

Idaho Medical Home Collaborative
Meeting Notes – January 28, 2015

Present: Scott Dunn (co-chair), Lisa Hettinger (co-chair), Matt Wimmer, Debbie Schreiner, Becki Wallace, Yvonne Ketchum, April Dunham, Susie Pouliot, Annette Phillips, Ted Epperly, Rich Rainey, Kevin Rich, Brad Leavitt, Kathy McGill, Mary Sheridan, Cynthia York, Greg Shubbata, Karl Watts, Scott Smith, Curtis Loveless, Melissa Carico, Heather Clark, Donna Colberg, Irene Collie, Teresa Martin

Topic	Discussion
Welcome and Agenda Review	Scott Dunn welcomed the group and reviewed the agenda. The previous meeting notes were reviewed and accepted.
Payer Updates	<p>Blue Cross – Becki reported their total numbers are at 1013 members. Ten out of eleven clinics have signed an extension for the program which will take them thru the end of September. They continue to work on attribution for a new program and said it is a challenge in the PPO environment.</p> <p>Ted asked about the clinic that chose not to continue in the program. Becki replied that it was Kootenai and they chose not to continue due to their resources. Lisa said that Kootenai has dropped out of the Medicaid program as well. Curtis said that Kootenai decided not to participate because they felt that their clinics were in different places in their readiness to proceed in PCMH and participate with Idaho Medicaid. They wanted to withdraw their final two clinics so they could regroup all of their clinics with a better approach and better aligned.</p> <p>Pacific Source – Not present at the meeting.</p> <p>Regence – Greg reported that they had a final meeting in December with participating clinics about ending the program. They discussed continued participation in the monthly Nurse Care Coordinator sessions. They are hoping to bring these sessions to Idaho. They will be sending out a “Save the Date” within the next few weeks. Scott asked if Regence is planning on any kind of a two year review and Greg replied no, not at this time.</p> <p>Medicaid – Curtis reported that in the Health Home program, they have 8858 members currently enrolled in 50 different service locations. Of that population, 4042 are enrolled at 30 pilot locations. He gave an NCQA update and of the 50 locations participating in health homes, 31 of them have been recognized and that 13 locations will be submitting an application by the March 31st deadline. The remaining locations that have not been recognized are either not due to receive their recognition or</p>

	<p>haven't had the requirement to apply yet. He said that they have shifted their focus to a quality assurance or quality assistance compliance. They are working with the clinics on an on-going clinic enrollment process, so they can continue to get new enrollees into the health home system as well as working with the clinics so that they don't miss reimbursement opportunities for qualifying members who are receiving care thru the PCMH model. Some of their efforts are around patient engagement and implementing strategies to engage patients and work in care plans with clinics.</p> <p>Scott asked about the drop in enrollment numbers. Curtis said that yes, the numbers are down a little bit. They have had a couple of locations drop out and that has affected the enrollment numbers, as well as problem with ongoing enrollment in the ability for clinics to send new enrollees that meet the diagnostic criteria and getting them enrolled in the program.</p> <p>Matt commented that a lot of the clinics are really focused on meeting the primary care activities for the enrollees that they do have rather than bringing on new enrollees.</p> <p>Scott asked about a grant that was offered to the pilot clinics to participate in regarding hypertension and diabetes.</p> <p>Matt explained that the grant is thru the Department of Health and Welfare, but not being delivered thru Medicaid. This grant is thru the Division of Public Health and being administered by April Dunham. April explained that they are currently working with 13 organizations under the grant funding and they are all either pilot clinics or FQHC's.</p> <p>Yvonne commented that in the multi-payer workgroup for SHIP, Noridian did a report about a new case management fee that was effective January 1st for case management. The code is 99490 and allows for clinical staff to spend 20 minutes to do care coordination.</p> <p>Ted said that Noridian has been at the last two SHIP meeting and will continue to be at all of the future meetings, with the explicit statement from Noridian thru Medicare that they want to be a part of this and will be at the table. He said it's a huge deal and really validates the work that this group has been doing. Lisa said that Medicaid always tries to stay in alignment with Medicare when possible and Medicaid will be reaching out to them to try to help them understand some of the other payment authorities that Medicaid has been granted, in order to make some of these more global payment arrangements with primary care physicians and PCMH.</p>
<p>Preliminary Medicaid Health Home Data</p>	<p>Lisa talked about the Medicaid Health Home data explained that this information is preliminary. The claims period for which this data is based off of has not closed yet. Medicaid has a one year timely filing limit, so it will be a little longer before this</p>

