

Medical Home Advisory Council Meeting
April 7, 2010
Lincoln Medical Education Partnership, Room 1

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

Members not in attendance: Dr. Hickey

DHHS Staff in attendance: Aishah Witte, Pat Taft, Margaret Brockman, Paula Hartig,
Heather Leschinsky, Kim Collins

Approval of March 2nd Meeting Minutes and Approval of Agenda

Dr. Werner convened the meeting at 1:08 pm. The minutes and agenda were approved.

Staff Update

Dr. Werner informed the Council that he met with Director Chaumont and Ms. Roberts-Johnson. Dr. Werner reported that Director Chaumont is very committed to the pilot project. Going forward, Ms. Taft will be playing a greater role and Ms. Roberts-Johnson will have a lesser role in the meetings but is still available to come to meetings on a request basis.

Ms. Taft gave some operational updates including the future meeting location, the Nebraska State Office Building. She reported that Dr. Filipi from BlueCross BlueShield (BCBS) Nebraska was present for the meeting and is ready to begin working with the Council on the pilot. Ms. Taft told the group that the State is working on lining up an evaluator/consultant to assist with the development of measurements and possible data analysis for the outcomes discussed at the March meeting.

Ms. Taft introduced the National Academy for State Health Policy (NASHP) group that would be presenting and encouraged the Council to ask questions throughout their presentations. The group members present were Mary Takach, Neva Kaye, and Jason Buxbaum. They are in Nebraska for a site visit related to the Technical Assistance award given to Nebraska last fall.

Discussion: Care Coordination

Ms. Takach presented first on care coordination. She has worked with 16 other states to advance their medical home initiatives. She is extremely impressed with Nebraska and the progress made in a short amount of time. She then went through her presentation slides.

Dr. Carnazzo asked who is usually hired for care coordinator positions and Ms. Kaye responded that the care coordinator does not necessarily need to be a nurse but needs to be someone with sufficient medical experience and who is able to dedicate a designated portion of their time to care coordination. Ms. Takach said some states do however require RNs.

There was discussion on including only patients with five or more chronic conditions in the medical home. Ms. Takach reported that Minnesota uses this approach and practices are already beginning to include patients with three to five conditions after experiencing success with those with five or more conditions. Dr. Werner asked what conditions were included. Ms. Kaye and Mr. Buxbaum referred them to the Minnesota website.

Dr. Carnazzo asked about patient buy-in and engagement. Ms. Kaye talked about North Carolina where they have a mandatory program and measure success across the entire population so even though there are some patients who do not engage, they still see improvement.

Ms. Takach continued through her presentation. She discussed the community care teams in Vermont and North Carolina. Additional discussion on funding and processes for care coordinators followed. Dr. Werner confirmed agreement from the group that integrated care coordination should be provided in-house by the practices possibly with supporting payments for this purpose.

Discussion: Pilot Area(s)

Paula Hartig and Heather Leschinsky discussed the methodology used to determine the number of Medicaid clients needed in the pilot to evaluate with confidence which would be a minimum of 1404. Using that minimum, DHHS identified communities that would have practices with sufficient numbers of Medicaid clients. Those included Scottsbluff, Sidney, Ogallala, North Platte, McCook, Lexington, Holdrege, Kearney, Hastings, Grand Island, Columbus, and Norfolk.

Sen. Gloor cautioned laying an importance on having a valid response rate as the legislature may be more impressed with anecdotal stores of success. Dr. Werner asked what would be needed to convince the legislature to move forward with a medical home initiative and Sen. Gloor replied that a financial savings would be most convincing but reminded the Council they should not be overly concerned with swaying the legislature because the Medicaid department does not need legislative approval to amend their payment structure.

There was some discussion over the challenges with determining the size of the Medicaid population and Ms. Leschinsky provided an explanation of the turnover rates in Medicaid referring to the adult population who may lose and regain their eligibility from month to month. The survey process was also discussed in detail.

