Evidence to Date



Medicare Shared Savings

ACO will not receive savings nor be eligible for savings during CAP



Medicaid Shared Savings

- Emphasized constructive learning framework approach
- Take instances of unwanted behaviors and learn from peers how to improve

### Design Group 4 Initial Perspectives & Ideas

- No matter what type of monitoring is performed, **the state will have a prominent role to play** unless a clear business case for payers or providers to do monitoring is established.
- The group that worked on the Health Neighborhoods program recommendations identified in greater detail **what** they wanted to monitor before determining who should do the monitoring and what the source of the data should be.