	<p>period closes and a true evaluation can be made. She said they did want to share the success. This information was shared at the JFAC presentation as part of the budget request for this year. Lisa said that they are thrilled with some of the progress that they are seeing coming out of the medical homes and providers should be really proud of what they have been able to achieve. They will continue to work on more robust data and are hoping, although it will be high level data, to be able to share regional data and potentially clinical level data within the next two to four weeks. They are hoping that when the final claims come in that they will continue to see some really good improvements in managed care.</p> <p>Ted added that data becomes really important and is a validator. He said that this is consistent with what's been seen across other states and their pilots nationally. He is very optimistic that this is accurate data, although there will be percentage point adjustments as it is finalized, but that this doesn't happen out of random chance. We are in the early stages of really integrating and coordinating care. He is very encouraged by this and appreciates Medicaid's diligence in getting the data, even though it is not thru the end of the reporting period, so that people get a sense of what we together are accomplishing.</p> <p>Scott Smith commented on their data from the VA national medical home and it looks very similar to this, but also includes decreased burnout in providers and increase in patient satisfaction.</p>
TransformedMed Update	<p>Matt reported that Medicaid continues to work with TransforMed. TransforMed has completed a provider satisfaction and change survey along the lines of Scott's comments regarding provider burnout. They are working with some of the other payers around aggregate claims data.</p> <p>Becki said she received an email just recently and will be working with them to get aggregate data.</p> <p>Greg said that they have been trying to identifying an internal path to supply data and it looks like they are looking at a data claims extract. They are meeting internally on Friday and will be coordinating with their informatics team to schedule a meeting with Chris soon.</p> <p>Matt said they are still on track to provide reports sometime in the summer and those reports will really compliment the numbers that were just presented. Curtis added that over the last 6 weeks TransforMed has gone to great efforts to contact providers and clinics to get their survey disseminated. They are engaged on their proposed plan and we hope to see results soon.</p>
SHIP Update	<p>Ted reported that the SHIP and the Idaho Healthcare Coalition continue to make great progress. They continue to meet monthly and now have 7 working groups. The first of the three new groups that have been added is the PCMH group which is</p>

	<p>as a result of the IMHC and honors all of the hard work that has been done and memorializes that effort into what we are creating for the state. The second of the three new groups is a group that looks at the integration of behavioral health and mental health with primary care and the third is a group looking at population health. These three groups join the existing groups around payment, quality, IT and data analytics. Denise Chuckovich, Elke Shaw and Ted met with all seven of the public health directors and regional collaboratives will be built in the 7 public health areas. The governance of these regional collaboratives will be by a board of directors that will have a chairman, along with community folks that will be critical to that regional collaborative. The public health directors will be as the administrator and facilitator of those groups. The Idaho Department of Health and Welfare continues to do tremendously good work in developing all of the requests for information and requests for proposals for all of the contracts that will come from the 40 million dollar grant. He said that they will be able to draw down money from CMMI on February 1 and will enter into a fairly active infrastructure development phase over the next 4 to 8 months as they start to get much of this in place. This grant is for 4 years and the first year is all about getting the infrastructure built right and solidly and then there will be three years of work where they will continue to roll out the number of practices into the patient centered medical home model with the development of the medical home neighborhood and the regional collaboratives, etc.</p> <p>Ted said that Director Armstrong spoke with JFAC and they have presentations coming up to both the Senate and House Health and Welfare committees and the legislature continues to be strongly supportive of all of the efforts related to the SHIP and the Idaho Healthcare Coalition.</p> <p>Lisa added that the IHC is truly listening to the information that is coming out of this workgroup in terms of how do we make sure that we learn all of the lessons we need to learn about this pilot, so that when we move forward with expansion for PCMH that we are doing it in a way that works well for providers and payers.</p>
<p>Discussion around NCOA</p>	<p>Ted said that one of the foundational elements of the IMHC was NCOA recognition. He said that with all of the work that has been done now and in looking at developing 150 patient centered medical homes, it is apparent that there are barriers that NCOA creates to many of the practices wanting or having the resources to move forward. What he has heard from the field is that there are a lot of practices that would like to move forward, but not with NCOA to achieve quality. He is wondering in terms of the IMHC recommendation – Should we develop an Idaho set of criteria. He said many of these could be similar to NCOA, but without the cost. Perhaps a collection of criteria that is necessary for practices to start to move along the continuum of integrated and team based patient centered care, that the patient centered medical home working committee could then judge and make recommendations as to practice's readiness to move forward. Ted is strongly in favor of that, because we don't want to have many practices that are on the verge of transformation pulling back at a time when we need to move forward. In summary, what he is asking for is "Would you feel comfortable with development of an Idaho specific set of</p>

