

**Payment Reform Meeting Minutes**  
**12/16/10**  
**3 – 4:30 p.m.**  
**DVHA Large Conference Room, Williston**

**Attendees:** Richard Slusky, Michael Del Trecco, Meg O'Donnell, Betsy, Davis, Anthony Otis, Tom Torti, Al Gobeille, Bill Lambrukos, Peter Cobb, Michael Davis, Lou DiNicola, Andrew Garland, Larry Goetschius, Joe Zimmerman, Denis Barton, Christina Colombe, Sarah Gregorek, Andy Majka, Diane Tetrault, Gerhild Bjornson, Heather Shouldice, Bard Hill, Julie Tessler, Steve Maier

1. Welcome and Introductions
2. Review and approval of minutes from 11/16/10 - Approved
3. **Review of Health Care Reform Goals, and discussion of Problems with the US Health Care System – Power Point Presentation.**
  - Richard reviewed the health care reform goals in order to establish a context for the discussion to follow. He then went on to present data from the Commonwealth Fund which compares a number of US health system data elements to those of other industrialized nations. Some of the observations and comments of the group are noted below:
    - i. The cost of healthcare is on an unsustainable trajectory. Health care costs could consume 31% of family income by 2019. They are @. \$10K per person in Vermont right now
    - ii. 50 million people in the US are uninsured today
    - iii. The US has three times more MRI's than most other countries
    - iv. Obesity is a major contributing factor to lower life expectancy – children are larger than ever. Statistic Dr. DiNicola read: Projecting that eventually 1/3 of health care costs will go to diabetic care.
    - v. We have little or no systemic data to measure outcomes of health care services over a continuum of time
    - vi. Insurance shouldn't be tied to employment.
    - vii. Other countries are more reasonable in how they manage end of life care and difficult conditions. The US is spending 60- 70% of health care costs in the last six months of an individual's life.

- viii. Medication misuse is a big issue – it was noted that as much as 30% of hospital admissions and re-admissions might be attributed to medication mismanagement

#### 4. **Discussion of the Blueprint for Health---Design, Goals, Funding Mechanisms, etc.**

- The Blueprint Pilot is a comprehensive and integrated approach that:
  - Gives patients easily accessible, familiar, and effective healthcare, as well as a means to integrate care with public health and prevention programs.
  - Gives primary care physicians information, tools, resources and a community care team to improve the care delivery processes within their practices
  - Funding of Blueprint practices is based on a Fee for Service model with enhanced payments for the providers based on compliance with NCQA scores. In addition, practices receive supplemental payments to support the community care team affiliated with the practice. Participating funders currently include BC/BS, MVP, CIGNA, and Medicaid (Medicaid is currently paying for the cost of Medicare beneficiaries enrolled in the Blueprint) Medicare has just agreed to participate in the costs associated with their beneficiaries enrolled in the Blueprint sites.
- Information systems are essential to :
  - Support providers' clinical and office workflow to be more efficient, effective and patient-oriented
  - Support information sharing across physicians, Community Care Teams, pharmacies, and community-based programs (e.g., self-help programs) to improve patient outcomes

#### 5. **Other Items Discussed**

- ACO and global payments: how much risk are physicians willing to accept, particularly those in smaller practices? Global Payments or risk-adjusted PMPM payments could be tailored to the scope of services the practices provide, and the degree of risk/reward they are willing to accept. Not all practices are at the same place in their willingness or ability to accept risk
- Are the specialists out of the loop? No, they must be a part of the system. A bundled payment to the specialists for specific patient populations (elderly) or

specific types of conditions might be considered. The primary care physician should eventually have a vested interest in the performance of the specialists he/she refers to. Sweden has established a bundled payment for knee and hip replacements for otherwise healthy patients which include all of the services provided (surgery, lab, imaging, the prosthesis, follow up visits, and the cost of any complications over a 2-5 year period). The provider payment under this bundle is \$8000 (US). In Vermont, the average price for joint replacement procedures is \$32,000. (cost @ \$18,000) It should be noted that the cost of pharmaceuticals and medical equipment in the US is generally higher because the US subsidizes the cost of pharmaceutical and DME companies around the world (research and development).

- NCQA scoring – physicians and hospitals need resources including training and education to help prepare for the Blueprint model, including preparation for the NCQA scoring.
- Under a Capitated or Global Payment Model, what happens if the ACO fails to meet its targets and needs an increase in payment? The ACO is at some risk under a PMPM or Global Payment system. We will need to create reasonable risk corridors so that the survival of the institution is not threatened in the short term. However, if the organization fails to meet targets or budgeted payments over the long term, it will need to reconsider its business model and/or practice design strategies.
- The public needs to be educated about what impact these changes to the health care system may have on them. i.e. choosing a primary care physician, establishing a medical home, avoiding unnecessary use of the ED, and other issues will need to be communicated clearly and repeatedly to consumers.
- Is anyone thinking about Mental Health treatment so that timely assessment can be introduced into the overall reform to begin to address the cost drivers related to the unmet needs of people with mental health and substance abuse problems? The Blueprint now includes behavioral health providers as part of the community care team; however the behavioral needs of the population need to be more comprehensively addressed. This is an issue that DVHA staff are currently discussing with mental health professionals.

The committee didn't get to the break out groups to discuss the questions so it was suggested that attendees send to Richard their responses to any of the 11 questions that were distributed. We will discuss the questions and responses received at our next meeting in January.

The next meeting is tentatively scheduled for Thursday, January 13<sup>th</sup> from 3- 4:30. We will check for any conflicts that might require a change in time. There was discussion of moving the meeting to Montpelier. Sarah will secure a site and notify everyone of the new meeting location.