



October 5, 2016

To: Health Care Cabinet

From: Ellen Andrews

Re: Response to Strawman shared/downside risk proposal

Connecticut has a very troubled history with financial risk models in health care. As the consultants have acknowledged, capitation “failed spectacularly” in our state in the 1990’s. They have offered shared risk/downside risk as their proposal to the Health Care Cabinet to control costs in Connecticut. They intend to begin with Medicaid and the state employee plan. Their arguments include:

- It’s everywhere, the feds are pushing it anyway
- It builds on Connecticut Medicaid’s PCMH+ program
- Shared savings isn’t enough to control costs
- There are consumer protections built into shared risk/downside risk
- Things are different now, we won’t repeat the mistakes of the past
- It’s inevitable, it’s the only thing that’s working elsewhere

Concerns raised by independent advocates and others include:

- The present administration made a commitment not to implement downside risk in Medicaid
- PCMH+ is very new, hasn’t yet been implemented and may not succeed
- Shared risk/downside risk is very new and experimental, more sophisticated states and programs are struggling to make it work
- Shared/downside risk has been very unpopular among providers, risking losing providers from the Medicaid program
- Shared/downside risk, based on loss aversion, will result in counterproductive disincentives to invest in innovation
- Consumer protections are wholly inadequate
- The model creates very strong incentives to “stint” on necessary care and “cherry pick” more lucrative patients
- In many respects, downside risk includes the worst features of both capitation and shared savings
- There are better, proven alternatives to both control costs and improve quality from Connecticut and other states

In shared/downside risk, networks of providers are paid on a fee-for-service basis for the care they provide to patients. At the end of the year, the total-cost-of-care (TCOC) for their patients is compared to estimates of what TCOC should have been. If there are savings (actual TCOC is below the estimate), provider networks share in the savings. However, if there are losses (actual TCOC is above the estimate), the provider network

has to pay back a share of the losses. The clawback payment is typically calculated and paid well after the end of the year when services were provided and investments were made.

Shared/downside risk is very new and experimental. Our survey of Connecticut Accountable Care Organization (ACO) leaders¹ in March found none had shared/downside risk contracts. In fact, they were not universally optimistic that the ACO model, even with only shared savings, would achieve the goals or be a large part of Connecticut's future health care landscape. The largest national experiment with shared/downside risk is Medicare's Pioneer and NextGen ACO programs. Of the original thirty-two organizations that began in the Pioneer program, only four remain. In this first year of the new NextGen program, three of the original twenty-one participants have already exited. Among Medicaid ACO programs, only Minnesota currently has any shared/downside risk participants.² Significant problems with calculating TCOC and shared savings have been documented, in some cases making large differences between saving or losing large sums of money. This is a significant problem for ACOs in fiscal planning and making investment decisions in care coordination or prevention.³ Recently Congress has signaled deep concerns with federal executive branch efforts to force providers into aggressive payment models.⁴

Although the consultants state that participation in shared/downside risk will be voluntary for providers, they have recommended linking any rate increases to participation in the model, as has Medicare, which has met with strong resistance from providers. More recently they have suggested offering initially higher savings shares to induce ACOs to make a future commitment to accept shared/downside risk. Unlike Medicare, it is fairly easy and far more lucrative to just stop taking Medicaid patients. A recent survey of Medicaid directors by the same consultants pointed out serious challenges to adopting aggressive alternative models such as shared/downside risk.

"In some states, payment reform is difficult to get off the ground because providers express concern about reimbursement rates already being too low, and are worried that any efforts would further reduce already low rates, similar to some of the models Medicare has implemented."

-- The Role of State Medicaid Programs in Improving the Value of the Health Care System, Bailit Health for the National Association of Medicaid Directors, March 22, 2016

The consultants argue both that shared/downside risk is **less burdensome on providers than capitation** because they are not at full risk, but that **it is also a stronger incentive** to save money because of loss aversion economic theory, as cited by the consultants. While the consultants have proposed limiting the level of networks'

¹ Survey of Connecticut Accountable Care Organizations, CT Health Policy Project, March 2016.

² Medicaid Accountable Care Organizations: State Update, Center for Health Care Strategies, September 2016; personal communications with state officials.

³ D DeLia, Calculating Shared Savings: Administrative Formulas Versus Research-Based Evaluations, Health Affairs Blog, September 26, 2016.

⁴ September 29, 2016 letter from 179 members of Congress to Andrew Slavitt and Patrick Conway, CMS.

shared/downside risk to 2 to 5% of revenue, that is a great deal of money and there is no guarantee that it will stop there. Examples noted in the consultants' memo include higher provider liabilities than they have proposed for Connecticut.⁵ It is harder to make a business case for investments to control costs in shared/downside risk as a model than for shared savings arrangements as penalties and rewards are very uncertain and are delivered long after networks must make those investments. Capitation with its upfront specified payments should have been a better model to encourage investments such as care coordination, analytic systems, and providing social services. Unfortunately, that didn't happen in Connecticut under capitation, which was a "spectacular failure", even with the better economic model.

