

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

Meeting Notes

CLIENT:	State of Idaho	MEETING DATE:	July 24th, 2013
SUBJECT:	Multi-Payer Strategies	LOCATION:	3232 Elder St, Boise, ID
ATTENDEES:	MERCER: Russ Ackerman, Scott Banken, Shelli Stayner, Dr. Jeff Thompson, Charles Lassiter, Sudha Shenoy	DISTRIBUTION:	STAKEHOLDERS: Dr. David Peterman, Yvonne Ketchum, Dave Self, Randy Billings, Melissa Christian, Blaine Peterson, Paul Leary, Kathy McGill, Larry Tisdale, Ty Barnett, Brent Seward, Bruce Krosch
	STAKEHOLDERS: Dr. David Peterman, Chair, Yvonne Ketchum, Paul Leary, Kathy McGill, Larry Tisdale, Blaine Peterson, Bruce Krosch, Randy Billings, Marnie Packard		MERCER: Jennifer Feliciano, Russ Ackerman, Scott Banken, Shelli Stayner, Dr. Jeff Thompson, Sudha Shenoy, Charles Lassiter
	GUESTS: Jeff Crouch, Elke Shaw- Tulloch		
	ABSENT: Ty Barnett, David Self, Melissa Christian, Brent Seward		

Summary

- Idaho needs staggered approach to increasing risk on care teams using PCMH model. First year should be straight PMPM payment to offset costs along with fee for service. Quality should be established based on identified opportunities for improvement. Shared savings and bonus pools in year 2 and beyond.
- Gaps and barriers identified: Current per member per month payment for high risk populations does not adequately cover the costs of creating a PCMH in primary care clinics., attribution methods only cover 50% of population, and already low utilization doesn't lend itself to shared savings.
- Decision made to adopt a PCMH model by region for Idaho as the initial provider payment model.

Notes and Key Ideas

- PCMH, as implemented in the pilot project and the Medicaid Health Homes, is still reactive instead of proactive. PMPM payment based on small at risk population. It still doesn't address prevention and is reactive to consumers who already have chronic conditions.
- Creating Patient-Centered Medical Homes costs money up front. So does focusing on prevention and wellness costs money.
- Currently, fully insured groups want to know what's happening to reduce costs on high-utilization members, not on healthy. Employers do not want to pay more for prevention (Questions from this statement provided to Employer Group focus groups).
- The PPO model currently in play is not conducive to the PCMH model because there is no PCP required and attribution is limited.
- One-Size fits all approach won't work. The model should be staggered in growth and applied differently in different regions due to population, cultural and access concerns.
- Concern on payment for the PCMH infrastructure and how attribution may affect funding in the future.
- Discussed four elements of the PCMH model – FFS, PMPM, and risk and quality measures with details to be filled in later.
- Regional PCMHs may have attribution and access issues that need to be addressed by other working groups.
- There may need to be other payment models added later like bundled payments, pay for performance.
- Need for other decision support tools for payment models were identified.

Follow-Up Items

- Need clarification of Steering Committee expectations to ensure MPWG is meeting all that is required.
- GAP analysis needs to be developed between current and future states.
- Definitions for models identified on the CMS grid.
- **Next meeting August 22nd.**