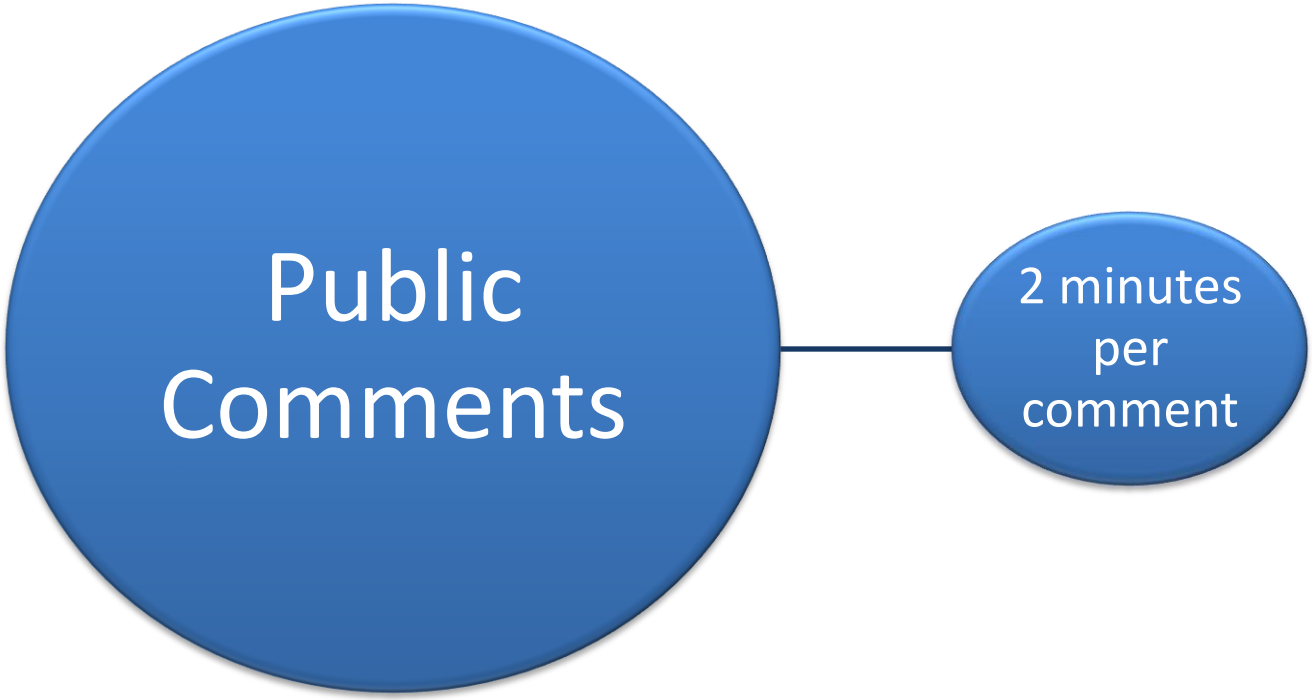
Healthcare Innovation Steering Committee