It's important to recognize that providers, like all humans, have complex motivations.⁶ Financial incentives are a small part of the mix. Much of providers' motivations to reduce low value care and reduce overtreatment have nothing to do with financial incentives.⁷ In the first year of Medicare's Pioneer downside risk program, there was a negligible impact on the use of low value services.⁸ In fact, poorly designed and untested disincentives like shared/downside risk can backfire and exacerbate the problem.

Risk adjustment and quality benchmarks have been offered by the Strawman's proponents as **sufficient consumer protections** against stinting and avoiding less lucrative patients in shared risk/downside risk arrangements.

The lists of **quality metrics** that ACOs are required to meet are both short and the metrics are very narrow. Typical quality benchmark lists tied to payment for Medicaid ACOs vary from four to twenty seven metrics.⁹ With the exception of patient experience of care surveys, most quality benchmarks apply to narrow populations and only the care specific to their conditions, i.e. adequacy of prenatal care, asthma-related care. A common joke is that these quality lists protect only pregnant 3-year olds with diabetes. Underservice or "stinting" on care for the large majority of patients on the large majority of services would never be affected.

Risk adjustment is a new and evolving science and its effectiveness is very dependent on the quality of the underlying data. While adjusting risk for age, sex, diagnosis and prescription utilization is helpful in deterring some adverse selection, it is far from perfect.¹⁰ Current methodologies do not account for social determinants, undiagnosed needs (i.e. behavioral, oral health needs), non-English speaking patients, behavioral risk

⁵ Why Shared Risk Payment Models Should be Considered by the Cabinet, Bailit Health, September 1, 2016.

⁶ D Pink, Drive: The Surprising Truth About What Motivates Us, 2009.

⁷ A Parks, From Choosing Wisely to Practicing Value – More to the Story, JAMA Internal Medicine, August 29, 2016.

⁸ A Schwartz, et. al., Changes in Low-Value Services in Year 1 of the Medicare Pioneer Accountable Care Organization Program, JAMA Internal Medicine 175:1815-1825, 2015.

⁹ Medicaid Accountable Care Organizations: State Update, Center for Health Care Strategies, September 2016.

¹⁰ J Bertko, [What Risk Adjustment Does – The Perspective of a Health Insurance Actuary That Relies on It](#), Health Affairs Blog, March 29, 2016.

factors (i.e. smoking, little physical activity, poor nutritional options), geographic access to care, or other member characteristics that could strain provider resources. Errors and opportunities to game risk adjustment models are well documented.¹¹

Loss aversion is a very strong incentive cited by the consultants to support shared/downside risk to drive cost control¹². Based on psychology experiments and financial markets, the concept of loss aversion is that people are far more attached to something they have in their possession, including money than something they do not yet hold.¹³ Shared/downside risk uses loss aversion to increase providers' motivation to keep money they have already received, rather than give it back. But this incentive can drive cost control in two ways – positively, by reducing overused care and duplication of services or, negatively, by underservice or stinting on appropriate necessary care.

Classic loss aversion experiment ¹⁴	Risk premium example ¹⁵
<p>Half of students in a class are given a mug with the university logo on it. The other students in the class get to examine a mug but are not given one to hold. The first set of students are asked at what price they would be willing to sell their new mug while the second set are asked what price they would be willing to pay to get one. The selling price for students to give up their mugs averages twice what other students are willing to pay to get one.</p>	<p>US treasury bonds offer rates of return three times lower than bond returns offered by the Philippine treasury. That difference is because they have to offer higher returns to attract buyers because the risk of loss is far greater for Philippine than US bonds.</p>

While applying this economic theory to health care is a significant stretch¹⁶, the theory predicts that loss aversion from downside risk would drive providers to work harder to

¹¹ D Blumenthal and M Abrams, Tailoring Complex Care Management for High-Need, High-Cost Patients, JAMA, online September 26, 2016; Michael Barnett, et. al., Patient Characteristics and Differences in Hospital Readmission Rates, JAMA Intern Med, November 2015; E Schone et. al., Risk Adjustment: What is the Current State of the Art and How Can it Be Improved?, Synthesis Project, Robert Wood Johnson Foundation, July 2013; M Geruso and T Layton, Upcoding: Evidence from Medicare on Squishy Risk Adjustment, NBER, May 2015.

¹² Bailit memo, September 1, 2016.

¹³ Richard E. Nisbett, *Mindware: Tools for Smart Thinking*, 2015.

