

CONNECTICUT  
HEALTHCARE  
INNOVATION PLAN



# Equity and Access Council Meeting

January 22<sup>nd</sup>, 2015

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Interview Themes	15 min
5. The EAC's Role	15 min
6. Rationale for Safeguards as Part of Payment Reform	20 min
7. A Design Framework for the EAC's Recommendations	50 min

**Appendix: Supplemental Material for Reference**

# Minutes

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- For approval at today's meeting, we have previously distributed minutes of the following meetings:
  - September 18, 2014
  - November 13, 2014
  - December 18, 2014

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# Interview Themes

*From 12/30/14 to 1/20/15 Chartis held individual conversations with individual Council members.*

*We were able to meet in person or by phone with 15 of 20 Council members to discuss the following topics:*

## **SIM Equity and Access Council Member Interview Topics**

- EAC context and purpose
- Individual perspectives and background that provide insight into the topics the EAC is addressing
- Healthcare equity and access in CT – today and under SIM reforms
- Potential solutions to equity and access challenges
- Expectations for EAC work product
- Process for conducting the EAC's work
- Ways to maximize members' ability to contribute to the EAC's work

# EAC Member Interview Themes (1 of 4)

## Theme

## Sample Comments (Paraphrased)

***1. It is critical that the EAC's charge, scope, and roadmap for completing its work be clearly articulated***

- The EAC can be a valuable forum, but its **focus needs to be made clear**
- The EAC's **charge is clear**, but it's not completely clear **how its recommendations will be implemented**
- EAC members need to understand what **other SIM councils** are working on
- Is SIM **prescribing solutions** or offering a **menu of options**?
- Not sure where the EAC is heading; we **need a roadmap** or work plan that lays out the steps
- Ensure that we get beyond procedural questions and **focus on the substance** of the issues at hand
- After the January 22 meeting and the one-on-one interview, **things are now clearer**

# EAC Member Interview Themes (2 of 4)

## Theme

## Sample Comments (Paraphrased)

*2. Actively participating in the EAC can be challenging for some members – for reasons of logistics and/or perceived lack of knowledge on the topics*

- **Disparity in level of knowledge** (actual or perceived) within the EAC makes it challenging to have an inclusive dialogue
- **Stronger meeting facilitation** will ensure everyone has a chance to speak and to keep discussions focused on the topic at hand
- Ensure that discussions are brought to closure and agreements documented so that the group **keeps moving forward**
- **More background information** in the form of read-ahead documents would be helpful
- Provide an **opportunity for members to ask questions** about the meeting topics in advance of meetings
- More work could be done via **remote (i.e. online) meetings** rather than in person
- Pre-reads have been getting better; would still like **more time to prepare**

# EAC Member Interview Themes (3 of 4)

## Theme

## Sample Comments (Paraphrased)

***3. Introduction of value-based payment methods has the potential to mitigate some of the core challenges that underserved populations face in the current fee-for-service system; however, it won't solve all of today's challenges, and a range of views exist about whether it is likely to generate new ones***

- Fee-for-service is clearly not the future; **we need a new payment method**, for commercial populations and for lower-income populations
- Financial incentives that reward truly **whole-patient-centered care** will create real benefits for currently underserved populations
- Shared savings programs have **potential to improve care for populations like Medicaid** where care for patients with chronic conditions is historically fragmented and often duplicative
- Shared savings programs **don't make sense for payer populations like Medicaid** where over-referral isn't a problem;
- Cherry-picking patients is not a substantial risk because payers structure payment incentives to explicitly **reward providers for taking on the most difficult patients**
- Cherry-picking patients is a risk because **providers always know more than payers** about a patient's true condition
- The system won't work if providers are held accountable for outcomes but **patients don't have any financial incentives**
- We won't know if safeguards work until we **test them**

# EAC Member Interview Themes (4 of 4)

## Theme

## Sample Comments (Paraphrased)

***4. A range of other issues, in addition to those explicitly assigned to the EAC, pose challenges for equity and access in Connecticut's historical and future healthcare landscape***

