

**Idaho Medical Home Collaborative**  
**Meeting Notes – February 25, 2015**

**Present:** Scott Dunn (co-chair), Lisa Hettinger (co-chair), Matt Wimmer, Cathy Libby, Susan Ault, Debbie Schreiner, Yvonne Ketchum, April Dunham, Annette Phillips, Rich Rainey, Kevin Rich, Mary Sheridan, Cynthia York, Greg Shubbata, Tom Fronk, Tim Heinze, David Peterman, Brian Windau, Deena Lajoie, Meg Hall, Curtis Loveless, Heather Clark, Donna Colberg, Irene Collie, Teresa Martin

<u>Topic</u>	<u>Discussion</u>
<b>Welcome and Agenda Review</b>	Scott Dunn welcomed the group and reviewed the agenda. The previous meeting notes were reviewed and accepted.
<b>Payer Updates</b>	<p><b>Blue Cross</b> – Debbie Schreiner reported that they were able to update their contracts with all 11 clinics for 2015 and that their numbers are about the same as last month at 1013. She said that Becki was able to connect with TransforMed and they are working on the data for them.</p> <p><b>Regence</b> – Greg thanked Meg in helping to facilitate the ongoing conversations with TransforMed and Cobalt Talon. They are working thru the nuts and bolts details and legal agreements. They have settled on a date and location for the Care Coordinator Academy. It will be held on May 12<sup>th</sup> and 13<sup>th</sup> in Lewiston at the Red Lion Hotel. This two day conference will be around foundational care management principals, motivational interviewing, shared decision making and there will be an opportunity for networking. Regence is excited to bring this opportunity to Idaho. Greg explained that there will be another Care Coordinator Academy which is scheduled in Seattle for the following week in May.</p> <p><b>Pacific Source</b> – Not present at the meeting.</p> <p><b>Medicaid</b> – Meg reported that they have 4121 in the pilot and 4806 in health homes for a total of 8927. This is up slightly from last month. In the last two months the practice coaches have been working independently with each of the clinics in providing resources and lists of potentially qualified enrollees. She said that of the 50 health homes clinics, 32 have achieved NCQA recognition, 2 have applied, 9 will be applying by March 31, 2015 and there are 7 yet to apply. Because they are newer health homes, they are not required to meet the two year deadline yet for the Medicaid Health Home Program. Compliance efforts continue on care plans and non-engaged patients.</p>

<p><b>SHIP Update</b></p>	<p>Lisa stated that the IHC would like to see the individual workgroup’s minutes forwarded to them. She said that the IMHC regular approval process means that the minutes are delayed until the next meeting, so the information we would be providing to the IHC would be old. She proposes that the minutes be handled differently and that an email be sent out with the minutes asking for any changes or modifications so that they can be delivered in a timelier manner to the IHC.</p> <p>Scott suggested to the group that if there is a period of time after the email goes out, such as a week and there are no comments or suggestions made, then we could accept them by acclimation. There were no objections to this proposal from participants on the call.</p> <p>Lisa reported that the SHIP continues with its ongoing meetings. They received an interesting report from the multi-payer workgroup in regard to quality. One of the things that they looked at is the quality measures and if any of the payers had measures that they felt like they wanted to add. She said there wasn’t anything that came thru and what they are looking at is “how do they attach perhaps a payment incentive from quality measures”? She stated that all of the workgroups continue to move forward and work toward actionable items. She said that an item that is on our agenda today is regarding certification. She said “what does it look like if we don’t go thru a certification process for the patient centered medical home and instead come up with some kind of an Idaho process?”</p>
<p><b>Medicaid rule changes around SHIP</b></p>	<p>Matt explained that internally, Medicaid has been considering what policy changes need to be made in support of the SHIP going forward. They recently convened a project team to work on this. He said that the currently they have a high level of support for primary care medical home in the form of the health homes program, but then they have a primary case care management program that only supports primary care medical home activities at a low level. They provide a tiered payment based on whether people are generally well or sick and then, provide an incentive for practices to have hours outside of normal access hours. He said they are looking at creating a path between these two programs, which means redesigning the Healthy Connections programs. So at every level, wherever a practice happens to be as far as their primary care medical home activities that there are incentives to move them up to achieve a higher level of primary care medical home care. What they are thinking about is incentivizing along a continuum and that would mean restructuring primary care case management to account for four different things. Those four things are patient complexity, the degree that a practice is pursuing and achieving practice transformation to become a medical home, the quality measurement reporting and then performance on those quality measures. This would all go into what a practice would be paid on a PMPM basis.</p> <p>Matt stated that they are realigning some of the requirements. The Healthy Connections program has a fairly strong focus on referrals and the idea behind that is that it promotes communication across practices and the medical neighborhood, but there are questions about whether this is achieving what it is intended to achieve. Other ways to achieve stronger communication</p>