July 16, 2015

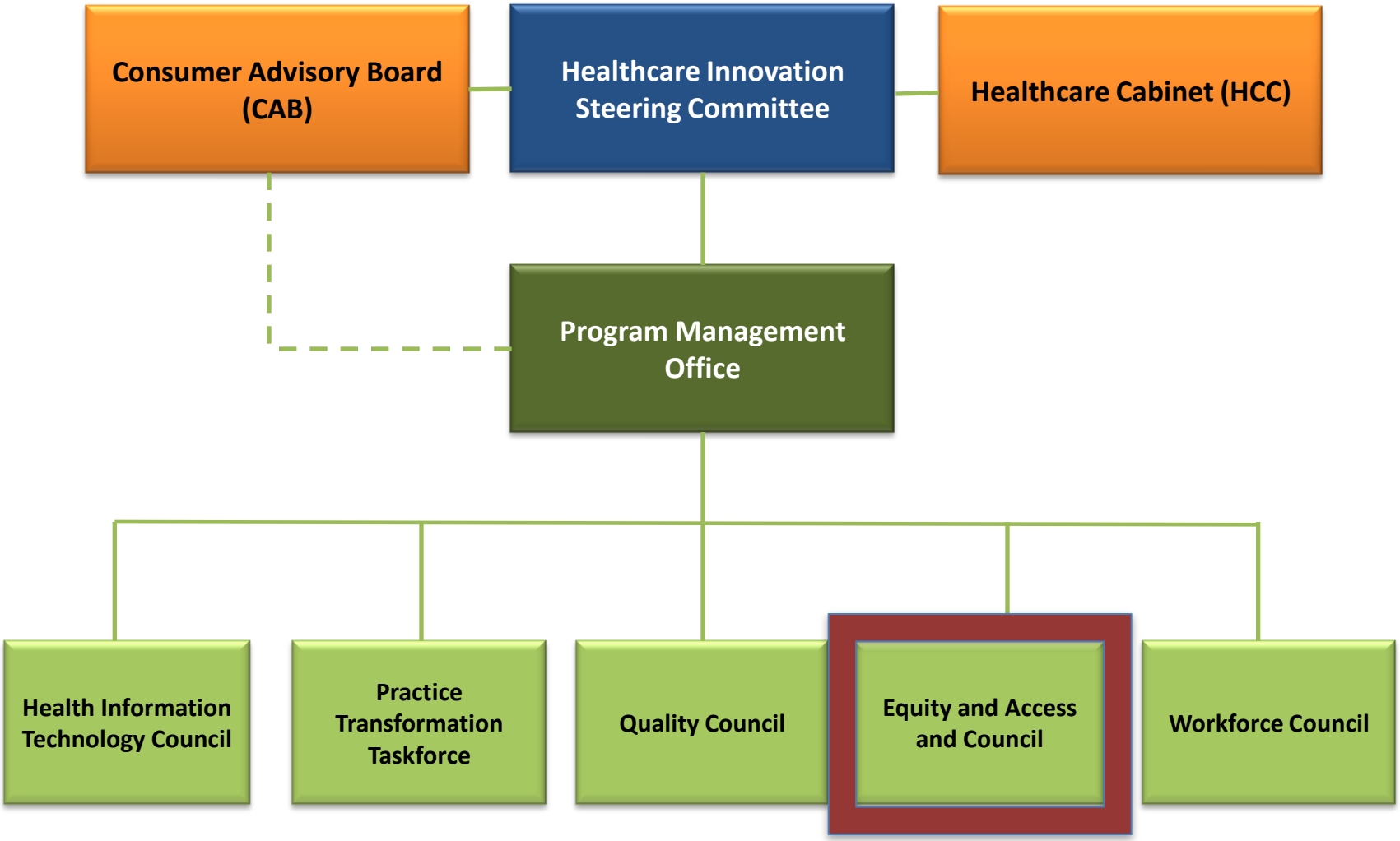
Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	10 min
3. Minutes	5 min
4. HIT Council nominations	5 min
5. Equity and Access Council - Recommendations	45 min
6. SIM related provisions in final budget	25 min
7. Conflict of Interest Protocol	25 min
8. Adjourn	


Public Comments
2 minutes per comment

Equity and Access Council Recommendations

SIM Governance Structure



Topics for Today's EAC Update to the HISC

1. **Present highlights** of the EAC's report on under-service and patient selection
2. **Provide an overview** of the process through which the EAC arrived at its recommendations, and discuss next steps
3. **Answer questions** that HISC members may have about the contents of the report
4. **Obtain input** from the HISC through a dialogue with the members

The EAC's Charge in the Context of SIM

SIM Vision

Healthcare system of today → More whole-person-centered, higher-quality, more affordable, more equitable healthcare

SIM Initiatives

One of the core areas of activity under SIM is **payment reform**:

- Shift the basis of reimbursement from volume to value
- Align payers around common high-level approaches and metrics

