

Vermont Health Care Innovation Project Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: May 12, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Agenda Review	Karen Hein called the meeting to order at 2:31pm. A roll call attendance was taken and a quorum was present. Karen Hein reviewed the meeting agenda.	
2. Approval of Minutes	Susan Aranoff moved to approve the April 15, 2015 minutes by exception. Penrose Jackson seconded. The minutes were approved with one abstention.	
3. Project Updates: <ul style="list-style-type: none"> • Prevention Institute • Collaboration with the CMCM work group • Technical Assistance Request 	<p><i>Prevention Institute</i> Karen Hein announced that Prevention Institute will be here in June to present on their work in researching examples of accountable communities for health around the country.</p> <p><i>Collaboration with CMCM work group</i> As part of the ongoing work looking to improve population health and to align the work efforts of both work groups, there is a collaboration effort between the Population Health Work Group and the Care Models and Care Management Work Group.</p> <p><i>Technical Assistance Request</i> The VHCIP Population Health Workgroup requests assistance in identifying policy levers that have been utilized by other States or communities, that enable them to incorporate population health specific goals into payment reform activities. A description of the request is included as Attachment 3 in the materials.</p>	
4. Paying for Population Health Prevention: Presentation by Jim	Jim Hester, who is a national leader in thinking about population health, presented from the slides contained in Attachment 4 of the meeting materials.	

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Hester	<p>The presentation focuses on paying for population health – this is the third goal of the Population Health Work Group. This includes components of the financial models that could be used, including the elements and criteria, issues and some examples.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • Chuck Myers asked what the nature of the CDFI investment is – Jim responded that this is about \$50 – 60 Billion. • AHEAD – a partnership between a CDFI (The Reinvestment Trust) and a public health organization (Public Health Institute) to fund these activities. • The financial model – a key component is a global budget for a defined population for a broad scope of services with aligned payments allocating funds to service providers. • Some potential models include <ul style="list-style-type: none"> ○ Allocation of global cap ○ Employer subscription fee ○ Transactional fees ○ Reinvestment of savings • A review of the chart from CMS – note that CMS has always defined the ACO Shared Savings Model as a transitional model – a step toward population based payments. This is where our current ACO SSP model resides (VT). • In generic issues, the presentation cited having no patient buy-in as a barrier – there is no way to engage the patient in changing behavior because the patient has no insight into the model – they are not aware of the payment reform that is happening. • There is an innovative idea – not yet implemented – that proposes to pay providers for an aggregate reduction in heart attack risk factors. The model includes a number of risk factors that can be identified, so as those are reduced for a given population, the provider is then paid. • The presentation highlighted a program for the city employees of Lexington KY – managed by Marathon Health where over a 2-yr period, nearly 40% of the population made improvements in measured risks. This is based on a model where Marathon is at risk for Triple Aim objectives. • The Oregon model included in the presentation uses a ‘global budget’ concept where the money is given to the CCO organization to administer. • In California medical groups under a global budget, the MD payment model changes according to the type of service – for example, fee for service is used for prevention services, but capitation type payments are used for chronic care services. • The Vermont model questions <ul style="list-style-type: none"> ○ How do we align payments ○ How do we define the population 	

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	<ul style="list-style-type: none"> ○ Should we test an enrollment model ○ Should we align specialty care payments (i.e. bundled payments) ● Questions – clarifications, how any or all of this applies to SIM/PHWG, how do we get from here to there? ● Ted Mabel asked if there are there some communities who are closer to this than others? Yes – there are a host of partial-model – For example, Hennepin County has its own Medicaid MCO organization that captures the savings. Also, 11 testing states under the SIM program are now using some aspect of population health in their projects. ● A follow up question was asked - Is the reinvestment at Dartmouth back in to the community? Yes, it appears it is back to the community and is how the ReThink Health initiative is being (at least partially) funded. ● Laural Ruggles noted that the question around payment models is that holding primary care and/or just hospitals accountable for the overall health, but the incentives are going to the primary care organizations only... the whole alignment of the community providers just isn't there yet. ● Jill Barry Bowen asked isn't that where the Blueprint UCC or RCPC is heading? Laural's point is that perhaps there is a difference in what is being proposed at the GMCB and what is being discussed in the communities. ● Cathy Hency asked what size population is needed to pull something like this off? Jim Hester responded that when the analysis was done initially, roughly 15K was needed for shared savings models. – and some estimates range up to 200K to ensure the infrastructure cost is covered. This is one the areas in testing now ● Steve Gordon commented that from the perspective of 'boots on the ground' there is only so much change that can be done at once – and there's no view yet into the impact of that to folks working in the provider practices and prospective results. There are already so many initiatives around the blueprint work, ACO collaboration and quality groups. In terms of assuming the risk in the Brattleboro area there are only 2500 participants in the Medicare program in that area and they wouldn't necessarily be willing to take the risk from that perspective. ● Jenney Samuelson pointed out that it has to be done in steps – what types of steps can be taken to get to where we want to go. ● Laural Ruggles, Jenney Samuelson and Jill Berry Bowen jointly commented that if all we do is include the clinical work, it doesn't allow for the work to be more systematic and thinking about the population overall by including the whole system – the care coordination is happening but the payment incentives are not happening. Jill's community is working to build the trust, establish measures and improve the care coordination. Some communities are further ahead and for example, Laural's community (St. Johnsbury) is further along in the care coordination and is looking to have the payments now follow the work. ● Susan Aranoff pointed out that CMS is not waiting and they are moving now toward value based care and payment. 	

Agenda Item	Discussion	Next Steps
6. Next Steps	Next Meeting: Tuesday, June 16, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	