

Medical Home Advisory Council Meeting
December 2, 2009
LMEP, Room 3

In attendance: Dr. Knowles, Dr. Carnazzo, Sen. Gloor, Dr. Woodruff, Dr. Werner, Dr. Darst, Dr. Hickey

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

Dr. Werner convened the meeting just after 1:00. He asked for revision and approval of the minutes from the November 17, 2009. The minutes were approved without revision.

Dr. Werner motioned to move agenda item number nine, "Discuss: Collaboration with Other Payers," up to be agenda item number four so Dr. Rauner could address the group on this topic as he needed to leave at 2:00 pm. Sen. Gloor seconded the motion citing that he also needs to leave early at 3:30. All Council members agreed to move the agenda item.

Collaboration with Other Payers

Dr. Rauner discussed the progress and status of his medical home initiative. He stated that most recently, their work had been focused on adoption of their core principles with input and verification from groups like the American Academy of Family Practitioners and the Nebraska Medical Association. Dr. Rauner reported that their concern is how to advocate for their initiative as physicians without any anti-trust issues. They will be working with Dave Phillipi, a consultant for BlueCross BlueShield (BCBS), and are planning to maybe start with BlueCross BlueShield then move on to other insurers. Dr. Rauner said that Dr. Grundy suggested aligning under a government entity, like under a Kerry Winterer for example.

Dr. Rauner has seen federal grants for multi-payer projects and hopes BCBS and Nebraska Medicaid could work together opening the door to these funds. A practice is not likely to implement change willingly and effectively for 5% of its patients so a multi-payer initiative would also help from this perspective. Dr. Rauner added that BCBS comprises 50% of his business. Dr. Werner also stressed the importance of having enough participating patients to make the pilot appealing to doctors and practices.

Sen. Gloor noted that Dr. Rauner's group could convene their meetings under the auspices of Medical Home Pilot Advisory Council meetings because the council is organized under statute and is therefore a government entity. Sen. Gloor recommended asking for feedback on this from the Department of Health and Human Services (DHHS) legal counsel. The Attorney General's office could be consulted as well but it would be preferable to consult with DHHS legal counsel first.

Sen. Gloor also noted that if BCBS were on board with participation in the pilot, it would be likely the other insurers in the state including Coventry would follow suit, as this is how they have proceeded in the past.

Dr. Rauner and Dr. Hickey exchanged information on experience BCBS has nationally with Medical Home pilots and the sophistication of their data systems as well as the systems of other top insurers such as Aetna and United. In discussing data capabilities, Dr. Rauner stated that Nebraska Medicaid is very limited in their ability to do queries. Ms. Roberts-Johnson clarified that Nebraska Medicaid is willing and able to do queries, data queries just take a long time to execute given the 33-year age of the Medicaid Management Information System (MMIS). She furthered that Nebraska Medicaid is working towards a new system, which is a three to five year build, but procurement is not currently underway for this.

Dr. Knowles cautioned that BCBS is not very easy to deal with and she does not want to it to seem as though the Council is empowering them. They do not cover preventive measures that other insurers do but she does think the Council should work with everyone else to spur competition especially in terms of buy in. Sen. Gloor added that the other insurers in the State lack the resources that BCBS has and are not as well organized. The other insurers will follow suit so they are not disadvantaging themselves further.

Dr. Hickey provided insight to the group on the Omaha insurance market. Sen. Gloor affirmed the importance of due diligence on the anti-trust issues, stating that he did not think other insurers would hesitate to make an issue out of this. Dr. Carnazzo maintained that she wants the Council to decide what is best for the patient and not let the insurers decide.

Dr. Werner asked Dr. Rauner if their pilot was anywhere beyond the conceptualization process of a medical home. Dr. Rauner responded that they were still in conceptual design process but they know they would like to work on a disease registry to help residents and would still like to do it Lancaster and Douglas counties. He said that they were still waiting for NMA board approval of their joint principles and were still leery of having everyone in the same room until they had sorted out any potential anti-trust issues. They do not want to use the NCQA model because it does not allow residency programs so they are focusing instead on proven core measures.

