

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Equity and Access Council

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

Workshop 2

March 5<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. Discussion of Retrospective and Concurrent Monitoring & Detection	35 min
5. Synthesis of Initial Hypotheses	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. Design Group Milestones and Timing

We will 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
Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2									
Group 2 - 1C-D: Performance-based payment calculation & distribution							M1			R1	M2	R2					
Group 3 - 2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
Group 4 - 2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

  
**Report containing Phase I recommendations**  
  
*Today*

- 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>	<b>X</b>
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. 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
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



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

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Design Group

A What are the current **methods utilized by private and public payers** for detection/monitoring?

4

### 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

- CHNCT tool used 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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Assigned to...

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.



# 4. 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

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

### 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

### 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



# 4. Design Group 4: Monitoring & Detection

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## Guarding Against Under-Service and Patient Selection:

Assigned to...

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

Design Group

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

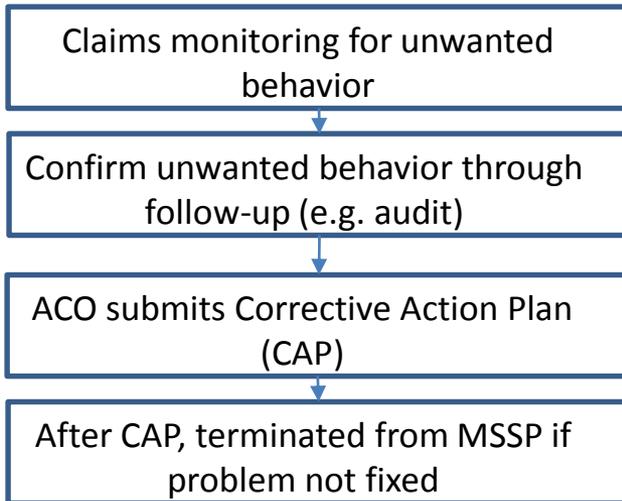
3 & 4

### 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.



# 4. 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 <b>methods utilized by private and public payers</b> for detection/monitoring?	<ul style="list-style-type: none"><li>• Public: CHNCT (DSS), robust quality metrics – including utilization metrics (VT Medicaid), CMS metrics pending</li><li>• Private: Anthem gaps in care</li></ul>
B Can <b>standard measures and metrics be applied</b> 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 <b>program integrity methods in use today by Medicare / Medicaid</b> 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 <b>other methods</b> 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 <b>Who will monitor, investigate, and report</b> suspected under-service and <b>what steps should be taken</b> 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 <b>mechanisms for consumer complaints</b> 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>

# 5. 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"/>