- Adequacy of provider networks has to be a concern for SIM; how do we measure **availability of different services in different regions** over time, and how do we use SIM to improve it?
- We need to look at the impact on poorly served populations of **over-service** in addition to under-service
- How will we isolate and **measure the impact of SIM reforms** from the impact of other factors driving changes in healthcare?
- **Medicaid reimbursement rates** remain a major obstacle to access to certain services, especially specialty care
- How do the **uninsured** fit into the proposed reforms?
- We need **additional players at the table** (e.g. drug companies, malpractice insurers) in order to address core problems of cost and access that consumers face
- Concern that the SIM initiative does not have sufficient resources to create **community health infrastructure** required to materially improve access for low-income populations
- **Alignment of state agency activity** around data standardization, planning coordination, and communication should be an element of SIM

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# SIM Goals, Initiatives, and Implementation Activities

The SIM vision will be carried out in the model test phase through seven identified initiatives, supported by a defined governance structure, a program management office, and a set of responsible state agencies.

## *What we will achieve together*



## *What we are doing in pursuit of our goals*



## *How we are organizing to implement the plan*

### Vision Articulated in CT State Healthcare Innovation Plan

Establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs

### Initiatives to Be Completed in SIM Model Test phase

#### *Statewide Initiatives*

- |   |  |
|---|--|
| 1 | Plan for Improving Population Health   |
| 2 | Value Based Payment & Insurance Design |
| 3 | Quality Measure Alignment              |
| 4 | Health Information Technology          |
| 5 | Workforce Development                  |

#### *Targeted Initiatives*

- |   |                             |
|---|-----------------------------|
| 6 | Medicaid QISSP              |
| 7 | Primary Care Transformation |

### SIM Implementation Activities & Structure

- |   |   |
|---|---|
| 1 | Participatory Governance Structure                          |
| 2 | Program Management Office                                   |
| 3 | State Entity Activity for Areas of Statutory Responsibility |

# SIM Governance Structure

Five work groups (councils) as defined below will be overseen by the Program Management Office (PMO) and issue recommendations for consideration by the Healthcare Innovation Steering Committee (HISC).

SIM Implementation Activities & Structure	
1	Participatory Governance Structure
2	Program Management Office
3	State Entity Activity for Areas of Statutory Responsibility



# EAC Roadmap: Phases of Work

## EAC Charter *What we will accomplish*

The EAC charter splits its task into two phases

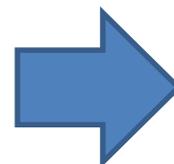
	Phase I	Phase II
<b>Scope</b>	<i>Focused</i>	<i>Broad</i>
<b>Summary of Desired Outcomes</b>	Issue recommendations for preventing, detecting, and responding to <b>under-service and patient selection</b>	Issue other recommendations that address <b>gaps or disparities in healthcare access</b> – those that currently exist and could be reduced through the SIM, or those that could arise as a byproduct of SIM reforms
<b>Described in Charter as ...</b>	<i>Required</i>	<i>Optional</i>
<b>Key Language in Charter</b>	“... what is the Council’s recommended approach for Connecticut’s public and private payers to monitor for and respond to under-service ... and patient selection?”	“1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services? 2. Care variations and standardization, evidence-based standards?”

*Today’s focus*

# EAC Roadmap: Phases of Work

## *SIM Vision*

Healthcare system of today



More whole-person-centered, higher-quality, more affordable, more equitable healthcare