Role of the EAC

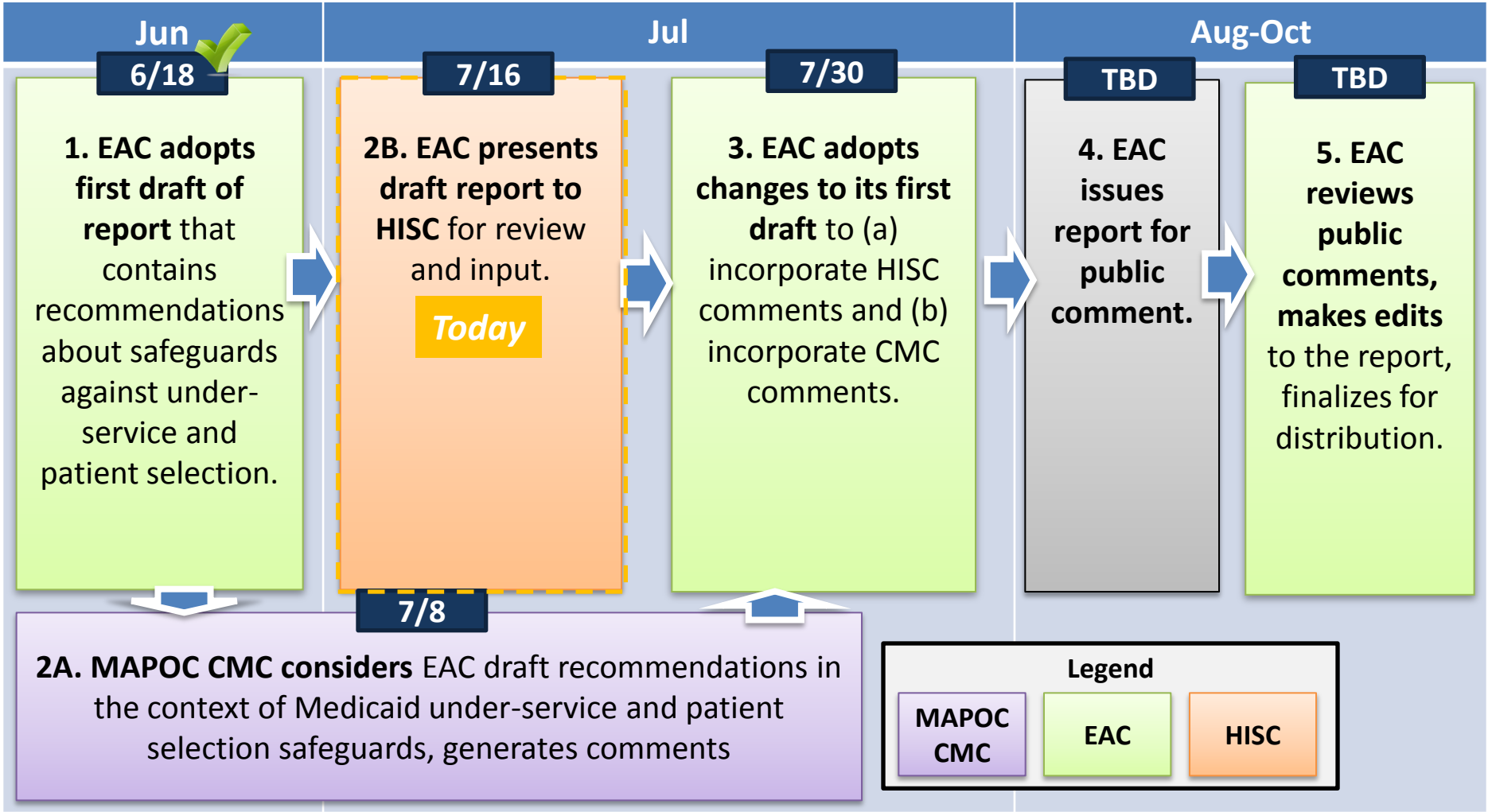
In the context of payment reform, the EAC's charter calls on it to issue recommendations for preventing, detecting, and responding to **under-service** and **patient selection**

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.

Patient selection refers to efforts to **avoid serving patients** who may compromise a provider's measured performance or earned savings.

EAC Completion of Phase I Report – Interaction with HISC & MAPOC

Proposed Steps and Timeline for EAC to Obtain Input on and Finalize Its Phase I Report



Types of Safeguards

What types of safeguards can be built into the proposed payment reforms?

The EAC proposed two categories of potential 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

Design Elements

1. Payment Design Features

Safeguard Type		Description
A	*Attribution of patients*	The method by which **patients are assigned** to a provider
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
C	*Provider payment calculation*	Other elements of the formula that **defines the amount of incentive payments** generated for a given patient population
D	*Payment Distribution*	The method by which individual **providers share in savings achieved**

2. Supplemental Safeguards

Safeguard Type		Description
A	*Rules*	Rules for **who can participate** in a value-based contract and **what activity is allowed** and prohibited
B	*Communication*	Methods of **informing consumers and providers** about the definition and consequences of prohibited activities
C	*Accountability*	**Consequences** for violating rules and **methods of enforcing** those consequences
D	*Detection: retrospective*	Methods of **detecting under-service and patient selection** by observing it **using data** produced after a period of performance is over
E	*Detection: concurrent*	Methods of **detecting under-service and patient selection in real-time** or near-real-time