¹⁴ D Kahneman, et. al., [Anomalies: The Endowment Effect, Loss Aversion, and Status Quo Bias](#), J Econ Perspectives, 5:193-206, Winter 1991.

¹⁵ Based on close of business September 26, 2016, ratios between Pilipino and US treasury bond rates of return were 3.4 and 3.2 for 2 year and 5 year bonds, respectively.

¹⁶ Only a few complications include reference points, the value of the investment to providers beyond money, their willingness to invest on behalf of a population such as

control the costs of care. However, following the theory, it will also inhibit providers from investing in innovations that could build value such as care coordination, social services, community linkages, or analytic and data capacity. For example, consider the buying decision for an ACO about a promising investment that costs \$100. In a shared savings model, the anticipated return would only have to be \$101 to be worthwhile, as the ACO is likely to gain 50 cents and possibly more. If there is a loss, it will not have to absorb it (although it would balance against other savings generated, so they would want to be fairly confident of savings). However, applying loss aversion theory to an ACO in a shared risk/downside risk model, the expected outcome would have to be \$200 to \$300 to make it attractive. This reluctance predicts that state and other payers will be less likely to realize savings in shared/downside risk models because ACOs will be less likely to invest in promising innovations.

Of course, all of this is very hypothetical. Applying theories to complex situations like health care is very unreliable and could easily result in unintended harm or unexpected cost shifting to other parts of the system ultimately increasing state spending.

Underservice monitoring and protections are prominently missing from the Strawman proposal. Underservice, or “stinting” on care, is the denial of appropriate, needed care to patients. Underservice occurs now across the health care system; less than half of older adults in Connecticut get recommended preventive care.¹⁷ But as bad as that is, both Connecticut’s Medicaid program and State Innovation Model planning acknowledge that, without monitoring and regulation, financial risk models such as shared/downside risk can encourage underservice.¹⁸ In fact, both Connecticut’s State Innovation Model (SIM), through the Equity and Access Council¹⁹, and the Medicaid program, for PCMH+ and health neighborhoods, have devoted a great deal of planning resources to detect and address underservice/stinting on care in the new financial models.

However the Strawman proposal is entirely silent on any regulatory system at all for ACOs, including critically important underservice/stinting protections. Connecticut does not now regulate ACOs either to ensure they can accept financial risk, or that they can provide the services they promise. Other states are developing ACO regulatory structures, but there have been no efforts yet in Connecticut.

The consultants cite Connecticut Medicaid’s PCMH+ program of shared savings as a foundation to move into even stronger financial risk models such as shared/downside

Medicaid members, for whose care they are paid less, emotions, other biases, conflicts of interest, etc. E Cartwright, Behavioral Economics, 2nd edition, 2011.

¹⁷ Aiming Higher: Results from a Scorecard on State Health System Performance, Commonwealth Fund, December 2015.

¹⁸ Connecticut Healthcare Innovation Plan, December 30, 2015; MQISSP – Under-Service Utilization Monitoring Strategy, Mercer, September 22, 2015; Underservice monitoring recommendation report, Underservice workgroup, Complex Care Committee, MAPOC, July 20, 2014.

¹⁹ Report of the Equity and Access Council on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements, June 25, 2015.

risk. However PCMH+ still hasn't been implemented or evaluated. It may or may not succeed. In fact, current negotiations with CMS may result in substantial changes in the plans' design reducing profitability that could affect ACOs' interest in participating. Pushing beyond PCMH+ before it's even started is reckless.

Another concern about the proposal to move Medicaid and the state employee plans into shared/downside risk is that **the current administration promised not to implement downside risk in Medicaid**. The reason given was downside risk's exceptional potential to amplify underservice, already a serious problem for Medicaid programs and to encourage stakeholders to engage in developing the shared savings program. This promise was made officially and unofficially in many forms including the MQISSP (now PCMH+) Request for Proposals, the MQISSP Concept Paper sent to the Centers for Medicare and Medicaid Services and in the official state Primer on MQISSP. The commitment was never conditional or time-limited based on the SIM timeline. It was a commitment of the current administration.²⁰

The consultants correctly identified a lack of trust as the biggest challenge to health reform in Connecticut. Breaking this important promise would set back Connecticut's hopes for reform significantly.

