**STATE OF CONNECTICUT**
**State Innovation Model**
***Equity and Access Council***
**Meeting Summary**
**Thursday, February 5, 2015**
**6:00-8:00 p.m.**

**Location**: Connecticut State Medical Society (CSMS), 127 Washington Avenue, East Building, 3rd Floor, North Haven, CT.

**Members Present**: Ellen Andrews; Linda Barry; Peter Bowers; Christopher Borgstrom; Arnold DoRosario; Alice Ferguson; Bonita Grubbs; Kristen Hatcher; Margaret Hynes; Gaye Hyre; Robert Russo; Donald Stangler; Keith vom Eigen; Robert Willig; Katherine Yacavone.

**Members Absent**: Maritza Bond; Deborah Hutton; Roy Lee; Kate McEvoy; Victoria Veltri.

**Other Participants**: Mark Schaefer; Katie Sklarsky; Adam Stolz.

## 1. Introductions

Linda Barry chaired the meeting. Council members introduced themselves.

## 2. Public Comment

There was no public comment.

## 3. Minutes

Arnold DoRosario moved to adopt the January minutes as drafted. Katherine Yacavone seconded. The minutes were approved unanimously. Bonita Grubbs abstained.

## 4. Design Groups: Review of Process and Orientation to "EAC Library" Housed on www.healthreform.ct.gov

Katie Sklarsky reviewed the EAC's charge in the greater context of the SIM initiative and explained the premise of the EAC Design Groups established to evaluate potential safeguards.

Ms. Sklarsky discussed the Design Groups' four areas of focus and their work processes. The design groups' conclusions will be summarized and presented to the Council to inform discussion and adoption of recommendations. The Council discussed member participation in the design groups.

Ms. Sklarsky provided the council with an overview of the EAC website. Council meetings and council design groups each have separate sections on the website.

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Additionally an EAC reference library was created as a resource and includes design group material. Peter Bowers suggested the council review https://www.pcpcc.org/. Linda Barry suggested the Chartis team email Council members when a new reference is posted to the EAC reference library; the Council agreed.

**5. Design Group 1: Patient Attribution and Cost Benchmark Calculation – Initial Review:**

Ms. Sklarsky and Adam Stolz of Chartis presented on findings from Design Group 1's first conference call, held on January 30. Ms. Sklarsky reviewed prospective and retrospective patient attribution models for shared savings programs. Dr. DoRosario briefed the group on retrospective attribution from the provider's perspective. Ellen Andrews expressed the concern that retrospective assignment would allow a year for providers to dismiss patients who are perceived to negatively affect their bottom line. Kristin Hatcher asked if a patient could be attributed to a practice rather than just to an individual provider; Ms. Sklarsky replied that they could.

Mr. Stolz led discussion about the results of Design Group 1's workshop. He tested the idea that the group did not find a compelling argument for either prospective or retrospective patient assignment as pertains to likelihood of patient selection or underservice. Dr. Andrews expressed support of prospective patient assignment as a safeguard against cherry picking. Ms. Andrews suggested the Design Group came to a consensus regarding the issue.

Keith vom Eigen presented a different perspective on the issue, citing models in which prospective assignment is akin to a gatekeeper model in which patient choice is restricted. Dr. vom Eigen suggested the group decide if they should focus on effective care management or the free choice of a patient. Dr. vom Eigen also suggested prospective assignment has a greater risk for allowing cherry picking. Dr. DoRosario and Dr. vom Eigen discussed retrospective assignment from the provider perspective. Katherine Yacavone felt the Council should look beyond two choices at a hybrid approach that incorporates where patients actually received care. Mr. Stolz clarified that a patient would not be locked into a provider with either method of assignment.

Gaye Hyre pointed out that as the medical field evolves to include medical homes, primary care centers associated with larger medical entities, and electronic databases, the point about attribution methodology may become moot, since an entire network, rather than a single provider, will be responsible for a patient. Dr. Andrews remarked that attribution is fundamentally about payment. Mr. Stolz clarified that if a patient is attributed to a larger group they may see a social worker or a team of providers and the larger group is responsible for achieving the outcomes.

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The group discussed scenarios that might lead to providers discontinuing their care of a given patient. Kristen Hatcher commented that patient selection and dismissal is a reality. Dr. vom Eigen said that patient dismissal is legally allowed and may happen if a patient misses appointments or fails to comply with physician advice. Dr. DoRosario informed the council that his biggest driving force for patient dismissal is noncompliance. Dr. DoRosario also noted that a patient's type of insurance is often unknown to the provider during treatment, also Kristen Hatcher expressed the importance of knowing the cause of patient noncompliance and addressing those underlying issues. Ms. Hatcher remarked that patients are first asked about their insurance before they are seen. Donald DoRosario clarified that administratively it is essential for a practice to ask patients about their insurance in order to accurately inform them about their financial obligations for services, especially given the growth in narrow or tiered networks.