Ms. Roberts-Johnson interjected that she and Director Chaumont have already discussed meeting with BCBS and want to collaborate with them.

Dr. Werner queried the Council on how to approach collaboration with BCBS and other insurers asking if they should coordinate with them up front or continue to meet independently and involve them later. Sen. Gloor proposed coordination with the insurers and the independent meetings take place concurrently. He advised the Council to talk with anyone they want but to do their own thing and stick tight to their principles. Dr. Carnazzo stated if the Council establishes the right medical home, the payer should

not matter. The insurance executives may not be happy but their objective is to bring costs down and provide better coordination of care.

Discussion flowed to obtaining data, the inability on the part of the insurance companies to provide useful data, and the difficulties practices without electronic medical records (EMRs) will have in providing data. Dr. Hickey referenced engaging the Nebraska Health Information Initiative (NeHIII), adding that they could be a coalescing tool for all the data. Ms. Roberts-Johnson furthered that Nebraska Medicaid has good connections with NeHIII. Dr. Knowles had reservations given that NeHIII is not currently tracking immunizations and noted that immunizations are one of the most cost effective things pediatricians administer.

Dr. Darst said he is interested in staying in parallel communication with Dr. Rauner. He said that he does not want to be inventing a cat when everyone else is inventing a dog and does not want the Council's pilot to be dramatically different because Medicaid will get the blame for it. There was agreement among the Council members that staying in touch would be beneficial for everyone.

Sen. Gloor reiterated that in the meantime, DHHS should check with their in-house counsel on the concerns with anti-trust implications.

Medicaid Data

Dr. Werner drew the Council's attention to the handouts provided.

Ms. Roberts-Johnson began by providing a map of where the Federally Qualified Health Centers (FQHCs) are located across the state as this came up in the last meeting. The 2009 Medicaid Reform report, a listing of states who received the NASHP grant, updated information on total numbers including Medicaid population by county, and visits per 1000 eligibles were also provided to the group. Ms. Roberts-Johnson cautioned that some of the higher utilization percentages might be more reflective of very small population sizes in those counties than actual frequency of visits. She noted that the highlighted counties are part of the Medicaid managed care program and excluded from the pilot. Ms. Taft was in contact with Paula Hartig to help with questions around confidence level numbers and provided information to the Council.

Dr. Darst asked for specifics on what level of detail Medicaid could provide in terms of data reporting. Ms. Roberts-Johnson reported that Medicaid could provide data at the patient and provider level using claims data. Dr. Hickey apologized for not providing a full listing of data that would be helpful in selecting a pilot but it is working on this. He also has been working with a consultant from Lewin who has provided additional insight. Dr. Knowles asked if the Aid to the Aged, Blind, and Disabled (AABD) could be split out by age to see what portion of the dollars are spent on pediatric patients.

Finalize Objectives, Implementation (Model), and Necessary Elements & Framework for Implementation

Dr. Werner suggested discussing agenda items 5 and 6 jointly. He discussed an idea brought up after the last meeting about site selection. Instead of working with different geographical locations, practices using the same Electronic Medical Record (EMR) system could be grouped together for the pilot. Practices in Lexington, Broken Bow, and Sidney all share the EMR. Ms. Roberts-Johnson expressed that Director Chaumont felt the legislation was specific to a geographic location. Sen. Gloor responded that it may still be okay to consider this option within the confines of the legislation. Ms. Roberts-Johnson suggested selecting two of the sites. Dr. Darst furthered that it was an interesting idea but wanted to be sure that it did not appear as though the Council were endorsing any particular EMR software.

Dr. Darst then also discussed the importance of having a third party help with or review clinical data from the practices. Dr. Hickey referenced NeHII again and their reporting capabilities. Discussion ensued on the use of Medicaid financial/claims data and potential partnerships with Axolotl or the University of Nebraska at Omaha students for assistance in data extraction and reporting. Dr. Werner noted that it would be beneficial to have the practice point out what it might want to use for its quality reporting measures given that the makeup of their patient population might dictate these.

