5. Consolidated List of Recommendations

Patient Attribution

Recommendation #1.1: Patient Attestation. Patients should be able, though not required, to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider's panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits.

Recommendation #1.2: Patient Notification. Patients should be made aware when they are attributed to a physician who is participating in a shared savings program. Notification should be in a manner that is accessible and understandable by all patients. Notifications should make clear that patients retain the right to choose or change provider.

Recommendation #1.3: Timing of Attribution. Prospective attribution provides a vehicle for generating provider and patient awareness and promoting effective care management and coordination, and provides a degree of protection against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment. When prospective attribution is utilized, it should be accompanied by an end-of-year retrospective reconciliation that de-attributes prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a physician. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year. In instances in which the retrospective reconciliation process determines that a patient should be de-attributed, that patient will not be re-attributed to another ACO.

Cost Target Calculation

Recommendation #2.1: Rewarding Improvement. Rewarding providers for improving cost performance year over year will minimize pressure on historically lower performers to achieve a fixed cost benchmark that is unattainable using clinically appropriate cost management methods. In turn, this may reduce the risk of under-service and patient selection. Use of a historical benchmark provides an inherent incentive to improve; a control group benchmark does not. When payers utilize a control group cost benchmarking methodology, they should consider rewarding providers based on their degree of cost improvement over the prior year, in addition to their performance against the group.

Recommendation #2.2: Adjustment for Unpredicted Systemic Costs. An end of year assessment should be conducted to evaluate the need to adjust for any systemic factors (e.g. the advent of new treatments, severe flu season) that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year. An adjustment can be made to the historic cost benchmark or an identified treatment can be temporarily carved out of the cost benchmark calculation.

Recommendation #2.3: Supplemental Payments for Complex Patients. An imperfect risk adjustment that does not account for hidden expenses associated with caring for socioeconomically complex patients may put some of the most vulnerable patients at greater risk for under-service and patient selection. To date, there is not a commonly accepted payment mechanism within shared savings programs to account

for this, but payers should consider ways to financially incent provider organizations to care for the most vulnerable individuals.

Recommendation #2.4: Retrospective Assessment for Risk Adjustment. In the long-term, data collected for under-service and patient selection monitoring purposes should be utilized to identify populations for which the current risk adjustment methodologies are not leading to improvements in equity and access, and should be adjusted accordingly using clinical or non-clinical factors.

Recommendation #2.5: Cost Truncation and Service Carve Outs. Truncating costs based on a percentile cutoff, and/or carving out select services, will eliminate any incentive to withhold required care after a catastrophic event or diagnosis in an effort to minimize overall costs, and will help to keep providers focused on managing the more predictable types of utilization that value-based contracts seek to improve.

Incentive Payment Calculation and Distribution

Recommendation #3.1: Eligibility Thresholds. ACOs should only be able to share in savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or patient selection (as defined in the EAC charter and incorporated in payer-ACO contracts).

Recommendation #3.2: Discrete Quality Payments. Providing discrete incentive payments that reward quality improvement, irrespective of whether savings are achieved, will serve as a counter-balance against any incentive to inappropriately reduce costs.

Recommendation #3.3: Rewarding Quality Improvement. ACO quality goals should be based, at least in part, on an ACO's prior performance, and should contain a range of goals (i.e. threshold, target, and stretch). By correlating the opportunity to earn savings with quality performance, increasing the share of savings the ACO receives on a sliding scale based on quality performance between their own threshold and stretch goal, payers can incent a pattern of continuous performance improvement. To ensure that ACOs are not penalized for accepting new patients who may be more challenging to care for, year over year changes in ACO quality performance should be calculated using patients who have been continuously attributed to the ACO during the prior year and the performance year.

Recommendation #3.4: Minimum Savings Rates (MSRs). MSRs should not be utilized, or should be structured in a way that allows for deferred recoupment of savings. In the former case, any savings achieved should be shared with providers (assuming quality thresholds are met), thereby reducing the "all or nothing" aspect of reaching or not reaching an MSR. In the latter case, if an ACO demonstrates savings over a multi-year period which failed to meet an MSR in individual years, but which in combination are statistically significant, the ACO should be retroactively eligible to share in those savings.