	<p>across the medical neighborhood and receive better coordination of care. They are considering changing the requirement from having the referral on the front end to communicating information back to the primary care provider on the back end so the provider has all of that information and use it affectively for the care and coordination of their patients. These are some of the things that they are looking at in terms of policy change. Any time there is rule making or policy changes at this level, they want to engage the community and feels that this group is a great start to engaging a primary care community. They will be going thru a formal negotiated rule making process and will ask for input from the IMHC and primary care providers. Matt explained they will be pursuing this over the next 6 to 8 months as they develop rules. They are trying to put this together in a manner that doesn't duplicate the incentives that the SHIP is already providing independently of any Medicaid program. He hopes to have a document by the next meeting that summarizes this information as a starting point for people to look at, talk about and provide suggestions to.</p> <p>Scott commented that he thinks the graduated incentivizing at each step is outstanding. This will help practices to stay motivated. Scott said that his other thought is, that as part of the medical home, they are trying to build teams and integrate other disciplines such as mental health, pharmacy, etc., "has there been any thought on incentivizing that as well"? Matt replied that as far as incentivizing other providers, at this time they haven't been thinking along those lines, but have had conversations with the behavioral health contractor, Optum, on how they can support behavioral health integration with primary care. Optum is currently participating in the behavioral health workgroup. Matt said they realize that you can't do this in isolation with primary care, but their focus is starting with the primary care program.</p>
<b>TransforMed Update</b>	<p>Matt reported that progress is happening with all of the payers on getting data to TransforMed. He expects that the report that TransforMed will provide in the next few months will be very informative as to what activities carry the most value and that will be important for the policy changes and rule making.</p>
<b>Medical Home Recognition</b>	<p>Scott started the discussion around the recognition process and said that what are used in the Pilot were the NCQA requirements and that clinics were to apply for them by the end of the 2 year pilot. He said that going forward with the IHC and as this is spread across the state, there has been concern and feedback that the NCQA process is onerous and expensive, and that perhaps more focused on the technicalities of reporting then it needs to be. He said that perhaps it is not as effective at really getting at what these practices should be doing. The concept was made that maybe we can adopt an Idaho recognition process which is more streamlined, a little more focused on the critical elements that are really going to make a difference and make the process be done in a shorter amount of time and with less costs. Six other states have done this, Oregon being the closest and he asked Tim Heinze to speak to this.</p> <p>Tim explained that he has spoken with a couple of colleagues with the Oregon Primary Care Association and an individual who was a fellow medical home facilitator in the Safety-Net Medical Home initiative, who now actually works for the Oregon Patient</p>

Centered Medical Home program that oversees the state specific recognition program. The program was developed prior to when Oregon implemented their Health Home program. They were on a little earlier trajectory than Idaho and did that back in September of 2011 and concluded in September of 2013. He asked the individuals that he spoke with “what was the driving force behind developing the state specific program? Their reply was that “they weren’t really sure.” One person said that they felt the 2008 NCQA standards were not rigorous enough but then when 2011 standards came out they were too rigorous. There were some comments to the costs to the practices. He said that if you look at their program, it is very similar to the NCQA standards. It is similar in that there are 3 levels of recognition. They have 10- must pass elements, where NCQA has 6 and one correlates with each standard. He said he asked about the effectiveness and what are the pros and cons of having a state specific program versus the others. He said that one of the concerns that Scott spoke about earlier was about the tool and if it actually measures PCMH and practice transformation. In Oregon they found that initially over 80% of the practices received the highest level, the third tier. There was a pretty wide spread feeling that maybe the standards weren’t rigorous enough. They really don’t require a lot of documentation and instead rely on attestation, similar to eligible providers in the meaningful use program. There was a concern that maybe the standards are not rigorous enough. Tim explained that the individuals he talked to didn’t have any information on costs.

