

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Equity and Access Council

Design Group 3: Rules (2A),  
Communication (2B), and  
Accountability/Enforcement (2C)

Workshop 2

March 31, 2015

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Discussion of Rules, Communication, and Accountability/Enforcement Safeguards	35 min
5. Synthesis of Ideas to Inform Recommendations	10 min

# 3. Two Categories of Safeguards

## CT's Process

1. **Evaluate evidence** for the hypothesized risks and options for preventive safeguards
2. **Establish safeguards** (incentives, policies, and processes) that prevent under-service and patient selection
3. **Implement** safeguards
4. **Monitor** and analyze results
5. **Adjust** safeguards based on lessons learned

***What types of safeguards can be built into the proposed payment reforms?***

**We propose two categories of safeguards:**



### **1. Payment design features**

***Concept:***

*Design new payment methods in a way that, taken together, do not create incentives for under-service and patient selection*



### **2. Supplemental safeguards**

***Concept:***

*Establish additional rules and processes to deter and detect under-service and patient selection*

# 3. Design Elements: Supplemental Safeguards



## 2. Supplemental Safeguards

Safeguard Type		Description	Hypothesis to Examine
<b>A</b>	<i>Rules</i>	Rules for <b>who can participate</b> in a value-based contract and <b>what activity is allowed</b> and prohibited	Requiring relevant minimum criteria for who may participate, and defining clear rules about undesired behavior, will minimize instances of under-service and patient selection
<b>B</b>	<i>Communication</i>	Methods of <b>informing consumers and providers</b> about the definition and consequences of prohibited activities	Aggressively informing consumers about the definition of patient selection, appropriate medical care, and how to report prohibited behavior will deter and identify the behavior. Aggressively informing providers will also deter the behavior.
<b>C</b>	<i>Accountability / Enforcement</i>	<b>Consequences</b> for violating rules and <b>methods of enforcing</b> those consequences	Disqualifying provider groups found to commit prohibited behavior from receiving shared savings will deter the behavior
<b>D</b>	<i>Detection: retrospective</i>	Methods of <b>detecting under-service and patient selection</b> by observing it <b>using data</b> produced after a period of performance is over	Analyzing provider performance and patient panel profiles over time will provide the primary method of identifying prohibited behavior
<b>E</b>	<i>Detection: concurrent</i>	Methods of <b>detecting under-service and patient selection in real-time</b> or near-real-time	Creating ways for consumers, providers, and payers to identify under-service and patient selection in real-time will provide additional opportunities to identify prohibited behavior

# 3. EAC Milestones and Timing

The agenda of upcoming EAC meetings will be organized around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January		February			March					April				May			
		Week of:		Week of:			Week of:					Week of:				Week of:			
		19	26	2	9	16	23	2	9	16	23	30	6	13	20	27	4	11	18
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																		
10	MAPOC Care Management Committee (CMC) Meetings					20						8							13

↑  
**Today**

- M1 Design milestone/workshop 1      R1 EAC initial review/input
- M2 Design milestone/workshop 2      R2 EAC final review/input
- M2 Design milestone/workshop 3 (if needed)      R3 EAC final review/input – continuation (if needed)

# 3. Design Group Process

Design Phase	All Design Groups	Progress
Workshop 1	<p><u>Goal:</u> Evaluate existing research and evidence and establish initial hypotheses</p> <p><u>Content:</u> Synthesis of research on topic and input from experts for group to discuss, provide input, and establish a point of view</p>	
Review 1	<p><u>Goal:</u> Feedback and reactions from EAC on initial hypotheses and suggestions on areas of further exploration and/or revision</p> <p><u>Content:</u> Present initial hypotheses from design group, review relevant materials, and pose any questions/concerns from the design group where EAC input was desired</p>	
Workshop 2	<p><u>Goal:</u> Develop draft recommendations based on additional research and EAC feedback</p> <p><u>Content:</u> Synthesis of feedback from EAC and additional research required for group to provide input and establish a final recommendation</p>	
Review 2	<p><u>Goal:</u> EAC to adopt recommendations</p> <p><u>Content:</u> Present revised recommendations from design group and pose any final questions for EAC input</p>	



# 4. Supplemental Safeguards: Rules



## 2A. Rules

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

### Design Options/Considerations



**1 Eligibility Criteria: ACOs** – what criteria should a provider organization have to meet to participate in value-based contracts? For example:

- Adoption of performance management policies or internal monitoring mechanisms
- Adoption of payment distribution policies that meet minimum criteria
- Reporting (to payer, to state, to public) – on what?
- Accreditation (e.g. NCQA/URAC)



**2 Eligibility Criteria: Individual Providers** – Criteria above and beyond existing licensure requirements are not warranted, except that providers found to withhold services or cherry-pick patients should be suspended from participating in earning from shared savings.



