

Nebraska Department of Health and Human Services  
Patient-Centered Medical Home Pilot  
QUESTIONS & ANSWERS

This is a compilation of questions asked during two scheduled audio-conferences and other questions that have come in. The answers are brief so please contact us if you need any clarification:

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- Q1: Do you know who the practice transformation contractor is and how will the practice transformation contractor interface with the pilot practices:  
A1: We are currently reviewing the proposals that came in through a formal RFP process and the contractor has not been selected. The contractor is to build a working relationship with the pilot practices to foster a supportive relationship and work plan that accommodates the financial and time commitment requirements of the practice
- Q2. Will the practice transformation contractor begin right away?  
A2. The current schedule is for the contractor to begin in late September meeting with the Department in preparation for conducting a mini-assessment of the finalists from the RFI and then begin technical assistance to the selected practices in December.
- Q3. How will the minimum standards be verified?  
A3. The contractor will work with the practices in achieving the minimum standards and verify that the standards have been met for the Department. The Department will then review the report from the contractor and validate that the standards have been met.
- Q4. How will the number of patients assigned to the practice be determined?  
A4. Medicaid clients will be connected with a practice through an attribution method. Several states have used this method. Our MMIS (Medicaid Management Information System) will do a look back of twelve months of claims and assign a client to the doctor s/he has seen the most in those 12 months. If two pilot practices are in the same community/area and there is a tie of number of visits, the practice that most recently saw the client will get the attribution. This attribution will be reviewed on a monthly basis, still looking back 12 months, with oldest month dropped off, and newest month added.
- Q5. Will the practice get a list of clients assigned?  
A5. Yes, it will come with the PMPM (per member per month) payment.
- Q6. How do we manage patients that do not come in to see the doctor? To try to do health care and not disease care and wait until they come to us when they don't think they need to come in.  
A6. You can utilize your monthly list for that purpose. Ex. if you see a patient on the list for the previous month has not been in recently, you can do outreach.
- Q7. Would it be possible to find out what those numbers of clients are for initial planning?  
A7. We can get an estimate for you – send an e-mail to Margaret or Pat requesting the list.

- Q8. Is 1500 Medicaid clients the minimum estimate needed to evaluate the pilot.  
A8. Yes, the Department will need 1500 Medicaid clients in the pilot so that we can evaluate with confidence.
- Q9. Do you have a maximum number of pilots that you want to participate?  
A9. Yes, 2-3, but could be in more than one area of the state.
- Q10. Is it my understanding that the patient can go to any practice at any time? How does that fit into the concept of the medical home?  
A10. Yes, a patient can go to any practice at any time - we are not assigning a patient, once that patient comes into the office, they would experience all aspects of a medical home. These are fee for service clients and we can not restrict who they see. The medical home concept is that the patient develops a relationship with the doctor and team so that the patient will come back there for their next visit.
- Q11. Do you have any feel for the volatility of those assignments or alignments between patients and physicians? For example, if your practice has 500 patients this month, how much could that change from month to month?  
A11: We selected 12 months to give a larger frame of reference keeping patients in your attribution longer so there would be less volatility. We have no data on the impact of change month to month.
- Q12. Is it a safe assumption to say that all of the clients attributed to them are in the medical home?  
A12. The attribution is specifically for the purpose of payment. The practice will receive a PMPM payment based on that's month's attribution. The practice should approach everyone that comes into the practice as part of the medical home as far as care and processes.
- Q13. How are you going to roll it out to the Medicaid clients?  
A13. The Department will not be notifying the Medicaid clients about the pilot – this should be a seamless transition for them. The medical home model is that the practice would be explaining to the patients if the practice will be doing things differently once transforming to a medical home.
- Q14. One of the important parts of this at least as I see it, is to decrease the number of inappropriate ER visits which is tremendously expensive part of medical care that is given for the Medicaid population. Is there anyway that we can do something to decrease the number of Medicaid visits to the ER in a way of prescreening or somehow or implementing a copay. I have had people who were going to have to wait a half hour so they went over to the ER. This will not change unless there is some sort of disincentive. If a patient shows up with a skinned knee at the hospital, they can't be turned away.  
A14. This is something that can be addressed with the patient by the practice in terms of education and increasing hours and accessibility. The max copay federal is \$3.00 and by raising these copays we end up paying the ERs less. The premise behind a medical home is when patients have a relationship with their doctor, they will not want to go the ER. The practice could also develop a relationship/agreement with the ER to refer back to the

medical home in non-emergency situations. Regarding the “can’t be turned away”, this is may be a liability issue for the hospital. You would need to consult your legal counsel to determine what is possible.

