An Opportunity for You !

Dear Primary Care Practitioner,

As medical costs rise, and the need for Medicaid Reform continues, we now have a solution that helps retain quality primary care physicians in Nebraska while improving health care and access for citizens.

The Nebraska Department of Health and Human Services (DHHS), in collaboration with the Medical Home Advisory Council, would like you to consider participating in a new two-year medical home pilot in your area for Family Practice, General Practice, Internal Medicine or Pediatrics. **The benefit to you would be an opportunity to take advantage of Medical Home best practice concepts, improve the health care and access to services for your patients, and receive enhanced Medicaid reimbursement in exchange for your care coordination.**

We see a patient-centered medical home as a win-win situation: For your patients, better health outcomes and improved patient experience; for your practice, measurable efficiencies, controlled cost of operation, and enhanced reimbursement.

We hope you will read the following prospectus and consider submitting an application of interest. We will be facilitating two toll-free audio conferences to answer the questions you might have (see page 7). In the interim, if you have questions, please feel free to contact: Patricia Taft, Pat.Taft@nebraska.gov, 402-471-7787 or Margaret Brockman, Margaret.Brockman@nebraska.gov , 402-471-9368.

Vivianne M. Chaumont
Director
Division of Medicaid and Long-Term Care

Tom Werner, M.D.
Chair
Medicaid Medical Home Advisory Council

Medical Home Advisory Council

General and Family Medicine

Dr. Thomas Werner, *Grand Island*, Council Chair
(O) 308-382-1100 tomw@kdsi.net

Dr. Robert Wergin, *Milford*
(O) 402-761-3307 rwergin@gmail.com

Pediatric

Dr. Jane Carnazzo, *Omaha*
(O) 402-955-7463 jmcarnazzo@cox.net

Dr. Nancy Knowles, *Omaha*
(O) 402-955-6878 nknowles@childrensomaha.org

Internal Medicine

Dr. Donald Darst, Omaha
(O) 402-552-6474 ddarst@nebraskamed.com

Dr. Lissa Woodruff, Kearney
(O) 308-237-2263 lawoodruff@mac.com

Hospital Representative

Dr. Martin Hickey, Alegent Health Clinic, Omaha
(O) 402 343-4411 martin.hickey@alegent.org

(Ex Officio) Health and Human Services Committee Representative

Senator Mike Gloor, Grand Island
(O) 402-471-2617 mgloor@leg.ne.gov

REQUEST FOR INTEREST
Nebraska Medicaid Patient-Centered Medical Home Pilot

The Nebraska Department of Health and Human Services (DHHS), in collaboration with the Medical Home Advisory Council, is seeking individual primary care practices or primary care multi-practice clinics that would be interested in **participating in a two-year Nebraska Medicaid Patient-Centered Medical Home pilot project beginning in 2011.**

The pilot will be in one or more of these communities: Scottsbluff, Sidney, Ogallala, North Platte, McCook, Lexington, Kearney, Holdrege, Hastings, Grand Island, Columbus and Norfolk. These communities were selected because they are not in a Medicaid Managed Care county and have practices that reflect a sufficient number of Medicaid patients to be able to evaluate the pilot.

Background

The 2009 Legislature passed LB396, Medical Home Pilot Program Act, to improve health care access and health outcomes for patients and to contain costs of the Nebraska Medicaid Program in one or more geographic areas of the state through a medical home pilot.

The Governor appointed a Medical Home Advisory Council to guide and assist DHHS in the design and implementation of the medical home pilot program. *(list included in this packet)*

General Information

A patient-centered medical home for the Nebraska Medicaid Medical Home pilot is defined as a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team. This team will provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner. The primary care physician will be specialized in family practice, general practice, internal medicine, or pediatrics.

The Nebraska Medicaid Patient-Centered Medical Home model is a **team** of individuals at the practice level, led by a physician, who collectively take responsibility for the ongoing care of patients. Rather than the traditional care model of practice-centered, the services are **patient-centered** and reflect the Joint Principles of the Patient-Centered Medical Home adopted by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Osteopathic Association (AOA). *(Attachment A)*

The benefits of a medical home include increased patient and family satisfaction; increased professional satisfaction; increased wellness resulting from comprehensive care; improved communication with patients, families and other providers; enhanced efficiency of services and office processes; improved coordination of care; enhanced efficiency of services; enhanced reimbursement and efficient use of limited resources.