## *SIM Initiatives*

1

**Payment reform:**  
FFS → Value  
All-payer alignment

2

**Other SIM initiatives**

## *EAC Function / Phase of Work*

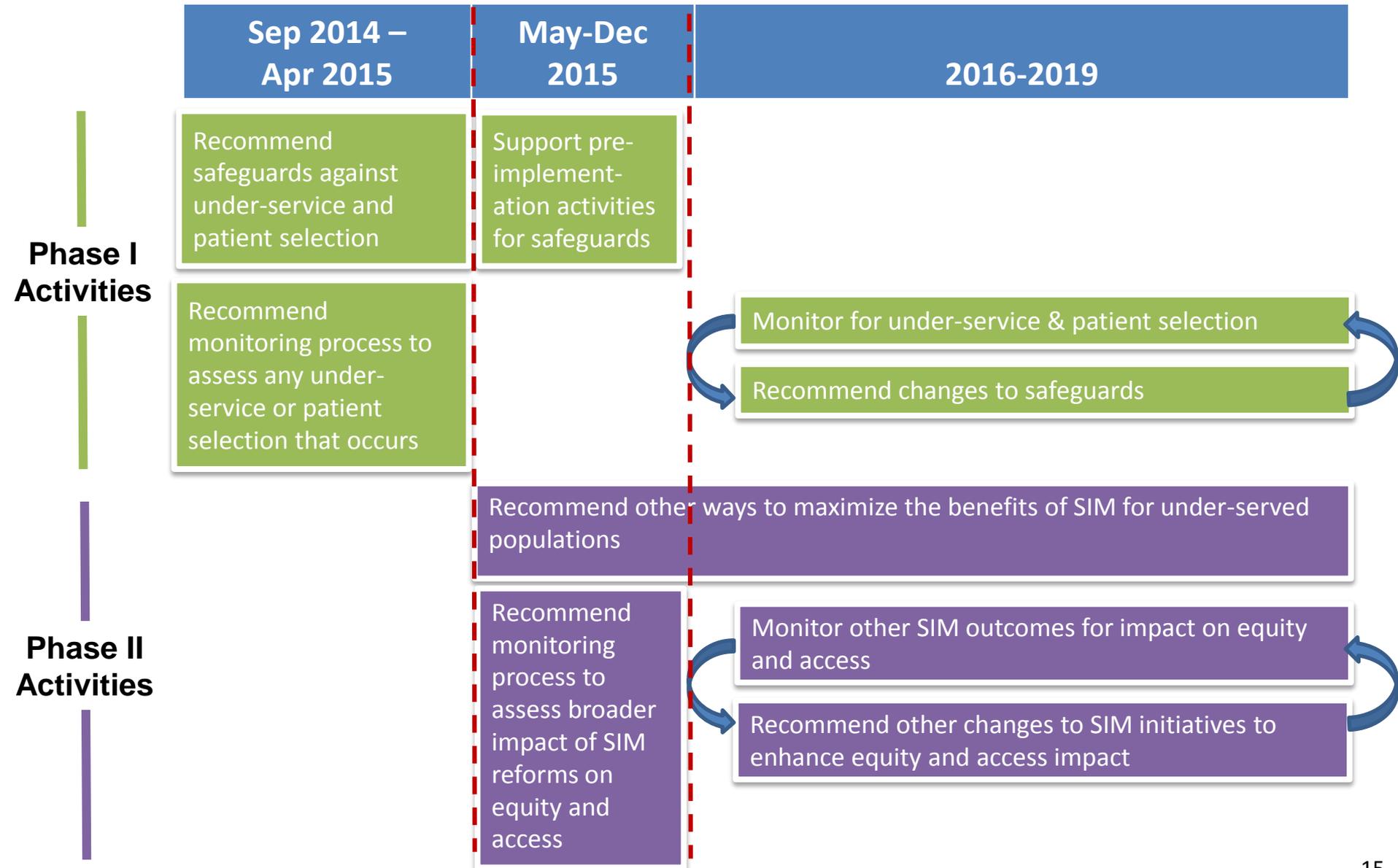
1

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

2

Issue other recommendations that address **gaps or disparities in healthcare access or outcomes** that can be impacted through SIM

# The EAC's Role Over Time



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# Defining the Rationale for Establishing Safeguards

It is important for the EAC to articulate the rationale for establishing the type of safeguards it envisions – from the standpoint of multiple affected stakeholders

- The EAC's charter calls for it to issue recommendations for preventing, detecting, and responding to **under-service and patient selection**
- Collectively, we refer to the methods that achieve this objective as **"safeguards"**

**What is the rationale or "business case" for implementing these safeguards?**

From the perspective of a ...