Nature and Intent of Recommendations

A few prefatory comments about the EAC's process …

- The EAC, like other components of the SIM governance structure, sought to **surface effective solutions** and to **create alignment among key stakeholders** in support of the goals established in Connecticut's State Healthcare Innovation Plan.
- The EAC's recommendations are intended to **inform the actions** of policymakers as well as those who purchase, provide, insure, administer, and utilize healthcare in Connecticut. They are **not binding** in any way.
- Consistent with the SIM test model grant narrative, the EAC's intent in articulating a perspective about payment design features was **not to prescribe a single standard shared savings contract model** for all-payer adoption. The EAC believes that **payers should consider the equity and access implications** related to the contract design choices that the Council explored.
- To arrive at the recommendations in this report, the EAC utilized a **consensus-based decision-making model** within which the Council attempted to find solutions that enjoyed broad support from its members. That a recommendation was adopted by consensus **does not imply that it was adopted unanimously**. Rather, it indicates that the Council on the whole supported the recommendation, and that none of the members chose to block its inclusion, even if they may not have personally been in favor of it.

EAC Recommendations: Introduction

The EAC's Phase I Report includes 28* recommendations. For the purpose of today's discussion we have organized them into five groups:

Payment Design Features

1. **Patient attribution (3 recommendations)**
2. **Cost target calculation (5 recommendations)**
3. **Incentive payment calculation and distribution (7 recommendations)***

Supplemental Safeguards

4. **Provider- and payer-led actions (6 recommendations)****
5. **Independent/State-led actions (7 recommendations)**

For each of the five groups, we will discuss:

- Why the EAC felt the topic was relevant to safeguarding against under-service and/or patient selection
- What actions, policies, or contractual terms the EAC believes are likely to reduce the risk of under-service and/or patient selection
- Open questions, alternative approaches, and different points of view articulated during the EAC's deliberations

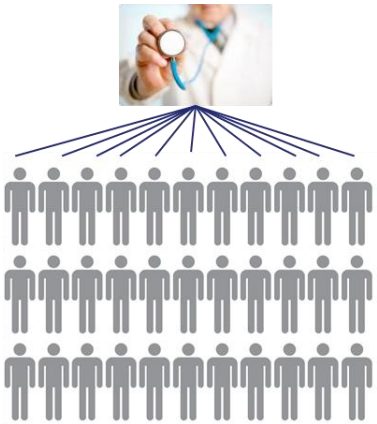
* One of the 28 recommendations that appears in the report was not agreed upon by a consensus of the EAC; it is included at this stage in order to inform readers about the underlying idea and the variety of perspectives about its merits that EAC members expressed

** We use the term payer in this document to refer to both self-insured and fully-insured health plans

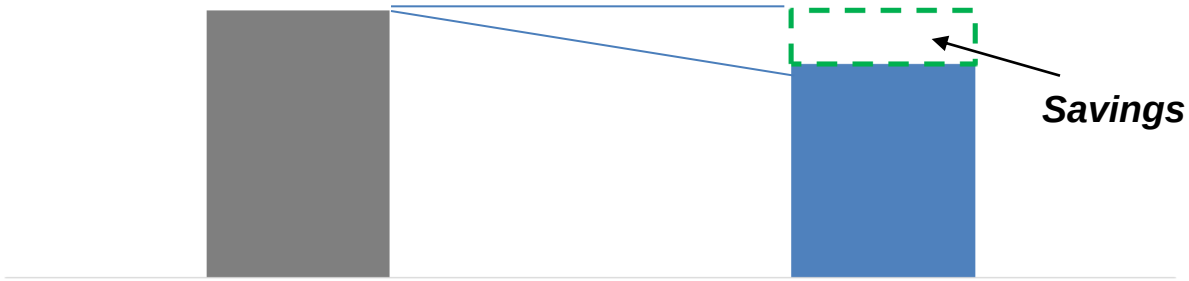
EAC Recommendations: Design Features Background