Participating practices will be a Medicaid provider and meet minimum DHHS standards in order to be recognized as a medical home. The medical home will receive enhanced financial reimbursement along with technical assistance to support transformation into a medical home that meets the DHHS standards. The pilot will be evaluated for improved health care access; improved health outcomes for patients; costs contained in the Medicaid program; and patient and practice satisfaction.

Medical Home Financial and Technical Support

The pilot medical homes will be provided enhanced financial reimbursement along with technical assistance to support transformation into a medical home that meets DHHS standards.

Financial Reimbursement

FFS:
The Medical Home Pilot practices will be reimbursed for all allowable Medicaid services at the most current FFS schedule.

NOTE; To receive the incentive payments below, the Medical Home Pilot practice will sign an agreement to work with the practice transformation contractor to meet Tier 1 minimum standards within 6 months. Tier 2 standards will be optional for the practice.

PMPM (Per Member Per Month):
For patient care coordination and administration expenses, the Medical Home Pilot practices will initially receive a $2 PMPM. This payment will begin once the agreement is signed and the practice must achieve Tier 1 standards within six months *(Attachment B).* If the Tier 1 standards are not met within six months, the PMPM will be suspended until the Tier 1 standards have been met. Once the Tier 1 standards are met, the payment will be increased to a $4 PMPM.

Enhanced FFS (Fee for Service):
Upon successful completion of Level 1 minimum standards, the Medical Home Pilot practices have the option of continuing to transform the practice to meet Tier 2 standards. Once the Tier 2 standards are met, the practice will receive an additional 5% enhanced FFS on selected Evaluation and Management procedures.

Technical Support

It is not important that you are a practicing medical home; true practice transformation is hard work and we can help you achieve that goal through technical support. **The willingness to transform your practice into a medical home is the important thing.**

Each medical home practice will be provided technical assistance and supports in transforming the practice to be recognized as a medical home under this pilot. Supports include:

- Formal assessment of the practice resulting in a plan for technical assistance and supports for practice transformation
- Learning sessions on components of medical home

- Two years of practice transformation coaching with on-site and virtual technical assistance for an effective practice transformation
- Access to a patient registry
- A staff person for care coordination

Medical Home Standards

Each medical home will be expected to achieve specific core competencies by meeting minimum standards in order to be recognized as a medical home. These are outlined in *Attachment B.* As noted before, practices will be provided with technical assistance to meet pilot standards and to continue improving as desired by the practice.

Pilot Participation Expectations

In order to be considered for participation as a medical home in the Medicaid pilot, the practice will agree to these participation requirements:

- Be enrolled as a Medicaid provider;
- Commit to two years in the pilot program;
- Engage in practice transformation planning and implementation with practice coaches to meet DHHS medical home standards;
- Participate in learning sessions *(time will be compensated;*
- Utilize a patient registry;
- Have broadband access;
- Facilitate a patient advisory committee *(practice can design this to be beneficial to the practice and does not need to be physician facilitated);*
- Submit claims within 60 days of service; and
- Willing to work with the State in evaluation of the medical home pilot.

Pilot Evaluation

DHHS will be evaluating the pilot for these outcomes:

a) Improved health care access
b) Improved health outcomes for patients
c) Contained costs in the Medicaid program
d) Enhanced patient satisfaction
e) Enhanced practice satisfaction

There will be a pre and post evaluation utilizing claims data, provider records, and patient and provider satisfaction surveys.

Practice Selection Process

Selection Timeline:

1. Application of Interest due: September 1, 2010
2. Finalists will be notified by: September 21, 2010
3. If needed, finalists will be scheduled for an interview
4. Practices selected for participation in the pilot: November 8, 2010
5. Agreements signed with the participating practices: November 22, 2010

Criteria for Practice Selection

The criteria for selection of practices to participate as a medical home in the Medicaid Medical Home Pilot include the following:

- Practice primary operations are in a Nebraska community without Medicaid Managed Care;

- Practice serves both children and adults;

- The Medicaid patient base is a sufficient number of adults and children to support an effective evaluation of the pilot;

- If multiple physicians are part of the practice, the leadership of the practice supports full participation, as demonstrated in a written agreement assuring the total cooperation from all practice participants;

- Quality improvement activities;

- Commitment to practice transformation; and

- Demonstrates a willingness to utilize information technology.