Q15: How will you judge the financial effectiveness of the program? Will it be financial or based on outcomes?

A15: We are evaluating the pilot for improved health care access and outcomes for patients, cost containment in Medicaid, patient satisfaction and provider satisfaction.

Q16: Will there be any interaction between the practices in the pilot?

A16: Yes, through the learning sessions and other opportunities.

Q17: Who will be brought to the learning sessions?

A17: Members of the medical home team as defined by the practice, but likely to include key physicians, nursing and office staff. DHHS will be reimbursing mileage and provide a practice honorarium. Depending on the size of the practice, the attendance may need to be limited.

Q18: Where will the learning sessions be held and for how long?

A18: The best location for the practices will be selected. There will be two sessions and each will be a one day event, 6-7 hours.

Q19: What are the core competencies you are looking for in a practice transformation contractor?

A19: They have to have experience in practice transformation and demonstrated success.

Q20: Is the Practice Transformation and care coordinator support separate offerings? Is the care coordinator someone we have to pay for?

A20: All of the technical support listed in the RFI is at no cost to the practice. The Department will be providing money for the cost of the care coordinator. There will be some specifications provided in terms of qualifications for the care coordinator. We have not worked out the details yet to determine whether or not it will just be a cash payment to the practice or otherwise. The practice transformation contractor will be providing training for this staff position.

Q21: Where we are located has a whole bunch of different languages. Regarding standard 1.1, we have accommodated Spanish for over 20 years but we have the potential for maybe 5 or more different African languages. Will be required to have all our different written materials in their language?

A21: Our requirements are not that detailed. A practice will need to have some sort of written plan for how they will be communicating with their patients. You just need to have a way to communicate whether it is relative to an interpreter for an office visit or a education brochure. The practice transformation contractor will be able to help with ideas for this standard.

Q22: What are your expectations in terms of expanded hours?

A22: We leave that up to the practice to develop a plan that meets their patients’ needs. You do need to have some sort of contact with patients outside of normal business hours (ex:

an on-call number) but we are not specifying how many. Patients just need some way of contacting you so they are not just going to the ER.

Q23: This is just a request for interest? Does it need to be mailed to your office?

A23: Yes, we are seeking a show of interest for practices that are interested in an opportunity like this and committed to the concept of medical home. The application can be mailed to us or attached electronically to an e-mail.

Q24: Will we be able to utilize getting information so that we can make decisions that will hopefully impact how things are done?

A24: DHHS will be generating data reports throughout the pilot for the practices.

Q25: Relative to generic medication utilization, reducing ER visits, and readmissions, will we be able to access information on where you are now?

A25: This information will be made available to the selected pilot practices. We will be able to provide you with a baseline and status reports throughout the pilot.

Q26: How will your judge achievement toward the core competencies? It's not waiting until you see definite numbers, just that we are trying to do something?

A26: Yes, the minimum standards within the core competencies require that the medical home has a plan or a process in place. While we will want to see some improved outcome overall in the pilot, we will not be judging the achievement of standards based on definite numbers that have to be reached.

Q27: As an FQHC, we have a reimbursement agreement with DHHS and we weren't sure how reimbursement would work for us if it would impact our rates.

A27: We do not intend for it to change for FQHCs generally. Your payment structure would remain intact and the PMPM would be additional. At this point, we haven't looked at FQHCs specifically, but we could look into it further for you.

Q28: Is it possible for two organizations to send in an application as a joint effort, a partnership?

A28: We need to ensure that the leadership in both groups is committed to the pilot and would need to look at the specific proposal for that.

Q29: Our group is affiliated with the hospital, multispecialty, and also working on medical home projects with other insurers, what is your concept of the multidisciplinary aspect and combining efforts with other pilots?

A29: We would need to have the owner or leadership demonstrate that full participation would be required of all. Our practice transformation technical assistance support would be devoted to those with specialties in general/family practice, internal medicine, and pediatrics.

