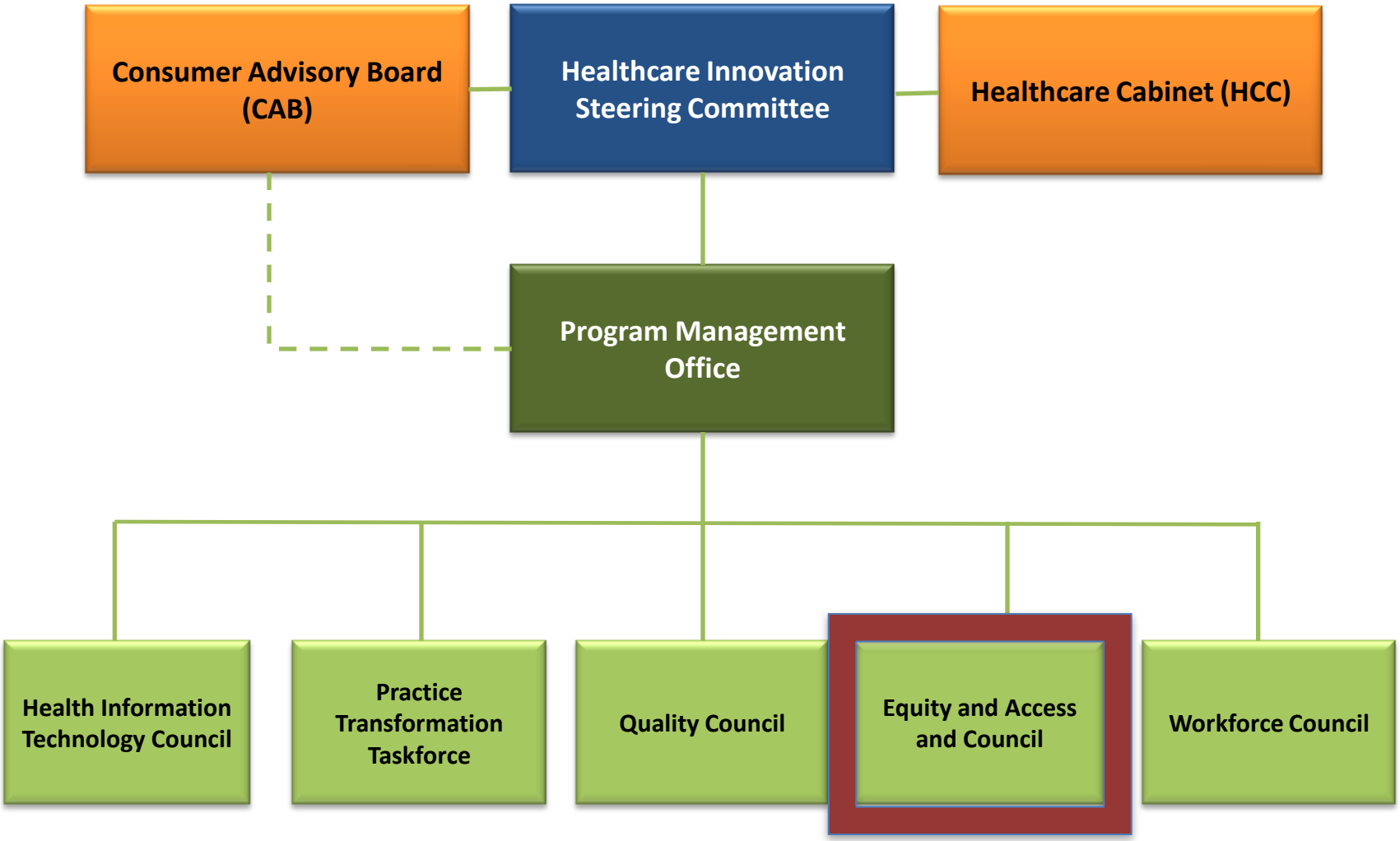
Healthcare Innovation Steering Committee

Equity and Access Council Update

February 5, 2015

SIM Governance Structure



Topics for Today's EAC Update to the HISC

1. **Background:** Provide a brief refresher on elements of the EAC's charter and its two phases of work

2. **Progress Report:** Update the HISC on work completed since the EAC's "reboot" in December 2014

3. **Approach to Developing Phase I Recommendations:**
   - Review the framework the EAC has adopted for evaluating the questions before it in Phase I of its work
   - Engage the HISC in a discussion about key issues the EAC has begun to address

4. **Roadmap:** Present an overview of the EAC's path ahead

5. **Questions:** Address questions and input from the HISC

1. The EAC's Charge

EAC Charter – Excerpts

What we will accomplish

This work group will [1] develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; [2] recommend a response to demonstrated patient selection and under-service; and [3] define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms.