**3 Definition of under-service and patient selection** –

- Wherever possible, utilize a standard definition of under-service and patient selection – the definition found in the EAC charter.

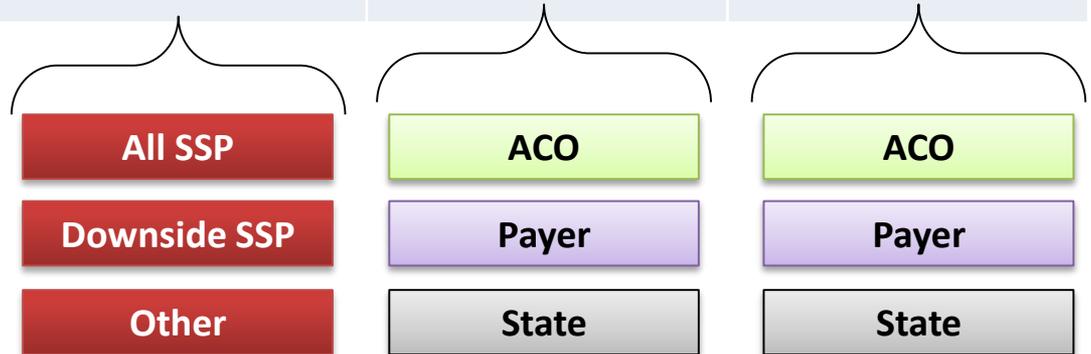


# 4. Supplemental Safeguards: Rules



	Potential Rules Related to ACOs	At what threshold should the requirement apply?	Who should establish the requirement?	Who should specify the particular method to use?
1	Adoption of performance management policies or internal monitoring mechanisms			
2	Adoption of payment distribution policies that meet minimum criteria			
3	Reporting (to payer, to state, to public) – on what?			
4	Accreditation (e.g. NCQA/URAC)			

*Should the EAC make recommendations about these aspects of ACO rules? If so, which of these options might be most appropriate to recommend?*





# 4. Supplemental Safeguards: Communication

## 2B. Communication



Methods of informing consumers and providers about the definition and consequences of prohibited activities, and how to report suspected violations

### Design Options/Considerations

#### 1 Consumer Communication –

- ✓ Information needs to be delivered in a language and manner that will allow the intended audiences to comprehend and act on it.
- ✓ Consumers should be explicitly encouraged to report instances in which they think their doctor may be making decisions based on financial incentives.
- ✓ These concepts are not that easy for most patients to understand. If patients are going to be educated about their doctors' financial incentives it needs to be done in a way that does not poison patient-provider relationships or turn providers off from participating in value-based programs.
- ? Should communications on this topic be stand-alone, or should it be wrapped into related messages and vehicles?



2 **Provider Communication** – what should be communicated to provider groups and individual providers about under-service and patient selection? Through what media?



# 4. Supplemental Safeguards: Accountability/Enforcement

## 2C. Accountability / Enforcement



Consequences for violating rules, and methods of enforcing those consequences

### Design Options/Considerations



#### 1 Accountability/Enforcement Principles

- The response to instances of under-service where there is no intentionality should not be punitive; it should be constructive / corrective.
- Any enforcement mechanism should have an appeal process and should be applied to the individual provider whose actions are in question, not to the entire ACO of which he is a part
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- Payers will have a role to play in enforcement



#### 2 Terminology – how should the EAC’s recommendations refer to this topic?

- “Accountability”
- “Enforcement”
- Both terms
- Other term?

*A starting point: “All payers commit to the principle that providers be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services, whether or not there is evidence of intentionality” – CT SIM Model Test Phase Final Project Narrative p20.*



# 4. Supplemental Safeguards: Accountability/Enforcement



## A Potential Layered Approach to Accountability DRAFT for Discussion

### State



- Plays a role in establishing what some or all of these entities are required to do within this type of system
- Could play an additional role in conducting independent analysis and/or issuing findings



### Payers



- Establish rules in contracts with ACOs
- Use claims data analysis, audits to monitor for compliance
- Rely on contract provisions for enforcement



### ACOs



- Establish rules for participating groups or individual providers
- Embed robust performance management and care variations analysis in ACO governance



### Provider Groups



MDS, PC

- Utilize peer review process to identify and correct any aberrant practices
- Structure individual provider compensation in a way that rewards clinical excellence and patient satisfaction



### Providers



- Subject to ACO and group policies
- Subject to existing standards for the practice of medicine

# 5. Synthesis of Ideas to Inform Recommendations

Objective: Summarize recommendations to share with the EAC at its 4/9 meeting

*Applies to.....*

2A. Rules	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

2B. Communication	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

2C. Accountability/Enforcement	Patient Selection	Under-Service
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>