Responding to this Request for Information

If you are interested in being considered for the Nebraska Medicaid Patient-Centered Medical Home Pilot, please complete the Application of Interest in Appendix C and submit to DHHS by September 1, 2010.

The Application of Interest form to fill out on your computer can be found electronically at: http://www.dhhs.ne.gov/med/Pilot/index.htm (Click on the Medical Home logo on the right.)

Mail your completed Application of Interest to:

Nebraska Department of Health and Human Services
ATTN: Pat Taft
P.O. Box 95026
Lincoln, NE 689509

OR **e-mail** your completed Application of Interest to: pat.taft@nebraska.gov

Critical Dates

August 17 & 18, 2010	Telephone Q&A conferences for interested providers
September 1, 2010	Application of Interest Due
September 21, 2010	Finalists selected
November 8, 2010	Practices selected and notified
November 22, 2010	Pilot medical home agreements signed
December 1, 2010	Practice transformation technical assistance begins
January 1, 2013	Pilot Concludes

Free Self-Assessment Resource. To access a free online self-assessment tool to determine how close your practice is to a medical home model, the Medical Home IQ Assessment is available at http://www.transformed.com/mhiq/welcome.cfm. This is not a requirement for the application and the results are only available to you.

QUESTIONS?

Question and Answer toll-free audio conferences will be available on these dates. Please contact one of the individuals listed below to reserve a line:

Tuesday, August 17, 2010: 12:30 pm – 2:00 pm (CDT); 11:30 am – 1:00 pm (MDT)
Wednesday, August 18, 2010: 11:30 am – 1:00 pm (CDT); 10:30 am – 12:00 noon (MDT)

For additional information about the Nebraska Medicaid Home Pilot and links to resource publications on the medical home concept: DHHS Medical Home Pilot Website
http://www.dhhs.ne.gov/med/Pilot/index.htm

For questions about the RFI, contact:

Patricia Taft, Pat.Taft@Nebraska.gov, 402-471-7787
Margaret Brockman, Margaret.Brockman@Nebraska.gov , 402-471-9368

Joint Principles of the Patient Centered Medical Home

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American osteopathic Association (AOA)

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

- **Personal physician -** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** — the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** — the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Nebraska Medicaid Patient-Centered Medical Home Pilot
MEDICAL HOME REQUIRED STANDARDS

A goal of the Nebraska Medicaid Patient-Centered Medical Home Pilot is to develop fully recognized and operating medical homes that meet the criteria of a patient-centered medical home. To achieve this, the pilot practices will receive technical assistance to help transform the practice into a recognized medical home including guidance on meeting the Tier 1 required minimum standards outlined below. The practice will receive a PMPM for care coordination and administration costs as a participant of the pilot. In exchange, the practice will agree to meet the Tier 1 minimum standards within six months.

Once the minimum standards have been met, the practice will have the option to receive an enhanced FFS on selected Evaluation and Management codes by meeting Tier 2 standards.

Tier 1 – Required Minimum Standards

Core Competency 1: Facilitate ongoing patient relationship with physician in a physician-directed team.

1.1	Practice utilizes written plan for patient communication including accommodation for hearing and visually impaired and English as a Second Language patients.
1.2	Practice utilizes written materials for patients explaining the features and essential information related to the medical home published in primary language(s) of the community.
1.3	Practice utilizes patient-centered care planning (includes patient's goals, values and priorities) to engage patients in their care. Practice plan can include a written "After Visit Summary" outlining future care plan that is given to patient at every visit.
1.4	Practice utilizes reminder/notification system for health care services such as, appointments, preventive care, and preparation information for upcoming visits; follow up with patients regarding periodic tests or screening and when planned appointments have been missed.
1.5	Practice provides patient education and self-management tools and support to patients, families, and caregivers.
1.6	Practice utilizes Medical home team that provides team based care composed of but not limited to the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
1.7	Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

2.1	Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2.2	Practice provides care coordination and supports family participation in care including providing connections to community resources
2.3	Practice utilizes a system to maintain and review a list of patient's medications.
2.4	Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient plus follows up after referrals, specialist care and other consultations.

