

**DC**

**State  
Innovation  
Model**

*Better Health Together*



**District of Columbia State Innovation Model**  
Payment Model Work Group: Meeting Summary

April 27, 2016  
3:00 p.m. – 4:30 p.m.

**Participants:** Karen Dale (Chair), Joe Weissfeld, Don Blanchon, Jackie Bowens, Mia Phifer, Suzanne Fenzel, Michael Neff, Keisha Mullings Smith, Brede Eschliman, Sharon Augenbaum, Samuel Woldeghiorgis, Aastia Subramanian, Amy Taylor, George Sprinkle, Brede Eschliman, Matt Ramirez, Jasmine Shih, Justin Palmer, Mark Weissman, Patricia Quinn, Suzanne Fenzel, Dena Hasan, Chris Botts, DaShawn Groves, Jess Foster, Gina Eckert, Johanna Barraza Cannon, Dan Weinstein, Gina Exkert, Kandis Driscoll

TOPIC	DISCUSSION
<p><b>Overview of D.C. Hospital Experience with Medicare and Commercial Value-Based Payment Reforms</b></p>	<p><b>Payment and Care Delivery Transformation Road Map</b></p> <ul style="list-style-type: none"><li>• A proposed 5-year timeline was presented to the work group detailing potential implementation timelines for payment model options, including pay for performance (P4P) that will help transition from fee-for-service to value-based payments. The goal is to provide a recommendation that turns into our SIM State Health Innovation Plan for payment model reform.</li></ul> <p><b>Medicare P4P Programs</b></p> <ul style="list-style-type: none"><li>• The work group discussed three main Medicare P4P programs focused on hospitals because it serves as a template for potential P4P measures and payment structures. Such programs are population-based and risk-adjusted compared to national targets.</li><li>• <u>Hospital Acquired Condition (HAC) Program</u>: A program that reduces payments to hospitals that rank in the worst performing quartile of hospital-acquired conditions. There is a one percent penalty on all Medicare discharges for top quartile of hospital-acquired conditions. As of 2015, there have been 1.3 million fewer hospital acquired conditions. CMS estimates \$360M saved in FY16.<ul style="list-style-type: none"><li>○ The HAC Program is not risk adjusted because CMS' views these as conditions which should never occur.</li></ul></li></ul>

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> <li>• <u>Hospital Readmissions Reduction Program</u>: A penalty only program in which CMS assesses performance on heart attack, heart failure, pneumonia, hip/knee replacement, and COPD. Rate is based on national averages from a retrospective 3 year period - up to 1% (FY13); 2% (FY14); 3% (FY 15 and onward) penalty on all Medicare discharges. CMS estimated 150,000 fewer readmissions between Jan. 2012 and Dec. 2013. <ul style="list-style-type: none"> <li>○ Work Group members suggested that District populations need risk adjustment and not just penalties as providers would be penalized for merely serving sicker populations.</li> <li>○ Work group members expressed the need to assess provider capacity to ensure supports are available to providers, encouraging them to make linkages and improve care post-discharge.</li> </ul> </li> <li>• <u>Hospital Value Based Purchasing Program</u>: A bonus or penalty (budget neutral) program that assesses performance based on: 1) clinical process; 2) patient experience; 3) outcomes; and 4) efficiency measures; compares to national benchmarks &amp; improvement. Hospital payments are withheld by 1% (FY13), 1.25% (FY14), 1.5% (FY15), 1.75% (FY16), and 2% (FY17) with opportunity to earn back more than withhold. <ul style="list-style-type: none"> <li>○ Work group members cited the need to develop and implement an aligned quality strategy. When looking at high-performing hospitals in terms of patient experience, length of stay is short and tends to treat specific cases</li> <li>○ The need was expressed for a proxy of value in value-based programs that could tie directly to controlling costs and improving quality across programs.</li> </ul> </li> </ul>
<p style="text-align: center;"><b>Open Forum for Stakeholders to Share Thoughts, Suggestions, &amp; Feedback on</b></p>	<ul style="list-style-type: none"> <li>• <b>Stakeholders identified an investment opportunity in improving wrap-around services, such as health literacy and education to improve health maintenance and reduce readmissions.</b> <ul style="list-style-type: none"> <li>○ Work group members noted when discharging patients, providers do not have the resources or networks to place patients with supports, which are needed to manage health outside of clinical care.</li> <li>○ Three phases of contact were noted: <ul style="list-style-type: none"> <li>▪ In-hospital contact, care, and planning (identifying the potential for readmission);</li> <li>▪ Discharge and post-discharge planning and community connections; and</li> <li>▪ Post-discharge contact by non-clinical providers for 60-90 days</li> </ul> </li> </ul> </li> </ul>

TOPIC	DISCUSSION
	<ul style="list-style-type: none"> <li>○ Work group members noted that such an approach would be particularly helpful for behavioral health populations and should include elements of interdisciplinary care that follows the patient into the community. In this regard, case management is an essential service during both the initial stay and throughout post-discharge.</li> <li>○ Work group members also noted that such programs should better leverage HIE and technology to improve post-discharge engagement. There was support for use of evidence-based research to look at how to structure such programs.</li> <li>● <b>The role of FQHCs was expressed as a key resource for making these linkages.</b> As hospitals do not always have visibility into the entire continuum of care, linkages must be made by other care entities present in the community. <ul style="list-style-type: none"> <li>○ Some work group members expressed the need to realign roles and responsibilities across the continuum of care as some entities, such as FQHCs, are more appropriate and adept at connecting patients with community and social service supports than are hospitals.</li> <li>○ Payment models would have to follow such realignment to incentivize this new continuum of roles and responsibilities.</li> <li>○ Work group members expressed the distinct need for a mechanism to reimburse care coordination activities, especially in caring for behavioral health and homeless populations who experience the highest rates of readmissions.</li> </ul> </li> <li>● The workgroup also suggested harnessing technology via health apps and smartphones as a way to coordinate care and manage patient health.</li> </ul>
<p style="text-align: center;"><b>Next Steps</b></p>	<ul style="list-style-type: none"> <li>● Formalize the payment model road map and align it with the District’s goals for care delivery;</li> <li>● Think of ways to reimburse for care coordination activities in a new payment model; and</li> <li>● Pull information on other states’ practices for P4P and reducing readmissions to inform the District’s approach.</li> </ul>