

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

Meeting Notes

CLIENT:	State of Idaho	MEETING DATE:	July 1st, 2013
SUBJECT:	Multi-Payer Strategies	LOCATION:	Oxford Suites, Boise, ID
ATTENDEES:	MERCER: Russ Ackerman, Scott Banken, Shelli Stayner, Dr. Jeff Thompson, Charles Lassiter, Ralph Magrish, Sudha Shenoy	DISTRIBUTION:	Jennifer Feliciano, Russ Ackerman, Scott Banken, Shelli Stayner, Dr. Jeff Thompson, Sudha Shenoy, Dr. David Peterman, Yvonne Ketchum, Dave Self, Randy Billings, Blaine Peterson, Paul Leary, Kathy McGill, Larry Tisdale, Ty Barnett, Melissa Farrar, Brent Seward, Bruce Krosch
	STAKEHOLDERS: Dr. David Peterman, Chair, Yvonne Ketchum, Paul Leary, Kathy McGill, Larry Tisdale, Ty Barnett, Blaine Peterson, Bruce Krosch, Melissa Christian, Randy Billings		

Decision Items

- Need to develop hospital focus group questions.
- GAP analysis needs to be developed between current and future states.
- ID existing private participants/payers: BC, BS, PacificSource, employers, some third party associations (TPAs), Select Health, Cigna, United, Tricare, Humana, and Noridian (Medicare TPA). Funding sources: premiums for private, self-insured, and Medicare, investment dollars, consumer co-pays and coinsurances. A couple of premium assistance programs through Medicaid/Children's health insurance plan. Shortcomings: Price and transparency, increasing medical loss ratios (MLRs). Constraints for insurance plans on admin budget vs. paid for claims due to MLR requirements. Make sure things are expense-able as a quality of care initiative and not a cost control initiative or you have to claim it as admin. Some things cost you money even though they save you money.
- Barriers to change besides regulations: Coding structures and contracts (current) being off cycle; employer/insurer contracts not synching with hospital contracts. Consumer expectations, plan design parameters, and limitations. Third party payers don't want to change/risk adverse.
- Public participants-current funding is State and federal dollars. Some county money pay hospitals within CAP fund. Shortcomings: Fee for service (FFS) siloed system, volume not value based. Where does workers comp and liability insurance (AUTO) fall? Barriers to change: Regulations.
- Nebulous-Medicare, Medicaid, large commercial plans, Blue Cross ~500-700K lives. Frame as covered lives: Short comings in current system or barriers to change, regulation, Lack of wellness programs or just starting, no incentive based payments. Everyone is working but not necessarily together-fragmentation. Lack of coordination from patient/provider side: Predominant market constructs, FFS and preferred provider organization (PPO) state. Very little managed care. 95% PPO. Barriers to change: Patient engagement. Deductibles have become barriers whether intended or not. Patient may not care about their disease as much as doctor does. Always going to be a barrier. Lack of patient accountability. This state never went through a managed care transition so people are not used to any utilization controls that are natural elsewhere, referrals, choosing provider networks etc. Scott-is this a barrier or an opportunity?-it's both. We have copay babies. Mom paid \$10, so now kid does. Lack of integrated and/or current data. Funding barriers:
 - Department of Insurance (DOI) and Medicare, HRSA
 - Geographic impacts for payers. This is an underserved state. Behavioral health (BH) needs are 100 underserved as defined by CMS but worse in rural areas. Only 6 pediatric psychiatrists in the state. Some overlap around other states, Lewiston/Spokane, southern area into Utah. Lots of primary care docs doing BH care and prescribing. Pattern of care for persons traveling significant distances. Heavy religious populations in certain parts of state and different healthcare philosophies and value systems between rural and urban environments-not socioeconomic. Demographic cultural norms. Some people will not pay for end of life care to pass it on to younger generations, others will. Some who will not sign up for public programs d/t pride? Some is geographically based.
- Innovations and opportunities-Recent, e-visits, telehealth, technology, cell phones. Patient-centered medical home (PCMH), in-home paramedic program in Ada County, transition of care codes from CMS make some services billable.

- Recent successes in delivery models: Telehealth, telepsychiatry, burns treatment at University of Utah is telemed, low back pain clinics (BC) close to founding a statewide trauma network. Idaho Health Data Exchange is a success. Statewide PCMH buy-in alone was a success despite lack of outcome or savings data yet. Pediatric Medical Home pilot/CHIC Utah/Idaho cross state project. Meaningful use is another opportunity.
- Recent failures of new system/payment models. Making reporting requirements too laborious to outweigh incentives for docs and have not been all-payer projects, no examples. Tried pay for performance and it wasn't successful d/t lack of volume to make it worthwhile. Silo-in.
- Shortages of every provider type in different pockets/geographic areas of state. 50 of 50 states in pediatrics and obstetric doc per capita in the country-confirm heard right? Deficits in geriatric care. Size of state cannot support a lot of pediatric specialty groups, i.e. oncology, cardiac etc.
- Patient engagement issues-already gleaned. Culture, geography, demographics.
- Trends that make impact: Telehealth and other successes that will make an impact. Chronic care. Lots of health education available.