2.5	Practice utilizes a patient registry.
2.6	Practice team defines and identifies high-risk patients in the practice who will benefit from care planning and provides a care plan to these individuals
2.7	Practice team provides and coordinates Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services.
2.8	Practice team provides transitional care plan for patients transferring to another physician or medical home.
2.9	Clinical data is organized in a paper or electronic format for each individual patient.
2.10	Practice utilizes a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the medical home.

3.1	Patient has on-call access to the medical home team 24 hours/day, 7 days/week
3.2	Practice offers appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.
3.3	Practice utilizes a system to respond promptly to prescription refill requests and other patient inquiries.
3.4	Practice provides day-of-call appointments.
3.5	Practice utilizes written practice standards for patient access.

Core Competency 4: Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

4.1	Practice implements an intervention to reduce unnecessary care or preventable utilization that increases cost without improving health.
4.2	Practice establishes at least 2 out of 3 of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

5.1	Practice has established a quality improvement team that, at a minimum includes one or more clinicians who deliver services within the medical home; one or more care coordinators, one or more patient representatives, and if a clinic, one or more representatives from administration/management
5.2	Practice develops a formal plan to measure effectiveness of care management.
5.3	Practice develops an operational quality improvement plan for the practice with at least one focus area.
5.4	Practice utilizes a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.)
5.5	Practice identifies one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.

Tier 2 – Advanced Medical Home Standards (OPTIONAL)

In order to be recognized as an advanced medical home and to receive enhanced Fee-for-Service for selected Evaluation & Management procedure codes, upon successful completion of the Tier 1 minimum standards, the practice will have the option to meet Tier 2 Advanced Medical Home Standards. IN DEVELOPMENT

Patient Centered Medical Home
NEBRASKA MEDICAID

APPLICATION OF INTEREST

To access this form electronically go to
http://www.dhhs.ne.gov/med/pilot/request.htm

(Deadline: September 1, 2010)

Name of Practice: _____

DBA (if applicable): _____

Type of practice: *(circle)*

General Practice **Family Practice** **Internal Medicine** **Pediatrics**

Practice location address: _____

Practice mailing address: _____

Website: _____ **E-mail:** _____

Primary telephone: _____ **Secondary telephone:** _____

Name of person completing this application: _____

Telephone number: _____ **E-mail:** _____

---

1. **Who owns the practice?**
2. **If a group practice, list the providers in the group and their specialty.**
3. **Estimated number of current Medicaid clients (if available).**
4. **Estimated percent of the practice that are Medicaid clients.**
5. **What information technology are you currently using?**

   __ e-prescribing **___ patient registry** **___ electronic health records**

   __ Practice management **__Other** *(please describe)*:

6. **Do you have dedicated personnel (shared or not) for the care management of patients?**
   ___yes ___ no
   If yes, please explain:

   If not, how could DHHS assist you in accomplishing this?

7. **What quality improvement activities do you participate in and which of these did you initiate?**

8. **In 350 words or less, please explain your interest in participating and how you feel your practice would impact the success of the pilot.**

By signing this Application of Interest, if selected, we would comply with the following participation requirements:

- Be enrolled as a Medicaid provider;
- Commit to two years in the pilot program;
- Engage in practice transformation planning and implementation with practice coaches to meet DHHS medical home standards;
- Participate in learning sessions *(time will be compensated;*
- Utilize a patient registry;
- Have broadband access;
- Facilitate a patient advisory committee *(practice can design this to be beneficial to the practice and does not need to be physician facilitated);*
- Submit claims within 60 days of service; and
- Willing to work with the State in evaluation of the medical home pilot.

SIGNATURES
(One signature must be by the primary owner of the practice)

_____	_____
Printed Name	**Printed Name**
_____	_____
Title	**Title**
_____	_____
Signature	**Signature**