How Shared Savings Are Calculated

Illustrative

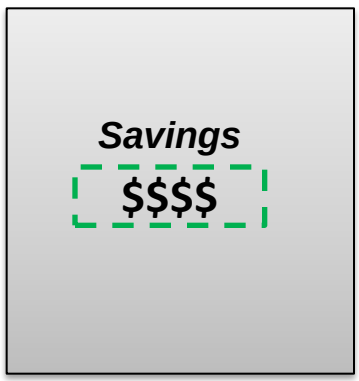


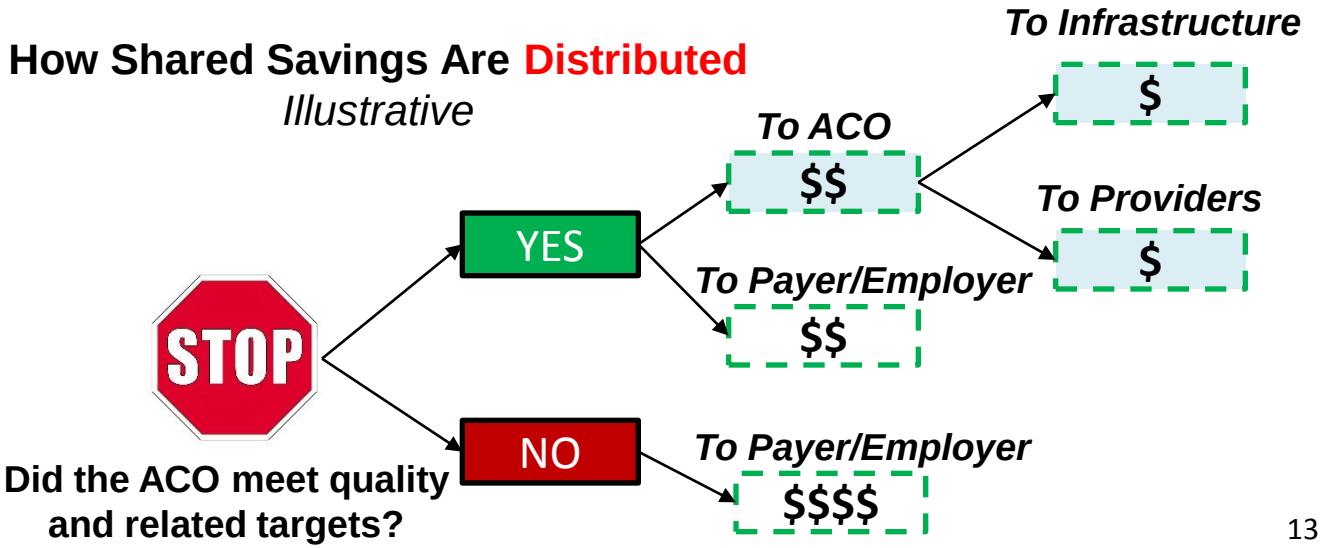
Population attributed to an ACO through its participating providers



How Shared Savings Are Distributed

Illustrative





EAC Recommendations: Patient Attribution

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

Why it Matters

- The method that a payer uses to attribute patients to a provider impacts the risk of patient selection that could occur as a byproduct of shared savings contracts.
- Prospective attribution can make it less practical and economically beneficial for a provider to discontinue patients who are "harder" to manage.
- Patient attribution methodology may also affect patients' access, or perceived access, to providers.

Recommendations in Brief

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.

1.2: Patient Notification. Patients should be made aware, using accessible media, when they are attributed to a physician who is participating in a shared savings program.

1.3: Timing of Attribution. Attributing patients prospectively (at the beginning of a performance period, using historical data; rather than after the fact) promotes provider and patient awareness and effective care management. It also provides a degree of protection against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment.

EAC Recommendations: Cost Target Calculation

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

Why it Matters

- The nature of the targets for managing ACOs' patients' cost of care will affect providers' ability and incentive to stint on care or avoid certain patients.
- If ACOs face attainable cost targets, they won't feel undue pressure to withhold medically appropriate services or otherwise "cut corners."
- If ACOs are adequately paid to care for socioeconomically complex or high-risk patients, they won't attempt to avoid those patients.

Recommendations in Brief

2.1: Rewarding Improvement. Rewarding ACOs for improving cost performance, rather than for hitting an absolute benchmark, will reduce pressure on historically lower performers.

2.2: Adjustment for Unpredicted Systemic Costs. An end of year assessment should be conducted to consider adjusting cost benchmarks for systemic unpredicted factors (e.g. the advent of new treatments, severe flu season).

