

## Report to the Legislature

### Legislative Resolution 22 (2015): Progress of Patient Centered Medical Homes and the PCMH Participation Agreement

Submitted to:

Health and Human Services Committee and  
Banking, Commerce and Insurance Committee  
January 5, 2016

Submitted by:

Senator Mike Gloor, District 35

## Introduction and Acknowledgements:

Patient Centered Medical Home, or PCMH, is a model of health care delivery that puts the patient at the center of care in new ways that require informed joint decision making on medical decisions with a focus on preventive care and management of chronic disease.

In Nebraska, PCMH has been the focus of legislative efforts since 2009 and efforts by the medical community since 2008. LR 22 reports on this multi-year, ongoing work to improve the health of Nebraskans through improved health care services delivery.

Many people have contributed to this effort in Nebraska. The following list is an acknowledgement of the people and entities integral to this work past and present.

Dr. Bob Rauner	Dr. Debra Esser	Dr. Joseph Miller
Dr. Ken Shaffer	Dr. Robert Wergin	Dr. Tom Werner
Dr. Jane Carnazzo	Dr. Nancy Knowles	Dr. Lissa Woodruff
Dr. Don Darst	Dr. Steve Lazoritz	Dr. Kevin Nohner
Dr. Michael Horn	Dr. Dale Michels	Dr. Carol LaCroix
Dr. Joann Schaefer	Dr. Scott Applegate	Dr. Matha Arun
Matthew Milam	Dr. Tony Sun	Jonathan Copley
Vivianne Chaumont	Margaret Brockman	Pat Taft
Heather Leschinsky	Calder Lynch	Jennifer Roberts-Johnson
Roger Keetle	Margaret Buck	Senator Mike Gloor
Senator John Wightman		

The National Academy of State Health Policy  
 Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care  
 Nebraska Department of Health and Human Services, Office of Rural Health  
 Aetna Better Health of Nebraska  
 Arbor Health Plan  
 Blue Cross Blue Shield of Nebraska  
 United Healthcare

Thank you to everyone named above plus the many others who worked with each individual or entity listed above for your work on Patient Centered Medical Home in Nebraska.

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### ***Section 1: Legislative and Stakeholder Process: Nebraska PCMH Participation Agreement***

In 2009 the concept of Patient Centered Medical Home was introduced to Senator Mike Gloor, District 35, by a group of local primary care physicians. During his first year in office, LB 396 was passed to create a pilot program in Nebraska Medicaid. That pilot program assisted two rural clinics, one in Kearney and one in Lexington, in a process to transform into Patient Centered Medical Homes. At the conclusion of the pilot in 2012, Nebraska Medicaid issued a report that included a recommendation to continue PCMH and requiring managed care contractors to support clinics transforming to PCMH.

In 2013 Senator John Wightman introduced LB 239 to adopt the Nebraska All-Payer Patient-Centered Medical Home Act. The bill mandated insurance coverage on an aggressive scale and time frame. LB 239 became the catalyst to get health care providers and insurance companies to the table to discuss and negotiate – which led to LR 513, an interim study resolution to study the issues surrounding PCMH. Thus, the stakeholder group was born.

Since January of 2013 this stakeholder group has been meeting regularly with an average attendance of 30 stakeholders. The meetings were not advertised and no official invitation was issued to the public. The stakeholders were self-selected from interested entities. Nebraska Department of Insurance and the Nebraska Department of Health and Human Services division of Medicaid and Long Term Care were specifically invited and participated in discussions. Since these meetings were not official hearings, no official legislative records were kept but agendas, minutes and related documents were made available on Senator Gloor's webpage and upon request.

As an alternative to statutory mandate and definition, an "Agreement" was crafted to define, to set minimal parameters and encourage the development of PCMH while allowing the flexibility to accommodate the quickly changing health care industry. The four largest health insurance companies in Nebraska along with the managed care companies with contracts with Nebraska Medicaid participated in the Agreement. The Nebraska Medical Association, Nebraska Academy of Family Physicians and the Nebraska chapter of the American Academy of Pediatrics all participated as well. The Participation Agreement took nearly two years to negotiate and finalize.

Much of the focus of the Agreement and work of the stakeholder group focused on two major issues. The first is a common menu of health care outcomes and quality measures. A focus on the same or very similar health care outcomes is necessary in order to provide the health care providers the ability to implement such a major transformation and the many components it requires.

The second major issue is the payment reform necessary to implement the transformation of provider clinics to PCMH. Since the transformation of a clinic affects all patients with their variety of insurance coverages, the achievement of payment reform and the sustainability of PCMH, can only be accomplished fully when all insurance providers are paying in a similar fashion. Legislative involvement provided the stakeholder group the forum to be able to collaborate within the confines of federal anti-trust law.

Along with the legislative effort, the National Academy of State Health Policy provided technical assistance and afforded Nebraska inclusion in a national learning collaborative. The Milbank Memorial Fund invited Nebraska to join their Multi-payer Collaborative of States that placed us in a collaboration with other states with federally funded Medicare demonstration projects.

In 2014, the first two-year Participation Agreement created the first common platform in Nebraska for health care providers and insurance companies to consider in contract negotiations related to PCMH. This agreement included a common set of core quality measures for adult, pediatric and prenatal care. (Appendix A: 2014 Agreement)

In December of 2014 participants provided the first reports of PCMH activity to the Stakeholder group. (Appendix B: 2014 Participant Reports)

From those reports and other applicable information a list of clinics was compiled. The locations were overlaid on a map of Nebraska with county populations. (Appendix: C: Map of PCMH Clinics)

In 2016, that Agreement has been revised to a one-year agreement, the quality measures updated and information requested as a report from stakeholders to the Legislature has been increased. The Nebraska Hospital Association and Senator Mark Kolterman have been added as signers of the Agreement. (Appendix D: 2016 Agreement)

The goals of PCMH are to improve patient experience and personal health, to improve the health status of all the clinic's patients and to contain or reduce costs. In addition, successful PCMH initiatives have also found an improvement in provider satisfaction. These goals are only partially realized in Nebraska and remain the goals of this ongoing transformation effort.

***Section 2: Timeline of PCMH growth in Nebraska***

- 2008 – Nebraska Academy of Family Physicians holds seminar with national speakers
- 2009 - LB 396 introduced by Senator Gloor, creates pilot program in Medicaid  
 Senator Gloor and Medicaid representatives participate in National Academy of State Health Policy grant
- 2010 – Nebraska Medicaid Pilot Program begins
- 2011 - Nebraska Medicaid puts PCMH requirement in managed care contracts
- 2012 – Pilot program ends in December  
 Nebraska Medicaid includes PCMH requirement in MCO contracts
- 2013 – LB 239, PCMH mandate introduced - held in committee  
 Medicaid Pilot Program report recommends PCMH continuation  
 Insurance and physician stakeholder group forms to discuss PCMH participation  
 Senator Gloor, lead physicians participate in NASHP multi-payer grant  
 Stakeholder 2-year Participation Agreement finalized and signed
- 2014 – Participation agreement implemented in January  
 Senator Gloor, lead physicians participate in NASHP multi-payer learning collaborative  
 Nebraska participates in Milbank Memorial Fund multi-payer states collaborative  
 Nebraska PCMH agreement included in NASHP publication and *Health Affairs*  
 3<sup>rd</sup> NASHP grant “Project Community” learning collaborative  
 December – Stakeholder reports at December meeting for year 1
- 2015 – LB 333, Senator Gloor to establish the Health Care Services Transformation program within NDHS, Office of Rural Health – held in committee  
 LB 549, Senator Campbell to establish the Health Care Transformation Act – held in committee  
 Nebraska Medicaid issues RFP based on PCMH principles: Goal is set for 30 % value based sub-contracts providing patient centered care by 2020 and 50 % by 2022. Contract awards to be announced in January 2016; implementation in January of 2017  
 Compilation of PCMH clinics: 180 clinics, 80% of Nebraskans live in a county with at least one PCMH clinic
- 2016 – Stakeholder 1-year Participation Agreement finalized and signed  
 Federal Practice Transformation Grant awarded to ENHANCE Health Network to train Nebraska health care providers in PCMH

***Section 3: Nebraska Medicaid Pilot: Executive summary and recommendations***  
(Appendix E: Nebraska Medicaid PCMH Pilot Program Executive Summary)

***Section 4: Medicare Accountable Care Organization (ACO) status in Nebraska***

Three ACOs in Nebraska are currently participating in the Medicare Shared Savings Program and have full performance measure reporting that is now publicly available. Several more are likely to begin participating in 2016 and 2017. Raw data can be accessed at: <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ay8x-m5k6>. Adult quality measures for the Nebraska PCMH Participation Agreement are the same as those used by this Medicare program. (Appendix F: Nebraska ACO Quality Summary 2014)

**Summary of performance of Nebraska Medicare Shared Savings Program ACOs:**

1. Overall quality score:
  - a. Alegent/UniNet 87.76%
  - b. SERPA ACO 93.57%
  - c. Midwest Health Coalition was in its pay for reporting year, so no summary score listed.
2. Patient Satisfaction ACO 1-7, all 3 Nebraska groups did well on this section.
3. Top Score in each of the 33 measures:
  - a. Alegent Health Partners 6
  - b. SERPA ACO 18
  - c. Midwest Health Coalition 9

Note: Southeast Regional Physicians Alliance (SERPA) ACO ranked 7<sup>th</sup> in the nation for quality of care measures in 2014.

<http://www.beckerhospitalreview.com/accountablecareorganizations/20-medicare-acos-with-the-highest-quality-scores-in-2014.html>

***Section 5: PCMH and Technology***

Patient Centered Medical Home depends on technology in a variety of ways. First is electronic medical records. Having searchable records enables a clinic to do “population health.” Population health includes electronically locating patients who need preventive care and follow up care and proactively contacting them to schedule that care. Population health also depends on the generation of lists, called disease registries, to alert a physician or health care provider to patients who need extra care management for chronic conditions like heart disease or diabetes. It enables the clinic to create educational opportunities for groups of patients. This type of data can also be used to motivate health care providers to change and improve the care they provide.

In other states, repositories for health care data are used to aggregate and analyze data on a statewide basis. This analysis can be used for public health uses but can also be used to make comparisons and reports used by health care providers and insurance companies in gauging PCMH success in health care, cost and value. To give an example of the capabilities available Appendix G is a report from Michigan’s use of a statewide database for PCMH.

Medicare provides data to ACOs in Nebraska but as of 2016 no statewide data analysis tools are available for PCMH use. Nebraska Health Information Initiative (NeHII) is beginning work on communications such as admission, dismissal and transfer data from a hospital to a health care provider office. The College of Public Health at the University of Nebraska is collaborating in a regional program to aggregate certain health care data. Nebraska Medicaid is beginning work on a new Medicaid Managed Care System that will enable data analytics. However, to fulfill the PCMH potential, the ability to analyze and communicate health care data effectively needs to be developed in Nebraska.

### ***Section 6: Nebraska Medicaid 2015 Managed Care Request For Proposals***

A note from Medicaid Director, Calder Lynch:

The Patient-Centered Medical Home (PCMH) pilot program was implemented in the Medicaid managed care delivery system in 2012. The managed care plans are currently required to support practices in becoming PCMH's following the standards developed for the pilot program. The current managed care plans also have signed the participation agreement and have participated in the stakeholder meetings. PCMH and patient-centered care is continued in the upcoming managed care integrated RFP, Heritage Health. The managed care plans awarded contracts set to implement January 2017 must promote and facilitate the capacity of its providers to provide patient-centered care by using systematic, PCMH management processes and health information technology to deliver improved quality of care, health outcomes, and patient satisfaction. The Heritage Health RFP continues to use the PCMH standards developed for the pilot program as the foundation for the managed care plans to use in recognizing and supporting PCMHs.

### ***Section 7: Payment Reform***

Payment reform is necessary to implement the transformation of provider clinics to PCMH. Care coordination, electronic communication, enhanced data capabilities, written aides to help a patient and doctor discuss and make decisions about conditions and treatments are all part of the enhanced health care in a PCMH but often are not reimbursed. Therefore, the medical and insurance communities need to agree on how to change the form of payment to cover all these services. Fee for service is still the predominant method of payment but new forms of payment are emerging and being encouraged by Medicare and Medicaid. A consistent payment methodology from all payers will require state agency involvement and a State supported statewide policy statement in order to provide full antitrust immunity.

Legislative involvement has provided the Nebraska stakeholder group the forum to be able to collaborate within the confines of federal anti-trust law. However, the full potential of PCMH will not be realized until further changes are made in methods of payment. Many state and national programs are analyzing results of pilot programs and demonstration projects to determine best practices. The stakeholders working on PCMH in Nebraska will need to continue to work toward consensus on payment reform in the future.

### ***Section 8: National programs***

PCMH efforts nationally include the multiple demonstration projects through the US Department of Health and Human Services and the Center for Medicare and Medicaid Services including the Comprehensive Primary Care Initiative (CPC), the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), the State Innovation Model Initiatives (SIM), and Accountable Care Organizations (ACO), which all receive federal funding. In addition, there are a variety of other federal, state and local programs providing transformation support opportunities.

In 2015 the United States Department of Health and Human Services announced the goal of tying 30 percent of Medicare payments to quality and value through alternative payment models by 2016 and 50 percent of payment by 2018. The above mentioned programs and the 2015 launch of the Health Care Payment Learning and Action Network are among the ways they intend to reach this goal.

Also in 2015 federal grants were announced to provide funding for practice transformation efforts. For Nebraska, the ENHANCE Health Network, working with the Iowa Healthcare Collaborative, is working to provide education and training to physicians and their staff to transform their medical practices to PCMH in order to reach the goals of better care and to be ready to work in a value-based payment environment. For more information: Appendix\_ : (Enhance Network's ppt)

### ***Section 9: Conclusion***

Transforming health care is an ongoing process that requires high level collaboration among stakeholders and state government. PCMH has been a focus in Nebraska for seven years. Partial success has been realized but much work remains to fully integrate PCMH in the health care landscape across the state. NDHHS is part of the transformation. The State of Nebraska as a consumer of health care for employees, is considering steps toward value based care and PCMH. Their move in that direction will help further the transformation. Continued legislative involvement is necessary to guide the transformation and provide government led collaboration. In order to create a consistent payment methodology for PCMH across the state, a strong policy statement from State government and the direct involvement of a state agency is necessary to provide full anti-trust immunity for the collaborative work of health care providers and insurance companies.

SENATOR MIKE GLOOR

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### COMMITTEES

Chairperson - Banking, Commerce  
and Insurance  
Health and Human Services  
Legislature's Planning

## Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Home

Facilitated by Senator Mike Gloor and Senator John Wightman

In 2013 we recognize health care delivery and health care insurance is in the upheaval of major reform and health care will endure ongoing transformation in both the public and private markets. This agreement is recognized as only pertaining to Patient Centered Medical Home as defined and agreed upon in this document.