**Consumer**



**Provider**



**Payer**

# 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 DRAFT – For Discussion
 <b>Consumer</b>	<ul style="list-style-type: none"><li>• Ensure access to appropriate services and providers</li><li>• Ensure access to information about available, appropriate interventions</li></ul>
 <b>Provider</b>	<ul style="list-style-type: none"><li>• Align reimbursement/contracting rules with medical ethics and mission to provide the best patient care</li><li>• Create a level playing field (i.e. no incentives to cheat)</li><li>• Establish clarity about what behaviors are and are not prohibited</li><li>• Create market advantage – ACOs that create effective mechanisms to ensure appropriate care, and deliver access to the right services, will win patients</li></ul>
 <b>Payer</b>	<ul style="list-style-type: none"><li>• Align with mission to act in consumers' interest, improve health</li><li>• Comply with applicable laws that prohibit certain activities</li><li>• Incent providers to take on the most challenging, most expensive patients</li><li>• Prevent patients from slipping through cracks in the care delivery system, which would increase costs over time</li><li>• 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</li></ul>

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# What CT Will Do to Create Safeguards

*What is the process through which Connecticut will prevent under-service and patient selection as byproducts of payment reform?*

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

# 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*

# 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**



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

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

## **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**

# Elements of Incentive Design: Payment Design Features

## 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



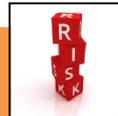
### **1B. Cost Calculation - Benchmark**

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



# Elements of Incentive Design: Payment Design Features



## 1. Payment Design Features

Safeguard Type		Description	Hypothesis
<b>A</b>	<i>Attribution of patients</i>	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>B</b>	<i>Cost target calculation (cost benchmarks &amp; risk adjustments)</i>	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
<b>C</b>	<i>Provider payment calculation</i>	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 lead providers to provide the right care, minimizing the risk that medically appropriate services will be withheld
<b>D</b>	<i>Payment Distribution</i>	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

# Elements of Incentive Design: Supplemental Safeguards



## 2. Supplemental Safeguards

Safeguard Type		Description	Hypothesis
<b>A</b>	<i>Rules</i>	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>B</b>	<i>Communication</i>	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.
<b>C</b>	<i>Enforcement</i>	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
<b>D</b>	<i>Detection: retrospective</i>	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
<b>E</b>	<i>Detection: concurrent</i>	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

# Elements of Incentive Design: Structure of Work

For the purpose of further research, evaluation, and solution design, we proposed organizing safeguard types into four clusters or “design groups.”

Design Group	Topics	Principal Questions to Answer:
1A-B	Attribution & cost target calculation (cost benchmarks & risk adjustments)	How to prevent patient selection
1C-D	Incentive payment calculation & distribution	How to balance incentives to promote medically appropriate, efficient, patient-centric care decisions
2A-B-C	Rules, communication, enforcement	How to set appropriate rules, communicate them, and enforce them
2D-E	Retrospective & concurrent detection	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

# Elements of Incentive Design: Structure of Work

For the purpose of further research, evaluation, and solution design, we proposed organizing safeguard types into four clusters or “design groups.”

Design Group	Topics
1A-B	Attribution & cost target calculation (cost benchmarks & risk adjustments)
1C-D	Incentive payment calculation & distribution
2A-B-C	Rules, communication, enforcement
2D-E	Retrospective & concurrent detection

## For each cluster of topics or “design group”:

- Solicit EAC members 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

# Elements of Incentive Design: Structure of Work

We propose to organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April			
		Week of:				Week of:				Week of:					Week of:			
		5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27
<b>3. Equity and Access Council (EAC)</b>																		
1	Healthcare Innovation Steering Committee (HISC)	8				5					12					9		
2	Equity and Access Council Meetings			22		5			26		12		26		9		23	
4	1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2									
5	1C-D: Performance-based payment calculation & distribution					M1		M1			R1	M2	R2					
6	2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
7	2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

- M1** Design milestone/workshop 1      **R1** EAC initial review/input
- M2** Design milestone/workshop 2      **R2** EAC final review/input