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Excel 97-2003 Worksfile

Follow-Up Items

- Dr. Thompson presentation-groundwork for what future state could look like. Themes, bundled payments (coordinated care organizations [CCOs]) and medical homes relating to integrated health. Some dealt more with primary care, some chronic care, some combos of both. Engagement of primary care docs to do BH. Can they do it-is the workforce ready for chronic care and BH?
- Lots of planning, all doing chronic, and BH care in addition to primary care. Nothing in grant applications that got down in weeds though or metrics. Looking at health care, payment, pay for performance-not as much in planning grants. Differences between planning grants and the actual models. Some overlaid duals grant as well. 18 other states vying for five or six slots. Patient-centered primary care home was fragmented in WA State. WA loves to pilot things but not go statewide. Apaca can be helpful. Planning grant needs to match up with waiver. Letters of support weren't tight. Competition is WA. Recommendation of a policy group to look at this as a public private partnership. What will governance structure look like? WA put together in six weeks. WA included Medicare and Medicaid managed care. Oregon bringing in state employees. Arkansas bringing in state. 50/50 bringing in private payers.
- Recommendation: Make health home definition consistent. WA had too many types. Challenge is defining high risk populations for enhanced per member per month (PMPM). It's implemented here with National Committee for Quality Assurance recognition. All payers looking at different outcomes but picked from Medicaid list so there is decent alignment of outcomes and PMs and PMPMs.
- NC, OR, and MA all have models of interest. Jeff talked about OR, concerned about overhead, politics of community involvement. Fully capitated/global payments for dental, mental health, and physical health. CCOs also doing enrollment.

PacificSource in Bend, OR. Klamath Falls CCO hires a TPA. State can't measure the 20 quality measures that don't align with the risks.

- MA-Russ overview-improve access, patient experience, quality, and efficiency through care coordination and opportunities to integrate behavioral health.
- Comprehensive primary care payments and shared savings combined with quality incentives.
- Integrated BH and PCMH.
- Spans Mass Heath managed care organizations and FFS. Trend 25% of members in year one 2013, 50% in July 14 and 80% by July 15. Their implementation grant was primarily Medicaid.
- Risk adjusted capitated primary care delivery system. Bundle includes acute care, diagnostics, health promotions, immunization, physical exams, and BH tier services (limited). Nine different tier cells. Same structures for federally qualified health centers and rural health clinics.
- Sample of bundled service codes shared. * codes are in the bundle
- Action Item for Russ: Request to get their State Plan Amendment (SPA) or Waiver from Massachusetts. Decent level of interest in MA model. Concerns about NC model being non-profit based and whether or not that would work in ID. Jeff-there has to be some kind of policy/practice/guideline centralized body.



Model Testing Awards.docx

Notes

- Data analysis expectations: What data is available? We don't have good ID-specific commercial data.
- Possibilities tab to parking lot from agenda.

Focus Group Questions

Providers

- Feedback-goal is consensus. Dr. Peterman comment. Lots of terms that providers will differ in interpretation in. Some words/buzz words that mean nothing to some doctors or practices.
- We need the letters of support from the providers so they are going to have to understand what we want. Docs are going to say they hate the current system, need help/list of stuff to help them not be miserable. Communications are full of insurance speak; need to simplify which is different than dumb-ing down.
- Example-sustain the community care network in State, docs have no idea what this means. Develop a model that rewards outcomes not encounters-what does that mean to me? Start with asking provider-what in system that is so frustrating and causing impediments needs to change.
- Benchmarks-Comment about potential physician's reactions: after all the work I do, all you care about is the A1C benchmark? Ask broader question-context of what makes patients upset. Focus of this focus group (FG) for providers is about payments! What do you like about how you get paid, what don't you like about it, paperwork, etc? Mercer to work on payment questions.

- What about impact of malpractice on cost? Do you think it's the problem of hospitals, insurance companies; whose problems are these? Do docs want to blame someone?
- Action item-Dr. Peterman and providers to construct four or five questions. Melissa to send some consumer questions. Due date: tomorrow.
- Are you familiar with a shared savings model? If doc is employed by hospital, they are not going to. This is a FFS world; docs don't necessarily get the concept of shared savings here.
- Question-FG selection-ID Falls late next week by attendees of kickoff.
- Added hospital questions. Randy and Larry to draft and send to Scott.
- **Next meeting July 24th.**