Medical Home System Advisory Council

Reimbursement Strategies Workgroup Meeting Notes

May 15, 2009

Members Present: Bruce Steffen, Jerry Wickersham, Tom Evans, Tom Kline, Nat Kongtahworn, Sheryl Nuzum, David Carlyle

IDPH Staff: Beth Jones

Review of last meeting/overview of group

Carlyle – the group has been tasked to try to come up with a reasonable reimbursement model that could be used as a multi-payer pilot across the state of Iowa with the hope that we will use as many payer groups as possible.

The hope for a CMS demonstration project continues but information we get is that Iowa is not likely to be included, because the cost of care is not high enough. Due to that information, we believe we will have to go forward with a Medical Home project outside the CMS demonstration.

Evans – if we are using Medical Home to change care, we are less concerned with CMS but we need to come up with a model with which to move forward.

Carlyle – try to present a new way to improve health care that will improve quality and efficiency and medical home is how we provide a better healthcare system.

Group shared their roles and what we think Medical Home can do.

- Wickersham – report to insurance commissioner and communicate to her, but included as a regulator of payers.
- Kline – representing Jennifer Vermeer, because of limited resources Medicaid lead but wants to be part of the discussion.
- Steffen – representing United Healthcare, there have been some medical home pilots and this may make sense for United to be involved as well so there is interest in being a partner.

Wellmark Pilots – Kongtahworn and Nuzum

Kongtahworn – High level thinking around supporting the healthcare system redesign and payment reform, viewed as a collaborative multi-payer effort and open to evolving thinking for the betterment of larger thinking . Slides were attached.

First we must realize, reform is a moving target that is large and complex and without one solution – how do we support individual components of the chronic care model through discreet and distinct pilots? Pilots are focused on primary care, supporting resources and payment reform.

Pay for performance pilot seeks to improve outcomes. It began in 2006 with a handful of clinicians and now close to 1500 primary care clinicians participate. This includes physicians and midlevel providers.

- A clinician who participates receives access to an electronic data registry (Wellmark selected MD Data Core though an RFP but open to interfacing with other data registries). They believe a registry is fundamental for population health management and the registry can be used for the entire population but for the pilot they only view data on Wellmark members.

- Care opportunity report – marries clinical practice guidelines to information in the data registry and generates a list of patients with needed services.

- As we look at this program we intend to align the financial incentives with the healthcare system to arrive at better outcomes and support clinical decision making through data collected and offer opportunities to make proactive outreach to the patients.

Other three pilots build on top of Collaboration on Quality. Wellmark believes data is foundational and now are adding pilots to demonstrate.

> Collaboration on Patient Centered Care and Collaboration on Pharmacist Pilot goals are team based care. Pharmacist Pilots is designed to have practice based pharmacist to do medication therapy management and looking at measures, started in April 2009 and have 10 practices.
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> Collaboration on Patient Centered Care Pilot – Wellmark has been working with physicians since last year but officially launched this pilot in March 2009. Wellmark has mobilized health care support teams that work collaboratively with clinician practice teams. Support teams are comprised of four professionals: 1) nurses trained in disease management (coaching, patient ed, etc.), 2) nurses for case management (support practices with acute and complex medical diagnoses) 3) MSW (specializing in identify social determinants of health and addressing challenges – reduce barriers to care and securing resources) and, 4) member health advocate (utility type person helps with HRA and facilitates appointments with primary care and specialist, schedules labs and diagnostic testing – supports coordination of care, facilitates transfer of test, labs, x-ray). Wellmark also offers financial incentives to offset the time to redesign practice. They are trying to establish resources in the community and facilitate involvement beyond Wellmark to be coordinated and support the individual practices. The goal is to engaged 78 practices, they started with 18 and hope to add 60 more. They are working to build trust in the health support team and get feedback on what is adding value and what is not. These pilots will go through February 2010; they are using collaboration on quality measures.

Kline- Are you familiar with Calhoun County and their medical home program? There maybe is a benefit to collaborating with them.