**Report containing  
Phase I  
recommendations**



# Incentive Design: Payment Design Features

## 1A. Patient Attribution



Method used to assign a patient to a provider in a shared savings model

### Design Options/Considerations

### Who Uses the Method (e.g.)?

- |  |   |
|--|---|
| <p><b>1 Retrospective assignment</b> of patients to a provider based on which provider a patient has most frequently sought out primary care from over a pre-determined timeframe (e.g. MSSP is the performance year).</p> | <ul style="list-style-type: none"> <li>• MSSP</li> <li>• BCBS of Illinois (Commercial)</li> <li>• HealthPartners (MN, applies to Medicaid)</li> </ul> |
| <p><b>2 Patient selects PCP</b> (i.e. gatekeeper model) when they sign up for insurance.</p>   | <ul style="list-style-type: none"> <li>• BCBS Alternative Quality Contract (Commercial HMO and POS)</li> </ul>  |
| <p><b>3 Prospective assignment</b> of patients to provider at outset of program.</p>   | <ul style="list-style-type: none"> <li>• Harvard Pilgrim (Commercial)</li> </ul>  |
| <p><b>4 Population-based</b> – assign patients based on geography.</p>   | <ul style="list-style-type: none"> <li>• New Jersey Medicaid</li> </ul>   |
| <p><b>5 Type of provider</b> eligible to have patient assigned to them (e.g.; only PCP, specialist, ED, etc.).</p>   | <ul style="list-style-type: none"> <li>• PCP or specialist (MSSP)</li> <li>• ED (New Jersey Medicaid)</li> </ul>                                      |



# Incentive Design: Payment Design Features

## 1B. Cost Calculation (cost benchmark)



Future cost estimation (i.e. budget) for population of patients attributed to shared savings program, from which shared savings calculations are determined

### Design Options/Considerations

### Who Uses the Method (e.g.)?

<p><b>1 Budget</b> – uses past patient experiences of shared savings population to project future expenses.</p>	<ul style="list-style-type: none"> <li>• Harvard Pilgrim Health</li> </ul>
<p><b>2 Control Group</b> – a group deemed to be similar to the patients in the shared savings program.</p>	<ul style="list-style-type: none"> <li>• BCBS of Illinois-Advocate</li> <li>• Medica and Fairview Health Services</li> </ul>
<p><b>3 Negotiated</b> – Benchmark determined based on either control or budget methodology and then further negotiated by providers.</p>	<ul style="list-style-type: none"> <li>• HealthPartners</li> </ul>

*Within some programs, if a budget cost benchmark is used, there is no additional risk-adjustment due to the belief that the needs of the population will not materially change over time*



# Incentive Design: Payment Design Features



## 1B. Cost Calculation (risk adjustment)

Method used to adjust future shared savings budget projections to account for overall risk of patient population

### Design Options/Considerations

### Who Uses the Method (e.g.)?

#### *Risk Assessment Methodologies*

- |   |   |
|---|---|
| <b>1 CMS Hierarchical Condition Categories (HCC)</b> – takes into consideration diagnoses and certain demographics.   | <ul style="list-style-type: none"> <li>• MSSP</li> </ul>  |
| <b>2 Adjusted Clinical Groups (ACG)</b> case mix system. Proprietary risk adjustment tool developed by Johns Hopkins. | <ul style="list-style-type: none"> <li>• HealthPartners</li> <li>• Medica and Fairview Health Clinics (MN, WI, N/S Dakota)</li> </ul> |
| <b>3 Verisk Health Sightlines DxCG</b> Proprietary risk adjustment tool.  | <ul style="list-style-type: none"> <li>• BCBS of Illinois-Advocate</li> <li>• Harvard Pilgrim Health</li> </ul>                       |

#### *Supplemental Risk Adjustments*

- |   |  |
|---|--|
| <b>4 Cost Outliers</b> – truncate high cost claims to be excluded for shared savings calculations.                                      | <ul style="list-style-type: none"> <li>• Minnesota Medicaid</li> <li>• HealthPartners</li> <li>• Harvard Pilgrim Health</li> </ul> |
| <b>5 Included Services</b> –programs opt to exclude particularly high-cost services (e.g. transplant) from shared savings calculations. | <ul style="list-style-type: none"> <li>• Numerous models</li> </ul>  |
| <b>6 Additional payment for high-risk patient</b> – enhanced FFS or PMPM care management fee.   | <ul style="list-style-type: none"> <li>• Some medical home models</li> </ul>   |



# Incentive Design: Payment Design Features



## 1C. Payment Calculation

Elements of the incentive design formula that determine the amount of savings achieved for a given patient, plus additional performance incentives, that will be eligible as payment to a provider

### Design Options/Considerations

### Who Uses the Method (e.g.)?

**1 Performance Incentives/Thresholds** – amount of savings paid out is dependent on reporting on and/or hitting performance targets.