The goal of both health care providers and health insurers participating in this agreement is to reform the delivery of health care services in order to improve the overall health of individual patients, patient populations, to promote an improved consumer experience, and to control or reduce expenditures through appropriate, evidence based, comprehensive care.

We, the undersigned insurance companies and physicians/health care providers agree to support and promote the creation of Patient Centered Medical Homes (PCMH) in Nebraska by using consistent requirements and measurements to promote the efficient transformation of primary care practices into patient centered medical homes.

The effective date of this agreement is January 2014 through January 2016. Insurers will have active PCMH contracts with approximately 10 clinics by the end of 2014 and approximately 20 clinics by the end of 2015. Insurers with contracts covering only a subset of the state's geography would have a number of clinics approximating the percentage of the state's population they reach in the counties they cover (e.g., if their geographic coverage area encompasses 40% of the state's population, they would have 4 clinics per year). All parties agree to work in good faith toward compliance and fulfillment of this agreement.

**Definition:** In Nebraska, a patient centered medical home, or PCMH, is defined as a health care delivery model in which a patient establishes an ongoing relationship with a physician directed team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.

In the event that a health insurer, as part of their PCMH program requires that a PCMH be certified or recognized as such, or to attain certification or recognition, insurers will accept the following standards:

- NCQA PCMH certification
- JACO PCMH certification
- Nebraska Medicaid PCMH Pilot Program, Tier I and II standards
- URAC certification
- 

In the event that a health insurer, as part of their PCMH program, requires that a PCMH clinic submit clinical measures to determine clinical outcomes, the measures will be selected from those listed in the following charts:

- Adult (see attached chart)
- Pediatric (see attached chart)

Health insurers have the option to use measures for their PCMH program outside of these clinical measures as long as they are clearly communicated, agreed upon by providers, and do not require the PCMH clinics to submit data.

**Payment:** Insurers offering a medical home program must utilize payment mechanisms that recognize value beyond the fee-for-service payment. Payments should be linked to clinical, financial and/or patient satisfaction measures in accordance with the goals of the Patient Centered Medical Home. Payments shall be directed toward the clinic's full covered panel of patients and not confined to a subset of diseases. The design and details of the payment mechanism will be left up to each individual health plan to determine through an agreement with the provider or provider group to be negotiated in accordance with the PCMH program cycle.

Nothing in this agreement shall guarantee that a clinic is included in an insurer's PCMH program by meeting the basic criteria. Nothing in this agreement shall preclude the development of alternative innovative models by an insurer for its group and/or individual policies, or alternative models and payment mechanisms to support PCMH.

**Progress Report:** Participating payers are asked to report annually, by letter, successes realized and challenges faced in their efforts to comply with this agreement. The report should include the number of PCMH contracts signed.

Date of Signing: December 18, 2013

Participants: Please sign with name and title

*Mike Gloor*

Senator Mike Gloor

*John Wightman*

Senator John Wightman

*[Signature] MD*

Blue Cross Blue Shield of Nebraska

*[Signature]*

Nebraska Academy of Family Physicians

*[Signature] VP Medical Affairs*

Coventry Health Care of Nebraska

*Kevin Nolane MD*

Nebraska Medical Association

*[Signature] medical Director Arbor North Platte Area*

Arbor Health Plan

*[Signature] MD FAAP*

Nebraska Chapter of the American Academy of Pediatrics

*Judith D Stark V.P. Health Management*

CoOpportunity Health

*Matthew W. Milen*

UnitedHealthcare

**Adult quality measures menu for Patient Centered Medical Home agreement**

Approved at December 3, 2012 meeting of the LR 513/LB 239 PCMH Stakeholder meeting

CMS Shared Savings/ACO Measure Title	NQF Measure/Steward	Data Source
Getting Timely Care, Appointments	NQF #5 - AHRQ	Survey
How Well Providers Communicate	NQF#5 - AHRQ	Survey
Patient's Rating of Provider	NQF#5 - AHRQ	Survey
Access to Specialists	NQF#5 - AHRQ	Survey
Health Promotion and Education	NQF#5 - AHRQ	Survey
Shared Decision Making	NQF#5 - AHRQ	Survey
Health Status/Functional Status	NQF#5 - AHRQ	Survey
Risk Standardized, All Condition Readmission	CMS	Claims Data
Ambulatory Sensitive Admissions: COPD	NQF#275/AHRQ PQI #5	Claims Data
Ambulatory Sensitive Admissions: CHF	NQF#277/AHRQ PQI #8	Claims Data
EHR Incentive Program Attestation CMS	CMS	EHR Incentive Program
Medication Reconciliation after Discharge	NQF#97 - AMA/PCPI/NCQA	EHR
Falls: Screening for Fall Risk	NQF#101 - NCQA	EHR
Influenza Immunization	NQF#41 - AMA/PCPI	EHR
Pneumococcal Vaccination	NQF#43 - NCQA	EHR
Adult Weight Screening and Follow Up	NQF#421 - CMS	EHR
Tobacco Use Assessment & Cessation Intervention	NQF#28 - AMA/PCPI	EHR
Depression Screening	NQF#418 - CMS	EHR
Colorectal Cancer Screening	NQF#34 - NCQA	EHR
Mammography Screening	NQF#31 - NCQA	EHR
Adults 18+ BP measured in last 2 years	CMS	EHR
Diabetes Composite: A1c <8	NQF3729 - MN Community	EHR
Diabetes Composite: LDL <100	NQF3729 - MN Community	EHR
Diabetes Composite: BP <140/90	NQF3729 - MN Community	EHR
Diabetes Composite: Tobacco Non-Use	NQF3729 - MN Community	EHR
Diabetes Composite: Aspirin Use	NQF3729 - MN Community	EHR
Diabetes Poor Control - A1c >9	NQF#59 - NCQA	EHR
Hypertension: Blood Pressure Control <140/90	NQF#18 - NCQA	EHR
Ischemic Vascular Disease: Lipid Panel & LDL<100	NQF#75 - NCQA	EHR
Ischemic Vascular Disease: Aspirin/Anticoagulant	NQF#68 - NCQA	EHR
Heart Failure: Beta-Blocker for LVSD	NQF# 83 - AMA/PCPI	EHR
CAD Composite: Drug Therapy for lowering LDL	NQF#74 - CMS/AMA/PCPI	EHR
CAD Composite: ACE/ARB for Patients with DM/LVSD	NQF#66 - CMS.AMA/PCPI	EHR

Abbreviations: NQF=National Quality Forum, AHRQ=Agency for Healthcare Research and Quality, NCQA=National Committee PCPI=Physician Consortium for Performance Improvement, AMA=American Medical Association

## **Pediatric quality measures menu for Patient Centered Medical Home agreement**

Approved at September 30, 2013 meeting of the LB 239 PCMH Stakeholder meeting

Set of quality measures with NQF numbers:

1. Immunizations
  - a. Infants – HEDIS Combo 4
  - b. Adolescents – NQF 1407
2. WCC/Developmental
  - a. First 15 months – NQF 1392
  - b. 3-6 years – NQF 1516
  - c. Developmental – NQF 1448 (Examples: ASQ/Ages & Stages, MCHAT)
3. Weight Screening – NQF 0024
4. Depression: By age 18 – NQF 1515
5. Smoking – NQF 1346
6. Asthma
  - a. NQF 1 – Asthma screening using a standardized questionnaire (e.g., Asthma Control Test)
  - b. NQF 25 - Management Plan for People with Asthma (Asthma Action Plan)

Background FYI: You can pull up each measure on the NQF website:

[http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx)

click “NQF endorsed measures” on the left and then type the number in the box to look it up.

Pediatric Measures Subcommittee Members: Steve Lazoritz (Arbor), Ken Shaffer (Kearney Clinic), Nancy Knowles (Children’s/NeAAP), Brad Brabec/Steve Russell/Scott Jansen (Complete Children’s), Bob Rauner (SERPA ACO), Deb Esser (Coventry), Scott Applegate (Children First Pediatrics)

## Prenatal Health Outcomes Measures - Approved September 8, 2014

Prenatal Measures Subcommittee: Bob Rauner, MD, MPH (SERPA ACO, NAFP), Margaret Brockman, RN (Neb. DHHS), Mike Horn, MD (UHC Medicaid), Dave Filipi, NE (BCBS-NE), Bob Bonebrake, MD (Methodist Physicians)

Background: You can pull up each measure on the NQF website: [http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx) click "NQF endorsed measures" on the left and then type the number in the box to look it up.

Measures discussed in order of increasing agreement:

**Measure 1:** Prenatal screening using a common state screening form based on the Arbor Obstetric Needs Assessment form (attached).

**Measure 2:** Timeliness of prenatal/postpartum care – NQF 1517

**Measure Description:**

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.
- Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

**Measure 3:** Frequency of Ongoing Prenatal Care – NQF 1391

**Measure Description:**

Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:

- <21 percent of expected visits
- 21 percent–40 percent of expected visits
- 41 percent–60 percent of expected visits
- 61 percent–80 percent of expected visits
- > or =81 percent of expected visits

**Measure 4:** Non-indicated induced delivery – NQF 0469

**Measure Description:**

This measure assesses patients with elective vaginal deliveries or elective cesarean sections at > 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

## **Highlights from December 2014 Multi-payer PCMH Stakeholder Participants**

41 different clinics in Eastern and Central Nebraska (from north to south) included in PCMH programs from Coventry/Aetna, BCBS Nebraska, United Health Care and Arbor Health Care

Arbor Health assists clinics in achieving NE Medicaid and NCQA recognition  
Their numbers: 6 clinics, 60 providers, 3179 patients  
Arbor Health named in 2014 MHPA Best Practice Compendium

BCBS Primary Blue PCMH clinics represented 4 % lower overall hospitalization costs, 11.87 % lower than expected outpatient costs, 12% lower than expected ER costs, more focus on preventive services, and as compared to a non-PCMH population 19.12% fewer potentially preventable readmission costs.

Coventry/Aetna: 19,000 members, 35 offices in 5 health systems across the state. Plans to expand to another 15 offices and 7000 members in Jan. 2015.

Reported types of payments include:  
PMPM, performance based contracts, PCP incentives, shared savings, care coordination fees and upfront grants for infrastructure building.

South East Rural Physicians Alliance, as compared to other Medicare Pioneer ACOs, reports fewer hospitalizations and ER visits, fewer CT and MRI events, med reconciliations performed in 82 to 100 % of office visits, depending on the individual clinic and lower discharge rates for COPD/asthma.

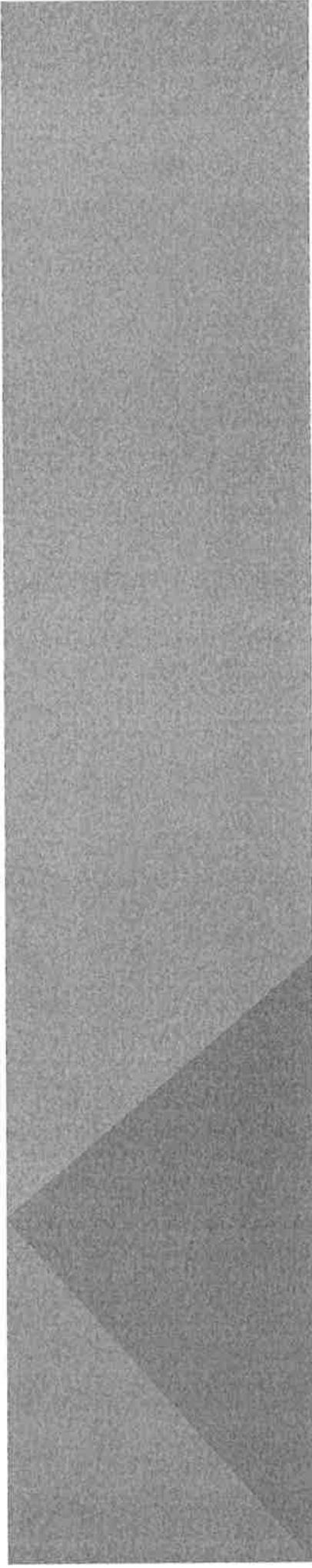
Uninet/Alegent reported (by email after the meeting) lower per member per month cost, a reduction in hospital admissions per 1000, a reduction in emergency room visits and a reduction in 30-day readmission rates – all over a 3 year period, 2012-2014.

For more specifics please refer to individual reports that are part of the Dec. 5, 2014 minutes.

AETNA BETTER HEALTH OF  
NEBRASKA  
PATIENT CENTERED MEDICAL HOMES

## **CURRENT**

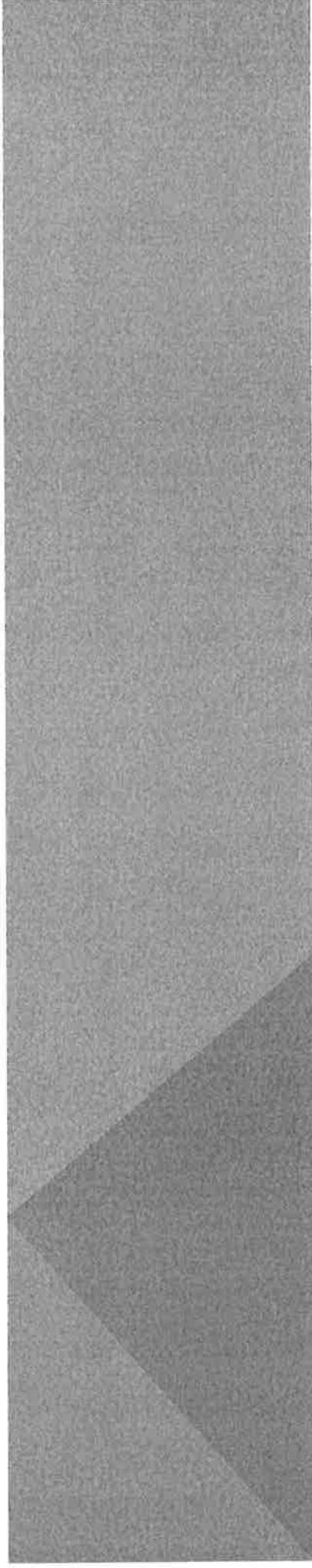
**19000 members covered by a PCMH  
35 offices in 5 Health systems across the state  
Plan for expansion to another 15 offices and  
7000 members in January 2015  
Further plans for another 2 Health system  
enrollment in first 2 quarters 2015**



## **VALUE BASED CONTRACTING**

**Planning to add Value Based Contracting to PCMH contracts in 2015**

**Would include quality bonus payments and the possibility of shared savings**



**Patient Centered Medical Home**  
**Arbor Health Plan Practice Transformation Program**  
December 5, 2014

Presented by:  
Robin Linsenmeyer, Quality Improvement Specialist  
Kathy Barnett, Acting Director, Quality Improvement  
Stephen Lazaritz, MD, Network Medical Director



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*Arbor* Arbor PCMH Project Development

- > The PCMH model is developed with a team within the Arbor clinic that is vested in the transformation.
- > Team decides on three diseases to focus on
- > Timelines are established
- > Tools are developed based on clinic needs
- > Staff training is completed
- > Project is monitored and changed as needed
- > Documents are gathered and cross checked with the criteria to determine if changes or updates are needed
- > Documents are submitted for certification to National Center for Quality Assurance (NCQA) or Department of Health and Human Services (DHHS)

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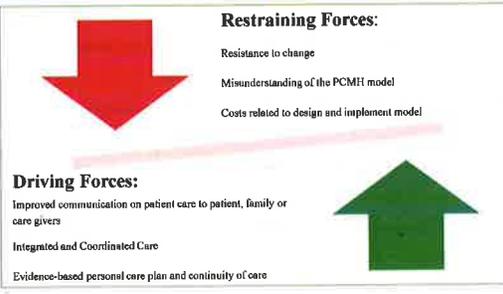
*Arbor* Driving and Restraining Forces

**Restraining Forces:**

- Resistance to change
- Misunderstanding of the PCMH model
- Costs related to design and implement model

**Driving Forces:**

- Improved communication on patient care to patient, family or care givers
- Integrated and Coordinated Care
- Evidence-based personal care plan and continuity of care



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*Arbor* Program Analysis

**Barriers with transformation include:**

- ❖ Appointment availability for after hours and/or weekends
- ❖ Lacking in provider buy in
- ❖ Electronic Medical Record capabilities and lack of funds to upgrade
- ❖ Lack of providers and dedicated staff
- ❖ Lack of understanding in the PCMH model
- ❖ Lack of policies and procedures.

