Payment/Delivery Reform Work Group
Monday February 27, 2012
8:00am
Meeting Minutes

Attendees: Mike Souza, Joan Kwiatkowski, Domenic Delmonico, Gus Manocchia, Amy Black, Paul Block, Ted Almon, Al Charbonneau, Patrice Cooper, Richard Langseth, Vera DiPalma, Beth Lange, Don Fruge, Bill Hollinshead, Steve Detoy, Linda Johnson, Viviane Weissman, Rebecca Kislak, Jason Martiesian, Terri Mota

I. Call to Order – Dan Meuse called the meeting to order at 8:00am. Thanked the host, United Healthcare, for their assistance over the past several months for allowing us to hold our sessions here. Mr. Meuse noted that coming out of this group there will be a report to the Executive Committee on the work and review thus far of this Work Group in Payment/Delivery Reform. Today we will review the topics discussed these past ten months, to refresh memories and touch up on what will be important to have in the report.

II. Review of Meetings to Date – Goal of today is to run through everything discussed. If you feel there were specific comments or senses of the work group, if feel senses need to be stated in a more clear fashion, please note. [Presentation available upon request]
   a. Accountable Care Organizations (ACOs) –
      i. Ted Almon –what about the Dartmouth data, doesn't it support the theory that ACOs will save money?
         1. Dan Meuse: This is not to say that it cannot save money, but at this time did not have evidence that demonstrated this works, and it will save money.
   b. Massachusetts and Oregon –
      i. Steve DeToy – That is not a fee for service model, that is how you adjust a model of care. DM: Yes, the comments were such that are providers ready to handle that
      ii. Beth Lange – Having a multidisciplinary care team model, vs. a business model of care. I don't feel providers adjusting to fee for service model is not the issue, it is weather we have the
      iii. Steve DeToy –The Oregon model is that there Medicaid system is fee for service, didn't have a managed care system. Similar to ours years ago
      iv. Gus Manocchia: The large number of small practices in this state is indeed an issue in moving forward with payment reform – how do we encourage physicians in small practices to merge to a group that can manage risk or have them merge into larger practices who are already equipped to do so. The

way we pay will force doctors to do that, and if they don't adapt they fall behind.

v. Patrice Cooper: Isn't it also the ability to accept risk - financial risk?
    1. Gus Manocchia: Yes, agree, that is why small practices will need to think about merging and common infrastructure or joining larger infrastructure to handle the requirements of a risk based contract.

vi. Ted Almon: We can see this happening dramatically in MA since this meeting took place. The catalyst really is capitol. The question for RI is where is this capitol going to come from.

c. Vermont Reforms –
    i. No additional comments or amendments

d. Value-based Purchasing –
    i. Ted Almon – at the time we had these meetings we have had some assumptions, such that the network of hospitals would stay the same. And it seems, regardless of whether Value Based Purchasing is happening or not, there are some restructuring, as there are unsustainable elements in the system. At some point we need to get focused on picking something to move forward with reform, as we will need to be confident.

e. Blue Cross Blue Shield Reforms –
    i. Al Charbonneau: Was the global contacts at South County Hospital negotiated independently with BCBSRI?
        1. Gus Manocchia: Yes

f. Medicare/Medicaid Dual Eligibles –
    i. No additional comments or amendments.

g. United HealthCare Reforms –
    i. No additional comments or amendments.

h. Other Reforms:
    i. There are those reforms which we have not yet had meetings on, including but not limited to: CSI, Chronic Care Collaborative, Safe Transitions and Health IT/ Electronic Medical Records.

III. Questions/Comments

a. Domenic Delmonico: The hard part is to try to convert this good discussion into actionable steps. The last thing we want to do is produce a product that lacks actionable steps.. One thing we did talk about is how we get through a transition period. Was speaking with colleagues from TX, who were working on reform, and the margins for the last two years have been minus 14% , interim point, fixed cost, pension, has to be covered that do needs to be figured out. I do like the point that ther are other things going on, that to the extent we can piggy back on them that would be great. I feel many of these reforms can work together. We are considered acute care plus Medicare initiative, large services with variability, with bundled ayments. Look

at commercial population data, look for the wide variations, and seek opportunity there. These variations suggest here are opportunities for savings if we are to bundle payments around.

b. Ted Almon: Agree. This transition that he speaks of, is easy to sit back and think it is the hospitals problem, but there is clear cut public policy and implications for hospitals that are being operated with negative margins. That transition process cries out for oversight.
    i. Dan Meuse: For the first time in a while, regulators are starting to realize that and beginning to move towards a rational thought process, on how everything fits together, how the financial system that is currently in existence works with the hospital system, and with coordinated health planning etc. We are getting there in a way we haven't in a while.

