

STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council

Meeting Summary
March 12, 2015
6:00-8:00p.m.

Location: Connecticut State Medical Society, 127 Washington Avenue, East Building, 3rd Floor North Haven, CT

Members Present: Linda Barry; Johanna Bell; Maritza Bond; Peter Bowers; Christopher Borgstrom; Arnold DoRosario; Alice Ferguson; Bonita Grubbs; Margaret Hynes; Gaye Hyre; Kate McEvoy; Robert Russo; Victoria Veltri; Keith vom Eigen; Robert Willig; Katherine Yacavone

Members Absent: Ellen Andrews; Kristen Hatcher; Roy Lee; Donald Stangler

Other Participants: March Schaefer; Katie Sklarsky; Adam Stolz; Sheldon Toubman

The meeting was called to order at 6:10pm. Vicki Veltri chaired the meeting.

1. Introductions

Adam Stolz of The Chartis Group facilitated roll call. Council members introduced themselves.

2. Public Comment

There was no public comment.

3. Minutes

Peter Bowers motioned to adopt the February 26th meeting minutes. The motion was seconded by Robert Willig. There were no objections.

Mr. Stolz gave an overview of the meeting objectives, the Equity and Access Council milestones, and the next steps in the recommendation development process.

4. Design Group 1: Patient Attribution and Cost Target Calculation – EAC Consideration of Recommendations for Adoption

Mr. Stolz reviewed the Council meeting materials including a [summary document](#) of draft recommendations created as a reference document for the evening's discussion.

Mr. Stolz and Vicki Veltri reviewed the process for adopting recommendations via consensus that the Executive Team agreed to utilize. Mr. Stolz explained that recommendations adopted today will be included in a slate for final consideration in April.

Mr. Stolz presented on and facilitated a discussion of draft recommendations from Design Group 1's discussion of patient attribution methodology that might bear on patient selection or under-service. The recommendations recorded in these minutes are as initially presented in the Council meeting.

1. *Attestation – "Patients should be able 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."*

The Council endorsed the recommendation while noting that patient attestation should be an option, not a requirement, and would exist as one attribution method among others. The Council expressed consensus to include this recommendation in the slate.

2. *Notification – “Patients should be made aware that when they are attributed to a physician who is participating in a shared savings program. They should also be made aware of the program’s goals and the role of the patient and the provider in achieving those goals.”*

Robert Willig noted that the practice outlined by the draft recommendation may not be practical and that it’s unclear who would do the notification. Peter Bowers expressed concern that patients may be confused by the notification. Katie Sklarsky informed the Council of the new generation Centers for Medicare & Medicaid Services (CMS) recommendations that eliminate patient notification by mail in favor of notification within the provider’s office. Sheldon Toubman remarked that notification can be misleading and must be accurate, meaningful, and complete. Bonita Grubbs and Katherine Yacavone commented that notification must also be clear and at a medical literacy level a lay person can understand. Dr. Bowers relayed the payer’s struggle to draft communication at a 6th grade reading level that also gives accurate information. Rev. Grubbs remarked that while it is challenging to make these concepts easy to understand, it is important to notify patients. Kate McEvoy commented on the difficulty of creating accurate information that generates real understanding of shared savings. Mr. Toubman suggested the language of the draft recommendation be modified to reflect the provider’s financial incentives in clear language. Vicki Veltri and Arnold DoRosario added that notification must also be given to providers. Mr. Stolz noted that the content of communication to patients and providers is addressed more broadly in the recommendations related to Design Group 3, and proposed to limit the recommendation under consideration here to notification that a patient has been attributed to a provider. The Council expressed consensus to include this recommendation in the slate, provided that changes be made to reflect Council discussion.

3. *Settings of Care – “Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or urgent care center). Payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage a provider to take accountability for their care.”*

Dr. Bowers discussed this recommendation’s degree of alignment with the SIM initiative’s focus on population health and whole person-centered care. For example, while a retail clinic is another potential setting of care, encouraging patients to utilize retail care in place of primary care does not align with SIM’s intent. Dr. Bowers also remarked that attributing a patient to an emergency department (ED) or on a geographic basis may pose substantial risks for providers. Christopher Borgstrom used Yale New Haven’s Emergency Department’s experience to illustrate an example where a patient has a primary care provider but continues to utilize the emergency department as their primary source of care. Mr. Borgstrom added that attributing these “frequent flyers” to providers may pose an unfair risk to providers. On the other hand, Dr. Bowers noted that the notification to providers of ED visits that accompanies attribution helps inform the providers of their patients’ utilization. Ms. Hyre and Dr. Bowers discussed the ED/primary care hybrid structure that is currently employed by some EDs in Connecticut. Dr. Bowers, Mr. Stolz, and Mr. Borgstrom discussed potential financial incentives around this model and decided to take the discussion offline for further dialogue. Katherine Yacavone articulated a concern that the broad nature of the draft recommendations does not account for implementation challenges that will arise once the details are addressed. Dr. Barry asked if an area lacks provider resources for a patient who then utilizes the ED, are they then attributed to a provider who does not have the time to treat them? Mr. Stolz explained that in a traditional attribution model the patient would not be attributed to the provider if they do not visit the provider. In the proposed model the owner of the ED would have financial incentive to refer ED utilizers to primary care, and to create additional primary care capacity if sufficient resources don’t currently exist.

