

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

Minutes

Idaho SHIP Multi-Payer Work Group Meeting, Phase III

Location 3232 Elder Street, Boise, ID 83701: Meeting Room BFO

Conference Call Number 1-877-451-3701; Conference ID 6126428722

Date 8/22/2013

Time 2:30 pm

Attendees

Mercer:	Russ Ackerman, Scott Banken, Shelli Stayner, Dr. Jeff Thompson Sudha Shenoy (Remotely)	Stakeholders:	Dr. David Peterman (Chair), Yvonne Ketchum, Dave Self, Blaine Peterson, Melissa Christian, Paul Leary, Kathy McGill, Bruce Krosch, Marnie Packard
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Topics

Meeting Minutes

Healthy Idaho Model (slides 2/3)

Dave: Looks too bureaucratic for the State to accept. Just listing payers is not enough.

Paul: Multiple small local networks will make up larger network

Jeff: BC is set up in 6 regions, where state is set as 7 regions. BC will not restructure to fit state networks, which, per Paul, should not need to do.

Paul: Provider networks may not need to restructure for payment. The providers networks for service don't need to completely align with network for payments.

Multi-payer Strategies (Slide 4):

SE PA, began in 2008

Interest in % of Primary Care Clinics participating (small number)

Yvonne: Need how much improvement/return/savings through course of program

Colorado

Yvonne: Need to understand how much commercial involvement there was.

Paul: Did payment level increase? Yes, by NCQA level achievement

Dave: Explained additional info on how NCQA attestation works

Jeff: Managing two areas contribute to solid care mgmt: Measuring transition: inpatient length & discharge planning, which are not spoken to by NCQA.

Minnesota

Jeff: There would be a lot of agreement around variable payment based on patient complexity level. BC study (mentioned received results today) 42% of commercial members had no E&M visits. Most of cost is due to 5% of patients. Risk adjustment of membership is right way to do it.

Dave: Asking additional questions. Up-front funding would be needed for establishing PCMH.

Jeff: Component for how well providers are treating certain conditions, etc. to ensure higher performing PCMHs are getting compensated better than lower performing

Dave/Russ: Three types of funding needed. Establishment, incentive for performance, and maintaining.

Melissa: Mentioned gift cards for coming in to have preventive services performed.

Recommendations (slide 5)

Jeff: Size of types of payments/incentives buckets is very important (incl shared savings, etc.)

Dave: 1) Need level of specificity, 2) Funding up-front cost (slide 7), 3) Enrollment-Timing, 4) Attribution, 5) PMPM escalation/PCMH patient complexity, 6) Value bonus

Attribution (Slide 6)

Jeff example

Dave: Got to point of managing population

Melissa: BS has a tiered attribution, must be consistent and set in stone. Full agreement from WG

Blaine: Patient needs to know where they are attributed.

Leary: Medicaid model is example

Dave: Stress need for patient responsibility/accountability

Enrollment – Timing

Most complex will need to be a part of PCMH at beginning

Blaine: Physicals and Wellness Screenings (forced by employer?)

Will employers pay for this? Melissa asked Shelli—“Generally yes”

Funding

Yvonne: Examples of payment for non-payment

Shelli: Employers willing to spend money to get ROI

Dave: Use grant money to start up, then longer term savings can get to funding of longer term cost

Yvonne: Agrees with approach, either funding mechanism or small pilot to start then expand

Paul: We need to ensure that population is attributed and reimbursed for properly to fund system.

80% question: What does it mean? Access? Involvement? How has CMS defined it? How can we define it? (look at Sally Jeffries Q)

Jeff/Scott: Up-front process bonus, then gravitate to outcomes bonus

Yvonne: Quality bonus vs process bonus

Jeff: *Bonus could be in form of increased fee schedules in future period* (similar to something Medica proposed/used with some providers).

Melissa: Capitation of primary care (requires correct wiring for attribution). Could be evolutionary, perhaps year 4...Specialty is held at payer level...*Russ note: I need more on this.*

Steering Committee Questions (Slide 8)

Jeff: BC does not currently pay for non-face-to-face visits (bullet #2). BS does.

Say that all payers will participate.

Bullet 1—Provide a detailed understanding of payments to providers: Addressed in the model: Agreed to by those present.

Bullet 2—Payments for tele-medicine and electronic consultations: Payers agree this should be paid for.

Bullet 3—Mercer has takeaway to better understand 80% parameter and how it applies to Idaho membership.

Bullet 4—Members will be classified based on levels of need: Yes

Bullet 5—Payment differentials will occur for rural practices: Yes

Bullet 6—Increased payment in the system will support increased payment to & ability of independent practices to continue. We believe this is more of a Network question instead of a Multi-payer question.

Bullet 7—Where available, there will be competition between PCMH networks, although specialists and independent practices may participate in more than one. The rural nature of Idaho means there may be some areas with only one PCMH network.

Bullet 8—Medicare Advantage demonstration/SPA is the likely answer to get more members into Medicare Advantage plans.

Bullet 9—We have the information to consider how to spend funding grants, where Idaho needs private/public investment, and where savings will have to pay for expansion of the model.