Sen. Gloor questioned whether or not there would be more people to survey and include in the data if the pilot commenced earlier than expected as well as additional cost savings

due to the additional time to realize savings from implementing preventive care measures. Debate ensued on this topic.

Dr. Woodruff provided the group with information on the clinics in her area including EMR status, urgent care facility proximity, and patient demographics. Ms. Taft clarified that York is excluded from the listings because it is a contiguous county to a managed care county. It was agreed that an RFI could be sent out casting a wide net to the communities selected. Selected practices could be sent a letter from doctors on the Council encouraging their participation.

Ms. Kaye stressed the importance of engaging communities by putting information in health association newsletters and having professional associations such as the AAFP and AAP send out letters as well.

MOTION: Dr. Woodruff moved to send out an RFI. Dr. Knowles seconded. Voting yes: Carnazzo, Darst, Knowles, Wergin, Werner, and Woodruff. Voting no: None. Abstaining: Hickey (not present at meeting).

Discussion: Practice Standards

Margaret Brockman and Margaret Kohl presented a handout on core competencies with breakdowns based on a model used by the state of Oregon. They then asked for general input from the Council. There was some discussion whether the competencies should be the same for all practices and whether or not variance would be allowed to account for community factors. The different doctors on the Council talked about their experiences and best practices for interpreter services and appointment reminders. Dr. Carnazzo felt it would be best to set guidelines that could then be adjusted based on practice culture and other factors. Dr. Carnazzo also questioned who should be monitoring practices to ensure they are following the guidelines set. Ms. Kaye reported that the means of reporting and notification for meeting the measures is usually standardized but the process for meeting them is not.

Ms. Taft refocused the discussion to data management and associated core competencies. Dr. Werner noted the need to identify patients with diseases/chronic conditions and track those patients. Dr. Woodruff cautioned that the Council would need to narrow their tracking for the pilot if they work with a practice that does not have an EMR. Dr. Darst said that NEHII and the assistance they could offer had been top of mind for most of the discussion and suggested their assistance be sought further down the road.

The Standards Resource Team will continue to develop draft standards to bring to the June meeting.

Discussion: Payment Methodology

Ms. Taft introduced Kim Collins from Financial Services with the Department of Health and Human Services. Ms. Taft walked through the proposed reimbursement method

developed by the Payments Resource Team mentioning that they looked at what other states are doing but it was difficult to find a match because they are mostly multi-payer and statewide initiatives. Ms. Taft advised there were no actual figures on the table and is just looking for personal reactions at this point. Dr. Carnazzo mentioned the national movement toward Medicaid reimbursing at Medicare rates and there was discussion on where Medicaid rates are in comparison to Medicare rates. Dr. Carnazzo does not believe that just a \$5 PMPM or the “package” presented will achieve practice buy-in. Dr. Darst felt that if the practices get all staff members working to the full extent of their licenses, efficiencies would be introduced making the payment methodology proposal seem more favorable.

Dr. Carnazzo felt it was important for there to be something left over for the physicians at the end of the month aside from the additional PMPM and assistance with EMR, disease registries, and funding for care coordinators. Dr. Knowles proposed that at least some sort of pay for performance be included in the package. She provided the example of bumping their fee schedule up to 90% of the Medicare rates. Dr. Darst also strongly argued in favor of pay for performance. For practices that already have an EMR, the incentives proposed may not be enough to overcome the difficulties associated with transformation.

Ms. Taft noted that the proposed methodology followed the PCCM model currently in place and this will facilitate CMS approval. She also reminded the group that Michael Bailit in his discussion said that practices will be motivated to transform without much outside incentive to improve the care they provide. Dr. Werner suggested tabling this discussion and continuing when Dr. Hickey was present as well.

Set Future Meetings

The future meetings dates were confirmed and scheduled for May 11, June 2, and July 6.

Public Comment

There was no public comment and Dr. Werner adjourned the meeting at 4:50 p.m.