How we define key concepts

[4] Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. [5] Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. [6] A finding of failure shall not require proof of intentionality or a plan.

How we will sequence the work*

Phase I

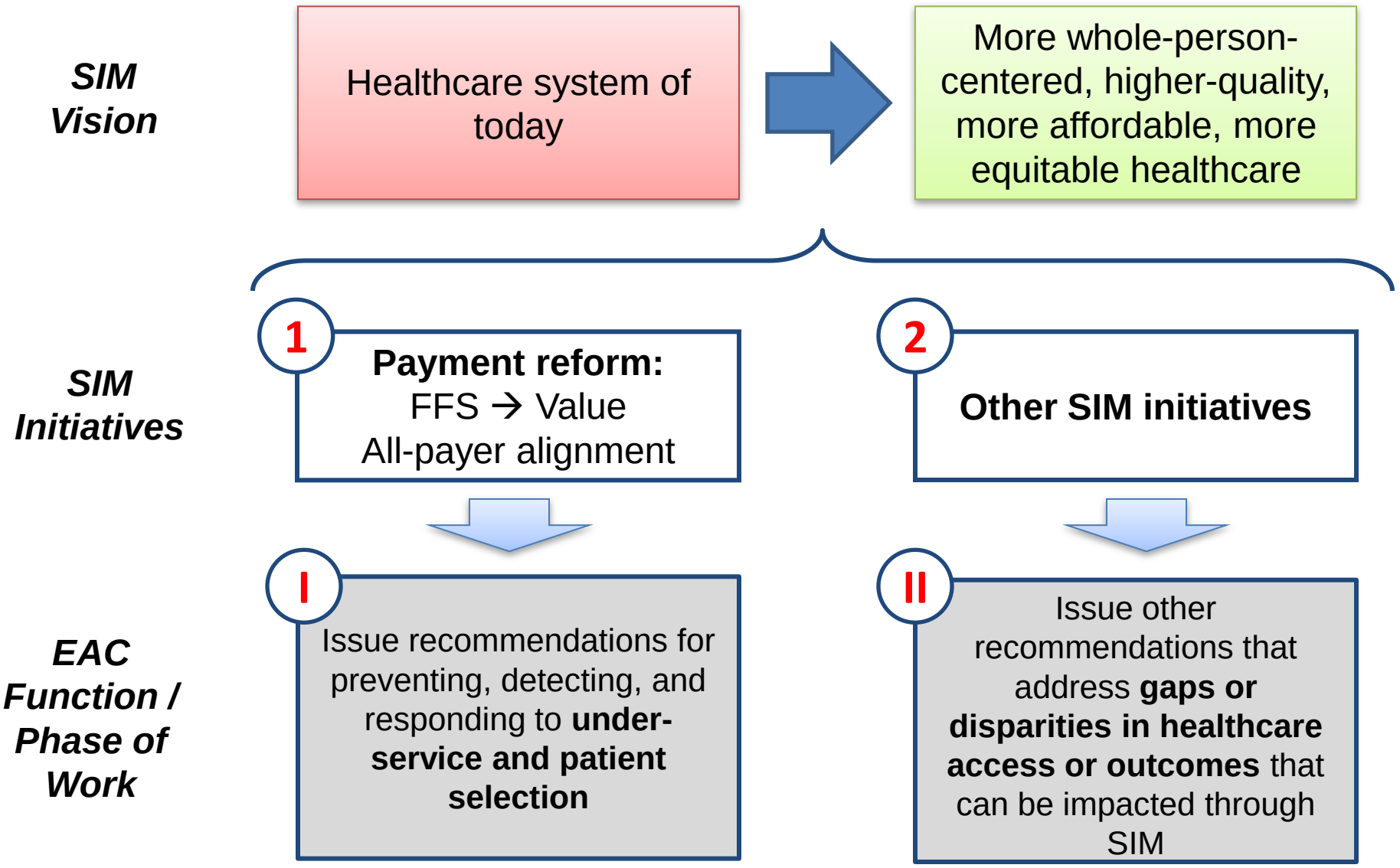
Issue recommendations for preventing, detecting, and responding to **under-service and patient selection**