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*Arbor* Practice Engagement

**Overview of PCMH practice site program participants.**

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*Arbor* CHILDREN AND ADOLESCENT CLINIC-HASTINGS

<ul style="list-style-type: none"><li>• Clinic Contact: Dave Long</li><li>• Number of Providers: 9</li><li>• Arbor Members in panel: 1,477</li><li>• Start Date: May 2013</li></ul>	<p><b>PCMH Status</b></p> <ul style="list-style-type: none"><li>• State criteria Tier I and II met</li><li>• NCQA Status: Documents being readied for submission by end of December 2014</li></ul>
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*Arbor* PRAIRIE PEDIATRICS-SIOUX CITY  
(2 Locations)

<ul style="list-style-type: none"><li>• Clinic Contact: Sandi Tomlinson</li><li>• Number of Providers: 11</li><li>• Number of Staff: 36</li><li>• Arbor Members in panel: 1,435</li><li>• Start Date: September 2013</li></ul>	<p><b>PCMH Status</b></p> <ul style="list-style-type: none"><li>• State criteria Tier I and II met</li><li>• NCQA Status: Documents being readied for submission by end of February 2015</li></ul>
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*Arbor* PAWNEE COUNTY MEMORIAL HOSPITAL-  
PAWNEE CITY

<ul style="list-style-type: none"><li>• Clinic Contact: Jim Kubik</li><li>• Number of Providers: 6</li><li>• Number of Staff: 16</li><li>• Arbor Members in panel: 40</li><li>• Start Date: December 2012</li></ul>	<p><b>PCMH Status</b></p> <ul style="list-style-type: none"><li>• State criteria Tier I and II met</li><li>• NCQA Status: Documents being readied for submission by end of December 2014</li></ul>
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*Arbor* COMMUNITY MEDICAL CENTER-  
FALLS CITY

<ul style="list-style-type: none"><li>• Clinic Contact: Jina Santos</li><li>• Number of Providers: 3</li><li>• Number of Staff: 15</li><li>• Arbor Members in panel: 38</li><li>• Start Date: December 2012</li></ul>	<p><b>PCMH Status</b></p> <ul style="list-style-type: none"><li>• State criteria Tier I and II met</li><li>• NCQA Status: Documents being readied for submission by end of December 2014</li></ul>
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*Arbor* MARY LANNING CLINICS (4 Locations)

- Clinic Contact: Tammie Johnson
- Number of Providers: 25
- Number of Staff: 16
- Arbor Members in panel: 155
- Start Date: October 2013

**PCMH Status**

- Currently gathering documents for State criteria Tier I and II
- NCQA Status: In process of documents being gathered, Site will apply for NCQA recognition by end of March 2015

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*Arbor* THAYER COUNTY HEALTH SERVICES AND MEDICAL CLINIC- HEBRON

- Clinic Contact: Melissa Grummert
- Number of Providers: 6
- Number of Staff: 15
- Arbor Members in panel: 34
- Start Date: May 2014

**PCMH Status**

- Currently gathering documents for State criteria Tier I and II
- NCQA Status: In process of documents being gathered

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Medicaid Health Plans of America  
2014-2015  
**Best Practices Compendium**  
For Medicaid MCOs, HMOs and PPOs



MHPA Best Practice Recognition

*Arbor*

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1919 Aksarben Drive  
 P.O. Box 3248  
 Omaha, Nebraska 68180-0001  
[nebraskablue.com](http://nebraskablue.com)

**Joann Schaefer, M.D.**  
 Vice President, Medical Management  
 and Medical Care CMO  
 Phone: 402-982-8834  
[E-mail: joann.schaefer@nebraskablue.com](mailto:joann.schaefer@nebraskablue.com)

December 4, 2014

Senator Mike Gloor  
 District 35  
 Room #1401  
 P.O. Box 94604  
 State Capital  
 Lincoln, NE 68509

RE: Patient Centered Medical Home

Dear Senator Gloor,

Blue Cross Blue Shield of Nebraska (BCBSNE) is pleased to report on our Patient Centered Medical Home (PCMH) initiative called Primary Blue. In addition, we have now contracted with SERPA to create comprehensive medical homes for our members of their practices under a different payment methodology that includes shared savings and risk.

Physician practices participating in Primary Blue are as follows:

<u>Year</u>	<u>Number of Offices</u>	<u>Number of Physicians</u>	<u>SERPA ACO Offices</u>	<u>SERPA ACO Physicians</u>
2012	38	191		
2013	54	279		
2014	79*	380*	(10)	N (70)

\*In October 2014, 26 CHI offices with 112 physicians were removed from our PCMH program.

BCBSNE continues to learn about processes which improve value. When we first started the program over 6 years ago we focused on incenting performance: treating members with diabetes, heart disease and hypertension. Then we added outcomes for mammography, pap smears, Body Mass Indices (BMI), and colorectal screening. In these phases we saw minimal improvement in medical costs, but some improvement in outcomes reported. We are uncertain whether the improved outcomes resulted from better care delivered or better reporting. Employers, health insurance brokers and individual purchasers of insurance are supportive of new models that focus on value, but are demanding stronger proof that these models are enhancing value.

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association

Therefore, BCBSNE came to the following conclusions:

- Focusing on individual disease markers may not translate to better overall care
- Our paying for a third party to obtain selected results was increasing expenses
- The third party collecting results were bothersome to some practices
- Member medical care costs had been essentially ignored
- Increasing the reporting work of practices should be avoided

Therefore, our 2015 Primary Blue program will change in the following ways:

- TREQ Solutions, a healthcare analytical division of 3M, will be used to risk stratify members, attribute members to each practice, and measure both quality and medical costs in a metric called the Value Index Score (VIS).
- Practices in our PCMH will compare both quality and costs with their Nebraska peers
- Our current system of gleaning quality measures from practices will be discontinued
- Office practices will be rewarded on a PMPM basis, based on quality performance relative to their peers and cost reduction.

BCBSNE is learning much through our pilots to evolve the program. PCMH is a process, not an outcome. Structuring performance targets do not necessarily result in improved value; that is, better clinical outcomes and reduced medical costs. Practices find changes from their existing operations difficult. Any requirement for reporting can create a barrier to implementation. As the PCMH program grows, the analysis of data collected becomes more difficult. We continue to investigate some key questions, including: What are the appropriate targets? How does one compensate for members of varying risk?

Despite active engagement in PCMH programs for over 6 years, BCBSNE realizes that we have not yet reached the goal of the perfect program that maximizes value for patients. Nevertheless, in working with our healthcare partners, BCBSNE is committed to explore and experiment with newer strategies and tactics to realize not only the powerful promise of PCMH but new payment methodologies and quality measurement. It is important to allow programs to innovate and evolve as we pursue high quality, better patient satisfaction and lower overall costs of care for all Nebraskans.

Sincerely,



Joann Schaefer, M.D.

## Patient-Centered Medical Home

### Positive Outcomes for Patients and Providers

Since 2009, Blue Cross and Blue Shield of Nebraska's Primary Blue patient-centered medical home (PCMH) program, has focused on quality of care and outcomes for patients with chronic conditions related to diabetes, vascular and hypertension issues.

Primary Blue empowers patients to approach these conditions proactively through greater access to and consistent use of preventive care. Physicians are encouraged to provide continuous, coordinated and monitored care to the patient in a timely manner.

During 2013, our PCMH clinics demonstrated favorable outcomes in resource management and cost measures.

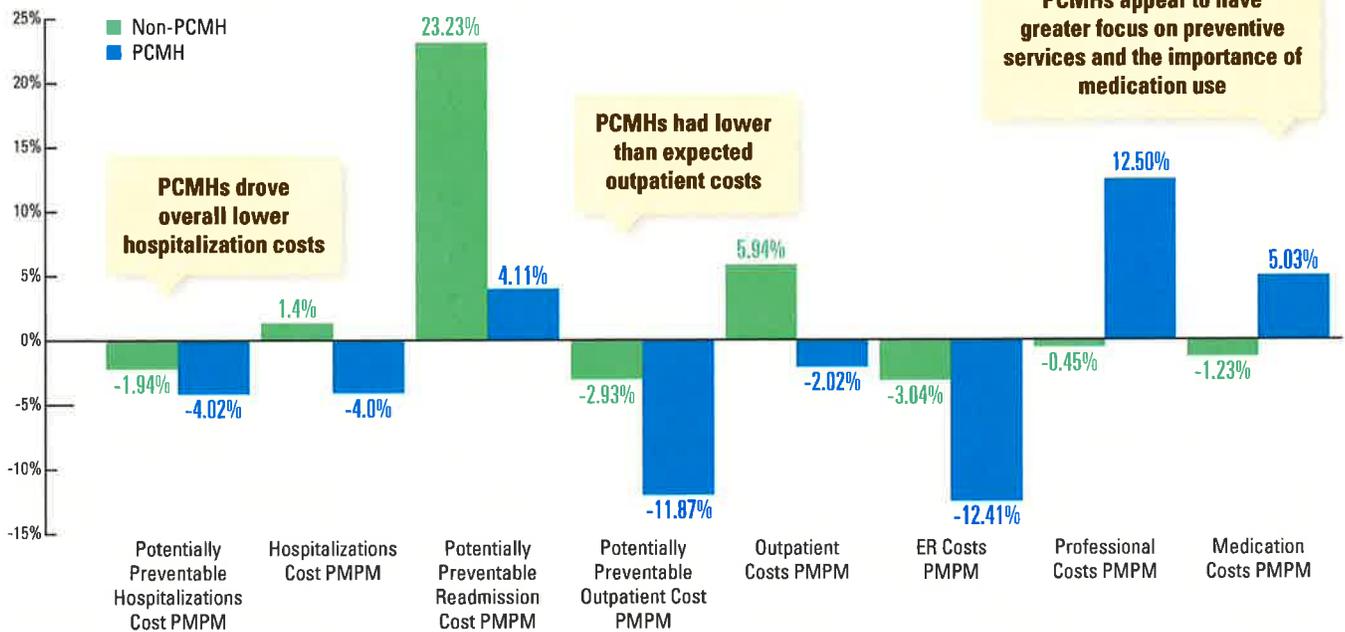
### Better Cost Management and Use of Services

Per member per month (PMPM) costs were lower than expected in the following areas:

- ✓ Overall hospitalizations
- ✓ Preventable hospitalizations and readmissions
- ✓ Preventable outpatient visits
- ✓ Emergency room visits

Professional and medication costs PMPM were higher than expected, demonstrating a focus on preventive care and medication use.

### Per Member Per Month – Percentage Difference from Expected



#### Graphs and program evaluation disclaimer:

The provided analysis excluded Blue Cross and Blue Shield of Nebraska members with out-of-state providers and members with Coordination of Benefit claims. Providers were located in Nebraska for comparison purposes. All measures are risk-adjusted.

The analysis is a review of performance only and is not intended to be an actuarial study. Measurement of costs and quality is in regards to best use of resources.

The 2013 PCMH population is large enough to establish preliminary comparisons between PCMHs and non-PCMHs.

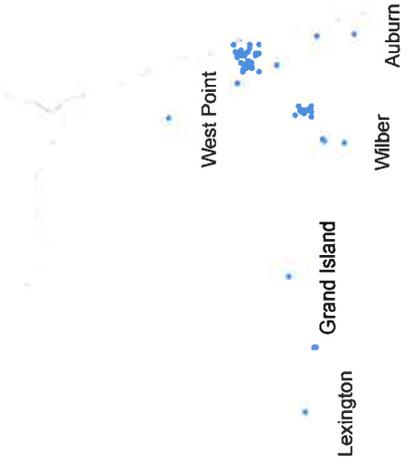
The methodology for potentially preventable hospitalizations, outpatient services and readmissions are provided by 3M Health Information Systems. The analytics were provided by Treo Solutions.