2.3: Supplemental Payments for Complex Patients. Given how difficult it remains to reflect socioeconomic and other non-clinical factors in risk adjustment methods, payers should consider other ways to incent ACOs to care for the most vulnerable individuals.

2.4: Retrospective Assessment for Risk Adjustment. In the longer-term, populations for which risk adjustment methodologies are not leading to improvements in equity and access should be identified, and methods should be adjusted accordingly using clinical or non-clinical factors.

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.

EAC Recommendations: Incentive Payment Calculation and Distribution

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

Why it Matters

- Preventing the actors in the healthcare system – ACOs, provider groups, individual providers, payers – from actually receiving any share of improperly generated savings is arguably the strongest safeguard available against under-service and patient selection.
- Providing multiple, incremental incentives rather than "all or nothing" incentives reduces the likelihood of excessive, inappropriate responses to new payment models.

Recommendations in Brief

3.1: Eligibility Thresholds. ACOs should only share in savings if they meet quality thresholds and are not found to have engaged in under-service or patient selection.

3.2: Discrete Quality Payments. Rewarding quality improvement, irrespective of whether savings are achieved, will counter-balance any incentive to inappropriately reduce costs.

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 (i.e. threshold, target, stretch).

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 if an ACO consistently achieves savings.

3.5: Reinvestment of Non-Retained Savings. When an ACO demonstrates cost savings, but is found to have stinted on care or inappropriately discontinued patients, the savings should be reinvested in the community's delivery system. ***[The EAC did not reach consensus on this]***

3.6: Advance Payments. Providing ACOs with up-front funds for infrastructure will allow them to invest in the resources required to effectively manage care for defined populations.

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 for the portion of savings they individually generate.

EAC Recommendations: Provider / Payer-Led Supplemental Safeguards

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

Why it Matters

- ACOs are well-positioned to enforce cultural and procedural norms that deter under-service and patient selection; they should be expected to do so.
- For payers to identify instances in which shared savings should be withheld and corrective action implemented, meaningful monitoring will need to take place.
- For the State to understand the impact of payment reform, relevant and appropriate results should be made public by the organizations involved.

Recommendations in Brief

4.1: ACO Internal Monitoring. ACOs should establish performance standards, monitor for inappropriate practices, and hold member groups and providers accountable.

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).

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.

4.6: Accountability: Corrective Action. When a payer determines that an ACO or its member provider(s) have engaged in under-service and/or patient selection, it should provide for appeal, validate the findings, and require the ACO to complete a corrective action plan (CAP).

4.8: Accountability: Public Reporting. ACOs, payers, and State agencies involved in shared savings contracts should publicly report information that allows for the effect of these contracts to be evaluated using an array of relevant data points.

4.9: Peer Reporting. The State should ensure that adequate whistle-blower protections are in place for employees or contractors of an ACO who report under-service or patient selection

EAC Recommendations: Independent / State-Led Supplemental Safeguards

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

Why it Matters

- Given ACOs' and payers' institutional economic incentives under shared savings arrangements, the state has a role to play in monitoring and providing for independent evaluation of the effects of payment reform.
- Consumers and providers need concrete, consistent, and accessible information about how healthcare financing is changing and what it may mean for them; and they need a one-stop clearinghouse to report and obtain information about the potential for inappropriate responses to new financial incentives.

Recommendations in Brief

4.4: Concurrent Monitoring: Nurse Consultant. A nurse consultant or ombudsman should play a key role as a one-stop source of information related to under-service and patient selection.

4.5: Mystery Shopping. Mystery shopping programs should be designed and implemented to detect potential patient selection activity amongst ACO participants.

4.7: Retrospective Monitoring: Long-Term Analysis. An independent party should conduct a retrospective, multi-payer evaluation of how value-based payment is affecting service delivery.

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.

5.2: Consumer Communications: Accessibility and Consistency. The type of information described in 5.1 should be communicated via a set of accessible, consistent messages.

5.3: Consumer Communications: Content Development. A work group should be convened to advise state agencies and payers on the content and media to be used for core messages.

5.4: Provider Communications. Providers should be informed about the nature of shared savings contracts, their objectives, and the financial incentives that they contain.

