

STATE OF CONNECTICUT
State Innovation Model
Equity and Access Council
Design Group 1 – Patient Attribution & Cost Benchmark Calculation
Design Workshop #2

Meeting Summary
Friday, February 13, 2015
12:00 – 1:00 p.m.

Location: By Webex and Conference Call

Members Present: Ellen Andrews; Chris Borgstrom; Robert Russo; Keith vom Eigen; Robert Willig

Other Participants: Steve Frayne; Katie Sklarsky; Adam Stolz

Agenda Items:

1. Introductions
2. Public Comment
3. Overview of Design Group Process
4. Synthesis of Attribution Recommendations
5. Cost Benchmark: Council Questions & Discussion
6. Synthesis of Cost Benchmark Initial Hypotheses

Meeting Summary:

The meeting was called to order at 12:00pm.

Katie Sklarsky facilitated a group discussion. Participants articulated a number of perspectives including:

Patient Attribution

- The council agreed to the following attribution recommendations:
 - Prospective attribution will provide the necessary level of provider and patient awareness, will allow for the most effective care management and coordination, will protect against patient discontinuation, and will outweigh any potential risk of under-service that might accompany prospective assignment.
 - Patients should be made aware of their attribution to a physician who is participating in a shared savings program.
 - Patients should be allowed to be attributed to a physician through a patient attestation process.
 - There should be process for retrospective reconciliation at the end of the performance year to remove prospectively attributed patients who no longer qualify to be attributed to the physician. This process should be balanced with sufficient safeguards to ensure that there is no inappropriate discontinuation of patients throughout the year.
- There was concern expressed that allowing a patient to pick a physician through an attestation process might overwhelm a provider's panel size or require the provider to accept patients who they believe are not clinically appropriate for them to care for. It was suggested that a provider be allowed to not accept a patient, but only because their panel is closed.

- Design Group participants believed that there are valid reasons to consider using the ED to attribute patients, but were interested in learning more about how ED attribution has worked in other states and whether or not it has been successful in decreasing cherry picking of patients and placing patients in ACO models of care who would otherwise not be attributed. Plan to speak with Minnesota SIM administrators in the near future to learn about their experiences with ED attribution.

Cost Benchmark

- There should be additional financial support to identify and support care management/coordination of super-utilizers, but there was concern about using enhanced shared savings to do so
- Bob mentioned a number of potential methods that can be used to financially support caring for higher risk patients (i.e. up front care coordination fee, capping high-cost claimants to not be included in shared savings calculations)

Follow Up Questions

- There were several detailed questions about how the prospective assignment and reconciliation of prospective assignment would work. Bob offered to circulate those questions within Aetna to provide insight into how they are doing these things today. These questions included:
 - Details on how the Aetna end of year reconciliation process works? Acceptable reasons for un-attributing a patient? Protections against inappropriate discontinuation? How many months of the year does a patient have to be attributed to a physician to still be included on their panel (e.g; 6 months? 10 months?)?
 - What is the process to ensure that providers are attributed an appropriate number of patients to manage (not too few or too many)?
 - Is there a process for physicians to say that they do not want to accept an attributed patient? What is it?
 - How is quality and cost data shared with providers throughout the year? How frequently?
- There were also follow up questions on the cost benchmarking process, in particular around risk adjustment/enhanced payments for risk adjustments:
 - What are all the methods used to financially support caring for higher risk/more complex patients?
 - How are the higher risk/more complex patients identified?

The meeting adjourned at 1:00pm.