

Idaho Medical Home Collaborative
Meeting Notes – June 10, 2015

Present: Scott Dunn (co-chair), Lisa Hettinger (co-chair), Matt Wimmer, Denise Chuckovich, Neva Santos, Heather Clark, Debbie Schreiner, Yvonne Ketchum, Kevin Rich, Richard Rainey, Deena LaJoie, Mary Sheridan, Zach Hodges, Kathy McGill, Cynthia York, Irene Collie, Bill Woodhouse, Teresa Martin

Topic	Discussion
Welcome and Agenda Review	Scott Dunn welcomed the group. The previous meeting notes were reviewed and accepted.
Medicare Participation	<p>Lisa said that the Department has been working with Noridian as Medicare is very interested in participating. The draft proposal that is moving forward from Noridian is pretty high level, but it is to look at their chronic care management (CCM) fee for service payment and make some recommended changes to it that would be more in line with the SHIP. The CMS estimate is that 66% of Medicaid fee for service patients would be eligible for this payment. The current participant rules around the CCM payment are that there is a co-payment made and that they must sign an authorization for the billing. The suggestion is that Medicare participates with the Idaho SIM grant by waiving the co-pay requirement. The Department hopes that if views this as a pilot package, they will see it at either support for the grant or as a preventive service that supports the grant and better patient outcomes. An additional element of the proposal to CMS is asking if they would consider making a reduced CCM payment for participants with only one of the listed chronic conditions. This would better support the grant's desire to affect 80% of Idahoans. This proposal aligns nicely with the 1st phase of the SHIPs payment reform goals. To support the other SHIP phases we might propose that CMS take our 16 identified quality measures to create an Idaho pilot physician quality reporting system (PQRS); We are not at this phase yet within the SHIP grant and so one of the things that the IHC will need to decide is whether we want to take baby steps with the items we recommend or whether we take a larger more aggregate proposal for SHIP alignment.</p> <p>Rich Rainey commented that Medicare only covers specified preventive services; Medicare does not cover non-specified preventive services. Medicare is more likely to cover chronic care management if that management does not include non-covered preventive services. Lisa said she would make note of this.</p> <p>Bill Woodhouse said he met with Dr. Gary Oakes and a focus group of local family doctors who were talking about the fact that Idaho has an extremely low rate of usage of preventative services. The discussion surrounded how difficult it was to do</p>

appropriate documentation and carve out a visit that is specific for the wellness visit without dealing with all of their chronic conditions. In their discussion they talked about how chronic conditions shouldn't preclude them from dealing with the preventive issues that are inherent in the wellness exam. Also, they should be able to have some sort of a qualifying code that would allow them to charge in instituting some of these preventive charges in a regular visit that isn't just a wellness visit. Bill said that this might be another area to look at as the SHIP moves forward to make the wellness visits and the "Welcome to Medicare" visits a meaningful clinic event instead of this odd ball that is hard to put into your schedule.

Mary Sheridan commented that as you are looking at the care coordination fee for Medicare and maybe proposing any changes this approach is not available to rural health clinics. It's in the fee for service world.

Yvonne Ketchum commented that at a meeting that she attended last year, she met Karen DeSalvo, who is the acting secretary and coordinator for Health I.T. for CMS and she gave a presentation on a learning action network. She said that it is bringing in payers and providers at the CMS level looking at alternate payment methodologies and how to shape nationally the health care system. She said that where they are going is pretty innovative and if there is any way to compliment what we are asking from Medicare to what they are trying to do, that it may help us. She will send documentation to Lisa regarding this approach.

Denise Chuckovich commented that she likes the idea of asking in the phased in approach to say "this is everything that we are interested in" and we hope that we can do this first one quickly so we can offer it to our PCMH cohort one, but then keep pushing beyond that.

Scott Dunn said that he has met with some of his colleagues in North Idaho and they had a discussion on what might make it work better, specifically in regard to the CCM system that is currently in place. One of the struggles has been the signed agreement that seems to create, partly because of the co-pay, but partly because patients are questioning it. The signed agreement can really slow down participation. Their recommendation was that they not require any kind of signed agreement. The signed agreement has been a stumbling block. There is also recognition that a mental health diagnosis will increase intensity of services almost across the board. The current system is two chronic problems of any sort, but one chronic problem being schizophrenia by itself is a very intense requirement for services and that might be one that would automatically qualify for the highest tier. The other concern that he has is that Medicare has traditionally had a site of service differential for payment, which is driving a lot of costs in our system across the state, in that it provides an uneven playing ground for people providing services. The same services are provided, but get paid differently from Medicare on whether they are owned by a hospital or not. Their thought is that whatever is proposed to Medicare should be site neutral.

Yvonne said she looked at the relative value weights for this code and it didn't appear that there is a site service differential.

She asked if Scott was looking at this as a particular case management code or services across the board?

Scott replied that if we are talking about making a proposal to Medicare to change the way they are paying this monthly fee, his first thought is that we need to be careful that it is not applied for that, but then the next discussion is even with regards to the fee for service as it is, right now the facility fee is driving a lot of the costs and if one of the goals of our trial here or if the innovation center is asking us to come up with something new that would not only improve patient care, but better value for the system, he feels this is something that needs to be looked at. It's a huge driver of costs.