# PCMH Clinic Distribution

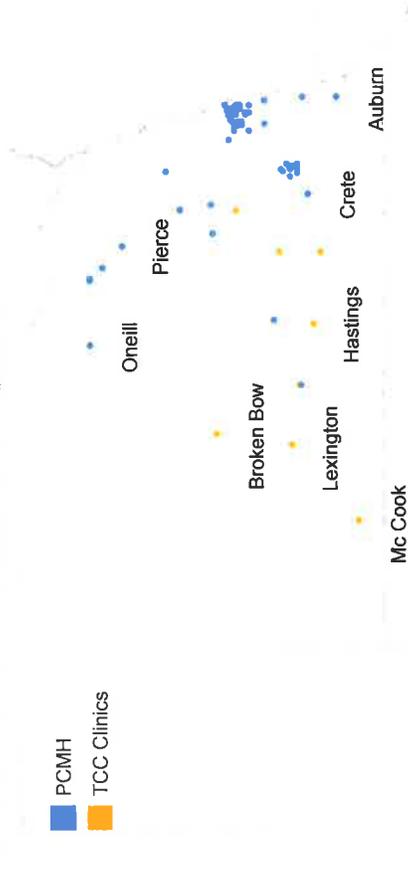
Distribution of PCMH Clinics in 2012



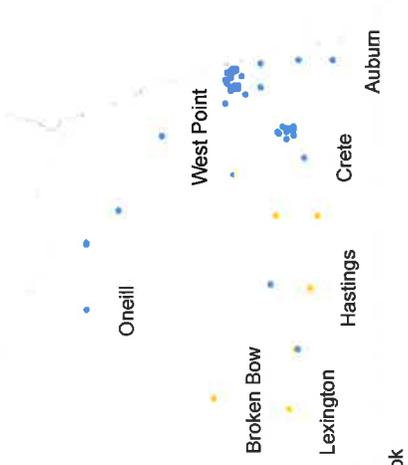
Distribution of PCMH Clinics in 2013



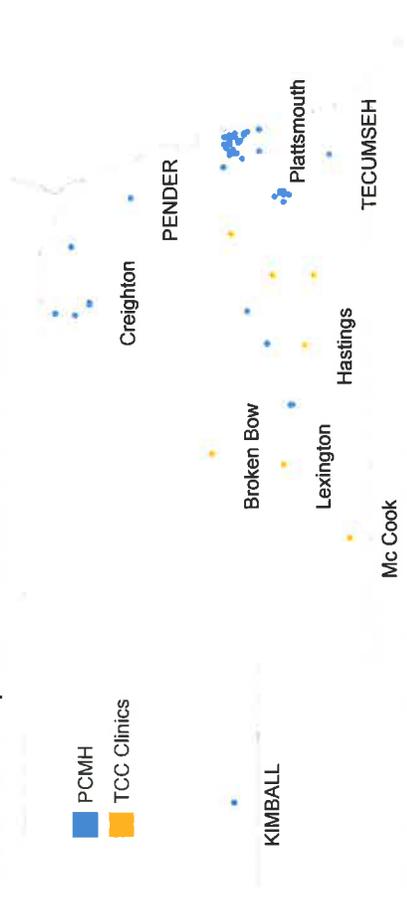
Distribution of PCMH & TCC Clinics in 2014 (prior to 9/1)



Distribution of PCMH & TCC Clinics in 2014 (post 9/1)



Distribution of Expected PCMH Clinics & TCC Clinics in 2015



Number of PCMH clinics and TCC clinics from 2012 onwards

	2012	2013	2014 (Prior 9/1)	2014 (Post 9/1)	2015 (Expected)
PCMH	38	54	79	54	60
TCC Clinics			10	10	10



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# PCMH Contracts: Progress Report 2014



# Incredible First Year Growth in Nebraska and Iowa

**97,605**  
as of 10/27/2014

<b>2033</b>	89,776
<b>2019</b>	72,940
<b>2018</b>	67,855
<b>2017</b>	60,693
<b>2016</b>	52,513
<b>2015</b>	31,500
<b>2014</b>	11,142

Surpassed original 20 year projection figure in 10 months!

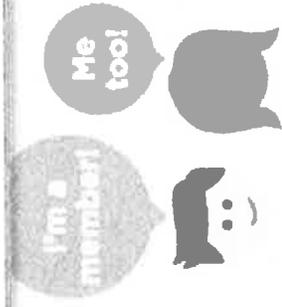
Special recognition to our key vendor partners for rising to the challenge of rapid growth:  
Midland Choice for provider network  
HealthPartners for administrative functions



# More than 50,000 members in Nebraska's 4 rating areas



# Community



OVERVIEW

MEDICAL HOME PILOTS

SPONSORSHIPS

GIVING

VOLUNTEERISM

## Medical Home Pilots

Coportunity Health believes strongly in integrated care as part of the larger solution to the issues of healthcare cost, quality and access. As part of its commitment to this ideal, CoOpportunity Health proposed the development of medical home pilots in its business plan submitted to the Centers for Medicare & Medicaid Services (CMS) which was applied for approval as Nebraska.

### Nebraska

SERPA-ACO

South East Rural Physician Alliance-Accountable Care

Organization

[www.serpa-aco.org](http://www.serpa-aco.org)



Pilot focused on seven practices using Nebraska Medicaid Medical Home Model that establishes standards for integrated care. Baseline patient surveys and electronic health record (EHR) data were used to measure outcomes. To date, 70 providers have achieved PCHM recognition.

# Benefit design incentives for patient engagement

## Healthy Rewards Incentive



## Three For Free

**3for  
FREE**

Through 10/25/14, 5,644 members have earned \$100 VISA gift card. Additional 7,605 members have completed HA; 10,869 members have completed preventive care exam. Eligible population of 76,939.

Three for Free not included in catastrophic or bronze plans.



## Challenges for CoOp in 2014

- ▶ Operational priority of maintaining high service levels for our unexpectedly large membership as a start up
- ▶ Transforming existing contracts for innovative payments
- ▶ Constraints of claims data processing infrastructure
- ▶ Uncertainty on what are effective payment incentives
- ▶ Baseline data for comparison
- ▶ RESULTS – no full PCMH contracts, but foundational agreements have been completed with 8 practices this year
- ▶ FUTURE – continuing to build toward value-based payment approaches



UnitedHealthcare  
2717 N 118th Street Ste 300 Omaha NE 68164-9672  
Tel 402 445 5000

December 5, 2014

UnitedHealthcare is participating and supporting Senator Gloor and Senator Wightman's "Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Home" through Value Based Contracting strategies and initiatives for many years.

UHC contracting models currently in place in Nebraska include multiple methods that meet the definitions provided in the Participation Agreement by promoting a health care delivery system that focuses on the patient and physician relationship to improve healthier outcomes utilizing clinical measures, evidence-based guidelines and cost efficiency standards. We currently have models in place with 19 clinics that are NCQA PCMH certified. In addition, we have more than 1500 physicians and 13 hospitals participating in one of our models described below that meet the definition of PCMH in the Agreement.

Following are examples of programs offered. Although they are all unique, there are some common elements across the programs. Providers in our value-based programs receive fee-for-service payments and can earn incentives or shared savings bonuses for meeting predefined metrics.

**Performance Based Contracts** are where cost efficiency and quality metrics are established and agreed upon in order for the provider to receive fee schedule incentives that are tied to these patient centered goals. This type of agreement is utilized by facility providers as well as specialist and primary care physician providers and has been in place in Nebraska for the last couple of years.

**Primary Care Physician Incentives** are programs that incent primary care physicians to support evidence-based medicine as well as cost effectiveness. Providers earn Incentives by meeting quality metrics and performance metrics.

**Shared Savings Contracts** - Providers who are ready for population health management share in savings with the Payor on an agreed-upon budget after meeting quality and experience thresholds.

We recently have added another **Shared Savings** program called the **Accountable Care Community Partnership** where community clinical teams actively measure, monitor and manage access to care, evidence based care and hospital utilization while taking action to drive continuous improvement in patient outcomes. Nebraska launched this model in 2014 and we anticipate expanded provider participation as we continue to share information with the providers and develop this product.

# SERPA ACO PCMH/Multi-Payer Experience

December 5, 2014

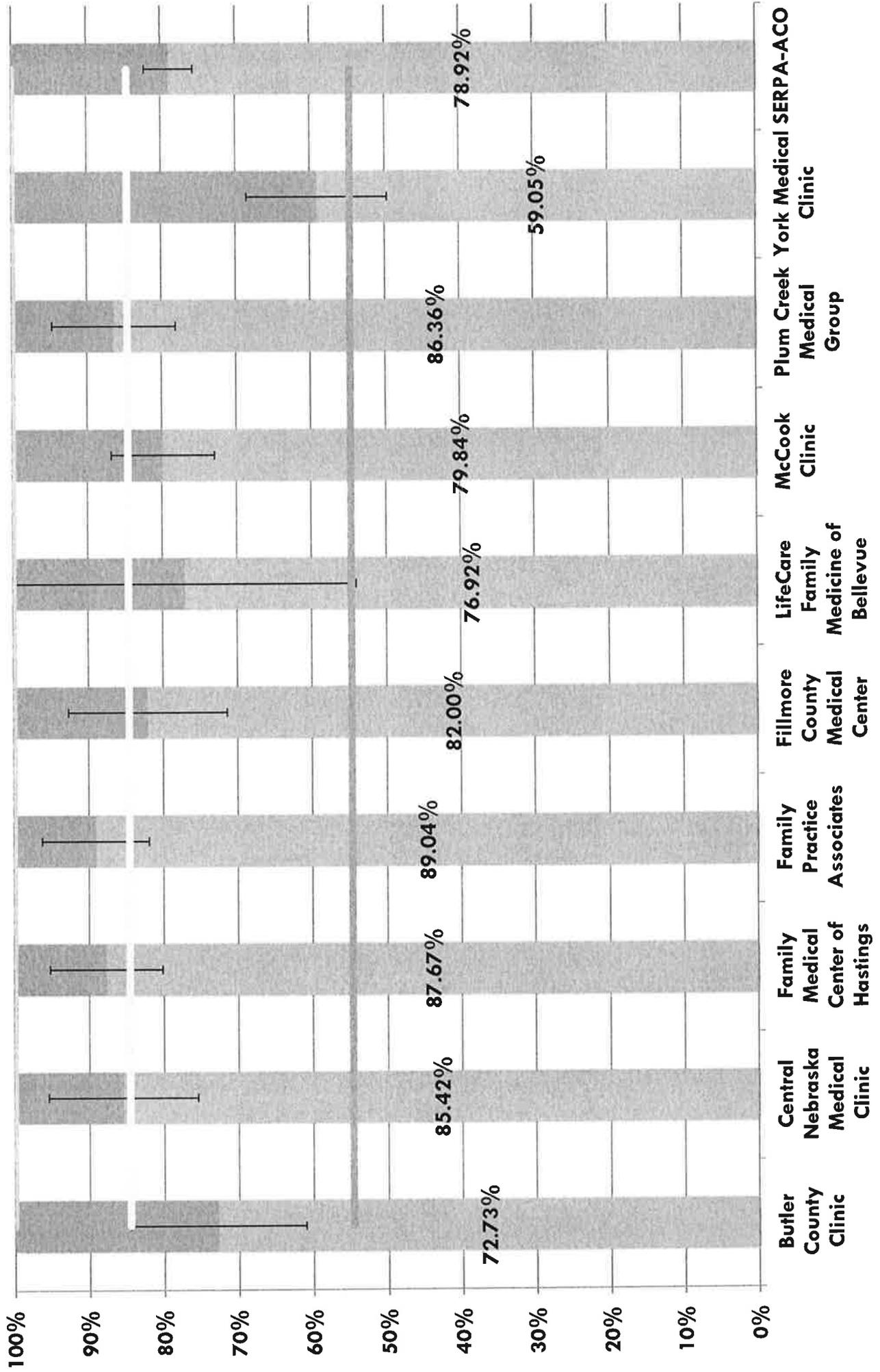
Bob Rauner, MD, MPH

# Successes

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Measurable  
improvements in  
Quality and Patient  
Outcomes

# ACO 15 - Pneumovax

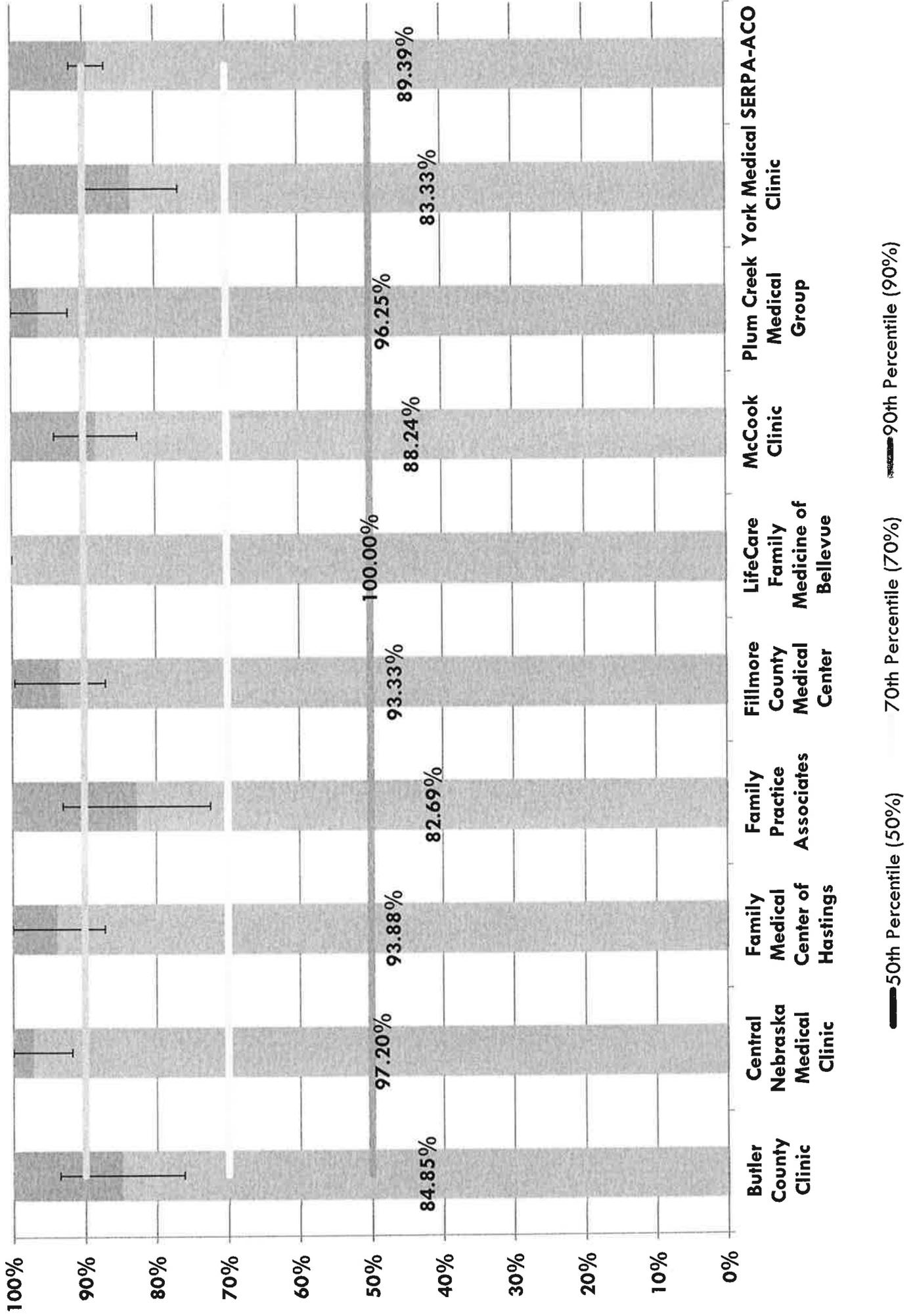


— 50th Percentile (54.62%)

— 70th Percentile (84.55%)

