

Medical Home Advisory Council Meeting
February 3, 2010
LMEP, Room 3

Members in attendance: Dr. Werner, Dr. Darst, Dr. Carnazzo, Dr. Knowles, Dr. Wergin,
Dr. Woodruff, Dr. Hickey

Members not in attendance: Sen. Gloor

DHHS Staff in attendance: Aishah Witte, Pat Taft, Margaret Brockman

Approval of January 5 Meeting Minutes and Approval of Agenda

Dr. Werner convened the meeting at 1:10 pm. He called for corrections to the January minutes and they were approved as written. He informed the group that Mr. Bailitt will present for the whole meeting.

Medicare Medical Home Demo

Before Mr. Bailitt began his presentation, Ms. Taft provided summary information on the two Medicare Medical Home pilot initiatives. She reported that the Nebraska pilot does not qualify for the demo at this time because the guidelines require an active medical home. Mr. Bailitt added that the letter from Sebelius said that states would need to have initiatives underway in 2010 including agreements for a prescribed set of activities or some sort of assistance provided to the pilot sites. Dr. Werner said that Nebraska would then need to have some sort of agreement with private payers to accomplish this. Mr. Bailitt reported that he has worked with initiatives that have been up and running in five and a half months. Dr. Hickey affirmed that this was a “doable” timeline.

Ms. Taft notified the council members that the mileage reimbursement rate has changed and she would distribute new forms to the group.

Bailitt Presentations:

[Planning a Medical Home Initiative: Recommended Design Steps](#)

[Payment Reform: A Review of Existing Models](#)

During the presentation, the Council members posed questions.

Question: What about integrating with other payers and what end goals will they want to see.

Bailitt Response: Dr. Bailitt responded that other payers would also be looking for a financial return. He recommended emphasizing those things that would generate a return in two years because without a demonstration of savings, the initiative is not likely to be continued. This requires a tradeoff because while some preventive measures may be

essential, they will not show an immediate savings. Ultimately, cost savings will come from better overall care for patients but there is a need to have some special focus on patients that will utilize the most services, particularly hospital services. Prescription drug costs go up in a medical home practice but hospitalizations go down.

Question: If standards like NCQA are used, how do we get buy-in from the practices?

Bailit Response: The exercise of reading the NCQA standards and procedures is not enough to transform a practice into a medical home. He advised reviewing the core competencies established by Massachusetts and Texas. Staff will provide these lists to the group. Mr. Bailit then discussed the benefits of practice coaches. Dr. Darst seconded that during his practice's process to become NCQA certified, having someone to help guide their practice would have been helpful.

Question: What do we need to think about regarding antitrust issues?

Bailit Response: State sponsored initiatives are helpful in overcoming concerns of this type. If only Medicaid and BCBS are working together, there are no concerns. Introducing other payers might be an issue. He reported that he was not aware of any states that have experienced any problems and usually a State representative of some type ranging from the Attorney General to the Insurance Commissioners have helped to pave the way for these collaborations.

Comment: We are concerned about having enough total patients to measure success.

Bailit Response: He affirmed this concern and stated it will be difficult with the current scope to demonstrate statistically significant cost savings or improvements. He emphasized the need to work with other payers and multiple practices. Texas, in their pilot, determined that they would need at least 5,000 patients and a colleague noted that she had not ever seen a pilot with less than 10,000 participants. He also discussed the need for a control group for measurement purposes. He suggested working with a statistician in Public Health to do an analysis using the primary utilization measures (e.g., ER visits, hospitalizations, wellness visits, and indicators for chronic diseases such as diabetes).

Question: Are electronic health records necessary?

Bailit Response: Mr. Bailit told the Council that he would not require an EMR.

Question: What are average PMPM fees?

Bailit Response: Nobody knows how much a Medical Home costs. Current fees range from \$3-\$8 for the general patient population and \$8-\$12 for Medicaid and disabled patients. Dr. Hickey and Mr. Bailit discussed P4Ps and how to ensure that an appropriate and desirable share of the cost savings go back to the physicians.

Question: Are salaried care managers that work for the practice better than those that work for the health plans?

Bailit Response: Practices want the care managers to be theirs but there have been examples where very good relationships have developed between the practice staff and the care managers from the health plans. Discussion among the group ensued on the benefits of care managers, the role they should play, and how to fund them.

