

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Equity and Access Council

Design Group 4: Retrospective  
(2E) and Concurrent (2D)  
Monitoring

Workshop 1

February 12<sup>th</sup>, 2015

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Retrospective Monitoring & Detection	15 min
5. Concurrent Monitoring & Detection	15 min
6. Synthesis of Initial Hypotheses	15 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. Supplemental Safeguards



## 2. Supplemental Safeguards

Safeguard Type		Description	Hypothesis
<b>A</b>	<i>Rules</i>	Rules for who can participate in a value-based contract and what activity is allowed 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 informing consumers and providers 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>Enforcement</i>	Consequences for violating rules and methods of enforcing 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 detecting under-service and patient selection by observing it using data 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 detecting under-service and patient selection in real-time 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. Design Group Milestones and Proposed Timing

We propose to organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April							
		Week of:				Week of:				Week of:					Week of:							
		5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27				
<b>3. Equity and Access Council (EAC)</b>																						
1	Healthcare Innovation Steering Committee (HISC)	8				5								12				9				
2	Equity and Access Council Meetings			22		5			26	12			26	9		23						
3	Equity and Access Council Exec Team Meetings		15					19				19				16						
4	1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2													
5	1C-D: Performance-based payment calculation & distribution							M1				R1	M2	R2								
6	2A-B-C: Rules, communication, enforcement							M1				R1	M2	R2								
7	2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2											

↑  
*Today*

↑  
**Report containing  
Phase I  
recommendations**

- M1 Design milestone/workshop 1     R1 EAC initial review/input
- M2 Design milestone/workshop 2     R2 EAC final review/input

# 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. Retrospective Monitoring & Detection



## 2D. Retrospective Detection

Methods of detecting under-service and patient selection by observing it using data produced after a period of performance is over

### Design Options/Considerations

- 1 Claims Data** – how can claims data be used to assess underservice/patient-selection?
  - Assess care provided against standard of care for specific diagnoses (e.g. CHNCT)
  - Utilization metrics that signify under-service/patient selection (e.g. overutilization of ED/hospital, specific measures for “at-risk” populations, etc.)
  - ACO performance data that compares risk profile of patients over time- For example, monitor to see if risk profile of patients attributed has gone down materially
  - Disparity metrics to determine variations in interventions received for a specific diagnosis by race/ethnicity
  - Audit of providers/provider group/ACO
- 2 Clinical Data** – how can clinical data be used to detect underservice/patient-selection?
  - Peer review of clinical data
  - Disparity metrics to determine variations in outcomes for a specific diagnosis by race/ethnicity
  - Practice variation analyses (e.g. Crystal Run)
  - Site visits
- 3 Other Data** – what other pieces of data could be useful in detecting underservice/patient selection?
  - Patient experience metrics that speak to receiving appropriate care (e.g. HCAHPs question regarding access to specialists)



# 4. Retrospective Monitoring & Detection

Retrospective monitoring and detection can potentially be done by individual payers, by provider groups, and/or by the State.

## Near-Term Focus For Recommendations

I.

Individual Payer  
Responsibility for  
Monitoring Under-Service  
and Patient Selection

II.

ACO/Provider Group Role  
in Monitoring Under-  
Service and Patient  
Selection

## Supplemental Consideration Over Long-Term

III.

State-Administered  
Program of Monitoring  
Under-Service and Patient  
Selection

*Is recommending a set of common standards for individual payers to monitoring for under-service and patient selection a feasible and appropriate safeguard?*

*Should provider organizations participating in ACO contracts track under-service and patient selection as part of their internal monitoring processes (e.g. include on performance dashboards)?*

*Is there enough of an added benefit to monitoring under-service and patient selection centrally at the state level that investments and/or recommendations should be made on how to move toward centralized reporting?*



# 4. Retrospective Monitoring & Detection

The features and limitations of each data source may help inform how they are used for monitoring, irrespective of who assumes responsibility for performing it.

## Claims Data



- Utilization Metrics: ED, IP admissions for ambulatory sensitive conditions, readmissions
- Disparity measures: Interventions per capita by diagnosis and race/ethnicity
- ACO Profile Data: comparative analysis of risk profile of ACO between years (pre-ACO and throughout)
- Audits – Should this be random? Tied to patient complaints or poor metric performance?

