

Medical Home Advisory Council Meeting  
June 2, 2010  
Nebraska State Office Building - Lincoln

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

Members not in attendance: Dr. Werner, Dr. Woodruff

DHHS Staff in attendance: Margaret Brockman, Paula Hartig, Heather Leschinsky, and  
Pat Taft

### Approval of May 11th Meeting Minutes and Approval of Agenda

The meeting convened at 1:05 pm. Dr. Darst chaired the meeting because Dr. Werner was unable to attend. Dr. Darst reported that Dr. Woodruff would not be able to attend either and Dr. Hickey noted that he would need to leave the meeting early. The agenda and the meeting minutes were approved as written.

### Staff Update

Ms. Taft reported that they are moving forward with obtaining some assistance with the evaluations and are talking with the University of Nebraska Medical Center, Department of Health Services Research & Administration. Dr. Hickey stated that his group has contracted with the same organization out for these services as well. Ms. Taft expressed that they are interested in filling Dr. Hickey's soon to be vacant spot on the Council with someone who is exactly like him. He said there are be three candidates within his health system that will all be good. He also reported that he may be around for a little while longer as well.

### Payment Methodology

Ms. Roberts-Johnson handed out a summary on the proposed reimbursement plan. A per member per month (PMPM) payment will be coupled with the normal fee for service code payments and the practice support valued at \$130,000. The practice support includes two years of practice transformation assistance, two years part time care coordination staff, travel reimbursement for attending learning sessions, and the possibility of an enhanced fee for selected primary care oriented service codes. Ms. Roberts-Johnson told the Council that the duration of the project does not allow for pay for performance, or cost sharing. They could however be incorporated at a later time if determined feasible. Ms. Roberts-Johnson asked the group if a stronger PMPM with a smaller percentage used for the enhanced fees for primary care focused service codes would be preferable over a weaker PMPM with a higher percentage allocated for the enhanced fees.

Dr. Knowles questioned when the PMPM would begin. Ms. Roberts-Johnson clarified that it would begin in year one. Some reservations were expressed by Dr. Knowles and Dr. Darst regarding the higher enhanced fees for services codes and the possibility of practices bringing patients back in and using these procedure codes when the visit may not be necessary. Dr. Wergin discussed the importance of both the PMPM and the enhanced fees but expressed the same reservations with the reverse incentive that enhanced fee for service codes may create.

Dr. Carnazzo discussed having a balance and tiers of payment but did not see that the second year should necessarily be the year with higher payments for administrative costs. Dr. Knowles referenced the costly administrative burden evident in identifying which patients are behind on their immunizations or asthmatics that have not been seen in an appropriate amount of time and other such concerns. Once tracking and alert systems are in place, the administrative costs would decrease.

Dr. Darst asked what happens in the practices when the transformation support ended after two years and if there was any thought put into gradually increasing the PMPM so when the support ended, the practice would be able to absorb the extra costs themselves instead of just dropping their medical home initiative. Dr. Hickey talked about the immediate savings evident from decreased hospitalizations and noted that if that it looks like it is working after two years then a gain-sharing program could be implemented for the practices avoiding a significant increase in the PMPM. The further feasibility of a gain-sharing and pay for performance plan was discussed. Ms. Roberts-Johnson said in their research, they did not find that practices achieved stable cost savings in the first 18 months, only cost neutrality. Dr. Hickey cited a recent study that found a 20% savings in the first two years. Dr. Darst asked if pay for performance incentives were off the table because of budgetary concerns or time constraints. Ms. Roberts-Johnson said both and they could be considered later as Director Chaumont is supportive of the concept. She furthered that they are not completely off the table but have not been determined to be the best approach for this two year pilot. Medicaid could implement a pay for performance structure after the pilot.

DECISION: The council unanimously agreed on Option B as presented by Ms. Roberts-Johnson – higher PMPM and lower enhanced FFS for selected codes.

