

STATE OF CONNECTICUT –ROUGH DRAFT
State Innovation Model
Equity and Access Council
Design Group 1 – Patient Attribution & Cost Benchmark Calculation
Design Workshop #1

Meeting Summary
Friday, January 30, 2015
12:00 – 1:00 p.m.

Location: By Conference Call and WebEx

Members Present: Ellen Andrews; Linda Barry; Chris Borgstrom; Peter Bowers; Keith vom Eigen; Robert Willig

Other Participants: Lisa Douglas and Salvatore Dias sat in for Anthony Dias; Deb Polun; Mark Schaefer; Katie Sklarsky; Adam Stolz

Members Absent:

Agenda Items:

1. Introductions
2. Public Comment
3. Overview of Design Group Process
4. Patient Attribution
5. Cost Benchmark Calculation
6. Synthesis of Initial Hypotheses

Meeting Summary:

The meeting was called to order at 12:05pm.

There were no public comments.

Katie Sklarsky reviewed the agenda and the design group process, and led a discussion about patient attribution.

There was agreement that there is likely not a one size fits all approach – an attribution method that works for commercial payers may not work for other payers and vice versa.

While further clarification is needed on the definitions of the attribution methods, the group's consensus was that providers should be aware of which patients they are responsible for as part of a shared savings payment model at the outset of the contract (i.e. a "prospective attribution" model). The group's sense was that this would permit patients to play a more active role in their care management, would promote buy-in by providers, and that, compared with a "retrospective attribution" model, the method would likely prevent rather than invite cherry-picking of patients.

There is also a need for further clarification/discussion on the groups' point of view about whether or not the attribution methodology has significant potential to impact (positively or negatively) patient selection and under-service. The most important thing to get right with the attribution methodology may be more around ensuring that it does not prohibit patient choice.

A hypothesis was discussed that attribution of patients to a group/network rather than to an individual provider might dissuade or otherwise reduce patient selection. The group did not express consensus on this point.

The group agreed to refer several issues to another EAC Design Group. Assuming that a methodology is used that allows providers to know who is in their shared savings program at the outset, it would be worthwhile to track why a patient attributed to one shared savings program at the outset ends up receiving care elsewhere during the performance period. This could be an indicator of a lack of access. Katie Sklarsky and Adam Stolz of Chartis recommended that the discussion on this topic be referred to the monitoring and detection safeguard group (Group 4: 2D-E, Retrospective and Concurrent Detection).

The meeting was adjourned at 1:05pm.