

LR513/LB239 PCMH Working Group
July 26, 2013 meeting DRAFT minutes

In attendance:

Senator Sue Crawford
Dr. Nancy Knowles
Dr. Ken Shaffer, Kearney Clinic
Mark Bowen, UNMC
Bryson Bartels, DHHS
Vivianne Chaumont, Medicaid
Dr. Bob Rauner, Healthy Lincoln
Dr. David Filipi, Blue Cross Blue Shield NE
Margaret Kohl, Staff, Senator Mike Gloor
Roger Keetle, Staff, Senator John Wightman
Ann Frohman, NMA
Jina Ragland, NMA
Eric Dunning, Nebraska Department of Insurance
Cora Schrader, Coventry
Bruce Rieker, Nebraska Hospital Association
Mary McConville, CoOpportunity Health

By phone:

Dr. Deb Esser, Coventry
Dan Clute, United Healthcare
Stephen Lazoritz, Arbor Health
Corinna Suiter, Arbor Health

A. Welcome: Senator Gloor welcomed the group and lead introductions.

B. Senator Gloor recited the antitrust guidelines that have been established for the group as to what is appropriate to discuss.

C. Margaret reviewed the documents for agreement:

I. Quality measure for pediatric patients:

Dr Rauner opened the discussion with a suggestion that a subgroup of pediatricians review the measures one last time. Dr. Esser agreed. Dr. Knowles, who served on the Medicaid PCMH advisory committee, made herself available for the review of the pediatric measures. The problems with screening for Chlamydia was discussed, such as privacy if the parents asked private insurance companies about tests that under insurance law must be disclosed to the parents as policy holders vs privacy laws that apply to the release of such information involving a child in other settings. Dr. Knolls stated that physicians do change behavior if evaluated using data they trust. Physicians are very competitive to achieve better outcomes. The small number of patients with asthma makes this measure difficult to measure. Preventable dental measures require more information than claim data creating a problem. The need to merge claims and clinical data is a challenge. Currently an outside vendor provides reports that can be trusted by both physicians and insurers.

Dr. Rauner expressed a preference for insurance companies to pick five focus areas from the extensive list of pediatric measures in the current draft. This would simplify and foster implementation. Vivianne Chaumont, stated that Medicaid must use the pediatric measures dictated by CMS but the

details are a work in progress.

Action item: It was agreed to establish a group to review the ped measures with the following members:

Dr. Knowles

Dr. Rauner

Dr. Schaffer

Dr. Esser

Dr. Lazoritz, and

A representative to be appointed by the AEP if they desire to be represented.

Margaret will supply the email addresses to Dr. Rauner of the subgroup members.

II. Payment “menu” draft language discussion:

Margaret read the first draft of the document. A copy of the draft is attached. Dr. Rauner commented that the document is consistent with the core principles adopted several year ago by the NAFP and the NMA several years ago. Dr. Filipi questioned if the draft addressed the issues of payment differences with doctors who are new to the PCMH program with doctors experience with PCMHs. Dr. Rauner stated the issue is the sustainability of programs in order to pay the increased overhead costs such as employees who are care coordinators. The costs must be paid for a program to be sustainable. Margaret stated that in this setting is would be possible to set a range or percentile without anti-trust issues.

Dr. Rauner suggested that in the State of New York the parities agreed to hire an independent actuary to work out a payment program. Dr. Esser and Dr. Filpi both stated they could not agree to the retention of an actuary and this approach.

Margaret asked if the two year time period of the proposal was a problem:

Dr. Knowles stated the two year time period was a minimum but really it takes at least 3 years to achieve more significant savings. Dr. Shaffer added that his research indicated 2-3 year is needed to transition but they did transition in six months but even now it is not a mature. From a policy standpoint it was his position that policy makers need to do what we can to improve the quality of care, control costs and improve patient and physician satisfaction. This takes a while and insurers need to assist by helping to pay for infrastructure costs. His practice is struggling to assume the upfront costs of being a PCMH under the Medicaid Pilot Project. Doctor Knowles agreed that it is a push to get physician practices to the next level. It's hard for physicians, particularly in rural areas, to delegate control to team members.

Dr. Rauner restated three concerns about the transformation to PCMH as follows:

Some insurer help with upfront costs of the transformation to a PCMH others get the benefit and are “freeloaders,”

A sufficient number of insurers must assist in the transformation to PCMHs to make the programs sustainable; and,

In order to make the PCMH sustainable and fair we need an “all payer” program.

Dr. Lazonitz responded that payers don't know what changes the Affordable Health Care Act will mean as the health care exchanges begin to operate. Physicians can negotiate with insurers to pay the upfront

costs of the PCMH.