Kongtahworn – want to reinforce the aim is to arrive at a reasonable reimbursement that could arrive for multiple payers. Wellmark wants to structure this effort so it's consistent to what is going on across the state. They are hoping it will be a process that can be applied to all patients in a seamless way.

Carlyle – have there been thoughts to comparing in-office to out of office pilots for the care coordination that's community based?

Kongtahworn – would be interested in doing that. The recognition that medical home is a place. There are capabilities there that we could not replicate with the same degree of effectiveness with this model, but the aim of the pilot is to make it possible to participate. However, if there are other aspects that would enhance the efficiency we would look at those as well.

Evans – agree there is some level of angst between disease management and medical home, but there's an opportunity to synergize. One of the key pieces that we talked about is accountability (team approach) to reduced fragmentation and coordinate care. We need to be careful about how we synergize because providers worry they will lose control and that a change in model of care will increase fragmentation rather than decrease fragmentation.

Kongtahworn – The intent is can we work in a collaborative way and recognize the current process is reactive and investments can be made in the practice infrastructure, but there are also other types of resources that could be leveraged to move us to a more proactive approach. We don't know what that looks like but we know we can add value if it is designed with the patient in mind. We are hopeful that we can achieve positive heath outcomes at a population level and we are working to figure out how to do that.

Sheryl Nuzum – Other Pilots –these are more concepts than realities but working toward some pilots.

Wellmark believes that one payment design doesn't fit all physicians and would like a payment model that follows the patient (aka. patient–centered payment). Most payers use resource based value systems, but if you just take it in a complete different direction, you may have other issues. Finally we realize that one form of payment is not going to fit every type of care needed.

For example, Wellmark has patients all over the board from healthy to catastrophic but the payment model is all Fee for Service (lower left quadrant) and doesn't work like we want it to for everyone. The patient would literally move from box to box in a new system.

Upper left hand quadrant are the high touch models, this is where medical home would fit, the upper right is more of a health partner (oncology, dialysis), the bottom right is something like surgery and could be a global payment model.

CMS has a global payment demo they are starting in mostly western United States using ACE (accountable care episodes) to hospitals (Billings MT).

Wellmark is farthest along in its thinking around the high touch model or the support of primary care payment reform. Current thinking is a risk adjusted shared savings payment.

The important factor is to prove it quickly. We will be reaching out to practices across IA and SD with high Wellmark concentration and high risk or illness burden. Additionally, we are being challenged in oncology community and will be doing some thinking about the future of oncology reimbursement (revenue for oncologists comes from drugs – drug pricing is one of the targets for getting reimbursement cuts). Oncology needs payment on professional services and knowledge not just based on drugs.

Possible collaborations would be to do a shared savings model and each payer can come up with ways that they can do that. We are interest in hearing what other payers have to say as well. We do know we must measure quality at the same time so it doesn't become a gatekeeper model (that is why we must include things such as registry).

Dr. Steffen – United Pilots

If we use this factory analogy – everyone gets the same payment regardless of how good or bad the product or service is (why not pay for quality) – we are missing something. We need to get to a place where we pay for quality as well as the service. No one has quite figured out how to get to that, but that is why PCMH is attractive. Total cost has to go down not up. Affordability is already a big issue.

Sheryl – I agree, we are also currently not taking into account the disease or illness. Regardless of how hard, easy, good or bad the patient is the provider gets the same level of reimbursement.

Carlyle – next week 8 Family Practice doctors are going to Washington and will be meeting with all of the delegation, specifically Harkin, Grassley and Braley.

There is a frustration that we likely won't get CMS, but is there any thought that we could go to DC and push for? For example, a medical home piece to Medicare advantage – does this have any connection to IA that we can speak to in going out to congressional delegation? If thoughts share or email those. Would there be interest?

ATTACHMENTS:
Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care
http://www.rwjf.org/files/research/prometheusmedicalhomes.pdf
Preserving Patient Access to Primary Care Act of 2009
http://www.thomas.gov/cgi-bin/query/z?c111:H.R.2350:
CMS – ACE Demonstrations
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1204388&intNumPerPage=10