There was some discussion on overall payment reform in health care, where the savings will come, and what industry changes will come about.

Question: What is your opinion on the two or three approaches that would be best for Nebraska's pilot?

Bailit Response: He recommended supplemental payments going to practices with an amount earmarked for care management. He said shared savings plans are complex and he generally likes them but would probably not employ one for a two-year pilot project. He recommended clearly defining the objectives for the pilot and the outcomes that would need to be achieved for the efforts to be sustained for more than two years. He advised funding the care management nurses outright. Dr. Carnazzo was in favor of this funding because she feels that the care managers will help the doctors who feel so inundated have more time to provide direct patient care and felt that this alone without any additional financial assistance would be attractive to the practices. Mr. Bailit responded that in the culture of primary care practices, some will say let's do it regardless of the financial incentives. He proposed having the practices who are excited about their medical home initiatives present to the pilot sites.

Question: Are there benefits in the programs where the practice was awarded money up front instead of just on the back end?

Bailit Response: Up front money is a good idea when the physicians are going to be out of the practice a significant amount of time for trainings and otherwise. He recommended providing some sort of good faith effort with money up front for a disease registry or something similar and if it works after two years, refocus and redesign the payment model after successes.

Question: Do payers pay the same PMPM in a multipayer initiative?

Bailit Response: They usually all pay the same thing but not the same in terms of fee for service. Dr. Knowles brought up concerns with paying a practice a PMPM for a patient that they do not see. Mr. Bailit laid out the importance of Medicaid running a "patient attribution algorithm model" to determine the assigned physician so this does not occur. To help patients stay with the same practice, he emphasized patient engagement, the development of a personal relationship between the doctor and the patient so patients will not head to the ER or consult specialists who may order costly tests without the primary care physician's knowledge.

Question: Are practices using the services of TransformED or other similar entities in their implementation processes.

Bailit Response: It varies and there is no preexisting labor pool of practice coaches. It is risky because you could end up with someone who is not qualified. QIOs and Disease Management companies are seeing practice coaching as a burgeoning business opportunity. Finding the right person for the job is challenging.

Question: Is it critical to have the pilot up and running this year to benefit from the Medicare money available?

Bailit Response: Yes, because the demo, as it stands now, requires an existing medical home to qualify. The Medicare share of the PMPM fees were also discussed and Mr. Bailit noted that they generally would not do more than what others are doing.

Question: What needs to be considered for accessibility and the benefits of alternative hours and alternative methods of communication between the practice and patients?

Bailit Response: He referred to his “ideal” medical home and while accessibility is listed, it is not at the top of his list of medical home attributes.

Other Discussion:

Dr. Werner asked for any public comments and there were none.

Margaret Kohl issued a reminder that Jenifer Roberts-Johnson mentioned last time that there may be some Medicaid money to use for the pilot and AAFP extended money in other states for this. She extended her help from a legislative perspective in attaining these funds.

Dr. Werner asked the Council about the agenda for the next meeting. It was noted that the Council would like to regroup, reprioritize, and review the core competencies established by other initiatives. Ms. Taft added that some items that were on the January meeting agenda but not covered could be carried over to the March agenda.

Dr. Hickey said that he would like to have the fundamentals decided before selecting the sites. He stressed the need to come up with some statistical support to determine what numbers are needed to demonstrate a meaningful difference. He suggested partnering with BCBS to accomplish this. He said that we need to have conceptual discussions so we can move on to the decision makers and be able to seek additional funding from outside sources. He remarked that Omaha is one of the most affluent cities in the world and if the Council can partner with the right people, funding could be available. He said that he knows some people to approach but the pilot needs to have some initial investment capability.

Dr. Werner renewed the need to get approval from the State to begin talks with BCBS to avoid antitrust issues. Mr. Bailit reiterated that there is not too much danger as long as the talks are only with BCBS.

Dr. Woodruff and Dr. Werner discussed the frequency of Council meetings and meeting again before the scheduled March meeting while so many things were still top of mind. Ms. Taft will query the appropriate parties about the Open Meetings law to determine if the Council can hold a conference call on the evening of February 18, 2010.

Dr. Werner adjourned the meeting at 5:10 pm.