- MA Medicaid Demonstration
- ME Medicaid Demonstration
- MSSP
- BCBS of Illinois - Advocate

**2 Medical Savings Rate (MSR)**– minimum amount of savings that needs to be achieved to receive a shared savings payment. There can also be a cap on the savings percent that can be distributed as shared savings (e.g. any savings above 6% will not be shared).

- Harvard Pilgrim Health (2%)
- MSSP (2%-3.9%, dependent on size)
- NJ Medicaid (none)

**3 Upside/Downside Risk** – providers share in savings and losses. Many shared savings programs phase in downside risk over time. There is also often a cap on losses for providers who accept downside risk.

- Pioneer ACOs (downside)
- MSSP (two tracks: upside and downside)
- MN Medicaid (phased in downside)



# Incentive Design: Payment Design Features

## 1D. Payment Distribution



The method by which providers share in the savings achieved

### Design Options/Considerations

### Who Uses the Method (e.g.)?

**1** **Relative distribution** of shared savings between payer and providers.

- Various methods used

**2** **Allocation of provider shared savings** within the organization and to individual providers.

- Various methods used



# Incentive Design: Supplemental Safeguards



## 2A. Rules

Rules for who can participate in a value-based contract and what activity is allowed and prohibited

### Design Options/Considerations

- 1 Eligibility Criteria: ACOs** – what criteria should a provider organization have to meet to participate in value-based contracts? For example:
  - Minimum number of attributed lives
  - Minimum services offered
  - Accreditation (e.g. NCQA/URAC)
  - Adoption of policies or internal monitoring mechanisms
  - Reporting
- 2 Eligibility Criteria: Individual Providers** – are there any criteria beyond licensure that providers should be required to meet in order to participate in value-based contracts?
- 3 Definition of under-service and patient selection** – what language and/or metrics will be used to formally define under-service and patient selection for purposes of enforcement? Who should “own” this definition?



# Incentive Design: Supplemental Safeguards

## 2B. Communications



Methods of informing consumers and providers about the definition and consequences of prohibited activities, and how to report suspected violations

### Design Options/Considerations

- 1 Consumer Communication** – what are the key messages that should be communicated to consumers about value-based payment models and the indicators of potential under-service or patient selection? How should the messages be conveyed? For example:
  - Publications
  - Workshops
  - Partnerships with community-based organizations / trusted sources of information
- 2 Provider Communication** – what should be communicated to provider groups and individual providers about under-service and patient selection? Through what media?



# Incentive Design: Supplemental Safeguards

## 2C. Enforcement



Consequences for violating rules and methods of enforcing those consequences

### Design Options/Considerations

- 1 **Consequences**— what consequences are appropriate for different types of prohibited activity?
  - Provider disqualification from shared savings payment
  - Provider disqualification from other performance incentive payments
  - ACO disqualification from value-based contracts
  - Licensure review
  
- 2 **Enforcement Methods** – what method should be used to reach findings in instances of suspected prohibited activity? Who should be responsible for conducting each enforcement activity?
  - Payers
  - ACOs
  - CID
  - DPH
  - Other?



# Incentive Design: Supplemental Safeguards



## 2D. Retrospective Detection

Methods of detecting under-service and patient selection by observing it using data produced after a period of performance is over

### Design Options/Considerations

- 1 Claims Data** – how can claims data be used to assess underservice/patient-selection?
  - Assess care provided against standard of care for specific diagnoses (e.g. CHNCT)
  - Identify potential performance metrics to include those that signify under-service/patient selection (e.g. overutilization of ED/hospital, specific measures for “at-risk” populations, etc.)
- 2 Clinical Data** – how can clinical data be used to detect underservice/patient-selection?
  - Peer review of clinical data
  - Assessment of care coordination/care management activities
  - Practice variation analyses (e.g. Crystal Run)
  - Audit of program
  - Site visits
- 3 ACO Profile/Performance Data** –how can the ACO be assessed more broadly to detect under-service/patient selection?
  - Comparative analyses between years – pre ACO and post ACO as well as throughout – For example, monitor to see if risk profile of patients attributed has gone down materially
- 4 Other Data** – what other pieces of data could be useful in detecting underservice/patient selection?
  - Patient experience metrics that speak to receiving appropriate care (e.g. HCAHPs question regarding access to specialists)



# Incentive Design: Supplemental Safeguards



## 2E. Concurrent Detection

Methods of detecting under-service and patient selection in real-time or near-real-time