Supplemental Safeguards: Summary of Proposed Roles

Topics

Payment Design Features

1. Patient attribution
2. Cost target calculation
3. Incentive payment calculation and distribution

Supplemental Safeguards

4. Provider- and payer-led actions
5. Independent / State-led actions

A Layered Approach to Rules, Monitoring, and Accountability

Payers

- Establish rules in contracts with ACOs
- Use claims data analysis, audits to monitor for compliance
- Rely on contract provisions for enforcement

ACOs

- Establish rules for participating groups or individual providers
- Embed robust performance management and care variations analysis in ACO governance

Provider Groups

MDs, PC

- Utilize peer review process to identify and correct any aberrant practices
- Structure individual provider compensation in a way that rewards clinical excellence and patient satisfaction

Providers

- Subject to ACO and group policies
- Subject to existing standards for the practice of medicine

State

- Plays a role in overseeing some of these activities
- Plays an additional role in initiating independent analysis
- Conducts or organizes a complementary set of concurrent monitoring activities

Questions?

Conflict of Interest Safeguards

Conflict of Interest Policy Provisions

- CMMI requires an advisory process that includes all the multiple stakeholder groups impacted by SIM
- It is in the best interest of the state and its citizens to include all of the stakeholder groups…it results in better program design and an investment in the program's success
- SIM governance structure is our primary means of providing for stakeholder involvement
- SIM governance structure includes Steering Committee, Consumer Advisory Board and the various work groups

Conflict of Interest Policy Provisions

- Under the State Code of Ethics
  - a member of an Advisory Board is someone who….has no authority to expend any public funds or to exercise the power of the state
  - members of an advisory board are not public officials and are not subject to the State Code of Ethics and associated conflict of interest provisions
- However, it is in the interests of transparency, fairness and full participation that the SIM adopt a set of standards to avoid substantial conflicts of interest consistent with Section 1-85 of the State Code of Ethics

Conflict of Interest Policy Provisions

- SIM governance is solely advisory
- SIM governance will not have a direct role in managing resources, financing initiatives or making funding award decisions
- Grant funds will be expended through procurements undertaken by the PMO or state agencies, not by the Steering Committee or other advisory bodies
- Anybody who participates in a procurement will be held to additional provisions of the State Code of Ethics

Conflict of Interest Policy Provisions

- SIM governance may provide advice regarding resource allocation or program design decisions
  - Participants have a duty to disclose actual, perceived or potential financial interest
  - Chairs will invite discussion and make a determination as to whether recusal is required
  - May be a conflict if individual or organization may directly benefit
  - Not a conflict if the benefit is no greater than that of the member's or the member's organization's profession, occupation or group

    (e.g., a physician is discussing medical home standards that would apply to anyone seeking medical home recognition, not just that physician or her practice)

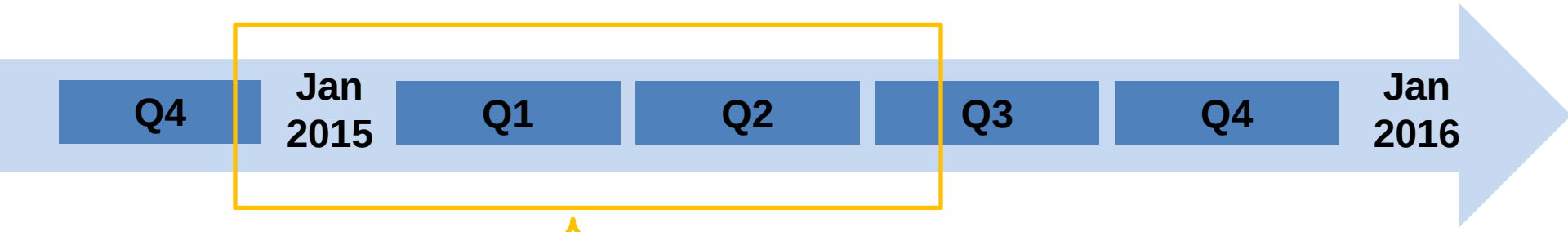
Conflict of Interest Policy Provisions

- Additional safeguards regarding program design:
  - Deliberations are public
  - Meeting materials and summaries are published on the SIM website

Adjourn

Appendix
Equity and Access

EAC Roadmap: Phase I Timeline



EAC Roadmap for 2015 Q1

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
EAC Meetings	12/18	1/22	2/5 2/26	3/12 3/26	4/9 4/23	5/7 5/28	6/18	
Key Activities	**EAC "Reboot": Adopt roadmap, approach, schedule, priorities**	**Research, evidence review**	**EAC articulation of options and preferences** **Design groups for identified safeguards**		**Draft & edit report**	**Report review by HISC** **Report review by MAPOC**		
	Public input							

From December through June, the **full EAC** and the **EAC Executive Team each convened 11 times**.