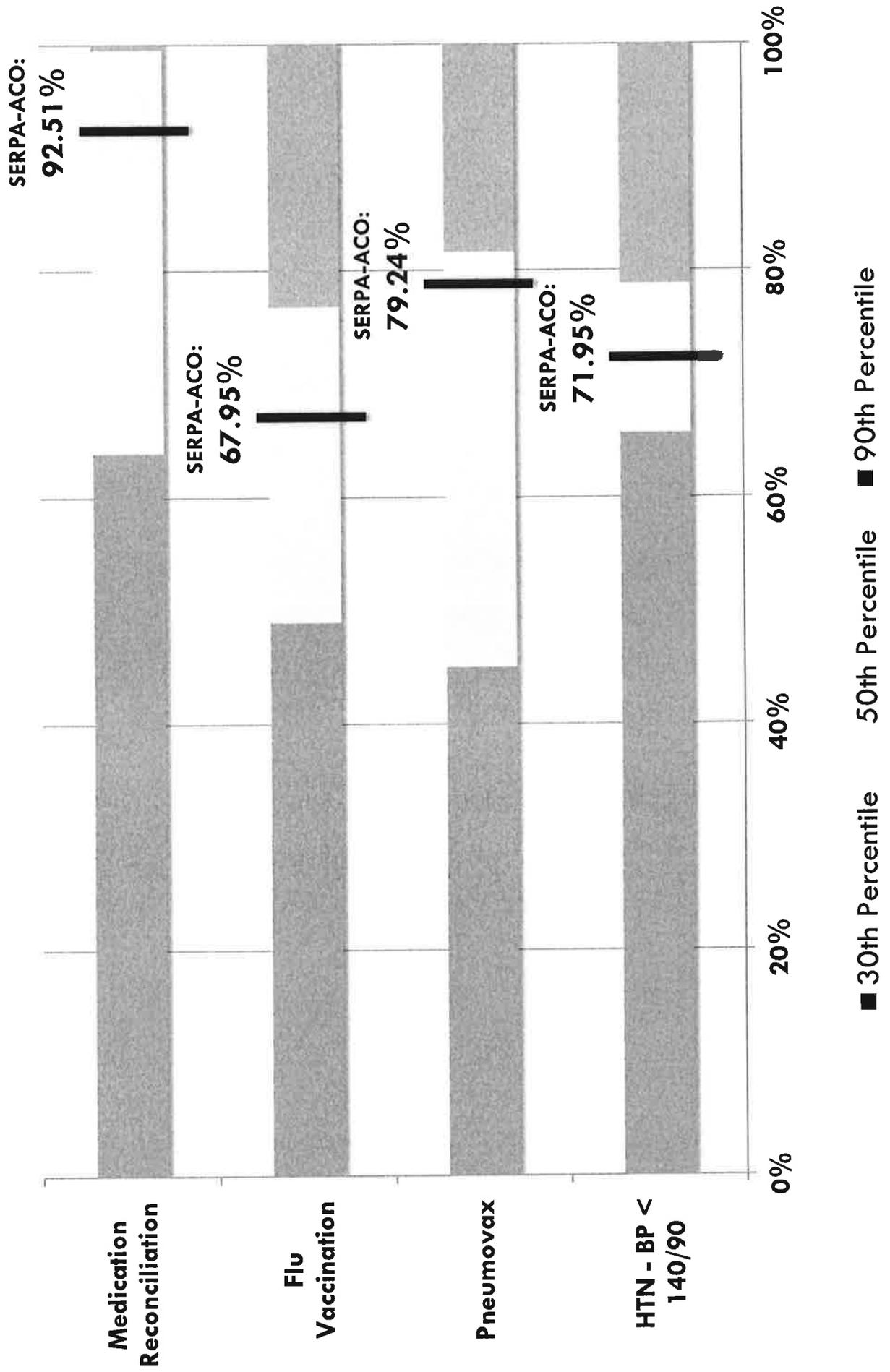
— 90th Percentile (100%)

# ACO 12 - Medication Reconciliation



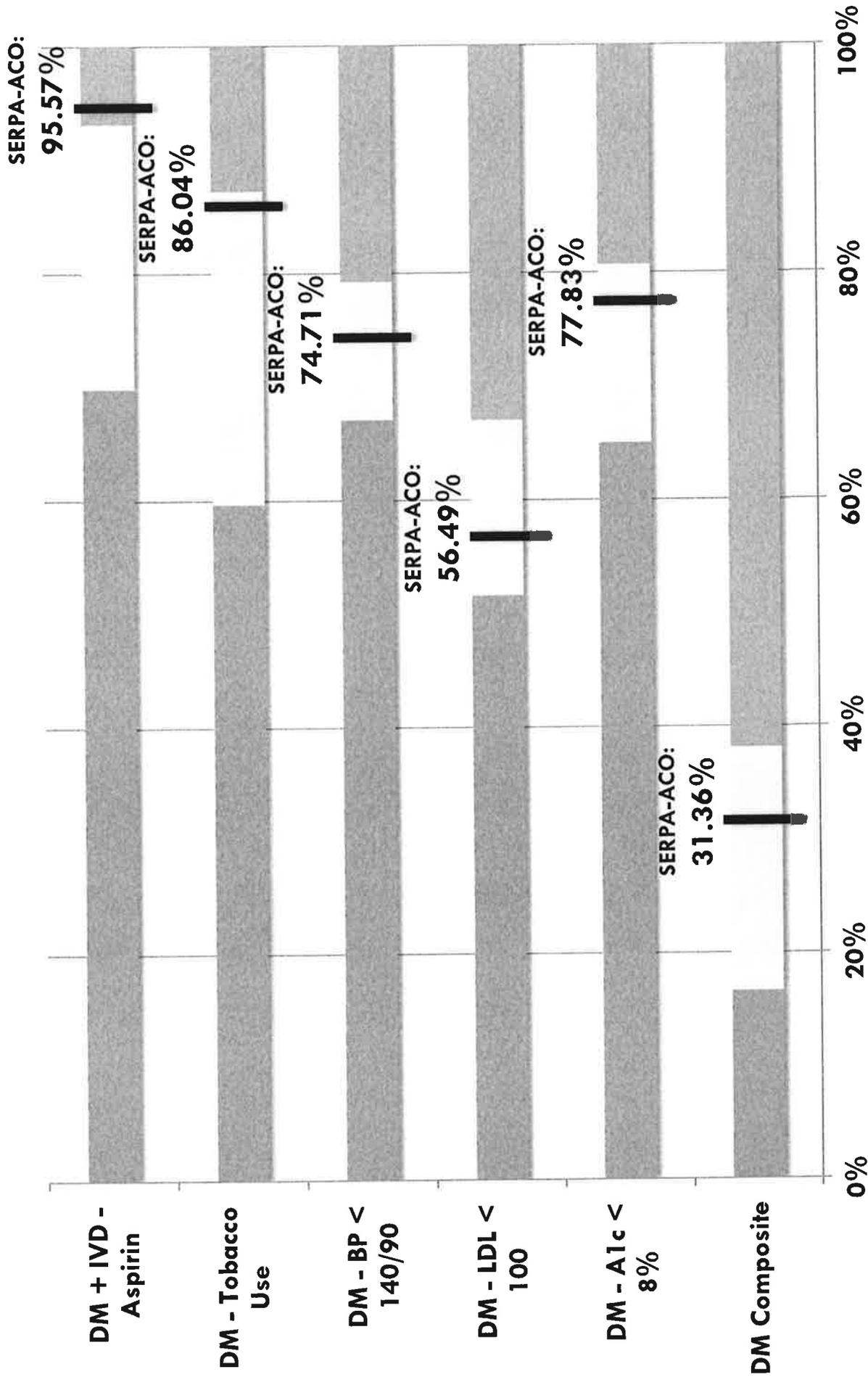
# 2013 GPRO Results

## SERPA-ACO vs. All ACOs



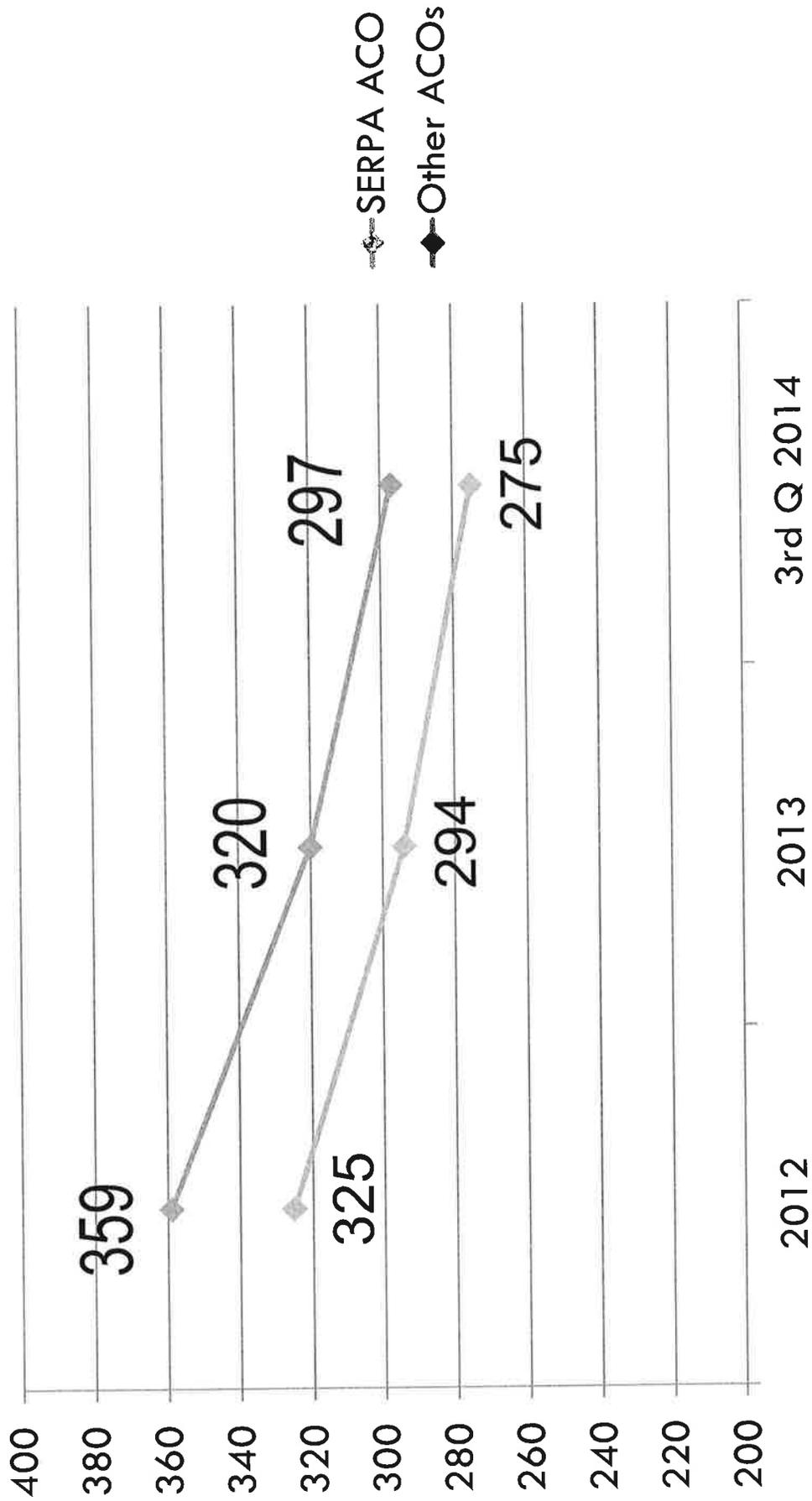
# 2013 GPRO Results

## SERPA-ACO vs. All ACOs



■ 30th Percentile    ■ 50th Percentile    ■ 90th Percentile

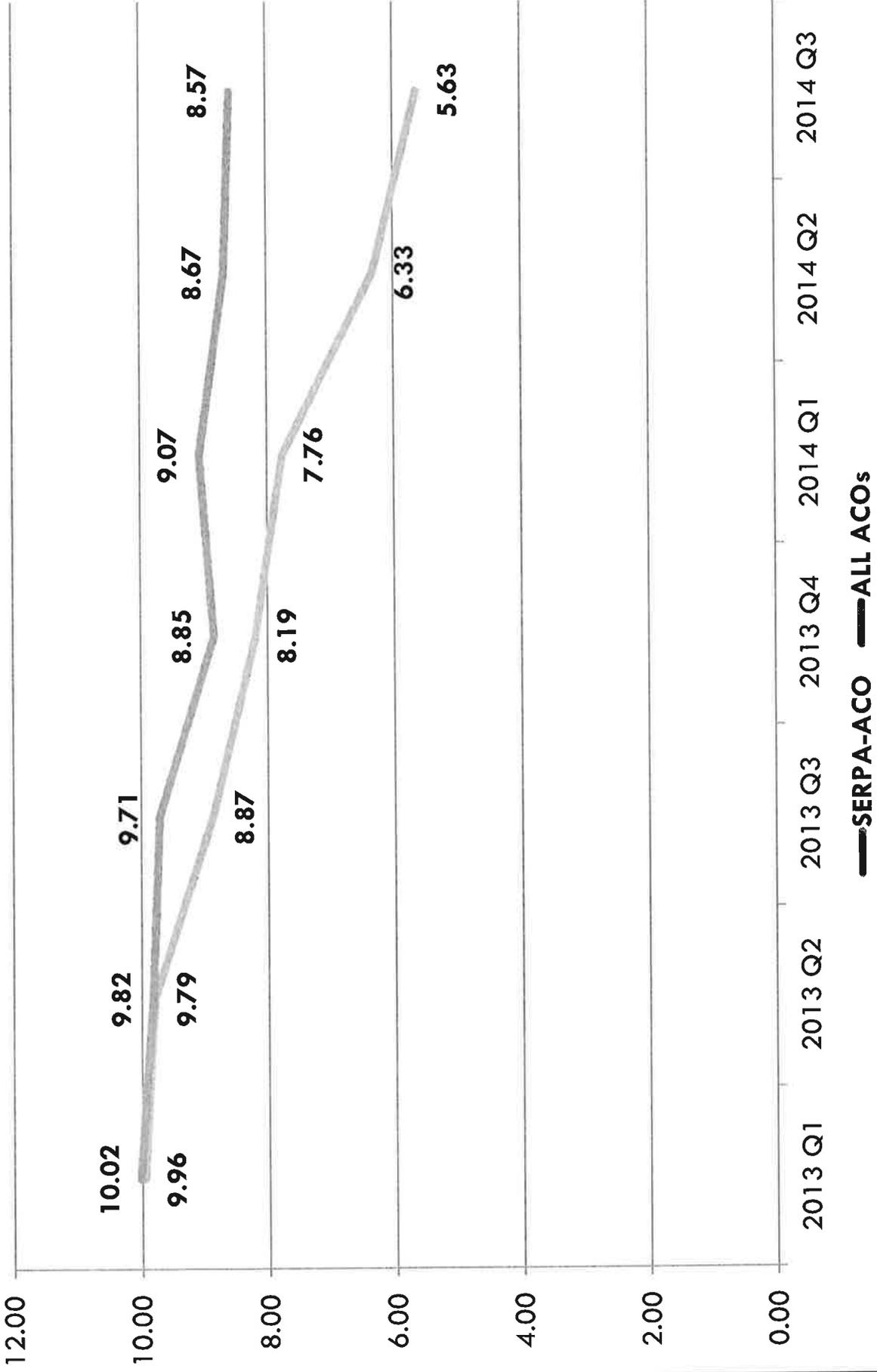
# Medicare Hospitalizations/1,000



2014 Qtr 3 Utilization (Per 1,000 Person Years) SERPA Others

Hospitalizations <sup>8</sup>	275	297	(22)
Emergency Department Visits	477	671	(194)
Emergency Department Visits That Lead To Hospitalizations	53	214	(161)
Computed Tomography (CT) Events	454	664	(210)
Magnetic Resonance Imaging (MRI) Events	160	269	(109)
Primary Care Services <sup>9</sup>	8,302	9,531	(1,229)
With a Primary Care Physician <sup>10</sup>	4,681	3,991	690
With a Specialist Physician <sup>11</sup>	2,433	4,481	(2,048)

