

Medical Home Advisory Council Meeting  
Lincoln Medical Education Partnership, Lincoln  
November 17, 2009

Members present: Dr. Carnazzo, Dr. Knowles, Dr. Werner, Dr. Wergin, Dr. Hickey, Dr. Darst, and Sen. Gloor

Members not in attendance: Dr. Woodruff

DHHS staff present: Pat Taft, Aishah Witte, Jenifer Roberts-Johnson, Margaret Brockman

Dr. Werner convened the meeting to order at 12:13. Dr. Werner stated that the challenge today is to narrow down the definition and concept of a medical home so that the council can move forward.

Dr. Werner then called for review and approval of the meeting minutes and the minutes were approved without revision. He asked for comments or revisions to the agenda. The agenda was approved without revision.

### Definition of Medical Home

Dr. Werner first asked that the Council work to establish a definition of a medical home. He presented that the definition from the Joint Principles discussed at the last meeting be used as a starting point and asked the Council members for their comments.

Dr. Hickey said he agreed with the definition but also wanted to present emerging concepts in medical home definitions that he has been exposed to and that were also presented at a recent meeting in Chicago of five different medical home groups including Massachusetts General, Fairview Health Services of Minnesota, and Dubuque, Iowa's medical home group. These concepts are as follows:

- a coordination of care or continuum of care aspect given that the care will be provided in multiple venues and formats,
- addressing the team approach that will be needed even if the care is physician directed that may not be implied in the current definition,
- implications the word care may have as denoting a correction of an abnormal physiologic state and instead using terminology like improving health status.

Dr. Knowles directed the group to the definition Kansas created. She likes the wording and it addresses the concepts Dr. Hickey presented. Dr. Carnazzo agreed that the definition established what a medical home is and what it should be. Dr. Darst expressed concerns that the Kansas definition does not clearly address safety and quality but was

otherwise happy with the definition. There was discussion on including verbiage that identified enhanced or improved accessibility to health care.

Dr. Wergin added that he was familiar with the process that Kansas went through to develop their definition and would be hesitant to include the “or other provider” terminology as this could allow specialty physicians and even non-physicians to direct a medical home. Dr. Carnazzo interjected that nephrologists and orthopedists should not lead a medical home. There was ensuing discussion on midlevel providers and Dr. Werner noted that the legislation establishing Nebraska’s medical home pilot specifies physician and feels the reference to other care providers should be removed.

Dr. Werner moved that the council use the Kansas definition and with modifications made by the Council that addressed the initial concerns as follows:

“In Nebraska, a medical home is defined as a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team, to 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.”

Dr. Wergin moved for a vote to accept modified definition as Nebraska’s official definition of a medical home. Dr. Knowles seconded the motion.

The votes are as follows:

Dr. Carnazzo, Yes  
Dr. Knowles, Yes  
Dr. Werner, Yes  
Dr. Hickey, Yes  
Dr. Wergin, Yes  
Dr. Darst, Yes

#### Adjustment to Agenda Regarding Stakeholders

Before beginning discussion on the next agenda item, Stakeholder Involvement, Dr. Darst questioned whether or not it would be possible to move the agenda items around because he felt the discussion on the vision for the pilot development should come before the stakeholder discussion. The council members then deliberated on whether or not defining the stakeholders before establishing the vision for the pilot would influence the vision. Dr. Carnazzo added that she would like to have a broad definition of what a stakeholder is before moving on. Sen. Gloor stressed the importance of defining the vision and goals first so it can be determined who needs to be at the table to make the pilot a success.

Dr. Werner stated that the stakeholders are clearly defined - patients, physicians, and payers (Medicaid) and with everyone else being peripheral. Ms. Roberts-Johnson added that community resources and the public health department should also be considered

stakeholders. Dr. Hickey added that hospitals should be considered stakeholders as well as there will be winners and losers among the stakeholders.

### Pilot Objectives – Vision – Necessary Elements

Dr. Werner suggested that the discussion be moved to defining the pilot's objectives and queried Ms. Roberts-Johnson as to what Medicaid sees as the objectives for the pilot.

Dr. Wergin interjected that while the pilot is directed by legislation, Nebraska Medicaid's objectives will also affect proceedings. Ms. Roberts-Johnson stated that Medicaid's objective was to implement the recommendations of the Council and Director Chaumont in conjunction with the appropriate policy staff members would intercede and help with resolution if there were potential problems with any recommendations.

Dr. Carnazzo then referenced an email she sent inquiring about how Nebraska Medicaid rates compare to the rates of other states. She stressed an importance in looking at what populations would most benefit from the medical home pilot and ensuring that primary care physicians would be properly reimbursed to not lose money because of their participation in the pilot. She also expressed concerns about potential cuts in Medicaid rates reported in the media. Ms. Roberts-Johnson clarified there were no pending reductions in Medicaid rates stemming from state budgetary issues only a freezing of rates despite what may have been reported in the media.

Talks ensued on what financial outcome would need to be achieved for the pilot to be perceived as successful by entities such as the legislature and Nebraska Medicaid. Dr. Hickey maintained that a decrease in the slope of overall cost trends would need to occur as costs maybe shift from money spent on hospitalizations to bonuses to physicians who effectively prevent the costly hospitalizations. Before excusing himself to return to the legislative special session underway at the Capital, Sen. Gloor commended the Council for their work so far and for the quality of their discussions. He said the hope is to have a successful pilot that can result in a change in the Medicaid payment system. If the pilot is not successful, Nebraska will have missed a major opportunity. What happens nationally will blow by the Nebraska pilot so one of the objectives is for the Nebraska pilot to act a springboard for future medical home initiatives down the road when additional money is available and Medicare medical home initiatives may be underway. Sen. Gloor directed the council to pick the "low hanging fruit" to be able to demonstrate a reduction in cost trending.