c. Gus Manocchia: This issue of transition, as Domenic mentioned, is crucial. When that happens, the state has a concern in terms of employment for those who work in the hospitals, and part of the transition work is how do we redeploy the staff. If talking the through going towards a integrated system, a medical home system, can folks be utilized in that way (redeployed from hospitals during times of transitions).
    i. Dan Meuse: As we are looking for places for employment and healthcare continues to be a growing sector, let us recall that is not free. Every job is more cost in the system, which is not necessarily a bad thing, but it needs to be done carefully.

d. Domenic Delmonico: In my employee population, I have 14K members, who are in PPO product – think we need to push away from that into something more focused around primary care provider centered area. Personally, I think back in the late 90s what kept us from moving capitation in RI, it didn't enable capitation, there wasn't traction as there wasn't a primary care based product. Believe we need some insurance reform at the same time - perhaps have to state need to list a primary care provider on a card even if one has a PPO. Make sure we have an insurance product.

e. Joan Kwiatkowski: Community based providers are also very important in this reform initiative. We have PACE in the state, which has been effective, and it is an expandable model. We may also loop in the home care and the more supportive pieces. In any model that we discuss there needs to be a more pointed effort to include community providers in a solution to this. There is a group of post acute care providers who are applying for a bundled payment model.

f. Steve DeToy: When writing this report, we have identified these barriers, I would rather call on this current environment, and note some of the conversation that has happened around the table this morning. The idea that we can get everyone in primary care, then we will have a great number of specialists and hospitals with that.

g. Angela Sherwin: As we are talking through what are the tools in the toolbox, as opposed to barriers, and how we get to actionable items, it feels like we should be explicit about where we want to go. Each of these initiatives has different "goal" items, and it may help to be explicit in a statement about where we want to go.
    i. Steve DeToy: Part of that is how we measure what has been going on, and at what point do we determine what has been going on. Perhaps it is too early, but a great number of items out there, instead of looking for new and more perhaps grow on those in existence.
h. Ted Almon: The small business people have no problem with your question, they merely want the premium number to go down.
i. Richard Langseth: There is a group missing from all of this, the "arissa" plan. Also the workers comp plan in RI, and I don't hear any discussion of "arissa" plans or workers comp at this table. The employees, the patients. I did hear a bit about PPO, but if you were a SIGNA person, you have to go through this book to identify a provider and that is difficult to find. Shouldn't there be an ETNA person here, a SIGNA person here, a workers comp person here. Some of these stakeholders can be huge drivers of cost. These ARISSA plans are out of control. The only way to get this to work is to get buy in from the people. The people are not all that satisfied with the payers – need a better voice for the people. The providers are great, the payers are great.
    i. Dan Meuse: We do try to bring community and consumer voices to the table. Our goal is to be sure the voices are heard as best they can.
j. Bill Hollinshead: Think it is important to extend the notion to things that are going well here to younger and lower cost populations. The state has more public health dollars invested in primary care than in most places in the country. Those populations we could easily do bad damage to the history of success by thrashing around in other ways to try to adjust this.
    i. Steve DeToy: Part of why we do not hear much about workers comp is that after years of turmoil we have a good system now in place, one that runs efficiently and be sure we don't disturb that either.
    ii. Dan Meuse: The medical system accounts for 10% of the cost system. We can tinker inside the 10% all we want, but until we deal with issues like obesity, and exercise and physical activity, and safety standards, we are to recall we are working on 10%.
    iii. Al Charbonneau: The danger of your comment, in my opinion, is that when one look at what is driving the premium. I wouldn't argue that its 10% of the total system that is driving premium.

1. Dan Meuse: I should clarify – the things that affect cost, 10% of them are in the medical system and we can change how we pay for things, but there are outside drivers of cost.
2. Al Charbonneau: I am making a comparison to other developed nations in the world, I think we would be misserving the issue of lowering premium if we think we only have 10% of the action. Perhaps look to other nations.

k. Paul Block: There do seem to be three themes that are running through the discussion here. There are those that center around primary care, then better coordination of care, and the third is managing the system change, whether it be the way the hospitals survive or the way to keep the system together moving forward. All of our efforts we are going for should be focused on achieving one of those three.
   i. Patrice Cooper: I think it is just a bit more than primary care – as Joan mentioned community care, but also long term care and behavioral care. Just be clear it is a care team. When we think about messaging externally.

l. Richard Langseth: Twenty years ago the loan for pharmaceuticals was a higher percentage. RI Medicaid doing a great job with pharmaceuticals. Really difficult to deal with, cannot walk away without discussing these.

IV. Going forward: Take this discussion, wrap it in with past discussion, Prior to that meeting we will have. Will have the report out in advance of that meeting, review at the next session, invite at the Executive Committee on the 26th.

V. Public Comment – No additional comment made.

VI. Adjourn