Phase II

Issue other recommendations that address **gaps or disparities in healthcare access** – those that currently exist and could be reduced through the SIM, or those that could arise as a byproduct of SIM reforms

* Phase I & II descriptions paraphrased from EAC charter

1. EAC Phases of Work in the Context of SIM



2. Progress Report

EAC Progress Since December 18, 2014 "Reboot"

1. Member Engagement	• HISC appointed and EAC onboarded **three new members** • **Met individually with all 20 Council members** to discuss expectations for the EAC's work, gathered perspectives on key topics, and identified barriers to participation • Issued a **member survey** to gather additional input to the EAC's work • Developed an **"EAC & SIM background document"** to communicate broader context • Established an optional **pre-meeting Q&A session** for members
2. Meeting Structure and Content	• Devoted **additional resources** to structuring meeting agendas, conducting research, and developing content to support robust discussion • Introduced **independent facilitation** to help drive group toward defined outcomes
3. Design Framework	• Designed and **adopted a systematic approach** that defines at the next level of detail the issues that the EAC will evaluate in Phase I of its work • Identified a **set of "solution areas"** in which the EAC will evaluate and propose safeguards against under-service and patient selection
4. Work Plan	• Split the work into **four design groups** to evaluate issues and options and inform the EAC's deliberation • Adopted a **design process** consisting of four milestones each and aligned upcoming meeting agendas with the topics to be addressed • **Established a timeline** to complete initial evaluation and issue recommendations to the HISC on Phase I topics by mid-April

3. Rationale for Safeguards

Each stakeholder group may have distinct, various rationales for the adoption of safeguards as part of payment reform.

Stakeholder Group	Potential Rationales for the Adoption of Safeguards Against Under-Service and Patient Selection
 **Consumer**	• Ensure timely access to appropriate services and providers • Ensure timely access to information about available, appropriate interventions
 **Provider**	• Align reimbursement/contracting rules with medical ethics and mission to provide the best patient care • Create a level playing field (i.e. no incentives to cheat) • Establish clarity about what behaviors are and are not prohibited • Create market advantage – ACOs that create effective mechanisms to ensure appropriate care, and deliver timely access to the right services, will win patients
 **Payer**	• Align with mission to act in consumers' interest, improve health • Comply with applicable laws that prohibit certain activities • Incent providers to take on the most challenging, most expensive patients • Prevent patients from slipping through cracks in the care delivery system, which would increase costs over time • Prevent delays in care, which will increase costs over time to the payer, even if it reduces costs in the performance year for the ACO

3. Types 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. Types of Safeguards: A Framing Hypothesis

A foundational hypothesis about the role of each safeguard type:

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

If value-based payments are designed in a way that ***encourages continuous clinical and cultural transformation*** *of delivery systems over time, and* ***provides little inherent incentive to withhold appropriate care*** *…*

2. Supplemental safeguards

Concept:

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

… then the ***supplemental safeguards*** *established to identify instances of stinting on care or inappropriately selecting patients to care for are much* ***more likely to be sufficient and effective*** *at protecting consumers.*

Note: this statement has not been reviewed or adopted by the EAC to date

3. How Safeguards Operate: Incentives and Outcomes

Payment Design

Provides financial incentive to provide high-quality, medically appropriate care to all patients

Supplemental Safeguards

Provide additional protection against any outcomes of payment reform that may adversely affect health equity and access

Incentives

Provider

Patient

Outcomes affect a portion of total payments for which providers are eligible

Patient experience is one of the factors directly incorporated into performance incentives

Health Outcomes for CT:

1) Healthy population
2) High-quality care
3) More equitable system of care delivery
4) Lower costs

Monitor performance over time to adjust payment design and assess the need for additional policies

3. Payment Design Features: Mechanics & Terminology

1. Payment Design Features

Determine Which Patients "Belong" to Which Providers

Determine Expected Annual Total Cost of Care for Attributed Patient Population

Determine How Much Each Provider Earns in Incentive Payments

1A. Patient Attribution
Patients are assigned to a provider based on where they receive primary care or other secondary factors