Ms. Yacavone remarked that many of these patients may have behavioral health issues as illustrated by her work with Southwest Community Health Center. The population was difficult to engage but having their ED utilization allowed Southwest to reach out and coordinate care. Kate McEvoy remarked that frequent ED utilizers are in a sense, from their own perspective, optimizing their care by using the ED. An ED provides a range of specialties, a meal, pharmacy services, and more in one location. Changing patient preference and habit of using the ED in this manner is difficult. Mr. Stolz summarized the intent of the recommendation and the case for ED attribution in particular as a method of promoting equity and access in patient attribution. By creating an attribution mechanism for patients who don't receive care in a physician office setting, ED attribution seeks to include these patients in the population that ACOs actively care for and provide services to, while incenting the ACO to shift more of these patients' care to a more efficient setting.

The group discussed how an ED attribution methodology would work in practice. Keith vom Eigen clarified that attributing through an ED will not result in patients being assigned to small independent provider organizations. In the ED attribution model patients would be attributed to organizations that (a) own an ED and (b) elect to participate in a given shared savings program that utilizes this method of attribution. In addition, if a patient sees a PCP during the course of a year, the patient will be attributed to that PCP irrespective of that patient's ED utilization (Mr. Stolz noted that this is the case in both traditional attribution models and in a model that includes ED attribution). Dr. vom Eigen suggested the language in the draft recommendation make these point clearer. Dr. vom Eigen, Dr. Bowers, and Dr. Willig discussed the definition of an ACO. Adam Stolz suggested the word "provider" be changed to "provider organization." Mr. Toubman agreed with Mr. Borgstrom's concern about creating an unfair risk to providers. Additionally, Mr. Toubman cautioned against creating a program that might deter providers from participating in Medicaid. On that point, Mr. Stolz clarified that independent providers unassociated with the ED owner would not be at risk of attribution via the ED. Council members agreed to provide more feedback on this draft recommendation via email. The Council expressed consensus to defer including this recommendation in the slate until language is revised and it can be reconsidered.

4. *Timing – "Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of underservice that might be heightened by prospective assignment."*

Dr. vom Eigen remarked that this method may not be logistically practical given the amount of work required. Ms. McEvoy agreed. Ms. Yacavone echoed earlier Council discussions that favored prospective attribution to inform providers of their patient population. Dr. vom Eigen suggested prospective attribution may be difficult for many practices who do not know who their patients are at the beginning of the cycle. Additionally, the Council must be mindful that it does not endorse assigning patients to a provider without provider and patient consent or involvement. Dr. Bowers and Dr. Willig explained current payer prospective attribution processes. Dr. DoRosario discussed his organization's strategy and stressed the importance of patient responsibility and participation. Mr. Stolz referred to a rationale for prospective attribution that Ellen Andrews had emphasized in earlier discussions – by assigning patients to a provider based on their prior utilization patterns, prospective attribution can serve as a method to prevent improper patient discontinuation. The Council expressed consensus to include this recommendation in the slate.

5. *Reconciliation – "An end-of-year retrospective reconciliation should be used to un-attribute 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."*

Ms. Yacavone and Dr. vom Eigen remarked on the fairness and benefit of documenting the actual panel of patients that a provider sees through a reconciliation method. Dr. Bowers stated that reconciliation could prove impossible from a timing standpoint given the need to close out a contract year for payers' customers. Ms. Sklarsky noted that CMS's reconciliation methodology does not re-

attribute patients retrospectively to a different provider than the one to which they were initially assigned. It only “un-attributes” such patients from their originally assigned provider; it does not reassign them. These patients are simply unassigned for the purpose of shared savings calculations. The originally assigned provider would still receive any PMPM payment since this would have likely been paid already during the course of the performance year. If a patient does not need to be reassigned, this would make the reconciliation more manageable from a timing standpoint.