### Design Options/Considerations

- 1 Ombudsman** – As described in the CT SIM test grant budget, a “nurse consultant” will be hired into OHA to handle disputes or complaints related to under-service or patient selection. This function will be similar to that of the nurse consultant hired under the dual eligibles initiative, but will work across payers. Procedures will need to be established for consumers and providers to report cases to and work with the ombudsman to address/look into complaints.
- 2 Mystery Shopper**– Utilizing existing State of CT and national programs as a guide, CT could establish a program in which state employees, posing as patients, test their ability to access providers participating in ACOs and to obtain medically appropriate care.
- 3 Concurrent Analytics** – CT could explore ways to obtain data in near-real-time about ACO performance and care provision, in order to accelerate the evaluation process from what might otherwise take place under a purely retrospective analysis
- 4 Other** – Are there other ways in which under-service and patient selection could be identified in as close to real-time as possible?

# Elements of Incentive Design: Structure of Work

We propose to organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY		January				February				March					April			
		Week of:				Week of:				Week of:					Week of:			
		5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27
<b>3. Equity and Access Council (EAC)</b>																		
1	Healthcare Innovation Steering Committee (HISC)	8				5					12					9		
2	Equity and Access Council Meetings			22		5			26		12		26			9		23
4	1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2		R2									
5	1C-D: Performance-based payment calculation & distribution					M1		M1			R1	M2	R2					
6	2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
7	2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

- M1** Design milestone/workshop 1      **R1** EAC initial review/input
- M2** Design milestone/workshop 2      **R2** EAC final review/input



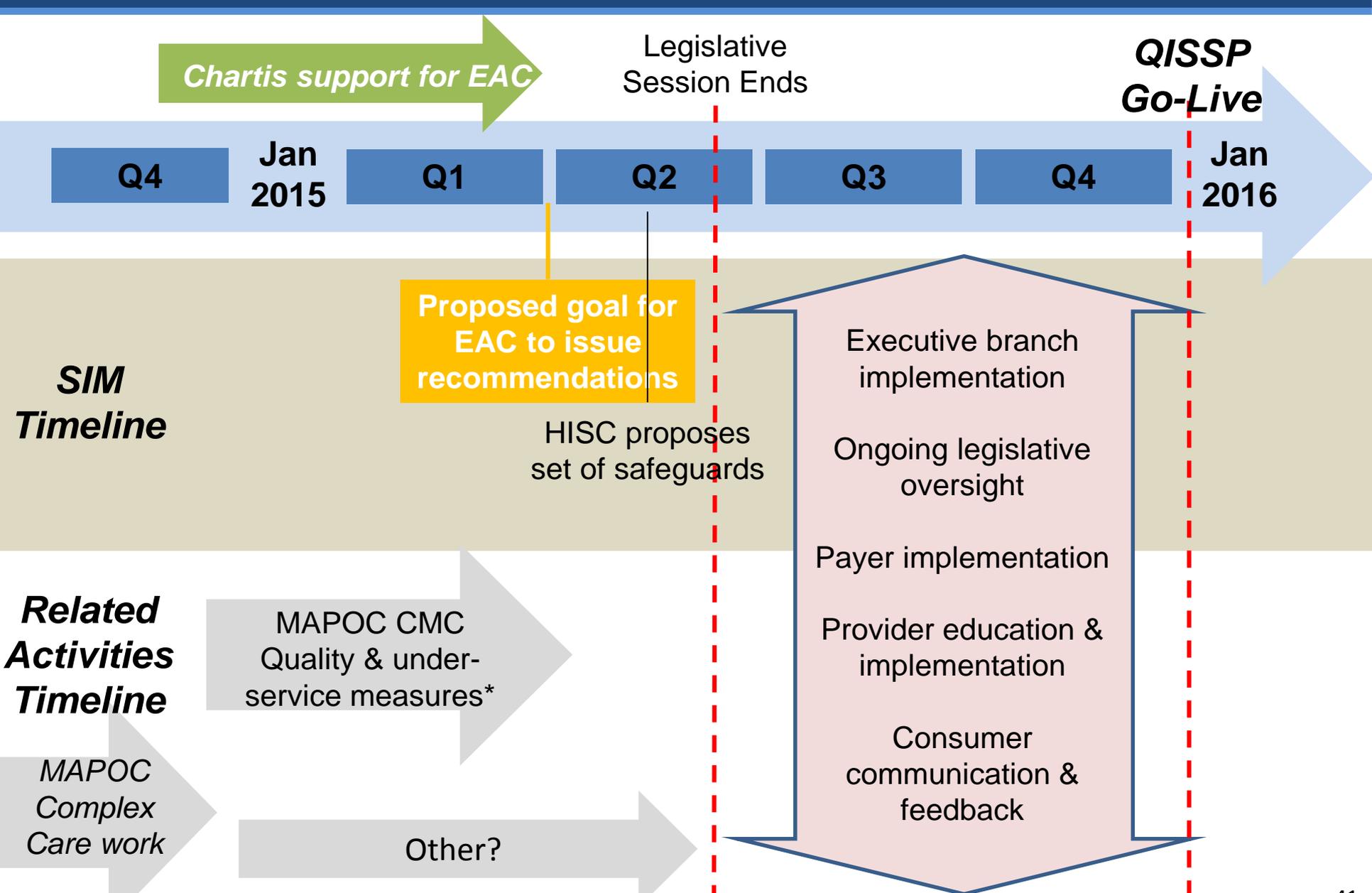
**Report containing  
Phase I  
recommendations**

# Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Interview Themes	15 min
5. The EAC's Role	15 min
6. Rationale for Safeguards as Part of Payment Reform	20 min
7. A Design Framework for the EAC's Recommendations	50 min
Appendix: Supplemental Material for Reference	

# EAC Phase I Roadmap

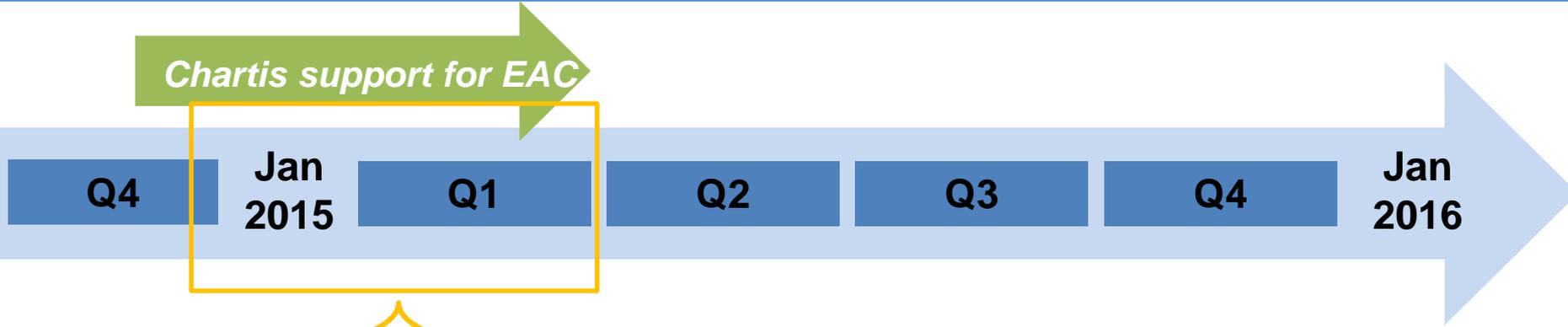
*Draft for discussion*



\*Timeline for completing review and adoption will be decided by MAPOC and DSS 41

# EAC Roadmap: Near-Term Timeline

*Draft for discussion*



## EAC Roadmap for 2015 Q1 Draft Proposal for EAC Discussion

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

# Proposed Meeting Schedule

*Draft for discussion*

Month	EAC	MAPOC CMC	HISC
Jan	Thursday, January 22, 2015		Thursday, January 8
Feb	Thursday, February 5, 2015 Thursday, February 26, 2015	Wednesday, February 11	Thursday, February 5
Mar	Thursday, March 12, 2015 Thursday, March 26, 2015	Wednesday, March 11	Thursday, March 12
Apr	Thursday, April 9, 2015 Thursday, April 23, 2015	Wednesday, April 8	Thursday, April 9
May	Thursday, May 28, 2015		Thursday, May 14
Jun	Thursday, June 25, 2015		Thursday, June 11