Recommendation #3.5: Reinvestment of Non-Retained Savings. When an ACO demonstrates cost savings, but is not eligible to receive the savings because it was found to have stinted on care or inappropriately discontinued patients, the funds should be reinvested in the community's delivery system via an independent entity that administers the funds and ensures that they are earmarked to support improvements in access and quality. [NOTE: The EAC did not reach a consensus to adopt this recommendation. It elected to include the text of the recommendation and related discussion in this

draft of the report in order to inform readers about the underlying idea and the variety of perspectives about its merits that EAC members expressed.]

Recommendation #3.6: Advance Payments. Providing ACOs with up-front funding dedicated to infrastructure will allow them to invest in the resources required to effectively manage care for defined populations. This incentive is especially important for smaller organizations or networks that are considering participating in MQISSP as ACOs. In addition, ACOs that have sufficient infrastructure will be more likely to lower costs through effective care management and less likely to lower costs by stinting on care or discontinuing patients.

Recommendation #3.7: Payment Distribution Methods. To reduce the incentive for providers to under-serve in order to generate savings, provider groups at the sub-ACO level and individual providers should not be rewarded based on the portion of savings they individually generate. Rather, provider groups and individual providers should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel.

Supplemental Safeguards: Rules, Monitoring, and Accountability

Recommendation #4.1: ACO Internal Monitoring. ACOs should establish performance standards, monitor for inappropriate practices including under-service and patient selection, and hold member groups and providers accountable. As a condition of participating in shared savings contracts, payers should require ACOs to establish governance and performance management processes that meet minimum criteria, including promotion of evidence-based medicine and patient engagement, reduction in variations in care, and monitoring for under-service and patient selection.

Recommendation #4.2: ACO Accreditation. Over time, payers and/or the state should consider requiring that ACOs obtain accreditation (e.g. URAC or NCQA ACO accreditation). This might apply to all ACOs or only to ACOs that do not demonstrate capabilities via consistent performance on quality and other outcomes.

Recommendation #4.3: Retrospective Monitoring Guidelines. Each payer that enters into shared savings contracts should monitor for under-service and patient selection on an annual basis using a set of analytic methods that it establishes. At a minimum, the standard under-service and patient selection monitoring performed by payers should include:

a) Under-service should be monitored by assessing utilization and total cost of care, over time and between groups, (i.e. between different ACOs and between ACO-attributed and non-ACO-attributed populations) to identify patterns of variation.
b) Patient selection should be monitored by evaluating the change in risk adjustment of a population assigned to an ACO over time.
c) For both under-service and patient selection, payers should identify populations that may be at particular risk (i.e. characterized by particular clinical conditions and/or socioeconomic attributes), and conduct population-specific analysis. For example, under-service should also be monitored by evaluating variations in utilization (i.e. of different interventions) by diagnosis where there is a specific under-service concern and well-established intervention guidelines. To be a more effective deterrent of under-service payers should not necessarily disclose to providers which diagnoses will be monitored.

d) Claims data analysis should only be used as a first cut to flag potential under-service or patient selection. When potential under-service or patient selection are flagged, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or patient selection is likely to have occurred.

Recommendation #4.4: Concurrent Monitoring: Nurse Consultant. A nurse consultant (i.e. ombudsman) will play a key role as a one-stop source of information related to under-service and patient selection for consumers and providers. The nurse consultant should be dedicated to addressing under-service and patient selection concerns arising from shared savings and related value-based contracting programs. OHA, with input from stakeholders, should devise a policy to define in more detail the nurse consultant's role and the protocol for handling and routing consumer inquiries and complaints.

Recommendation #4.5: Mystery Shopping. Mystery shopping programs should be designed and implemented to detect potential patient selection activity amongst ACO participants. These programs should include core elements of the one that CHNCT administers today on behalf of DSS, with modifications appropriate to the type of activity being detected and each payer population.