1B. Cost Calculation - Benchmark
Total cost of care is estimated for patient panel attributed to provider

1B. Cost Calculation - Risk Adjustment
Estimated costs for population attributed to a provider are adjusted based on clinical and other risk factors

1C. Payment Calculation-Shared Savings
Amount of savings eligible to be paid to provider based on minimum savings rate. In downside risk arrangement, money owed back to payer if costs are above benchmark

1C. Payment Calculation-Performance Component
Clinical quality and patient experience metrics are used to qualify for shared savings payment and/or additional incentive payments

1D. Payment Distribution
Shared savings and other incentive payments are distributed amongst providers

Note: This illustration refers to payment methods often referred to as "shared savings programs" or "total cost and quality contracts" A variety of other types of value-based contracts exist in the US marketplace.

3. Design Elements: Payment Design Features

1. Payment Design Features

Safeguard Type		Description	Hypotheses to Examine
A	*Attribution of patients*	The method by which **patients are assigned** to a provider	How patients are assigned to an ACO will impact the ability to conduct improper patient selection
B	*Cost target calculation (cost benchmarks & risk adjustments)*	The method by which a **patient's benchmark (expected) cost of care is determined** and adjusted for clinical and other risk factors	Creating benchmarks that accurately reflect patients' expected cost of care – or that exceed expected cost of care for patients at greatest risk of being selected against – will minimize improper patient selection
C	*Provider payment calculation*	Other elements of the formula that **defines the amount of incentive payments** generated for a given patient population	Balanced financial incentives that make providers financially indifferent to providing more care vs less care will incent providers to provide the right care, minimizing the risk that medically appropriate services will be withheld
D	*Payment Distribution*	The method by which individual **providers share in savings achieved**	Rewarding providers based on ACO performance, rather than individual performance, will minimize any incentive for a provider to withhold appropriate services, while facilitating monitoring for improper behavior

3. Design Elements: Supplemental Safeguards

2. Supplemental Safeguards

Safeguard Type		Description	Hypothesis to Examine
A	*Rules*	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	*Communication*	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.
C	*Accountability & Enforcement*	**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
D	*Detection: retrospective*	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
E	*Detection: concurrent*	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

4. EAC Roadmap: Organizing the Design Process

To support further research, evaluation, and solution design, the EAC has organized its safeguard solution areas into four design groups.

Solution Areas

Design Groups
(1A) Attribution (1B) Cost target calculation (cost benchmarks & risk adjustments)
(1C) Incentive payment calculation (1D) distribution
(2A) Rules (2B) Communication (2C) Accountability/enforcement
(2D) Retrospective detection (2E) Concurrent detection

4 Design Groups

Design Groups	Principal Questions to Answer:
1	How to minimize improper patient selection by appropriately defining expected outcomes and accountabilities
2	How to balance incentives to promote medically appropriate, efficient, patient-centric care decisions
3	How to set appropriate rules, communicate them, and enforce them
4	How to evaluate for under-service and patient selection – as both an enforcement/deterrence tool and an evaluation tool – after the performance period and/or in near-real-time

4. Design Groups: Concept

Each design group will recruit standing participants to contribute and communicate its progress to the full EAC on an ongoing basis.