# Discharge Rates for COPD/Asthma Per 1,000 Beneficiaries



# Challenges

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- No Interest from several payers
- Critical Mass / Freeloading

# Sustainability

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- New York Medicaid – Adirondack Medical Home Demonstration Project
  - PCMH Level 1 \$2 PMPM
  - PCMH Level 2 \$4 PMPM
  - PCMH Level 3 \$6 PMPM
  - Adirondack Demonstration Level \$7 PMPM

[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/pcmh\\_initiative.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf)

# Sustainability

- Assumption Overhead is \$4 PMPM

<b>Payers</b>	<b>Panel Size</b>	<b>PMPM Payment</b>	<b>Overhead</b>	<b>Profit/Loss Per Month</b>
Medicare	2,500	\$4	\$4	\$0
Commercial 1	3,300	\$7	\$4	\$9,900
Commercial 2	2,300	\$0	\$4	(\$9,200)
Medicaid MCO 1	1,000	\$4	\$4	\$0
Medicaid MCO 2	900	\$0	\$4	(\$3,600)
<b>Total</b>	<b>10,000</b>			<b>(\$2,900)</b>

# Questions?

Bob Rauner, MD, MPH

Chief Medical Officer

SERPA ACO

[brauner@healthylincoln.org](mailto:brauner@healthylincoln.org)

From Kevin Nohner, Uninet (Alegent) after the December meeting:  
 The metro numbers looked better but we do not have the integrated PCMH model in place for all CHI across the state yet. Kevin

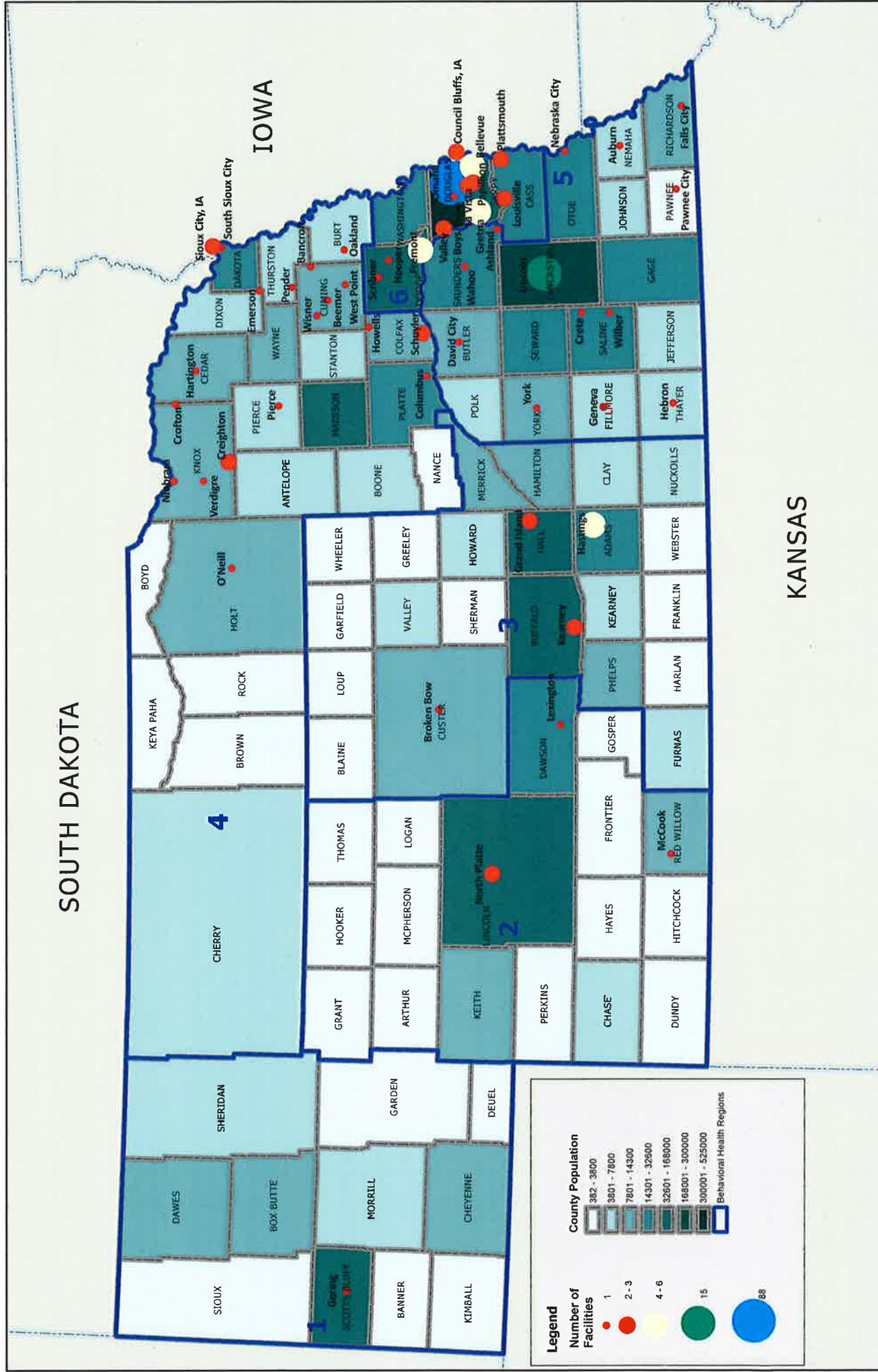
Legacy Alegent

Performance Measure	2012	2013	2014
Per Member Per Year Spend (Total Costs)	\$4,437	\$4,428	\$4,111
Hospital Admissions Per 1000	85.2	73.25	71.2
ED Visits Per 1000 Enrollees	165.46	149.76	149.6
30-Day Readmission Rates (Percentage)	13%	8%	7.02%

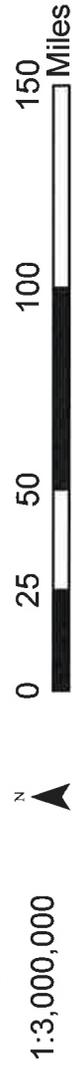
Legacy CHI NE

Performance Measure	2012	2013	2014
Per Member Per Year Spend (Total Costs)	\$4,551	\$4,319	\$4,994
Hospital Admissions Per 1000	88.79	67.89	73.02
ED Visits Per 1000 Enrollees	139.16	125.83	128.42
30-Day Readmission Rates (Percentage)	9%	8%	8.68%

# Potential Patient Centered Medical Home (PCMH) Clinic Locations



Map Created by Casey Durn  
 Compiled for Health and Human Services Committee  
 and Banking Committee, LR 22 (2015)  
 U.S. Census Bureau, 2013 ACS 5-year Estimates  
 30 September 2015



# Nebraska State Legislature

## SENATOR MIKE GLOOR

District 35  
2120 Barbara Avenue  
Grand Island, Nebraska 68803  
(308) 382-8572

Legislative Address:  
State Capitol  
PO Box 94604  
Lincoln, Nebraska 68509-4604  
(402) 471-2617  
mgloor@leg.ne.gov



## COMMITTEES

Chairperson - Revenue  
Banking, Commerce and Insurance  
Legislature's Planning

## 2016 Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Home

Facilitated by Senator Mike Gloor

In 2016 we recognize health care delivery and health care insurance is in the upheaval of major reform and health care will endure ongoing transformation in both the public and private markets. This agreement is recognized as only pertaining to Patient Centered Medical Home as defined and agreed upon in this document.

The goal of both health care providers and health insurers participating in this agreement is to reform the delivery of health care services in order to improve the overall health of individual patients, patient populations, to promote an improved consumer experience, and to control or reduce expenditures through appropriate, evidence based, comprehensive care.

We, the undersigned insurance companies and physicians/health care providers agree to support and promote the creation of Patient Centered Medical Homes (PCMH) in Nebraska by using consistent requirements and measurements to promote the efficient transformation of primary care practices into patient-centered medical homes.

The effective date of this agreement is January 1, 2016 through December 31, 2016. All parties agree to work in good faith toward compliance and fulfillment of this agreement.

**Definition:** In Nebraska, a patient centered medical home, or PCMH, is defined as a health care delivery model in which a patient establishes an ongoing relationship with a physician directed team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access and health outcomes in a cost effective manner.

In the event that a health insurer, as part of their PCMH program, requires that a PCMH be certified or recognized as such, or to attain certification or recognition, insurers will accept the following standards:

- NCQA PCMH certification
- JACO PCMH certification
- Nebraska Medicaid PCMH Pilot Program, Tier I and II standards
- URAC PCMH certification

In the event that a health insurer, as part of their PCMH program, requires that a PCMH clinic submit clinical measures to determine clinical outcomes, the measures will be selected from those listed in the following charts:

- Adult Health Outcomes (see attached chart)
- Pediatric Health Outcomes (see attached chart)
- Prenatal Care Health Outcomes
- Prenatal Intake Form

Health insurers have the option to use measures for their PCMH program outside of these clinical measures as long as they are clearly communicated, agreed upon by providers, and do not require the PCMH clinics to submit data.

**Payment:** Insurers offering a medical home program must utilize payment mechanisms that recognize value beyond the fee-for-service payment. Payments should be linked to clinical, financial and/or patient satisfaction measures in accordance with the goals of the Patient Centered Medical Home. Payments shall be directed toward the clinic's full covered panel of patients and not confined to a subset of diseases. The design and details of the payment mechanism will be left up to each individual health plan to determine through an agreement with the provider or provider group to be negotiated in accordance with this PCMH Participation Agreement.

Nothing in this agreement shall guarantee that a clinic is included in an insurer's PCMH program by meeting the basic criteria. Nothing in this agreement shall preclude the development of alternative innovative models by an insurer for its group and/or individual policies, or alternative models and payment mechanisms to support PCMH. The Agreement does not limit the ability of any of the signatories to establish Patient Centered Medical Home agreements/contracts with primary care providers other than physicians nor does it limit the ability of signatories to use definitions for Patient Centered Medical Homes that include primary care providers other than physicians.

**Progress Report:** Participating payers are asked to report annually, by letter, successes realized and challenges faced in their efforts to comply with this agreement. The report should include the number of PCMH contracts signed and give a list of clinics by name, location, number of providers, number of patients covered and may include aggregate financial or health data that comply with the anti-trust statement governing this collaboration (attached).

Date of Signing:

Participants: Please sign with name and title.

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Senator Mike Gloor

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Senator Mark Kolterman

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Blue Cross Blue Shield of Nebraska

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Nebraska Academy of Family Physicians

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Aetna Better Health of Nebraska

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Nebraska Medical Association

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Arbor Health Plan

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Nebraska Chapter of the American Academy of Pediatrics

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UnitedHealthcare

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Nebraska Hospital Association

## Adult Health Outcome measures menu for 2016 Nebraska Patient Centered Medical Home Participation Agreement

CMS Shared Savings/ACO Measure Title	NQF Measure/Steward	HEDIS	Source
<i>Domain: Patient Caregiver Experience:</i>			
Getting Timely Care, Appointments, and Information	ACO 1 -NQF #0005 - AHRQ	CAHPS	Survey
How Well Your Providers Communicate	ACO 2 - NQF#0005 – AHRQ	CAHPS	Survey
Patient's Rating of Provider	ACO 3 - NQF#0005 - AHRQ	CAHPS	Survey
<i>Domain: Care Coordination/patient safety</i>			
Risk Standardized, All Condition Readmission	ACO 8 – NQF#1789 - CMS		Claims
Ambulatory Sensitive Conditions Admissions:			
- COPD/Asthma in Older Adults	ACO 9 – NQF#0275 - AHRQ		Claims
- Heart Failure	ACO 10 – NQF#0277 - AHRQ		Claims
Documentation of current medications	ACO 39 – NQF#0419 – CMS	MPM	EHR
<i>Domain: Preventive Health</i>			
Breast Cancer Screening, Mammography	ACO 20 – PREV 5/MSSP	BCS	EHR
Colorectal Cancer Screening	ACO 19 - NQF#0034–NCQA	COL	EHR
Influenza Immunization	ACO 14 - NQF#0041-AMA/PCPI	FVA/FVO	EHR/Survey
Pneumococcal Vaccination	ACO 15 - NQF#0043 – NCQA	PNU	EHR/Survey
BMI screening and follow Up	ACO 16 - NQF#0421 - CMS	ABA	EHR
Tobacco Use: Screening & Cessation Intervention	ACO 17 - NQF#0028 - AMA/PCPI		EHR
High Blood Pressure Control <140/90	ACO 21 - NQF#0018 – NCQA	CBP	EHR
Clinical Depression Screening	ACO 18 - NQF#0418 - CMS		EHR
<i>Domain: At-risk population:</i>			
Diabetes: Hemoglobin A1C poor control	ACO 27 – NQF#3729 – NCQA	CDC	EHR
Diabetes: Eye Exam	ACO 27 – NQF#0055 – NCQA	CDC	EHR
Hypertension: Controlling Blood Pressure	ACO 28 – NQF#0018 – NCQA	CBP	EHR
Ischemic Vascular Disease: Aspirin/Antithrombotic	ACO 30 - NQF#0068 - NCQA		EHR
Heart Failure: Beta-Blocker for LVSD	ACO 31 - NQF#0083 - AMA/PCPI	PBH	EHR
CAD: ACE/ARB for Patients with DM/LVSD	ACO 33 - NQF#0066 - AMA/PCPI	MPM	EHR

Abbreviations: ACO=Accountable Care Organization, NQF=National Quality Forum, AHRQ=Agency for Healthcare Research and Quality, NCQS=National Committee for Quality Assurance, PCPI=Physician Consortium for Performance Improvement, AMA=American Medical Association, MNM=Minnesota Community Measure, Hedis=Healthcare Effectiveness Data and Information Set

Background FYI: You can pull up each measure on the NQF website:

[http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx) click “NQF endorsed measures” on the left and then type the number in the box to look it up.

