State Innovation Model Advisory Committee

Meeting Minutes

October 14, 2015

3:00-5:00pm

Members Present: **LaQuandra S. Nesbitt, MD** (SIM Chair, Department of Health), **Richard Bebout** (Green Door), **Jacqueline Bowens** (DC Primary Care Association), **Karen Dale, RN, MSN, CS** (AmeriHealth Caritas District of Columbia), **Jonathan Blum** (CareFirst BlueCross BlueShield), **Lisa Fitzpatrick, MD** (Department of Health Care Finance), **Amy Freeman** (Providence Hospital), **Christopher King, PhD** (Georgetown University School of Nursing and Health Studies), **Maria Gomez, RN, MPH** (Mary's Center), **Mara Krause Donahue**(Medicaid Beneficiary Representative), **Erin Leveton** (for Laura Nuss, Department of Disability Services), **Christy Respress** (Pathways to Housing),**Tanya Royster, MD** (Department of Behavioral Health), **Rayna Smith, Esq.** (Committee on Health and Human Services), **Claudia Schlosberg** (Department of Health Care Finance), , **Mark Weissman, MD** (Children's National Health System), **Reverend Christine Wiley** (Covenant Church), **Laura Zeilinger** (Department of Human Services).

Members Present via Teleconference: **Christian Barrera** (Office of the Deputy Mayor of Health and Human Services), **Angela Diop, ND, CHCIO** (Unity Healthcare).

Members Absent: **Jullette Saussy, MD** (Fire and EMS Department), **Stephen Taylor** (Department of Insurance, Securities and Banking), **Reverend Frank D. Tucker** (First Baptist Church).

DHCF Staff: Derdire Coleman, DaShawn Groves, Dena Hasan, An-Tsun Huang, LaRah Payne, Robbin Rowe, Shelly Ten Napel, Michael Tietjen, Joe Weissfeld, Constance Yancy

Guests: Michael Bailit, President, Bailit Health

Topic	Discussion
Introductions	Dr. Nesbitt called the meeting to order.
National Payment and Delivery System Reform	Michael Bailit discussed how Medicaid programs have moved from monitoring contractual compliance to setting expectations and achieving greater value. He discussed several different payment models. Fee-for Service (FFS)

Landscape	payments not only rewards volume, but rewards volume of high priced services. They don't create incentives for providers to do the right thing and coordinate services. There are four primary alternatives to FFS payment: 1. Incentive Bonus: a financial reward for performance. The bonus is built on top of a FFS payment. 2. Supplemental Per Capita Payment: a per member per month investment that supports non-reimbursed services and infrastructure development. This is still built top on a FFS payment and does not promote accountability. 3. Episode-based Payment: a fixed dollar amount that covers a set of services for a defined period of time for either a condition or a procedure such as total hip or knee replacement. This type of payment motivates a real change in the perspective because delivering more services to the episode will cost the provider money. 4. Total Cost of Care: a budget on per capita basis on a population. This can be for limited services such as primary care. Providers can share in savings and/or risk. Questions from the Advisory Committee: • Do states implement incremental changes or full blown approaches to reform? It is has been a mixed bag for states, some have been more incremental and others like Arkansas have just jumped in. Mark Weissman brought up that some states have risk corridors that providers take on more risk as years progressed. Bailit said risk assumption allows providers to adjust to the changes. • Can you clarify statement that payment drives delivery? Jonathan Blum pointed out that models work best when payment model supports delivery. Bailit agreed and stated payment models all have flaws and they need to develop counter measures for their shortfalls. • Question around providers moving away from higher acuity patients. Bailit responded that when risk-adjustment is built into a payment model then providers who are serving complex patients are receiving higher payments than providers serving less complex patients. However he noted risk adjustment is not perfect. • Is quality measure the built in counter measure for some of the payment models? Yes, that was missing in earlier rounds of risk-based payment. Bailit cautioned you have to pick the right measures. • Have you seen social determinants of health factored into risk adjustments? Social determinants of health are widely desired but not implemented due to the lack of administrative data. • What is a high level of effort in the state examples presented? Incentive Bonus and Supplemental Payments are low level efforts and less impactful. Arkansas episode of care payment model is hard to do. Ohio and TN have tried to replicate the model, but no other states.

	Total cost of care is not as complicated as episodes of care. • Many of the examples are clinical. What is happening with the social and community relationships? Some states have required community connections such as Minnesota and Oregon. • What does not work? The status quo doesn't work. The take away is the payment models are intended to spur changes in care delivery. Providers have to be able to respond to the incentives and delivery care differently. • What has been done around practice transformation and helping providers develop the infrastructure needed to make changes? Some states provide funding and some states have not. In Minnesota, the FQHCs had to seeks funds to make such investments.
Vision for Care Delivery and Payment Model Reform	Dr. Nesbitt introduced the driver diagram that reflected the feedback from the September Advisory Committee. Small groups were formed to talk about the goals and objectives for the delivery system and payment reform in the District taking into account demographics and the transient nature of the populations. Feedback included: • How we engage the right partners - health care is not going address the issues • We want to incentive and improve accountability and outcomes; not just hold accountable • There is broad agreement to improve care coordination, but there needs accountability for the social services and community providers. There is also the challenge that there are gaps in coordination as well as duplication in some places. There is parallel activity but it is not generating the desired outcomes. • We need to identify who is going to get paid. • The process needs to reflect a need for capacity building for changing business models. What investments and supports will be in place for small providers to help them transition their care delivery?
Next Steps	Dr. Nesbitt reminded committee members to fill out the survey in order to sign up for work groups, request background information and share information on any promising practices and innovative initiatives already underway in the District. She tasked members to continue to recruit individuals to participate on the workgroups. She also announced the new SIM website: www.dhcf.dc.gov/innovation. Next Advisory Committee will be on January 13th at 2pm at 441 4th St NW – Room 1028.