The two state examples for shared/downside risk given by the consultants, Massachusetts and Minnesota, are very different than Connecticut. Large provider practices predominate in both states unlike Connecticut, which still has a strong tradition of small independent practices. Both example states also have a long history of successful health reforms, working out problems, building regulatory and monitoring capacity and trust; none of which exists in Connecticut. Extrapolating between states is very unreliable, especially in health reform.²¹

Fortunately, there are **numerous alternative options**, in Connecticut and from other states, which are proven to both improve quality and control costs without the substantial problems of shared/downside risk. Since moving away from capitated private insurers, **Connecticut's Medicaid program** has enjoyed significant improvements in quality and access to care while simultaneously lowering the cost of care.²² Thousands of new providers are participating in the program, avoidable emergency department visits are down, prenatal care adequacy is up, well-child visits are up, the percent of members with diabetes with controlled hemoglobin HBA1c levels and retinal exams is up, and probably most telling – patient experience of care surveys find that well over 90% of members are happy with the care they are getting and 92% of adults are able to access care immediately when needed. Connecticut Medicaid was

²⁰ Medicaid Quality Improvement and Shared Savings Program (MQISSP) Participating Entities Request for Proposals (RFP), DSS, June 2016; A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP), April 13, 2015; Medicaid Quality Improvement and Shared Savings Program (MQISSP) CONCEPT PAPER to be Submitted to the Centers for Medicare and Medicaid Services, December 3, 2015.

²¹ J Goldsmith and L Burns, Fail to Scale: Why Great Ideas in Health Care Don't Thrive Everywhere, Health Affairs Blog, September 29, 2016.

²² State Agency Response To Request For Input/Feedback On Possible Strategies and Current Context, DSS to Health Care Cabinet, June 14, 2016.

able to achieve all these improvements while still saving more than states featured in the consultants' Strawman report.

	Savings
Connecticut	\$392 million (avg. ann. 2013 to 2015) ²³
Oregon	"marginal" ²⁴
Vermont	\$14.6 million ²⁵
Minnesota	\$14.8 million (2013) ²⁶ \$61.5 million (2014)

Medicaid faces some significant challenges – low provider payment rates and a fragile and costly membership with significant social service needs. If Medicaid can make such remarkable progress, the rest of Connecticut's health system can as well. How did Connecticut do it?

1. An inclusive, transparent process that engaged everyone – the engagement process was not passive just accepting whoever applied to be at the table. It was impossible to avoid participating in the process.
2. Unparalleled access to timely data on how the program is working, and the political will to use it in designing and adjusting the program. No sacred cows were exempted from accountability for the data lessons and the clear expectation that any shortcomings would be fixed.
3. A real commitment to delivery reform – person-centered medical homes and intensive care management to start
4. An equal commitment to improving quality – meaningful provider bonuses tied to performance, Administrative Service Organization withholds, provider dashboards, and the peer pressure of full transparency about shortcomings and accomplishments
5. Rebalancing Long Term Services and Supports – there isn't an idea DSS hasn't tried to improve care for the costliest members
6. Always innovating and addressing the next challenge. Projects now in development include
 - a. PCMH+ -- ACO networks with meaningful quality and quality improvement incentives, underservice monitoring and prevention, and policies that emphasize person-centered care
 - b. High-cost, high-need member project with a deep dive into data, a search for appropriate interventions that are working elsewhere, and starting implementation
 - c. Plans to explore bundled payments

²³ Calculations based on DSS enrollment and financial reports to MAPOC; savings calculated from prior year actual spending, not from trended forward estimates.

²⁴ M Peterson and D Muhlestein, ACO Results: What We Know So Far, Health Affairs Blog, May 30, 2014.

²⁵ Medicaid Accountable Care Organizations: State Update, Center for Health Care Strategies, September 2016.

²⁶ Study of Cost Containment Models and Recommendations for Connecticut, Straw Model, Bailit Health, July 12, 2016.

- d. Meaningful connections to housing security and other social services
- e. A massive and long overdue eligibility and enrollment IT system upgrade
- f. Dozens of smaller projects to target specific issues

Colorado Medicaid offers another promising example of how to reform the health system without shared/downside risk. Colorado achieved \$37.7 million in Medicaid savings in FY 2015 – better than other states with shared/downside risk. Their program covers 985,000 people, three quarters of the total Medicaid population. They did it essentially as Connecticut has -- by emphasizing care coordination, person-centered care, quality and access. To get the best features of ACOs without the risks of shared/downside risk, Colorado created Regional Care Collaborative Organizations (RCCOs), essentially ACO-like networks of providers across the care continuum however they are not at financial risk.²⁷

Next steps for Colorado include:²⁸

- ensuring adequate rates for high-value services
- integrating physical and behavioral health
- incorporating social determinants of health into risk adjustment
- exploring bundled payments
- tying more compensation to quality performance
- stakeholder engagement to set quality standards

Connecticut should look to Colorado's lessons for guidance in reforming our health system.

²⁷ Supporting a Culture of Coverage: Accountable Care Collaborative, 2105 Annual Report, Colorado Department of Health Care Policy and Finance, 2016.

²⁸ ACC Phase II Concept Paper, Colorado Department of Health Care Policy and Finance, October 20, 2015.