Recommended by Subcommittee: Dr. Bob Rauner, Healthy Lincoln, Dr. Deb Esser, Nebraska Blue Cross Blue Shield, Dr. Steve Lazowitz, Arbor Health, Dr. Ken Shaffer, Uninet, Dr. Dale Michels, Lincoln Family Medical Group, Dr. Matha Arun, Aetna, Dr. Michael Horn, United Health Care, Margaret Brockman, Office of Rural Health, Heather Leschinsky, Nebraska Medicaid, Margaret Buck, Senator Mike Gloor’s office.

## Pediatric Health Outcome Measures menu for 2016 Nebraska Patient Centered Medical Home Participation Agreement

Measure Title	NQF Measure/Steward	HEDIS	Source
<i>Domain: Care Coordination/patient safety:</i>			
1. Documentation of current medications:	NQF#0419 – CMS	MPM	EHR
<i>Domain: Preventive Health:</i>			
1. Immunizations			
a. Infants (w/ Rotavirus and Influenza)	HEDIS Combo 9	CIS	EHR
b. Adolescents	NQF 1959	IMA	EHR
c. HPV	NQF 1959	HPV	EHR
2. WCC/Developmental			
a. First 15 months	NQF 1392	W15	EHR
b. 3-6 years	NQF 1516	W34	EHR
c. Developmental (Examples: ASQ/Ages & Stages, CSBS-DB, MCHAT)	NQF 1448		EHR
3. Weight Screening	NQF 0024	WCC	EHR
4. Depression: By age 18	NQF 1515		EHR
5. Smoking	NQF 1346	MSC	Survey
6. Asthma - (Asthma Action Plan)	NQF 25		EHR
7. Chlamydia Screening for female	NQF 0033	CHL	EHR
<i>Domain: At Risk Population:</i>			
1. Depression Screening	NQF 1515		EHR
2. Smoking	NQF 1346	MSC	Survey

Background FYI: You can pull up each measure on the NQF website:

[http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx) click “NQF endorsed measures” on the left and then type the number in the box to look it up.

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## **Prenatal Health Outcomes Measures menu for 2016 Nebraska Patient Centered Medical Home Participation Agreement**

**Measure 1:** Prenatal screening using a common state screening form based on the Arbor Obstetric Needs Assessment form (attached).

**Measure 2:** Non-indicated induced delivery – NQF 0469

**Measure Description:**

This measure assesses patients with elective vaginal deliveries or elective cesarean sections at  $\geq 37$  and  $< 39$  weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

Background: You can pull up each measure on the NQF website: [http://www.qualityforum.org/Measures\\_Reports\\_Tools.aspx](http://www.qualityforum.org/Measures_Reports_Tools.aspx) click “NQF endorsed measures” on the left and then type the number in the box to look it up.

Recommended by Subcommittee: Dr. Bob Rauner, Healthy Lincoln, Dr. Deb Esser, Nebraska Blue Cross Blue Shield, Dr. Steve Lazowitz, Arbor Health, Dr. Ken Shaffer, Uninet, Dr. Dale Michels, Lincoln Family Medical Group, Dr. Matha Arun, Aetna, Dr. Michael Horn, United Health Care, Margaret Brockman, Office of Rural Health, Heather Leschinsky, Nebraska Medicaid, Margaret Buck, Senator Mike Gloor’s office.

**PROVIDER INFORMATION**

PROVIDER NAME:	MEDICAID ID:
PHONE:	ALTERNATE PHONE:
FORM COMPLETED BY:	

**MEMBER INFORMATION**

MEMBER NAME:	MEMBER ID / MEDICAID ID #:	
ADDRESS:		
DATE OF BIRTH:	PHONE:	ALT. PHONE:
LANGUAGE PREFERENCE:	SCHEDULED HOSPITAL FOR DELIVERY:	

TOBACCO USE	PRE-PREGNANCY	CURRENT
Average # of cigarettes smoked/day (If none enter 0; 1 pack = 20 cigarettes)		
TOBACCO COUNSELING OFFERED? <input type="checkbox"/> YES <input type="checkbox"/> NO		TOBACCO COUNSELING RECEIVED? <input type="checkbox"/> YES <input type="checkbox"/> NO
EXPOSURE TO ENVIRONMENTAL SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO		COUNSELING FOR EXPOSURE TO SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO

**PREGNANCY INFORMATION & HISTORY**

DATE OF FIRST PRENATAL VISIT:				17P CANDIDATE: <input type="checkbox"/> YES <input type="checkbox"/> NO			
EDC:	by LMP of:	by US Date:	GA at 1st Visit:	Gravida:			
Full Term:				Pre-Term:			
Depression Screen? <input type="checkbox"/> YES <input type="checkbox"/> NO				Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative			
Previous AB:	Previous SAB:	Previous TAB:	Living:	Height:	Weight:	BMI:	
Last PAP: / /				Last chlamydia Screen: / /			
Dental Visit Last 6 months? <input type="checkbox"/> YES <input type="checkbox"/> NO				Dental Referral? <input type="checkbox"/> YES <input type="checkbox"/> NO			

**ACTIVE MEDICAL CONDITIONS**

- NO ACTIVE MEDICAL / MENTAL HEALTH CONDITIONS
- ASTHMA
- CARDIAC DISEASE
- CHRONIC HYPERTENSION, PRE-GESTATIONAL
- DIABETES, PRE-GESTATIONAL
- RENAL DISEASE
- OTHER \_\_\_\_\_

- BEHAVIORAL HEALTH CONDITION: \_\_\_\_\_
- SOCIAL, ECONOMIC AND LIFESTYLE ISSUES: \_\_\_\_\_
- SUBSTANCE ABUSE:
  - ALCOHOL: \_\_\_\_\_
  - DRUG: \_\_\_\_\_

Physician Signature # _____
Date Signed: _____

## **Multi-Payer Medical Home Antitrust Guidelines for Meetings**

1. Set an agenda for each meeting and focus your conversation on the agenda topics. Do not let the conversation wander into subjects that have antitrust sensitivity.
2. The agenda may include discussions and joint decisions on the elements of the PCMH structure, including what services physician practices will be asked to perform as medical homes.
3. Participants may not discuss how to set reimbursement for PCMH services or how much will be paid for PCMH services. However, program elements related to reimbursement that are essential to execution of the program may be discussed and agreed upon.
4. Competitively sensitive and confidential information (e.g. provider fee schedules, payers' market shares, premiums, or marketing plans being developed) may not be discussed.
5. Providers and other participants in the meetings may not discuss how much they want to be reimbursed for their services.



**FINAL REPORT**  
**Patient-Centered Medical Home Pilot**  
**(LB 396 – 2009)**

**Provided to the**  
**Governor of the State of Nebraska and the**  
**Health and Human Services Committee of the Legislature**

**Prepared by**  
**Vivianne M. Chaumont, Director**  
**Division of Medicaid and Long-Term Care**  
**Nebraska Department of Health and Human Services**

**November 1, 2013**

# NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

## PATIENT-CENTERED MEDICAL HOME PILOT

### FINAL REPORT – Executive Summary

#### INTRODUCTION

In 2009, the Nebraska Legislature, through enabling legislation (*Attachment A*), initiated the Nebraska Medical Home Pilot Program Act to be designed and implemented by the Division of Medicaid and Long-Term Care (DHHS). The two-year pilot began in February, 2011, with two rural practices and 7000 Medicaid patients. The focus for the pilot was to transform the two practices into recognized patient-centered medical homes (PCMH) in order to improve health care access and health outcomes for patients and contain costs of the medical assistance program. The pilot concluded February, 2013.

#### FINDINGS

The findings for this pilot culminated through the collection of data and information from Medicaid claims, clinical data, patient satisfaction surveys, provider and employee satisfaction surveys, and the general experience of the practice management teams. The pilot operated under multiple assumptions and constraints, including the factor that it takes one to two years to set up a PCMH properly with any measurable return on investment taking additional years. In spite of this, the early return on findings for this two-year pilot included some noteworthy results:

- significant decrease in the rate of overall Emergency Room (ER) visits per 1,000
- no significant difference in revisits to the ER for the same complaint
- a slight increase in hospital readmissions, yet noticeable reduction in proportion of all admissions that were caused by ambulatory care sensitive conditions tracked in this pilot
- small decrease in costs for high-tech radiology
- significant decrease in the rate of prescriptions written and spending per 1,000
- total expenditures per client per month reflected a slight decrease
- patient indicators suggested an increase in satisfaction with the services provided
- provider and employee satisfaction fluctuated over the course of the pilot and did not reflect overall significant improvement by the end
- distinct improvement in patient health outcome

The practices successfully transformed into recognized PCMHs through meeting prescribed standards that moved them from doctor-centered to patient-centered services. The most significant finding was the improvement of health for the population through targeted care coordination. This component of the model increased patient education and patient engagement in taking responsibility for management of chronic health conditions. Additionally, through the utilization

of care coordinators, there was individualized attention given to overutilization of the ER, follow-up on referrals to specialists, medication management, and whole person health care.

## RECOMMENDATIONS

DHHS determined that the Patient-Centered Medical Home model has merit. This pilot demonstrated improved patient satisfaction, marked efficiencies with the modification of office practices, improvements in patient health through care coordination and patient education, and indicators showing potential for containment of costs.

Based on this experience, DHHS recommends the follow:

- Payment Reform. Consideration should be given to linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency and improved health outcomes.
- Continue PCMH. The PCMH model should be continued in the provision of services through the Medicaid Managed Care Program statewide due to the large number of Medicaid clients and longevity of the program. In 2012, DHHS required the Managed Care contractors statewide to develop and maintain a certain minimum of PCMH practices, following the model of this pilot.

*Quality is often defined as providing the right care in the right way at the right time. But a patient-centered vision would define quality as providing the care the patient wants in the way the patient wants at the time the patient wants it...Increasingly, patients want direct access to information and the ability to be active partners in their care. That will require listening to patients much more and reorienting primary care practice to provide care that works for patients." – Commonwealth Fund*

## Nebraska Medicare Shared Savings Program ACO Quality Summary 2014

Bob Rauner, MD, MPH, FAAFP  
Legislative Chair, Nebraska Academy of Family Physicians

### Background:

Medicare has publicly released the results for all Medicare Shared Savings Program ACOs. You can access the raw data here - <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ay8x-m5k6>. The full quality results of Nebraska's 3 Medicare Shared Savings Program ACOs (Alegent Health Partners, SERPA ACO and Midwest Health Coalition ACO) are shown on page 2. The 33 quality measures are grouped into 4 major categories/sources of data:

1. Patient Satisfaction (ACO 1-7). Source: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
2. Utilization (ACO 8-10). Source: Medicare claims data
3. Electronic Health Record Meaningful Use (ACO 11). Source: EHR Incentive Program
4. Clinical Quality Measures (ACO 12-33). Source: combination of Medicare claims data and physician medical records

### Summary:

1. Overall quality score:
  - a. Alegent/UniNet 87.76%
  - b. SERPA ACO 93.57%
  - c. MIPPA was in its pay for reporting year, so no summary score listed.
2. Patient Satisfaction ACO 1-7, all 3 Nebraska groups did well on this section.
3. Top Score in each of the 33 measures:
  - a. Alegent Health Partners 6
  - b. SERPA ACO 18
  - c. Midwest Health Coalition 9.

### Context for Multi-Payer Patient-Centered Medical Stakeholder Group:

The first joint voluntary Nebraska PCMH agreement used the 2013 and 2014 Medicare Shared Savings Program quality measure specifications for its list of adult measures. These provide a common method of comparison for Nebraska PCMH initiatives. Because all 353 Medicare Shared Savings Program ACOs in the United States will be using these quality specifications, we should consider using these measures for Nebraska initiatives to measure quality in adult populations. These 3 Nebraska ACOs already likely take care of >25% of Nebraskans, with several more ACOs likely to launch in Nebraska for 2016 and 2017. However, Medicare has revised the prior set of measures, so it would make sense to adopt the newer 2015 Medicare Shared Savings Program quality measure specifications for use in the future as adult measures for any Nebraska Multi-Payer Patient-Centered Medical Home initiatives. You can find more detail on these specifications here: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Ry2015-Narrative-Specifications.pdf>

- Note that for the 3 utilization measures Measure (ACO 8 - Readmissions, ACO 9 - COPD/Asthma Admissions and ACO 10 - Heart Failure Admission) and the Diabetes Poor Control measure (ACO 27 - Diabetes A1c Poor Control) a lower number is better.

ACO Legal Business Name	Alegent Health Partners, LLC	SERPA-ACO	Midwest Health Coalition ACO
States Where Beneficiaries Reside	Iowa, Nebraska	Nebraska	Nebraska, Iowa
Agreement Start Date	1/1/2013	1/1/2013	1/1/2014
Track	Track1	Track1	Track1
Successfully Reported Quality	Yes	Yes	Yes
Quality Score	87.76%	93.57%	P4R
ACO-1: Getting Timely Care	81.22	82.35	88.19
ACO-2: Provider Communication	93.89	93.48	94.46
ACO-3: Patient's Rating of Provider	93.57	92.22	93.35
ACO-4: Access to Specialists	84.01	84.62	85.44
ACO-5: Health Promotion and Education	56.53	56.25	55.78
ACO-6: Shared Decision Making	74.07	76.33	73.04
ACO-7: Health Status/Functional Status	74.19	73.07	71.86
<i>ACO-8: Risk Standardized Readmissions</i>	<i>15.1</i>	<i>14.68</i>	<i>15.25</i>
<i>ACO-9: Asthma/COPD Admissions</i>	<i>1.76</i>	<i>0.92</i>	<i>1.06</i>
<i>ACO-10: Heart Failure Admissions</i>	<i>1.17</i>	<i>0.84</i>	<i>1.06</i>
ACO-11: EHR Meaningful Use	94.41	100	64
ACO-12: Medication Reconciliation	97.61	98.39	97.19
ACO-13: Fall Risk Screening	43.54	76.81	56.76
ACO-14: Influenza Vaccination	60.72	78.97	66.78
ACO-15: Pneumococcal Vaccination	62.93	88.25	70.44
ACO-16: Body Mass Index Screening	54.55	58.46	78.29
ACO-17: Tobacco Screening/Counseling	87.48	95.33	88.07
ACO-18: Depression Screening	41.3	69.35	54.44
ACO-19: Colorectal Cancer Screening	48.26	66.43	49.16
ACO-20: Breast Cancer Screening	67.43	71.72	67.89
ACO-21: Blood Pressure Screening	53.72	63.48	90.86
Diabetes Composite	35.21	37.88	31.03
ACO-22: Diabetes A1C Control	78.35	80.61	76.94
ACO-23: Diabetes Lipid Control	66.45	65.53	67.09
ACO-24: Diabetes Blood Pressure Control	74.05	75.58	72.96
ACO-25: Diabetes Tobacco Use	77.69	88.33	69.39
ACO-26: Diabetes Aspirin/Antiplatelet Use	90.48	89.6	89.29
<i>ACO-27: Diabetes A1c Poor Control</i>	<i>10.41</i>	<i>9.16</i>	<i>12.66</i>
ACO-28: Blood Pressure Control	72.39	75.5	71.99
ACO-29: Ischemic Vascular Disease Lipid Control	69.23	55.7	70.95
ACO-30: Ischemic Vascular Disease Aspirin Use	96.15	88.21	92.74
ACO-31: Heart Failure Beta Blocker Use	93.46	88.65	89.74
Coronary Artery Disease Composite Composite	69.37	61.35	84.56
ACO-32: Coronary Artery Disease Lipid Control	78.5	64.4	90.41
ACO-33: Coronary Artery Disease ACE/ARB Use	76.79	83.49	83.76

- Note that for Italicized measures above, a lower number is better.