EAC Process for Developing Recommendations

From January through April, the EAC held **nine design group workshops** via conference call/webex, in which a total of **16 EAC members** and **15 non-members** participated.

Design Group	Solution Areas
1	(1A) Patient attribution (1B) Cost target calculation (cost benchmarks & risk adjustment)
2	(1C) Incentive payment calculation (1D) distribution
3	(2A) Rules (2B) Communication (2C) Accountability
4	(2D) Retrospective detection (2E) Concurrent detection

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

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*	**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

EAC Membership as of 7/7/15

Ellen Andrews, PhD (Executive Team) *CT Health Policy Project*	Margaret Hynes, PhD *Department of Public Health*
Linda Barry, MD (Executive Team) *UConn Health Center*	Gaye Hyre *ArtBra New Haven*
Johanna Bell *Cigna*	Roy Lee *Consumer/Advocate*
Maritza Bond *Eastern AHEC*	Kate McEvoy, JD (Executive Team) *Department of Social Services*
Peter Bowers, MD (Executive Team) *Anthem Blue Cross Blue Shield*	Robert Russo, Jr., MD *Robert D. Russo MD & Associates Radiology*
Darcey Cobbs-Lomax *Project Access*	Donald Stangler, MD *UnitedHealthcare*
Arnold DoRosario, MD *Northeast Medical Group*	Victoria Veltri, JD, LLM (Executive Team) *Burgdorf Health Center*
Alice Ferguson – Ex Officio *Consumer Advisory Board*	Keith vom Eigen, MD *Burgdorf Health Center*
Renee Gary *Windsor, CT*	Robert Willig, MD *Aetna*
Kristen Hatcher, JD *Connecticut Legal Services*	Katherine Yacavone *Southwest Community Health Center, Inc.*

Features of Shared Savings Arrangements

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

1C. Payment Calculation
Amount of savings and other performance bonuses for which the ACO is eligible based on contract with the payer

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

Value-based payment

- Broadly aligned around the Medicare SSP
- Responsible for overall cost of care for their patients
- Rewarded with a share of any savings *if they meet quality and care experience targets*
- Goal is to create a practice culture that is organized around increasing value

$$\text{Value} = \frac{\text{Quality + Care Experience}}{\text{Cost}}$$

Shared Savings Program

- Project how much it should cost for provider to serve their patients for one year
- Similar to establishing an annual budget--actually a *virtual* budget, because provider *continues to be paid fee-for-service*
- Projected budget higher for consumers with chronic illnesses
- This is called risk adjustment

Shared Savings Program

- Although the provider is paid fee-for-service, the costs for their panel of patients are tracked relative to the projected budget
- Budget includes all costs of care including hospitalizations, lab/diagnostic imaging, and specialty care.
- Provider earns a share of the savings if the overall costs for their panel of patients for the year are less than was projected by the payer.

Shared Savings Program

- In some arrangements, providers returns funds if their costs exceed the projected budget. This is called a risk arrangement
- Providers will typically try to achieve savings by providing high quality care and more efficient care
- For example, if they improve their ability to quickly find the right diagnoses for a patient, and to provide the right care the first time so as to avoid hospitalizations
- However, they may also achieve savings by eliminating wasteful and duplicative services

Over- service

- Fee for service programs reward volume of services, even if those services are unnecessary or ineffective
- Sometimes these unnecessary services are costly or inconvenient or even harmful
- Most payers look at their claims data to identify providers who provide more services than are necessary
- They have program integrity or audit divisions that look for over-service

Under-service

- Shared savings programs create an incentive to provide only those services that are necessary and effective
- However, there are concerns that they might also create incentives to provide *fewer* necessary services
- This concern about under-service is the primary reason that this Council was established

Over- and Under-service

- Setting quality targets reduces the risk of under-service for target conditions
- However, they may not reduce the risk of under-service in the treatment of other conditions
- It could also lead to avoiding patients who are going to be harder than usual to treat…this is called “patient selection”