### Medical Home Minimum Standards

Ms. Brockman and Margaret Kohl presented the latest draft of minimum standards. This information will be included in the RFI. Ms. Brockman discussed the approach taken in identifying the standards and the two-tier system outlined if enhanced FFS is adopted. One tier for the start-up period and the second if the practice meets a second set of standards. Dr. Hickey questioned a statement made by Ms. Brockman where she said that the standards should be harder in reference to actual implementation of the pilot which essentially addresses putting well thought out policies into action. Dr. Hickey felt that the urban practices would have a difficult time meeting the standards raising concerns for the rural practices that would participate in the pilot as well. He felt some

items would pose an administrative burden to the practices. Dr. Carnazzo echoed this saying that there seemed to be a great deal of paperwork needed to meet these standards taking time away from patient care. She advocated for more practical standards and said that some of the standards fell into basic standards of care.

Dr. Knowles said that confirming an active drug list with the patient is a basic level activity and should be done every time. She also discussed the importance of knowing if the prescriptions were filled and Ms. Brockman confirmed that Medicaid could provide this information. This drugs discussion resurfaced later in reviewing the standards one by one. Dr. Knowles believes that the patient should have something in writing when they leave the appointment including a visit summary, current prescription information and instructions, and after visit instructions such as when to follow up with the doctor. Dr. Darst agreed that this was an important and useful step that cuts down on questions, phone calls, and confusion. Dr. Knowles also cited a Kaiser Permanente study affirming the utility of an after visit care plan type document.

There was general consensus from the group that the standards need to be basic, simple, not paperwork-intensive, and measureable. Sen. Gloor cautioned from stripping away very much from the written policy aspects of the standards and stressed the need for identified and standardized policies and procedures among the doctors in a practice. Dr. Hickey noted that implementing standardized practices for the doctors in his experience fell in line over time and was not as cumbersome nor were the doctors as resistant as first anticipated.

The Council felt it was important that the practices not spend the first year drafting written plans and policies but focus on behavior change. It was agreed that it would be helpful to provide modifiable templates for care plans, policies, surveys, and other needed documentation to the practices so that they do not all expend time separately creating similar documents. Workflow processes and the challenges with introducing new policies within a given practice culture were discussed. Dr. Darst shared success he has had with making the evaluation of workflow and duty assignment a fluid process taking into accounts the details of the duty such as how far do you have to walk to complete the task for example.

The Council reviewed and discussed each standard and offered suggestions to combine standards and revise wording for clarity and intent in addition to lowering expectations or raising expectation on several. Ms. Brockman and Ms. Kohl will incorporate the recommendations to develop a final draft for recommendation by the Council.

### Practice Transformation Support

An RFP will be published to find a contractor to provide technical assistance to the pilot practices to assist with practice transformation. Ms. Taft presented a draft list of expectations for the transformation support that will be provided. Ms. Taft reported that they expect the vendor to guide the practices, help them to achieve the minimum standards, and provide consultation to the Department. She went through the details of

these expectations and asked the group for items that may have been missed. Dr. Darst suggested adding reference checks to the selection process. Dr. Knowles recommended that the vendor have experience with rural practices and Dr. Wergin affirmed this. Dr. Knowles referenced the importance of experience with similar medical homes so they can share best practices as well as failures to avoid.

#### Set Future Meetings

Ms. Taft asked if the Council felt it would be helpful to have practices present that have had transitioned to a medical home at a future meeting. Dr. Darst liked the idea of saving this for after the practices have been selected. The next meetings are scheduled for July 6, and August 10.

#### Public Comment

A representative from the Nebraska Dietetic Association presented and encouraged the Council to include dietitians in the ancillary staff in the medical home. The representative detailed the services they could offer the practices. Ms. Brockman offered some clarification on what Medicaid covers for nutrition counseling services. Dr. Darst adjourned the meeting at 5:05 pm.