Q30: Where is the technical assistance coming from?

A30: The RFP process for the practice transformation technical assistance is closed and we are now reviewing those proposals, so no decision as been made. We should know who the contractor will be in early September.

Q31: In terms of the timeline, would a more formal application have to be submitted?

- A31: No, the council wanted to make it really simple for the practices to apply. There will be a mini-assessment done by the contractor to determine practice readiness in the finalists. If you are a finalist, you may have to complete a survey or give some additional information but there is no formal application.
- Q32: What is the timeframe for that mini-assessment ?  
A32: End of September to mid-October.
- Q33: Is there a timeframe to have the electronic documentation in place?  
A33: There is no requirement that the practices have anything in place, however we will be assisting with a patient registry for the practices which would be ideal to have in place early in the first year to help the practices manage their care.
- Q34: We have a registry in place for diabetes, depression, and other diagnosis. Would we need a separate registry for Medicaid patients?  
A34: We will look to see if what the practice has in place is sufficient or if they need something supplemental. We will want aggregated data on the Medicaid population.
- Q35: Is there a concern about HIPAA and the transmission of other payer information?  
A35: We will only be asking for Medicaid patient information and will not gather the information related to other clients so the patient registry will need to be able to separate patients by payer.
- Q36: Will there be autonomy in selecting the quality improvement projects?  
A36: We will not expect the pilot practices to all focus on the same thing. For standard 4.2, the practice is given a selection, but for standard 5.5, the practice chooses the health outcomes they want to improve.
- Q37: Are all Medicaid patients enrolled in the pilot or are they allowed to choose? Are they allowed to go wherever they want once they are in the pilot?  
A37: This will not be like managed care, they will not be limited in where they can go.
- Q38: Will only one physician be identified to receive the payment?  
A38: The payment will go to the practice. So if a practice has 5 doctors that see 10 Medicaid clients each, the payment to the practice will be for 50 clients.
- Q39: What if the patient has more visits to the urgent care or the ER in the last 12 months will we forgo that PMPM?  
A39: We will only be looking at the practices in the pilot, so if the practice has seen that patient within the 12 months and the patient has been attributed to that practice, regardless of number of visits to the ER or urgent care, the practice will be paid the PMPM.
- Q40: Will there be a disincentive for the client if they go to the urgent care or walk-in center?  
A40: There will not be a disincentive to the client. The intent is that the medical home will establish a relationship with the patient so they always want to come to you and will not want to go to the urgent care. We are also hoping that the clients will get information

from the practice about appropriate use of the ER. Accessibility to the doctor and the team will also be a factor.

Q41: Could you be more specific in what you are referring to in terms of outside of normal hours?

A41: We are leaving that up to the practices and not mandating how many hours that would be just that there are some hours outside of regular business hours.

Q42: If we have urgent care in our office will this suffice?

A42: No, we want the patients to be seeing the same physicians and not physicians at an urgent care. We may just need more information on what you mean by urgent care, if it's a separate facility etc ...

Q43: If our office is open from 8-6:30 would that count as non-traditional hours?

A43: Yes. Thinking outside of the box, it could also mean opening up email access and other means like that for access and while that is not a covered Medicaid fee-for-service, the PMPM would help in that change in practice.

Q44: Will it be required that all providers in the practice come to the learning sessions?

A44: There will be 2 learning sessions that will require the practices to have their team available.

Q45: How many sites do you plan to include in your pilot?

A45: 2-3 in non-managed care counties that could in different parts of the state.

Q46: Are we bound to participate if we submit an RFI since there are a lot of details that have not yet been worked out?

A46: No practice is bound until the final agreement is signed. Signing the Application of Interest means that the practice is interested in being a participant and would be committed to the participation requirements listed, but it is not a binding document.

Q47: What do you expect with the patient advisory councils? Will the group only be comprised of patients? Are you hoping for a certain number of people to serve on that?

A47: We feel that patient input and feedback will be important as the practice works towards transforming into a medical home. We do not specify a certain number. The practice transformation contractor can help in deciding how you want to set that up and what works best for the practice. If you are utilizing an advisory group that you already have in place that includes patients, we would expect that a representative sample would be Medicaid clients.