Mr. Toubman commented that reconciliation might undermine the safeguard that prospective attribution is intended to create. Mr. Stolz and Ms. Sklarsky suggested that reconciliation might provide clues to patterns that need further examination. For example, if a provider group has a particularly high number of patients “un-attributed” to it by virtue of reconciliation, that should prompt a review of why that occurred, and whether the patients that left that provider did so for appropriate or inappropriate reasons. Mr. Toubman and Mr. Stolz discussed the definition of plurality. Ms. Hyre asked about those patients who may “fall through the cracks” when they are referred to a specialist who cannot see them. Ms. Sklarsky clarified that in a shared savings program, the PCP would want to ensure that their patients gain access to specialty care required to effectively treat and manage their condition, in order to minimize the risk of untreated conditions leading to more expensive interventions such as ED use or hospitalization. Mr. Borgstrom agreed and commented that the PCP would lobby hard for the patient to be seen. Mark Schaefer discussed the elements of the scorecard that other parts of SIM are developing.

Mr. Stolz noted that the portion of the recommendation stating that a reconciliation process should include safeguards against patient discontinuation is just as important as the portion stating that a reconciliation should take place. Alice Ferguson stressed the need for patient education around the importance of having a primary care physician. Ms. McEvoy agreed with this point and discussed some of what Medicaid is doing in that area. The Council expressed consensus to include this recommendation in the slate, provided that changes be made to reflect Council discussion.

Mr. Stolz reviewed the Cost Target Calculation draft recommendations.

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.”*
2. *Control Group Adjustment – “When a historical methodology is used to set a cost benchmark, a concurrent control group benchmark should also be calculated to evaluate the need to adjust for any systemic factors that substantially increased the cost of caring for the population – or a sub-population – beyond what was predicted for that year.”*

The Council considered the first two recommendations in tandem. Mr. Stolz explained the definition of control group as a comparison of an ACO’s performance against a market average, not necessarily against the non-ACO patient population average. Dr. vom Eigen echoed the Design Group’s discussion about the potential impact of variance in cost of care due to economic differences between different geographic areas of the state. Dr. Bowers agreed that comparing costs in one county such as Fairfield to another like Tolland without any regional adjustment is inappropriate. Dr. vom Eigen remarked that the Council also does not want to preserve pockets of poor performance when adjusting for geographic cost discrepancies. Dr. Willig and Dr. Bowers discussed the current practice among payers in this respect.

The group discussed rationales for using current year “control group” costs to supplement a historical benchmarking methodology. The Council’s sentiment was that events like a bad flu season

are not a primary concern, since there will be variance in both directions, but that the advent of new treatments and their implication for cost benchmarking is a concern. Mr. Toubman brought up a hypothetical situation of a new, expensive drug that cures a disease – the medical cost may be greater upfront, but over time the intervention saves money and lives. The Council wants to encourage a system where a provider is not penalized for ordering the drug that has more upfront costs. Dr. Willig noted that a current example is the Hepatitis C drug Sovaldi. Dr. Bowers noted that payers want to increase access to drugs like this and are trying to get prices lowered. Although there is no perfect solution, onetime unexpected costs due to innovation should be removed from the cost calculation or capped in some manner. The Council expressed consensus to include the first recommendation in the slate, and to include the second recommendation in the slate provided that changes be made to reflect Council discussion.

3. *Supplemental Payments for Complex Payments – “Use of a PMPM payment should be considered for patients who have socioeconomic attributes that are demonstrated to increase resource-intensiveness of providing care but that are not well-captured by purely clinical risk adjustment methods.”*

Mr. Stolz asked for five minutes for more discussion. The Council agreed. After brief discussion about the practicality of this recommendation, the Council agreed to table it for further discussion and to submit comments via email.

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.”*

The Council’s sense was that this recommendation is straightforward and should be included in the slate.

5. *Cost Truncation– “Truncating costs based on a percentile cutoff will eliminate any incentive to withhold required care after a catastrophic event 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.”*

It was noted that cost truncation is just one method of capping provider risk; the recommendation should allow for other methods such as service carve-outs. The Council expressed consensus to include this recommendation in the slate, provided that changes be made to reflect Council discussion.

The Council agreed to send additional comments that members may have on any of the cost benchmarking recommendations to Mr. Stolz and Ms. Sklarsky to consider for incorporation in the next iteration that the Council reviews.

5. Design Group 4: Retrospective and Concurrent Monitoring and Detection – EAC First Review

This agenda item was tabled.

6. Closing Comments

Vicki Veltri motioned to adjourn. The Council agreed. The meeting was adjourned at 8:08pm.