Dr. Wergin noted that it is imperative to ensure the cost savings do not go back into state general funds but instead stay within Medicaid program because North Carolina is seeing the downside of not making this assurance up front.

There was additional discussion on education of patients, office staff, and physicians playing a crucial in the paradigm shift necessary to implement a medical home so a nurse at the end of her shift does not direct a patient to the emergency room and patients

Payment reform was transcribed as the first objective of the pilot. Dr. Carnazzo expressed hesitation in using this term payment because it seems to have a pejorative connotation. Ms. Roberts-Johnson suggested that payment methodology be used as an alternative. The

Council discussed the importance of payment reform to the pilot no matter the words used to describe the concept.

Dr. Werner re-centered the discussion by stating stakeholders are the Who, objectives are the What, and vision is the How. His thoughts for the vision were focused on implementation including decisions such as type of practice. He also clarified that the legislation specified a rural location and Ms. Roberts-Johnson added that the site has to be outside of the Medicaid managed care counties (Douglas, Sarpy, Lancaster, Otoe, Cass, Washington, Saunders, Dodge, Gage, and Seward). This led to a discussion on some concerns with managed care held by the group and Dr. Carnazzo reported receiving lower reimbursement rates for her managed care patients. There was discussion centered on locating the pilot in a community where patients have access to an emergency room, urgent care, and specialists to allow for a realization of cost savings.

Dr. Knowles requested Medicaid information including number of ER visits by member and frequency of visits. Dr. Werner asked Ms. Roberts-Johnson for her input and she affirmed that Medicaid should be able to provide most of the data on populations to assist in the decision on where to have the pilot. She also expressed that if there are multiple sites utilized, there would be fewer resources to support the sites. Dr. Hickey also noted the importance of choosing a practice with a high Medicaid population.

Discussion followed on whether or not electronic medical records should be considered in the selection process and the availability of stimulus funds for practices to convert to medical records.

Dr. Wergin asked about seed money and whether or not money originally intended for use on the medical home project was still available. Senator Gloor reported the money realized from managed care savings was no longer available but part of the Technical Assistance awarded to Nebraska is to assist in locating funding opportunities. Dr. Hickey referenced funding opportunities that exist in the pending national health care reform legislation.

Discussions reverted to concerns with Medicaid managed care and Ms. Roberts-Johnson noted that Medicaid was supportive of the medical home pilot because the department knows that there is room for improvement in the current system.

### Stakeholders

Talks then moved to who will stand to benefit from the pilot including large employers and others that may want to help fund the pilot initially. Providers of ancillary support services were identified as stakeholders as they will play a role in improving health care for participants in the pilot.

### Additional Data and Future Meetings

Dr. Knowles brought the discussion back to the data needed in order to select a potential site. The number of providers in the community, size of Medicaid patient population, age breakdown of Medicaid patients, and cost by patient. Dr. Hickey asked about breakdown by cohorts and cost by cohort. Ms. Roberts-Johnson reported that she was unsure

whether DHHS maintained data in that format. Dr. Knowles also reiterated that the suggestion that university students would be a good resource in assisting with data assemblage. It was agreed that Dr. Hickey would provide the data breakdown requests to Medicaid that would be most helpful drawing on his experiences.

Dr. Werner asked Dr. Hickey what amount of cost savings would be statistically significant. He reported that in a well functioning medical home, in six months you should be able to see a range of 10-20% savings not including what is needed up front to allow for the savings realized.

Ms. Taft asked the Council to consider whether they wanted to do an RFI and the value of an RFI in garnering interest in the pilot and nurturing buy-in from the potential practices.

Dr. Hickey brought up reinsurance and its role in the pilot particularly if gain sharing is employed as an incentive.

Dr. Wergin talked about some areas that might have an easy implementation such as Grand Island as it is kind of a hub for the central part of the state because people from smaller, surrounding communities drive to Hastings and Grand Island to get their care.

Dr. Werner queried the group on how to approach the next meeting and the feedback centered on examination of the data cuts and establishing a sort of critical mass of Medicaid patients or dollars spent in the potential pilot communities.

Dr. Hickey mentioned a potential partnership with the Gallup organization on well-being tool they are beta testing. Dr. Wergin spoke about assessment tools that are available from the Commonwealth fund as well.

Dr. Carnazzo asked about connecting and networking with the seven other states that won the Technical Assistance awards. Ms. Roberts-Johnson talked about the documentation we already have on their initiatives as well as the opportunity to bring in speakers and experts to meet with the Council.

Dr. Werner began a discussion on payment structures asking the Council if they are in general agreement that the pilot payment structure will have incentives on a per member per month (PMPM) basis. The Council then briefly discussed what would make the pilot financially attractive.

In closing, Dr. Werner advised the Council that per the open meeting laws, if he sends an email to one person, it is not public record but if the number of people copied reaches a quorum, then the email is public record. Ms. Robert-Johnson also advised the Council that any email sent to a DHHS employee is public record as well.

Future meetings were scheduled for Tuesday, January 5 and Wednesday, February 3 from 1:00-5:00 in the same meeting place.

Dr. Werner asked for public comment and as there were no public comments, the meeting adjourned at 3:56 pm.