Dr. Hickey talked about a seminar he attended on measurement in medical homes. There are essentially three categories of measurement; biometric measures of diseases being seen, cost measures such as utilization, emergency room visits, and hospitalizations, and overall wellbeing of health status reported using depression tools and other surveys administered to the patient at least 2-3 times over the course of the measurement cycle. Dr. Knowles said that it would be nice to have national benchmarks for the measurement that takes place.

Dr. Carnazzo, Dr. Werner, and Dr. Woodruff then led a discussion on access to care and possibilities for measurement. Dr. Wergin talked about health care coaches and the role they would play. Dr. Knowles brought up safety measures and the Council discussed what safety means. Medication errors and medication reconciliation were noted as the primary safety concerns. Preventing re-hospitalizations and the challenges therein were also discussed.

Dr. Carnazzo and Dr. Knowles talked about case managers and preventing the introduction of too many layers of communication. The benefits of having in-house case managers at the practice were also discussed. Dr. Knowles brought up after visit summaries and their use as a safety measure. Dr. Hickey added that looking at medications prescribed vs. medications filled could be another measure.

Sen. Gloor refocused the group by saying that hypothetically you could measure many things but realistically, the tighter and more accurate the measures are, the easier it will

be to convey the success of the pilot. Dr. Hickey referred to them as dashboard measures and suggested that the group look at emergency room visits, hospitalizations, readmissions, one health status measure, and one depression measure. These measures would be more plausible than measures incorporating the tracking of diseases given the smaller population sizes that will be participating in the pilot.

Dr. Wergin recommended that the Council decide on a few core measures they feel are imperative and then allow the practices to decide on other measures they want to incorporate as well. Dr. Darst disagreed because he feels that the doctors will already have measures in mind that may or may not be true indicators of improved access and coordination of care. Sen. Gloor said that the Council should not ignore the demographics of the practice. It will be important to have the dashboard indicators but the pilot site may be unique enough in some way that they will have something to add to their list.

Dr. Hickey said that Sen. Gloor said something profound at the last meeting just before he left for the special session. Sen. Gloor introduced this bill because he felt it would reduce costs and what he needs for his purposes to help advance medical homes across the state is to show how much of the state's money was saved during the pilot and how the existence of the medical home improved health outcomes. First and foremost, the pilot needs to deliver on the cost savings and improvement of health outcomes to generate future policy change.

Dr. Werner asked the Council to focus on just a few clinical outcome and cost measures. Discussion ensued on what the quality measures should be. Dr. Knowles expressed concern that it would appear outwardly that the Council's only focus was on cost measures. She asked that the Council be cognizant of this perception and that ultimately the focus be on improving the quality of care, which will in turn bring costs down.

A discussion followed on proper education for patients so that they do not sabotage their own health and the best ways to approach this education.

Sen. Gloor excused himself and told the group he is very pleased and appreciates everyone's hard work. He said to focus on primary care and even going back to old gatekeeper models. Medication savings seem like an easy win as well but just focusing on primary care will reduce overall medical costs noting that what an ENT may prescribe for an ear infection might be different from what a pediatrician or family doctor would prescribe.

Dr. Carnazzo initiated a discussion on nursing home costs since they comprise such a large portion of Medicaid expenditures. Potential cost savings for the nursing home population were discussed. Dr. Darst talked about the benefits of explaining a code to the families of nursing facility patients and having annual family conferences on limitations of care.

Framework for Implementation:

The process for converting practices and implementing the medical home with assistance from organizations such as TransformED was discussed. Dr. Werner asked if the process should be to take the Council's quality measures and then try to sell the pilot to a practice. Dr. Wergin said that by looking at the numbers and being familiar with some of the practices, he wants to push for the selection of a site with an EMR. He reported that Hall, York, and Dawson counties all have the same EMR. Hall county has a large group of adult Medicaid eligibles as well as a higher ER utilization percentage. Dr. Wergin also reported having a good relationship with Dr. Joe Miller in Dawson county and felt that Dr. Miller would be a proponent of the pilot.