Oregon has six people on staff, a director, a compliance specialist a program analysis a communication person and two practice enhancement specialists. They also contract with clinical transformation consultants, which is a group of about a dozen MD’s. These physicians go out and do site visits. The funding for these positions come from the state and was something that was legislated. The first couple of years they only had about 30 site visits out of the 200-300 practices. Their goal now is to go out and do 100 site visits per year. They currently have approximately 525 practices, which mean they would only be seeing the practices once every 5 years.

Tim said that Portland State is conducting an evaluation about the PCMH project and it should be coming out soon. One of the things that he wanted to mention is the cost consideration. NCQA does offer a discount for sponsored practices of 20%. He said the license fee is \$80.00 and the fees are based on the number of providers and increases with more providers. The other cost is the cost of the actual transformation.

Scott talked about the additional information that was sent to Collaborative members, the link to the Oregon website and to their recognition criteria quick reference guide. He said it is very similar to NCQA.

Kevin Rich spoke about the re that he wanted to give a brief history of why NCQA was chosen for the Pilot. He said at the time, that it was the only national recognition program that was fully developed and working well. He said that our program needs a marker of transformation. The markers of transformation are these programs - whether they are the national programs or a

state run model. He thinks that Idaho needs to think of the administrative burden in these recognition programs. Oregon's model doesn't have a lot of administrative burden and then you have NCQA – although some of the administrative burden has been lifted just recently. Another thing that is needed is that the payers need to be on board and participating in the rule making or recognition for practice transformation. The most successful program that he has seen at a state level is the Blue Cross/ Blue Shield Michigan model. The insurers took a huge role in developing the PCMH transformation model. The cost of this in the Oregon model is born by the state and in Idaho we will not have the cost born by the state. Medicaid cannot absorb the cost or manpower of practice coaches, practice reviewers, etc. The money has to come out of the SHIP funds and we want SHIP funds to go to the practices for transformation. He said it's going to be tough to come up with our own plan, there still has to be reviews, site visits, documents and proof of how they have transformed. NCQA has become somewhat of a bad word and something that people don't want to go thru.

Meg commented that they have studied six states and what they have found is that they are either a pretty close NCQA knock off or they are their own tiered program, following the six NCQA standards or the eight Safety Net Core changes. Oklahoma and Nebraska each have their own programs and they don't look complicated. They do follow the same general standards but in every instance they are seeing a self-attestation. It's one of the biggest changes they are seeing in the program.

Greg commented that he has worked with the PCMH staff at the Oregon Health Authority. He said it's going to be very difficult for payers that service multiple states to participate when you have different standards in different markets. It's not impossible, but it can be challenging. He said that there will be quite a bit of administrative cost by some agency that would need to facilitate the development of multi stake holder standards for the state of Idaho. When you talk to the Oregon Health Authority it is not an insignificant task, in addition to the resources required to implement, monitor and site visits. "If 80% of the practices are at tier 3, what does that say about a true tiering of providers based on infrastructure and ability to deliver?" That being said, everything that has been said about the NCQA guidelines hold true as well, but at least gives you something that is being seen nationally, something that a lot of payers and providers understand the validity of whether or not NCQA accreditation actually leads to the quality cost and experience outcomes is ongoing. Regence believes in a patient centered medical home, whether or not that is NCQA is yet to be determined. It's too early to say. He said he would stay with what you have built on thru the Idaho Medical Home Collaborative. You have practices engaged in it, you're seeing, hopefully thru the evaluation, and impact and the way care is being delivered. What does this say to those collaborative participants if you change and create standards that are different than what they have signed up for?