Recommendation #4.6: Accountability: Corrective Action. When a payer, via monitoring and follow up investigation, determines that an ACO or its member provider(s) have engaged in repeated or systematic under-service and/or patient selection, it should provide the ACO with a written finding of relevant facts. The ACO should have an opportunity to appeal any such finding. If the finding is verified, the payer should place the ACO on a corrective action plan (CAP) for a period of time during which the ACO will not be eligible for receiving shared savings. If after the CAP period is complete, performance concerns are not addressed, the ACO may face termination from the shared savings program. The same process should apply if ACOs do not abide by required rules for participation in a shared savings program. Initially when an ACO is placed on a CAP support should be provided through collaborative learning with well performing ACOs or other means that will help the ACO to identify and address areas of concern.

Recommendation #4.7: Retrospective Monitoring: Long-Term Analysis. After Connecticut gains more experience with shared savings contracting, an independent third party (non-payer, non-provider) should conduct a retrospective, multi-payer evaluation of how value-based contracting is impacting service delivery. This analysis may rely on the all-payer claims database (APCD) and/or other sources of data. This analysis should be overseen by a committee of clinical and analytic experts who will use available data (i.e. claims data, patient feedback, clinical data) to evaluate the impact of shared savings contracts on healthcare delivery practices and outcomes. This will include patterns of under-service and patient selection. The analysis will seek to understand root causes and recommend adjustments to contracting methods and supplemental safeguards going forward. The goal of this more comprehensive analysis will be to identify and address any programmatic elements or unwanted ACO/provider behaviors not captured by initial recommended monitoring that are contributing to equity and access problems, in particular under-service and patient selection.

Recommendation #4.8: Accountability: Public Reporting. Entities involved in the use of shared savings contracts in Connecticut should report information in order to inform the public and allow for the effect of these contracts to be evaluated using an array of relevant data points. At a minimum, this should include:

a) Payers should publicly report on an annual basis: the names of the ACOs with which it has shared savings contracts, the number of lives attributed to each, a description of methods that it used during the prior year to monitor for under-service and patient selection, and a summary of the results of that monitoring which includes a statement describing any instances in which an ACO was placed on a corrective action plan and shared savings were withheld from an ACO.
b) OHA should publicly report on an annual basis a summary of the activities it undertook related to under-service and patient selection including: patient complaints received by the nurse consultant, cases referred to payers, ACOs, provider groups, and/or licensing authorities for further evaluation, and actions taken to initiate corrective actions.
c) ACOs participating in any payer's shared savings program should be required to have a compliance officer, and to publicly report information about their participating providers, leadership, quality performance, and shared savings, including payments (if any) received by the ACO, the total proportion of shared savings distributed among ACO participants, and the total proportion used to support quality performance and program goals.

Recommendation #4.9: Peer Reporting. The State ensure that adequate whistle-blower protections are in place for employees or contractors of the ACO who report evidence of under-service or patient selection, or of undue pressure from the ACO to engage in either type of activity.

Supplemental Safeguard: Communication

Recommendation #5.1: Consumer Communications: Scope. Consumers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to manage the total cost of care and improve quality, definitions of under-service and patient selection, and the manner in which financial incentives could lead to under- and over-service. In the context of value-based care delivery, consumers should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.

Recommendation #5.2: Consumer Communications: Accessibility and Consistency. The type of information described in Recommendation 5.1 should be communicated to all consumers via a set of consistent messages. Messages should be written and distributed in a manner that is accessible and comprehensible by all consumers. Information should be made available both in advance of receiving care (e.g. at the time of insurance enrollment) and at the point of care (e.g. in writing in the provider office). While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different insurance products, people with different clinical conditions), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as consumers' insurance or health status changes, and give providers standard guidance about engaging consumers that aligns with what consumers are being told.

Recommendation #5.3: Consumer Communications: Content Development. A work group should be convened to advise state agencies and payers on the content to be contained in the core messages described in Recommendation 5.1, and also on the appropriate media through which messages should be distributed in a manner consistent with Recommendation 5.2. This work group should recommend

specific language to be incorporated in messages. The work group should be composed predominately of consumers, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

Recommendation #5.4: Provider Communications. Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain for providers and/or organizations that deliver care. This should include, but not be limited to, information about incentives to lower the total cost of care, definitions of under-service and patient selection, and methods that are in place to guard against such.. This latter information should be communicated in a consistent manner to all providers.