Dr. Carnazzo said that Medicaid might need to pay more to be able to sell the pilot concept to the practice and Ms. Roberts-Johnson said that Medicaid knows it needs update and change its payment methodologies. She reported that she has found a fund that could be used at least initially to help with implementation costs.

Dr. Woodruff said that her practice hired a nutritionist and registered diabetic educator. She asked if there would be money to hire similar people and Ms. Roberts-Johnson said that Medicaid does not cover diabetic educators at this time.

Dr. Darst stated that a PMPM fee could help fund additional ancillary services like a diabetic educator. He said that there should be an incentive in addition to the pmpm so the doctors can feel like they could reward themselves, a carrot on a stick. Ms. Roberts-Johnson suggested a goal that could be set forth with a backside monetary incentive. Dr. Darst then laid out the following plan that was later repeated and affirmed by Dr. Werner:

- cover additional administrative costs with the pmpm fee,
- preserve the current fee schedule and not increase fees by code as this may encourage doctors to just churn out more codes, and
- an incentive for reaching established goals.

Dr. Darst mentioned that there might be some sensitivity among the doctors when it comes to gain sharing type incentives because of past experiences with HMOs in the state. To attain buy-in, the incentive concept will need to be approached with awareness of these doctors' experiences. Dr. Hickey said that a gain-sharing incentive is important to achieving overall cost savings even if the doctors may be hesitant to sign up for something labeled as such.

Dr. Wergin discussed the need to ensure cost savings are funneled back into the project and do not go back into State general funds. This happened in North Carolina. Ms. Roberts-Johnson responded that the incentive is a more concrete way to get the money back so the money does not go away if there is a budget shortfall. There was also discussion on ensuring the practices and doctors benefit from the incentives instead of the money going to hospital associations that may own and run the practices.

Dr. Wergin talked about hiring a FTE funded by Medicaid that could help with number crunching possibly through the local public health departments. Ms. Roberts-Johnson

felt that this would be acceptable in the short term but would not likely work as a long-term solution. She reported that partnering with the Health Departments is a way to maximize resources.

A discussion followed on making sure that the doctors are committed to the project and set up for success in the beginning. Dr. Hickey mentioned that the pilot in Fairview, MN had a set of criteria laid out to determine a practice's openness to change. Dr. Darst noted that in articles he read, the practices that participated in medical home pilots that failed to save money shared an inability to effectively change their behaviors and workflows.

Margaret Kohl asked Ms. Roberts-Johnson to explain the Request for Information (RFI) process. Dr. Wergin expressed a need to identify those practices that are most likely to succeed over sending out a general request.

Determine Support Needed from Outside Resources

Dr. Werner referenced the money that may be available from the State; BCBS may be a source, and then grant money that may be available at some future point. The increased population penetration gained by collaborating with BCBS was discussed. Ms. Kohl reported that CMS was planning to send out an RFI for a medical home partnership by January. Dr. Hickey spoke about involving Sen. Ben Nelson for his assistance with a response to the RFI and said he would pursue this further.

Frequency of reporting quality measures was then discussed. Dr. Carnazzo wondered if monthly reporting would be discouraging but Dr. Darst felt that monthly reporting could spur competition among the doctors and nurses furthering the success of the pilot.

Closing

Dr. Werner asked for public comment and Ms. Kohl responded that she would email a list of items to Dr. Werner.

Dr. Werner then advised the group that a representative from TransformED who has helped sites transform their practices and does consulting would be presenting via teleconference at the next meeting. Ms. Taft said that TransformED is not in to sell but to share their knowledge and experience.

Dr. Werner asked for feedback on the next meeting's agenda and Dr. Woodruff said she would like to review the high points of the discussions today and spend time on implementation. Dr. Knowles asked that the age breakdowns of the Medicaid population and the expenditures be reviewed.

Dr. Werner adjourned the meeting at 5:00 pm.