

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
April 1, 2015

Meeting Location: CT Behavioral Health Partnership, 500 Enterprise Drive, Rocky Hill

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Jessica DeFlumer-Trapp (for Karin Haberlin); Deb Dauser Forrest; Daniela Giordano; Robert Hockmuth; Elizabeth Krause; Steve Levine; Arlene Murphy; Robert Nardino; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff; Robert Zavoski

Members Absent: Mark DeFrancesco; Steve Frayne; Amy Gagliardi; Kathleen Harding; Kathy Lavorgna; Donna O'Shea; Meryl Price; Rebecca Santiago

Other Participants: Deb Amato; Sandra Czunas; Faina Dookh; Monica Farina; Jane McNicol; Thomas Raskauskas; Mark Schaefer; Adam Stolz

Call to Order

The meeting was called to order at 6:05 p.m. Steve Wolfson chaired the meeting. Participants introduced themselves.

Public Comment

There was no public comment.

Value Based Payment

Adam Stolz from Chartis presented on value based payment ([see presentation here](#)). Arlene Murphy asked whether they would discuss attribution and the differences between being assigned to a provider versus being assigned for payment. Mr. Stolz said VBP involves assignment for payment, rather than telling a patient he or she has to see a particular provider. Todd Varricchio said there may be variation in payment. He said Aetna uses industry-standard methodology and the same attribution method across the entire base regardless of the program they are in. They do not have double attribution. They also pay care coordination fees prospectively. Dr. Schaefer provided an example of how attribution works within an ACO. Measures are built on the attributed population. Mr. Varricchio said that attribution is done based on the primary care physician specialty. Dr. Schaefer said it is less about the patient's medical conditions and more about the physician and visit codes used.

Arlene Murphy asked whether there were active plans in place for shared savings programs. Andrew Selinger said that for ProHealth, their shared savings program contracts were split about 30-70 percent Medicare and commercial. Thomas Woodruff said that for Anthem and United, 60 percent are attributed to an ACO. Robert Hockmuth said Cigna was at 70 percent. Robert Zavoski said that 68% of their population is in ACOs but not in shared savings.

Dr. Wolfson said that as a cardiologist, if a patient develops congestive heart failure, they are likely to spend the majority of their time under his care. He said if that patient is attributed to a primary care physician who rarely sees the patient, the statistics are skewed. Mr. Varricchio said that if they don't see a PCP at all, they won't be attributed. Dr. Selinger asked what happened if they saw the PCP once but saw a cardiologist 12 times. Mr. Varricchio said it would depend on which provider is within the group. He noted that the PCP is supposed to coordinate across specialists.

Steve Levine asked for a sense of how often shared savings is actually realized. Mr. Stolz said the experience in Medicare was mixed at best. Medicare started with "Pioneer" entities and many dropped out within the

first two years. On the whole, he said, most ACOs have not realized shared savings but, other than investment costs they have not lost money either. The arrangements are primarily upside only. Dr. Hockmuth said he oversees 25 shared savings contracts for New England and that 85 percent had shown positive results based on an upside only model and performance relative to the market. Mr. Varricchio said risk adjustment is positive as providers are not harmed financially for having sicker patients.

Rohit Bhalla said that transparency and assumptions are important. Dr. Schaefer noted that Mr. Stolz is the lead facilitator for the Equity and Access Council (EAC Council), which is carefully looking at how programs are designed and the degree to which providers are incentivized with respect to serving more challenging patients. Mr. Varricchio said that there are no financial model experts on the EAC Council. Mr. Stolz said that the EAC Council is only making recommendations central to issues of equity and access and not value based payment. He said they weren't recommending models but rather contract features. Dr. Schaefer noted that there are health plan liaisons on the EAC Council who can confer with in-house experts.

Ms. Murphy said it may be helpful to connect the work of the groups so that everyone can weigh in. Mr. Stolz said there are a host of features that the state may want to include beyond the EAC charge. The EAC charge is only looking at what is important from an EAC standpoint. Dr. Wolfson said he would endorse a joint discussion with the EAC.

Deb Dauser Forrest asked for clarification on payer expectations. She asked whether the payers would be expected to align their methodology. Dr. Schaefer said they are required to align broadly around Medicare shared savings but there is not a value based payment alignment work group to recommend how to weight measures and he did not expect that would be necessary. He said there may be a need to look at alignment for payer agnostic measures but that is yet to be determined. He noted that the aim of the presentation is to provide a stronger foundation of understanding of how quality measurement fits into value based payment reform.

Ms. Murphy asked whether a provider would need to be recognized as an ACO to participate in a shared savings program. Mr. Varricchio said that was correct. The provider entity needs to be large enough for population health management. He noted that the state defines insurer and provider types but does not define what an ACO is. Dr. Hockmuth said there are things that they look for, including PCMH recognition.