Dave Peterman commented that as a co-chair of the multi-payer group, the payers at the table are firm in saying "we are not going to pay for you becoming an NCQA medical home". It is not believed they accomplish what they need to do by paying for meeting some requirement. Having said that, they think it does lead to better and efficient care. Their payment is going to

revolve around some specific metrics. He said given the way the grant is described and the vision of the group, we do have to move towards primary care moving to a patient centered medical home model. While there are aspects of NCQA that are somewhat onerous and unrelated to the practice of medicine, specifically care plans, which he thinks are bothersome and not helpful in a lot of instances, he's not sure how else you do this unless you use NCQA. He said he agrees it is expensive and there is a time lag from when you start and go forward. But on the other side, the state of Idaho does not have the entity or the resources to manage site visits or assure that those are attesting are truly qualified. His own personally belief is to use something different than NCQA, but just doesn't know how that would be done. Is it possible we could see one of the other national recognition's? He doesn't have a problem with that. If this group recommends this to the IHC, that the SHIP will accept progress towards any of the three national entities, he would be fine with it. True care coordination is demonstrated by what you really do and what patient satisfaction is and your ability to really impact costs and quality. Whether a practice is a level 2 or 3, would not tell as much as the other data. He thinks it important that we are not going to reward the practices for the levels that they reach. He agrees 100% with Kevin that you actually have to demonstrate that you have done something that is transformative.

Scott asked Dave if it would make a difference to have a financial reward for achieving. Dave replied that he feels that every practice at one point has to achieve level 2. He said from the multi-payer group, their incentives will not be tied to NCQA.

Scott said that one of the concerns that Ted Epperly has that as we try to recruit practices and require NCQA that it may be a deal breaker for some of them and lose interest.

Meg said they have had a couple of clinics, based on their organizations, that are achieving one of the other nationally recognized programs and have chosen not to join the Idaho Health Home program. She said some of the issues that have come up such as the transformation lead has left or upgrading EMR has been an absolute crisis for some clinics trying to achieve the documents. Those types of things, that are every day events, have affected the timelines. The SHIP was recommending that clinics achieve NCQA in one year and they are into the pilot two years and the majority of them are just reaching that at the end of the two years.

Matt asked "are clinics struggling more with the PCMH transformation process and less so with the cost of the NCQA? Heather Clark said she would agree. One of the biggest issues with the clinics she works with is obtaining the data from their EHR. Meg said that documentation is quite a challenge for many of these clinics.

Tim said he also agrees with Matt in that it's not hard to scan a copy of a schedule showing that you offer same day appointments, it's actually changing the workflows. He said people use words like onerous, but there is some confusion

	<p>between practice transformation and the documentation of that. Frequently a lot of the clinics are doing the work but they haven't documented it. They should have standing orders, protocols, things in writing. He said there are a lot of tools out there that exactly follow NCQA standards and elements. He disagrees that it's all of the documentation. There are some challenges as Heather said with their reports and their EHR, but they need to be moving in the direction of having greater capabilities and report writing and data validation with their EHR anyway and feels a lot of this is value added.</p> <p>Dave Peterman said the problem with becoming a patient centered medical home is the major change in systems and behaviors. His recommendations are that payers are not going to pay for achieving some level of NCQA and thinks it's very valid that small practices are concerned with what NCQA represents. They probably don't have enough knowledge to know how difficult practice transformation is. Nevertheless, that is one of the impediments they see and from his perspective from sitting on the board and the limits of the resources of Health and Welfare, maybe it would be helpful if this committee could investigate what the criteria and the costs would be for the other two national entities and then maybe make a recommendation to the SHIP board.</p> <p>Tim said that the MGMA did a comparison among the 4 national PCMH accreditation recognition programs in 2011. They used as a basis for that, the guidelines for PCMH recognition and accreditation programs and that was something that was put together by the AAP, AAFP, AOA and the ACP in 2011. That work has already been done and one of the factors that they look at is cost and NCQA ends up being the cheapest. Part of the reason is because the NCQA model is on-line. Joint commission and AAAHC and URAC all do on-site visits. The upper end of the cost for the Joint commission is about \$27,000.00 as opposed to \$2200.00 for NCQA for a 5 provider practice.</p> <p>Mary Sheridan wanted to remind everyone that we have to recruit 165 PCMH's over the course of the three years and believes that providing some options, especially when we think about recruiting small rural clinics as part of those 165, will be very important.</p> <p>Scott reminded everyone that the next meeting is scheduled in April. A meeting in March is not scheduled, but there might be a need to bring this group together so that recommendations can be put together for the IHC. Collaborative members are encouraged to watch their email for further information.</p>
<b>Next Meeting</b>	The next meeting will be a conference call, Wednesday, April 22, 2015 from 12 – 1:30 MST.