	<p>criteria for which we can deem practices moving along the continuum of the patient centered medical home?" He said that we could use other states that have done this in terms of at least getting an idea, such as Oregon. Ted said that doesn't mean that people can't move towards NCQA as recognition as some point, but he is worried about the issue of not getting to the 165 practices because many may not have the resources.</p> <p>Kevin Rich spoke about the reason why NCQA was picked in the beginning of the pilot. He said they did discuss coming up with their own set of standards perhaps mirroring NCQA, but decided not to for a couple of reasons. One of those reasons was the administration of how practices were going to demonstrate how they met certain standards. He is in favor of looking outside of Idaho to see how other states are doing it. He said that the Michigan model has been working for a long time. He said do we require the practices to work towards something and hope they get it right or have some kind of an evaluation process that they can demonstrate that they have gotten it right.</p> <p>Scott commented that part of the initial thinking was also that originally practices felt like they needed more reimbursement in order to change delivery, but payers felt that in order to justify paying more they needed to see that they were getting more. Part of seeking some kind of recognition wasn't that you just achieved it but that you went thru the process identifying internally some things that you needed to do to become a medical home, so that payers could have some confidence that practices were accurately delivering a product that was different instead of business as usual. Scott asked the payers on the line what they thought about the idea of not having a national recognition but more of internal state wide recognition and how formal would you need that to be to have confidence that the practices are doing the work?</p> <p>Becki replied that she likes the idea. In her discussion with some of her clinics they found that the financial aspect of NCQA is a barrier for them. She said it is something that she would want to talk with others in the company to get their take on. It is a novel idea, but it does have some appeal for Blue Cross to develop those.</p> <p>Lisa commented that Medicaid is very interested in this dialogue and shares some of the same thoughts as with Blue Cross. As payers, we do need to see something that is robust and valid, but do we really need an external entity to bless a practice or can we craft something that we all mutually agree that is a reasonable equivalent and demonstrates that there has been change in transformation. She said they would be very open to that conversation.</p> <p>Annette Phillips said that they did find the process valuable because it laid out what they had to do for transformation, but it was expensive and time consuming both for administration in the practices and for people in the practices. It took away the time to do the transformation in to complete the application. They found NCQA not easy to work with at times, so that added another level to it. She reiterated that the process is valuable, but is one of their concerns moving forward. She said she would</p>
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	<p>need to talk with others at SAMG, but would be in favor of looking at something different, perhaps something with a streamlined approach would be better.</p> <p>Dr. Watt's commented that he wanted to support Annette's comments and feels that it would be very feasible to go thru this process without NCQA. What they used was the Safety Net Medical home curriculum to take them thru the process, which hit on pretty much all of the points in NCQA. He would encourage everyone to look at the Oregon model. SAMG is familiar with that model as they have some clinics in Oregon that are using it. It basically takes you thru many of the points especially looking at quality, but is not such an onerous workload.</p> <p>Ted said he found this conversation very helpful from payers and practices. He said they would still have a pretty robust and rigorous process. He said it makes economic sense, the see the finances invested internally into the practices, instead of into NCQA. In the grant, they will still have coaches and have people to help practices get there, but feels that they can construct a rigorous process that will meet the criteria that the payers are looking for. Other states have gone down this track and they have learned that they can achieve the outcome they are looking for with less expense and a more user friendly process. The money can be reinvested into the practice itself to achieve the outcome versus to an outside entity for proof that it has happened.</p>
Next Meeting	The next meeting will be a conference call, Wednesday, February 25 th , 2015 from 12 – 1:30 MST.