The Council discussed selecting quality measures with substantial potential for improvement. Mr. Varricchio said they give incremental rewards for improvement so they can begin to improve, otherwise, the threshold could be too high and discourage providers from trying. Dr. Bhalla said that if a provider makes incremental improvements, that helps towards population health but if everyone else shows improvement, it doesn't mean anything for the practice.

The Council discussed how weighting is done. Mr. Stolz said that CMS weighs by domain. Dr. Dalal said it is important to know the methodology as there may be value judgments at play. Mr. Varricchio said that in hospital pay for performance programs, there are CMS measures that have been in use for some time that are not weighed heavily because there is not much room for improvement. He also noted that all providers need to be weighted the same way. Mr. Stolz said Medicare chose to be fairly consistent in weighting across the board with the exception of electronic health records. Daniela Giordano asked about the process ACOs go through. Mr. Stolz said that a payer will set the method of assigning points that are applicable to all ACOs within a given contract type but different ACOs may have different targets. Dr. Forrest asked whether it would be a problem if weighting is different across payers and Dr. Schaefer indicated he did not think so. Dr. Woodruff said that there may be different populations within the same group. Dr. Schaefer proposed the limits of the work at the current stage be to define quality measures for payers to select for contracts and for payers to determine the weighting.

Ms. Murphy asked whether pay for reporting was the same as pay for performance. Mr. Stolz said it was but it depends on the context. Dr. Bhalla said Medicaid scores on the same measures tend to be lower so there is a little bit of a control. He noted that when comparisons are mixed, there is a risk of creating inequity and unintended consequences. Mr. Stolz said one reason for aggregating across payers would be equity and

access. Dr. Schaefer said that in discussions to date, they have not wanted to do anything that would incent providers to reduce their Medicaid case-mix. He did not know of a state that is aggregating cross payer. Delaware may be contemplating moving in that direction but it is a cutting edge idea. Mr. Varricchio said that risk adjustment only works with certain types of measures and Aetna looks at them separately as each group's populations are different. They still take risk adjustment into account. Dr. Hockmuth said that self-insured plans have different programs that they want to know are working. Dr. Wolfson said it raises suspicion about comparison among hospitals which have little control over their case mix. He asked whether there were efforts being made to look at the categories separately for each hospital. Mr. Varricchio said they use CMS as part of their metrics but others are based on the hospital's experience with Aetna. Dr. Bhalla said Medicare's approach for the Hospital CAHPS uses socioeconomic status adjustment. In readmissions, there is no adjustment. Clinical practice measures all equally. He noted there are divergent approaches.

Elizabeth Krause asked what design choices would implicate a reduction in disparities and access. Mr. Stolz said there are multiple answers. He said rewarding improvement only can promote health equity as providers with more difficult populations are not penalized. They can reward providers for narrowing gaps on performance within race/ethnic stratified populations. Dr. Schaefer said there are tradeoffs. Commercial may not be identical but could cut down base rates significantly. He said the Council could decide the commercial populations are close enough to pool and do race/ethnic stratification. Dr. Dalal asked that if that decision came to the Council, was there a role for quantitative modeling around anticipated benefits. He said it could be done on a population level or via a disparity analysis. Mr. Varricchio said that gets into issues similar to that of electronic medical record measures. There are issues of who will review and audit the data.

Questions from HIT Council

Dr. Schaefer provided an update on the request for a proof of solution from the Council to the Health Information Technology Council (HIT Council) (see [presentation here](#) and [proof of solution here](#)). The Program Management Office is suggesting dividing the original request into two parts. The HIT Council will look at potential means of standing up the measure: edge server technology and the All Payer Claims Database.

Dr. Forrest asked whether de-identifying data meant that payers wouldn't know who the patients were. Dr. Schaefer said the data would come back as numerators and denominators at the level of the ACO. Dr. Dalal asked whether the HIT Council discussed data integrity issues and whether Stage 1 could be a big lift. Dr. Schaefer said the HIT Council is considering these challenges. Their work will focus on technological solutions. The Council may look at audit processes and data integrity issues.

Ms. Krause asked whether they could push back and see if there is more than could be done. Dr. Schaefer said they could convene a design group but that may not allow time. The Council decided to discuss this on April 15th. Ms. Murphy asked whether the consultant could speak on the issue. Dr. Schaefer said that Dr. Tikoo could participate in a future meeting, but noted that she is not available on the 15th.

Update – Measures under Review

This was not discussed due to a lack of time.

Next Steps

There will be a meeting scheduled in advance of April 15 to discuss the inter-council memo approach.

The meeting adjourned at 8:09 p.m.