4 Design Groups

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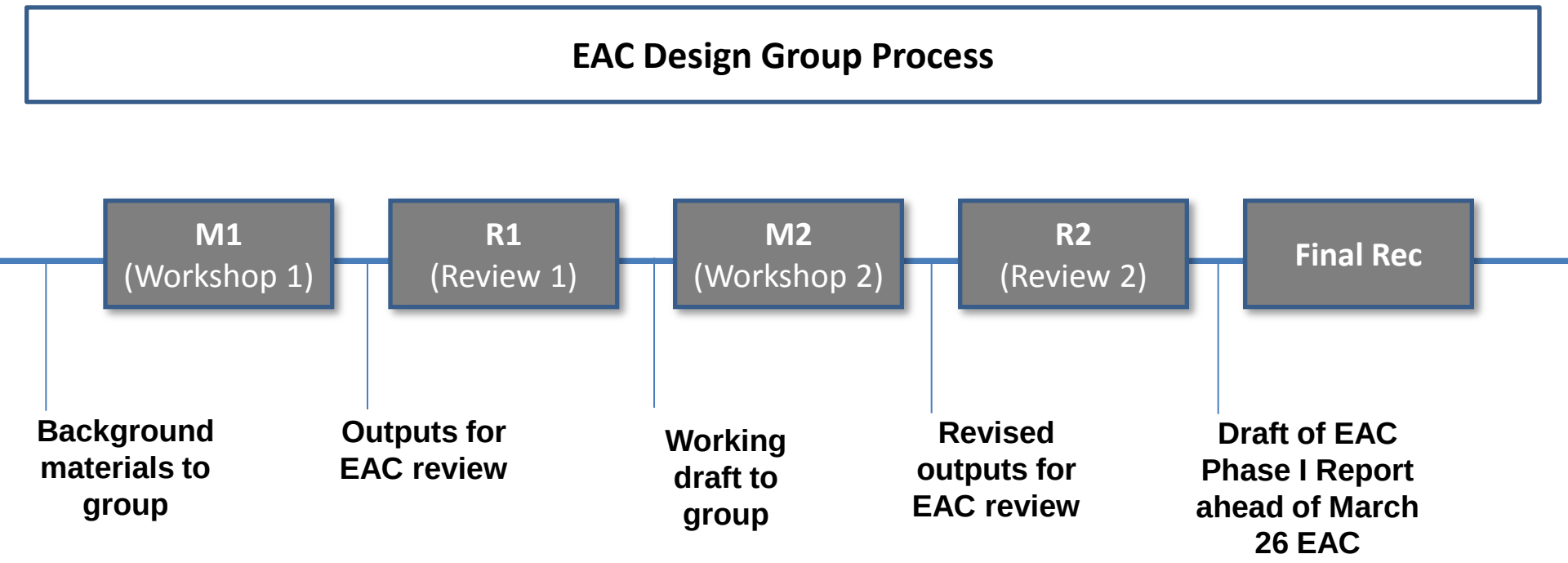
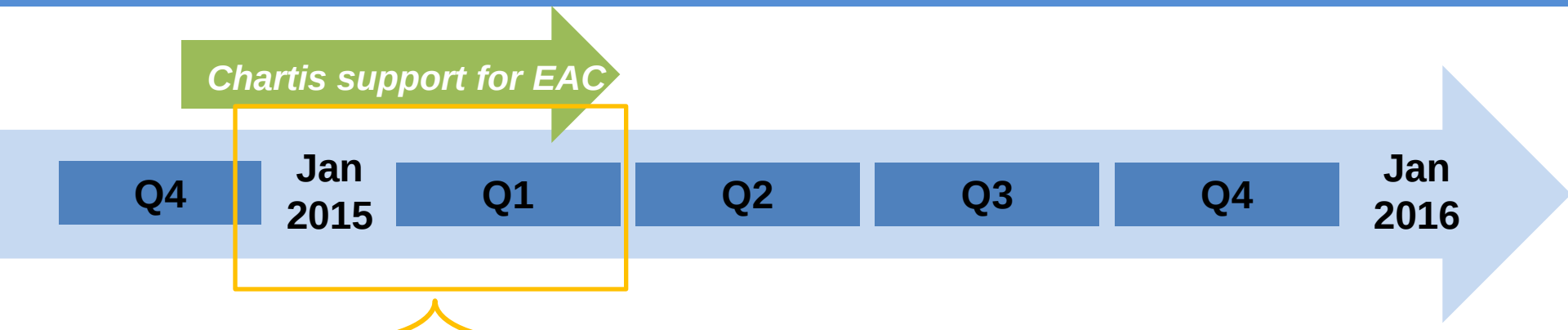
For each cluster of topics or "design group":

- ❑ EAC members have opted in to participate in the design group on a standing basis
- ❑ Organize relevant materials for the EAC to review
- ❑ Develop working design solution(s)
- ❑ Solicit design group input
- ❑ Hold one or more "workshops" by conference call, with participation open to all EAC members, and to the public
- ❑ Solicit input of the entire EAC via a two-stage review process