Kevin Rich asked if that would exclude the big clinic systems that are hospital owned?

Scott replied but does it add any value? He said that studies show that it doesn't add any value especially in primary care clinics. If you're talking about an innovative way that Medicare is going to provide for payment of services we need to look at where the value really comes. These kinds of perverse incentives don't provide value.

Kevin said that one of the triple aims is to lower cost and this would add to that part of the triple aim.

Scott said that there may need to be some carve out situations such as teaching centers, but to him this is a big driver in what is happening in the health care landscape.

Matt Wimmer commented that we need to have a good awareness of what Medicare policy is before we make our proposal because there are things that they can and can't do based on their own statutes and regulations.

Rich commented that he agrees to Matt's point, but what we need is to propose a way that they can do it, because they can't just change that. He said that if you charge that monthly fee, then for your visits you have to do a global visit versus a facility, this would be one way to do it.

Lisa said what would be helpful is for folks to email her their recommendations by the end of next week. Scott said some of this is has to do with trying to be innovative and get outside of the box a little bit or maybe a lot and then scale it back if they say that's not possible.

Rich asked Yvonne if she has confirmed the facility code and she replied yes. Rich said that the point to make is to hold your ground that you already have. The monthly fee does not have a facility component and that's the way it should be and the way it should be kept, because there is going to be an effort to probably get a facility fee.

<p>Medicaid Proposal</p>	<p>Lisa explained that for us to fully support movement to more PCMHs, there are some rules that need to be changed. She asked the group to look at the rules and provide any comments as negotiated rulemaking occurs. Medicaid will use a tiered structure for phase one pmpm payments. This will help fund clinics that are ready to start moving to the continuum towards PCMH but keep the Healthy Connections system in place for other clinics. She reviewed the information regarding the first tier and indicated that it is the basis for all of the other tiers and mirrors the current Health Connection payment methodology. This method takes a relatively simplified approach to stratifying the population into healthy and not healthy. One of the conditions, to Dr. Dunn’s point, that will put you instantly into the not healthy is a severe and persistent mental illness (SPMI). Part of what is going on with the rules is talking about the referral system. The question is why continue with the referral system, when what we are looking for is integration and folks using the electronic tools available thru electronic health records. They are starting to shift the pendulum into that direction with their Healthy Connections program.</p> <p>Once you move into tier two, the PMPM amount starts to reflect where clinics are on the PCMH journey. Everybody that is moving along the PCMH journey will also get either the tier one “well or not well” payment. This document is still in a draft form and it is possible that some of the criteria will change.</p> <p>Tier three is for a more established PCMH and there will be a differential between tiers two and three in their payment structure.</p> <p>Lisa said they wanted to keep the first tier where it would be easy to digest, that didn’t wind up creating all kinds of attribution questions and concerns. They will use the attribution method currently being used by the Healthy Connections program, which is that the participant gets to pick their clinic and if they don’t pick one after 90 days, it is chosen for them.</p> <p>Matt added that negotiated rule making sessions have been scheduled for the end of this week in Boise and for next week in Coeur d’Alene and Pocatello. Comments are welcome in any format and there is further information and a draft of the rules on the Department’s webpage.</p> <p>Scott commented that one of the things they felt should be considered is to avoid the managed care disincentive. Physicians find it frustrating with the current mental health payer, with all of the prior authorizations, denials and time consuming processes.</p> <p>There was a question regarding the other recognition’s which were referred to in Tier Three. Matt replied that Medicaid is</p>

	<p>moving towards the direction in allowing other recognitions as well.</p>
<p>Reimbursement and attribution from the multi-payer workgroup</p>	<p>Lisa said that what Blue Cross seems to be looking at, in general, is that they are going for pay for performance in the early period, but not pay a pmpm for PCMH transformation. The exception is that Blue Cross will still recognize the Health Home model and related PCMH transformation with a PMPM payment.</p> <p>Blue Shield proposal has remained the same. They are moving towards a total cost of care/shared savings model.</p> <p>Select Health would like to take some of what they are doing in Utah and bring it to Idaho.</p> <p>Denise clarified that Cynthia York and Yvonne are working on a written summary of the presentation.</p> <p>Yvonne said they have a draft proposal that is supposed to go to the IHC in July and has been sent out to the group to review. Attached to that will be some sort of high level matrix of what each payer is proposing. Clinics will have an expectation of what they can expect from each payer, but then each payer’s proposal will go directly to the clinic.</p> <p>Scott said that for clarification the continuation for what the payers are doing now for the current enrolled clinics would terminate February 1, 2016 – because that is the date when the new phase starts. Clinics can expect that their current payment methods will continue thru the end of January, with the new one starting February 1, 2016.</p>
<p>Next Meeting</p>	<p>Rich commented that as the consultant to IHC for medical homes, he said we should get a list of tasks from the IHC, which would help clarify what the future schedule should be. Lisa said she would talk to the IHC regarding this request and in the meantime the group decided to schedule our next meeting for July 22, 2015 from 12:00 to 1:30 MT.</p>