## Clinical Data



- Clinical data can make disparities in care more apparent in cases where claims data may be insufficient
- Quality Council Health Equity Design Group (HEDG) plans to propose monitoring disparities in care for conditions where known disparities exist
- Tracking disparities through quality performance metrics could simultaneously provide a vehicle for under-service monitoring

## Public Data



- Consumer Assessment of Healthcare Providers and Systems (CAHPS) – survey that asks consumers to report on and evaluate their experiences with health care
- New England Journal of Medicine article suggested that certain consumer ratings were significantly improved within an ACO compared to a control group, in particular for more complex patients. Can this type of analysis be replicated and applied in a local context?

***Which metrics will be required to flag under-service and/or patient selection? What other metrics should be considered that are not mentioned here?***



# 5. Concurrent Monitoring & Detection



## 2E. Concurrent Detection

Methods of detecting under-service and patient selection in real-time or near-real-time

### Design Options/Considerations

- 1 Nurse Consultant** – As described in the CT SIM test grant budget, a “nurse consultant” will be hired into OHA to handle disputes or complaints related to under-service or patient selection. This function will be similar to that of the nurse consultant hired under the dual eligibles initiative, but will work across payers. Procedures will need to be established for consumers and providers to report cases to and work with the nurse consultant to address/look into complaints.
- 2 Mystery Shopper**– Utilizing existing State of CT and national programs as a guide, CT could establish a program in which state employees, posing as patients, test their ability to access providers participating in ACOs and to obtain medically appropriate care.
- 3 Concurrent Analytics** – CT could explore ways to obtain data in near-real-time about ACO performance and care provision, in order to accelerate the evaluation process from what might otherwise take place under a purely retrospective analysis
- 4 Other** – Are there other ways in which under-service and patient selection could be identified in as close to real-time as possible?



# 5. Concurrent Monitoring & Detection

## Nurse Consultant



OHA works with nurse consultants who support their mission to “assist consumers with health care issues” through acting as advocates for patients who have grievances with the health care system. The SIM grant has put aside funding in the first year to dedicate a nurse consultant to work with patients expressing grievances specifically related to SIM related shared savings programs. The ***Equity and Access Council has been asked to make recommendations*** on the ***process and procedures*** the dedicated nurse consultant will follow to detect and respond to under-service and patient selection.

### Patient Grievances

- I cannot find a provider
- I do not know what my insurance covers
- I do not think I am getting adequate care
- My insurance provider is denying coverage

***How will patient grievances be flagged as related to under-service or patient selection?***

### Nurse Consultant



- Investigate and respond to grievance
- Track grievances – identify patterns

***Can tracking mechanisms be used to identify patterns of under-service or patient selection?***

### Grievance Response

- Refer patient to appropriate government agency (e.g.; DPH for standard of care issue)
- Address issue with provider or payer
- Notify payer of provider issue and work with to resolve
- Advocate for policy change at state and federal level

***If under-service or patient selection is expected, is there a necessity for a standardized response (e.g.; audit)?***



# 5. Concurrent Monitoring & Detection

## Mystery Shopper



Utilizing existing State of CT and national programs as a guide, CT (and/or individual payers) could establish a program in which employees, posing as patients, test their ability to access providers participating in ACOs and to obtain medically appropriate care.

## Discussion Questions

<p><b><i>What should mystery shopping include? What behaviors imply under-service and patient selection?</i></b></p>	 <b>Phone</b>	 <b>Walkthrough Visits</b>	 <b>Patient Visits</b>
<p><b><i>Who should be responsible for conducting mystery shopping?</i></b></p>	 <b>Payers</b>	 <b>State Agency</b>	
<p><b><i>If a mystery shopper reveals suspected under-service or patient selection, what should the response be?</i></b></p>	 <b>Audit/Investigation</b>	 <b>Handoff to Other Entity</b>	<p><b><i>Note: The question of accountability/enforcement will be explored by Design Group 3</i></b></p>

# 6. Synthesis of Initial Hypotheses

## Objectives:

1. *Summarize initial hypotheses to share with the EAC on what its recommendations should say about design of patient attribution methods and cost calculation benchmarks to safeguard against patient selection and under-service.*
2. *Recommend discussion topics and material to support the EAC's discussion on these topics at its 2/5 meeting*

***Applies to.....***

<b>2D. Retrospective Monitoring &amp; Detection</b>	<b>Patient Selection</b>	<b>Under-Service</b>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

<b>2E. Concurrent Monitoring &amp; Detection</b>	<b>Patient Selection</b>	<b>Under-Service</b>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>