4. Design Groups: Process



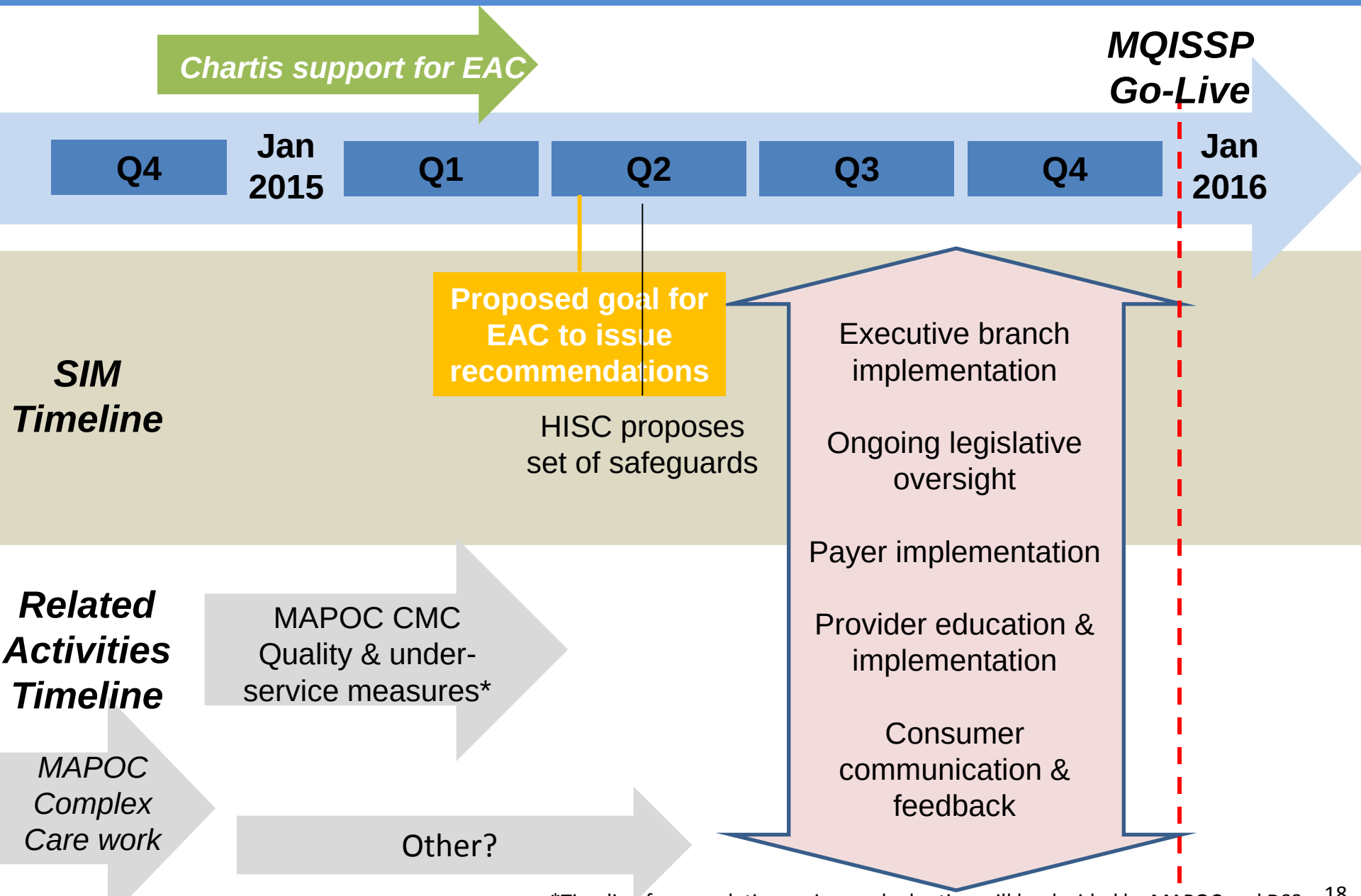
4. EAC Roadmap: Phase I Timeline



EAC Roadmap for 2015 Q1

	Dec	Jan	Feb	Mar	Apr
EAC Meetings	12/18	1/22	2/12 2/26	3/12 3/26	4/9 4/23
Key Activities	EAC "Reboot": Adopt roadmap, approach, schedule, priorities	Research, evidence review	EAC articulation of options and preferences Design groups for identified safeguards	Communication with MAPOC CMC Draft & edit report	Report revisions, additional coordination with MAPOC CMC as needed
	Public input				

4. EAC Roadmap: High-Level Context



*Timeline for completing review and adoption will be decided by MAPOC and DSS