Dr. Rauner responded that some insurers control such a large share of insureds in certain communities in their plan that physicians have little negotiation power to recover the additional cost to sustain a PCMH type of practice.

Dr. Filipi commented that an all payer state law would not solve the fact that plans under the federal ERISA law can not be required to participate in a state law authorizing all payer system. He expressed his position that it was too early to require any certain health care delivery payment structure.

Dr. Rauner suggested that perhaps a disclosure law would provide “public shaming” of the “freeloaders” is in order.

Margaret added that the State of New York used permissive language and the reason for these meetings was to avoid mandatory compliance. She asked the participants to review Senator Gloor's Draft as the terms of a possible gentleman's agreement with wide latitude to achieve compliance.

Dr. Filipi raised the concern that his company held the position that it should only pay for the costs of transformation to PCMH for their insureds.

Senator Gloor responded that at this point the Medicaid pilot program was paying the infrastructure costs to transform the system for all payers, including private insurers. He stated that it may take a hammer to get all payers to share the infrastructure costs of the transformation to a PCMH type of medical practice. Dr. Rauner agreed.

Director Chaumont raised issues about what type of PCMH program will be required in that Medicaid must follow federal requirements and how do we know what type of PCMH program will be the most cost effective. Dr. Rauner responded that the proposal was to be based on the Medicaid pilot program definitions and quality measures. Director Chaumont responded that some of her colleagues from other states were concerned about the cost of their PCHM programs and their effectiveness.

Dr Filipi also responded that his companies PCMH had not produced cost savings but had increased quality and quality of life. Dr. Knowles added that prevention takes time to produce savings.

Director Chaumont stated in her opinion she did not think one model of PCMH was a good policy.

Senator Gloor responded that he believed a level playing field was needed but it was not his intent to be overly prescriptive and to allow innovation and evolution of the PCMH model. He believes the delivery system must be changed.

Dr. Knowles stated it appeared to her that it is difficult even to get information on even the number of practices using the PCMH approached. Others commented that certain PCMH physician offices that are privately certified can be found on line. Margaret commented that no central source of PCMH practices located in Nebraska exists.

Dr. Rauner stated that studies show that PCMH do save money but the studies must have a large enough sample size, be given enough time to produce results, and involve all patients from all insureds. If so another benefit is that physician's get a greater satisfaction from their work and will stay in primary care. If the primary care physical workforce is not encouraged it will only lead to more

expensive specialist care.

Senator Gloor stated that because of the hour item D on the agenda will be discussed at the next meeting. (Item D is With whom or where will our agreement reside?)

Senator Gloor inquired if the language “ % range” be removed from the draft it would be acceptable to the insurer representatives' Director Chaumont stated she could not agree on behalf of the Medicaid program and the language “both the public and” was removed from the first sentence. The draft would read as follows:

PCMH Stakeholder Group

July 2012 Draft

In 2012 we recognize health care is in the upheaval of reform and this agreement, particularly payment reform, will endure ongoing transformation private markets.

Payment reform menu to include:

Prepayment tier:

- per member per month
- Care coordinate fee

Post payment tier

- enhance feed for service
- performance bonus
- shared savings

Members of this agreement will use at least on form of payment from each tier in a payment combination amount that reasonably covers the estimated cost of provider transformation for at least two(2) years from the beginning of the provider transformation. Specifics, with these parameters, will be decided upon by each payer and provider contract negotiations.

It is expected that beyond the initial two (2) years providers and payers will negotiate further payment structures that maintain recognition and incentives for PCMH.

Dr. Clute responded that his company United Health care can not agree to any prepayment tier payment. United Health care will negotiate on a pay for performance basis only.

Senator Gloor stated that the group does not have a consensus to proceed with the draft agreement.

Senator Gloor, as previously announced, deferred item D until the next meeting;

Agenda Item E Updates:

Margaret gave a grant update. Information was shared about how the State of New York implemented their PCMH program and that documents are available.

Next week a telephone call is scheduled concerning the use the PCMH model for the provision

of employee programs and how the State of Oregon program operates. Another call will be held with representatives of the Wellness Program Program for the State of Nebraska Employees and the Governor's Policy Research Staff. Others were invited to join the call. If interested they should contact Margaret.

Senator Gloor presented an update on LR 22 which is to look at planning for Nebraska's Health care system for the next 10 to 20 years and has a long term focus. PCMHs will be a topic of discussion.

Item G Set next meeting time and date. Margaret will send out an email with proposed dates and based upon Stakeholder feedback a date will be set.

The meeting was adjourned.