Dr. Andrews suggested that the system be structured such that providers cannot discontinue patients simply because the provider will not get paid. Donald Stangler reviewed the prospective model used by United Healthcare. Dr. Stangler explained that prospective knowledge of your patient panel promotes successful care management. Peter Bowers explained the insurance company attribution model at the request of Ms. Yacavone. Mr. Stolz summarized that prospective assignment offers benefits for providers and patients.

The group agreed not to use the term "firing" to refer to a provider discontinuing care for a patient, whatever the cause.

The Council discussed how different visit types affect patient attribution. There was discussion about whether urgent care providers could have patients attributed to them, with Mr. Stolz suggesting that this is currently possible if an urgent care center bills as a physician office. There was also discussion about use of EDs for attribution. Ms. Sklarsky noted that this model has been tried for Medicaid populations in order to ensure that patients are attributed even if they do not see a primary care provider.

Alice Ferguson expressed the importance of understanding the reasons patients are discharged from providers; a patient could miss a visit for a number of reasons and is not necessarily non-compliance with care. Ms. Ferguson suggested there be guidelines to find the root cause of a patient's noncompliance. Dr. DoRosario affirmed that a doctor does not dismiss based on insurance. Patient dismissal is a direct result of abuse of staff or noncompliance.

Katie Sklarsky reviewed the role of and cost benchmarking and risk adjustment. Ms. Sklarsky explained the concept of cost outliers and their role in cost calculation. Dr. Schaefer expanded on the subject. Gaye Hyre requested clarity on outliers that would not occur on a yearly basis. Robert Willig explained that even some routine care can qualify as an outlier, such as an expensive knee replacement. Many

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methodologies could be included in one arrangement. Dr. vom Eigen pointed out that every year a population becomes sicker. The insurers could game the system and set the target slightly lower each year. The benefit could look attractive but there would never be enough savings to profit. Dr. Andrews supported the idea of a control group.

Mr. Stolz suggested a method to raise the risk adjustment to ensure people who are risky are still taken on as patients. Peter Bowers reviewed ways that self-funded clients can help manage their cost trends. Dr. Bowers made the point that self-funded clients want to pay their appropriate amount without subsidizing another client whose members may be sicker. Dr. DoRosario reviewed the way providers are being proactive and getting compensated to care for the most complex patients, such as a chronic care management fee and transitional care management fees. Dr. DoRosario pointed out the movement towards prorated payment. Dr. Willig added that one needs to consider the degree of financial risk the provider is taking as compared to the payer. Dr. Andrews noted that the risk adjustment methodologies in use do not inspire confidence based on statistical correlation with actual costs incurred Mr. Stolz noted that though risk adjustment's predictive power have limits, that does not suggest that patients are necessarily under- or over-adjusted in a single direction, and that over a sufficiently large population the risk from random variance should be tolerable. Dr. vom Eigen suggested that there is no perfect model and the incentive should favor providing extra access which would benefit population health as a whole.

Mr. Stolz asked the council for additional topics for Design Group 1 based on the discussion. Dr. Willig requested the group explore a way to enhance payments for high risk patients and look at evidence on prior programs. Dr. vom Eigen suggested the group look at ways to inspire provider participation by decreasing the risk providers will lose money by caring for a sick patient. Dr. DoRosario and Dr. Willig discussed care management fees. Dr. Andrews suggested the group discuss "quality gates." She commented that she liked the idea of excluding outliers – both high and low – from the cost calculation. Ms. Yacavone reviewed the importance of care management for the highest-utilizers. Dr. Schaefer suggested further consideration of how to determine specificity of risk stratification, i.e. is it as simple as two tiers or is a more granular method needed.

**6. Guidelines for Participation of Alternates in Council Meetings**

Dr. Schaefer reviewed the handout on participation guidelines for alternates that were distributed to the council. He thank the Council members for surfacing the issues that the guidelines are intended to address, and provided clarity on the appointment process of council members. Dr. Andrews expressed agreement with the guidelines' provision for identical policies for alternates for all members Ms.

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Hatcher expressed her appreciation for the PMO's rapid turnaround on providing clarifying guidelines.

**7. Design Group 2: Incentive Payment Calculation and Distribution – Preview**

This agenda item was tabled

Linda Barry motioned to adjourn. Peter Bowers seconded the motion.

The meeting adjourned at 8:05pm.

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