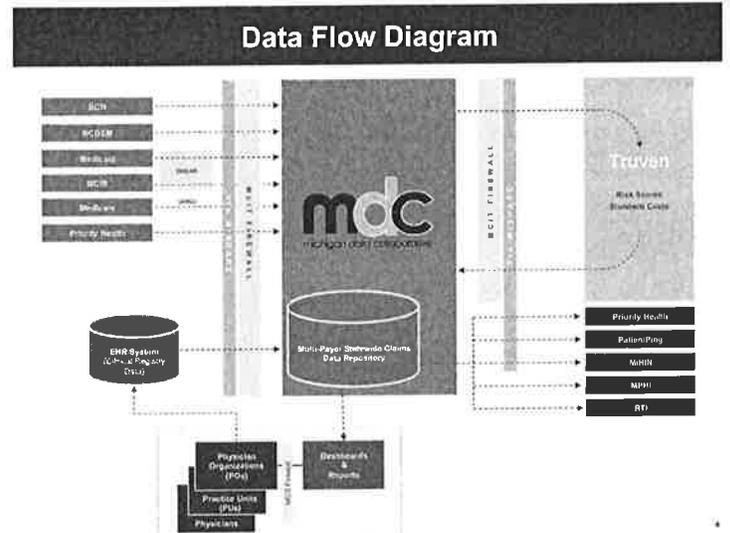
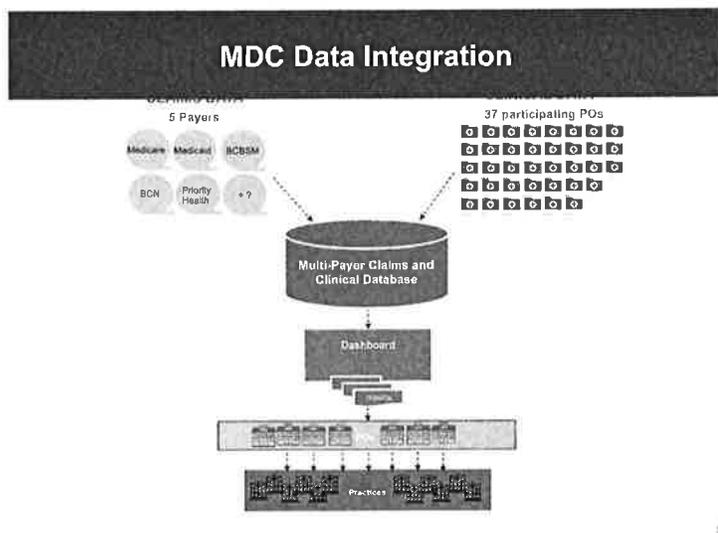
## Michigan Data Collaborative

A non-profit data aggregation, enrichment, and provisioning organization, established at the University of Michigan – serving the data needs for the Michigan Primary Care Transformation Project (MIPCT)

- Dashboards    Ad Hoc Reporting    Incentive Calculation    Access Control
- Downloadable Reports    Inpatient Utilization    Data Aggregation
- Multi-Payer Member Lists    Emergency Department Reporting
- Multi-payer Attribution
- Clinical Data Integration    Data Warehousing    Benchmarking
- Analysis    Quality Measures    Electronic Data Interchange
- Identity Management    Secure Portal and Website Management

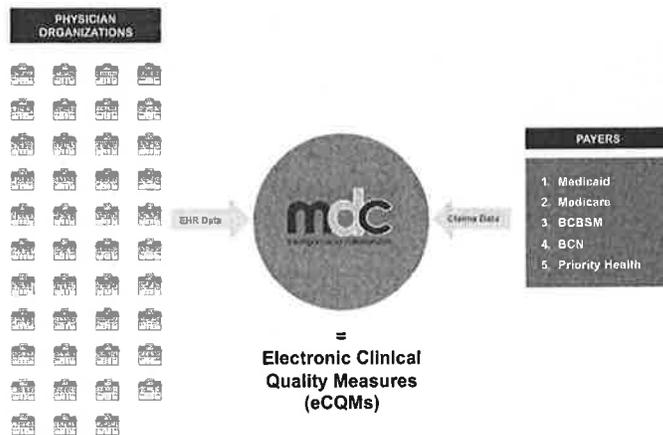
## The MIPCT Multi-Payer Data Resource

December 09, 2015

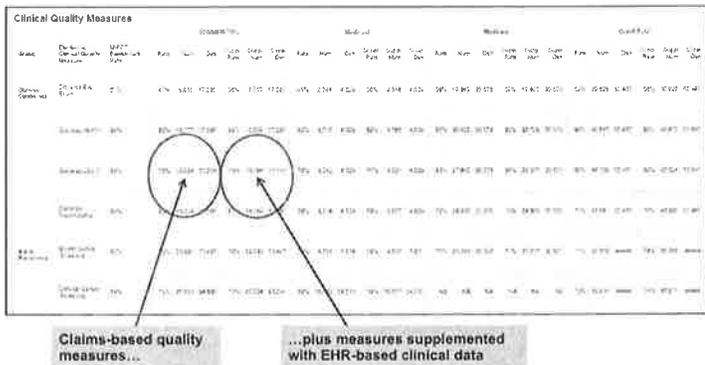


## MDC by the Numbers

37 Physician Organizations (out of 42 statewide)	> 4 million Covered Lives	1.3 billion Medical Claims over five years
355 Practices	4.5 Terabytes of Data	over 147 million Pharmacy Claims over five years
1,814 Physicians	6 years Of Multi-payer Claims Data Aggregated	over 62 million Clinical Data Records



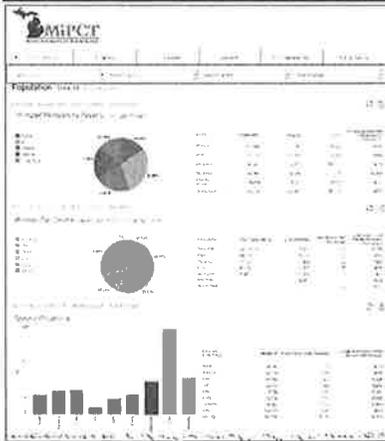
## Aggregating Claims AND Clinical (EHR) Data Together



	# Patients	% Patients
Medicare	186,997	16.1%
Medicaid	214,745	18.5%
BCBSM	361,802	31.2%
BCN	275,316	23.8%
Priority Health	119,990	10.4%
<b>Total</b>	<b>1,158,850</b>	<b>100.0%</b>

March 2015 snapshot. MDC patients only. Does not include the Control Group

## MiPCT Dashboard – Population Page



Project level view of payer-mix and chronic disease in the Attributed Population

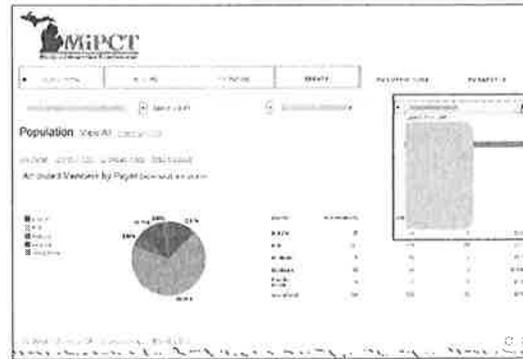
Users can choose the PO or Practice or Provider for population management

Tables and Charts are drillable for analysis

Pages available for selection are:

- Population
- Quality
- Utilization (IP and ED)
- Trends over time
- PO Comparisons
- Downloadable Reports and a tool for quick analysis (Report Writer)

## MiPCT Dashboard – Selecting a Provider



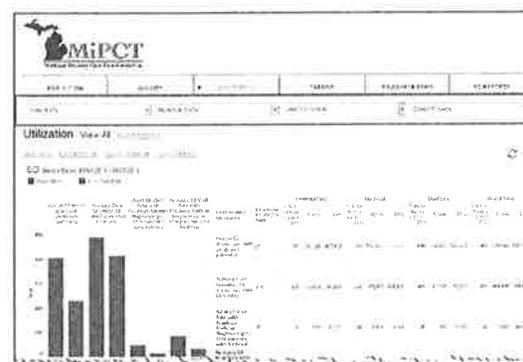
Example of the display after choosing a provider.

## MiPCT Dashboard – Quality Page



Benchmarks are created at the practice level using the best in class approach (top 20%)

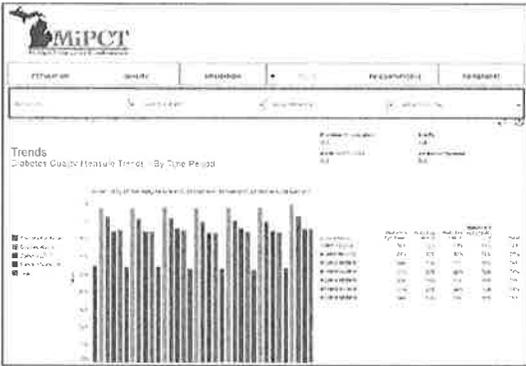
## MiPCT Dashboard – Utilization Page



Utilization Page contains information about Inpatient and Emergency Department measures.

All data is downloadable to excel or html or pdf formats

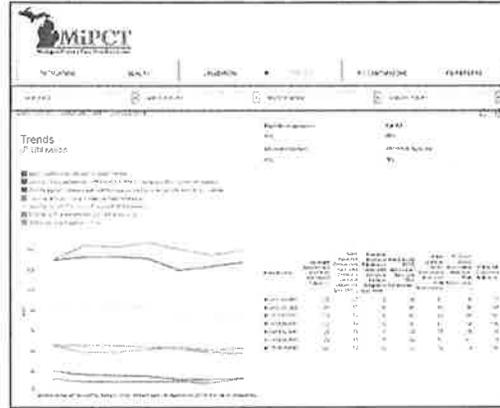
## MiPCT Dashboard – Trends Page Diabetes Quality Measure Trends by Time Period



The Diabetes Quality Measures are displayed over time.

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## MiPCT Dashboard – Trends Page IP Utilization



Utilization Trends are also available over time

All data can be downloaded at the patient level.

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## MiPCT Dashboard – PO Comparisons Page Diabetes Table

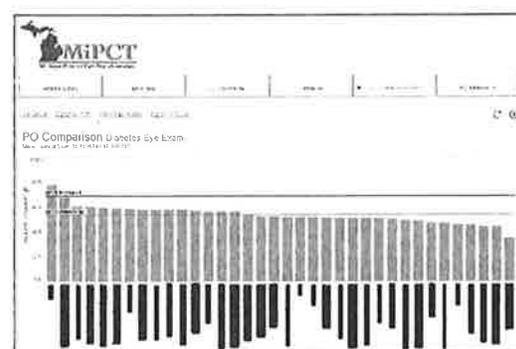
The screenshot shows the MiPCT PO Comparisons page for Diabetes Table. The table lists various measures and their values for comparison. The table has the following columns: Measure, Value, and Comparison.

Measure	Value	Comparison
Diabetes A1C	78.5	79.2
Diabetes Eye Exam	75.0	76.0
Diabetes Foot Exam	70.0	71.0
Diabetes Blood Pressure	85.0	86.0
Diabetes Cholesterol	80.0	81.0

In the Physician Organization Comparisons Page, Measures can be compared and ranked.

15

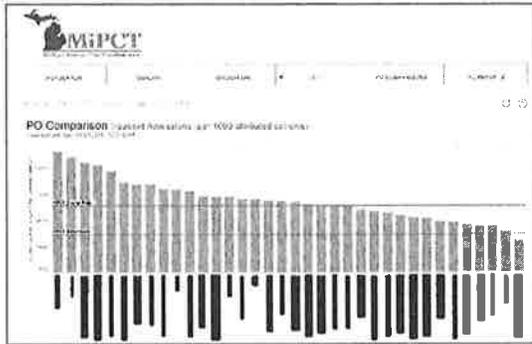
## MiPCT Dashboard – PO Comparisons Page Diabetes Eye Exam Graph



Graphic Depictions of the Quality and Utilization measures are available for download.

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## MiPCT Dashboard – PO Comparisons Page Inpatient Admissions Graph



Charts are easily exported to pdf

## MiPCT Dashboard – Download PO Reports Page

Physician Organizations have access to PO specific reporting.

Here they can download their All Payer Patient list which is supplemented with Risk information such as:  
 Dual Eligibility  
 Prospective Risk Score  
 Concurrent Risk Score  
 Count of Chronic Conditions  
 Detailed Chronic Conditions  
 Participation in State ACA Medicaid Expansion program  
 Count of ED visits  
 Count of Admissions.

## MiPCT Dashboard – Report Writer

The Report Writer is also located here.

This allows users to choose from a menu the different areas of interest for analysis.

Each page is represented with its elements for ad hoc analytical reporting.



Border to Border  
and  
Coast to Coast

Questions?

## ENHANCE HEALTH NETWORK- COMPASS PTN

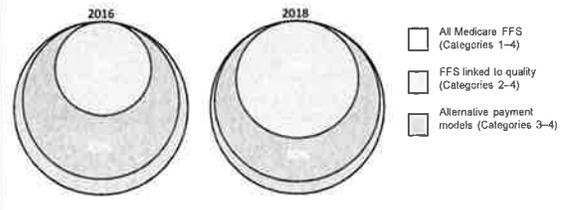
Transforming the Medicare benefit to support the needs of our beneficiaries  
 and the needs of our providers  
 through a new payment model  
 that is focused on quality and value



### I. THE MOVEMENT FROM VOLUME TO VALUE

For the first time in the history of the Medicare program, the HHS has set explicit goals for alternative payment models and value-based payments.

*Target Percentage of Payments in FFS Linked to Quality and Alternative Payment Models by 2016 and 2018*



- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

**The passage of MACRA in April 2015 repealed the Sustainable Growth Rate (SGR). More importantly, however, it changed how Medicare will pay physicians and signaled further changes ahead.**

**TRACK 1:**  
MIPS — MODIFIED FEE-FOR-SERVICE TRACK

- » The Merit-Based Incentive Payment System (MIPS) incorporates upside and downside risk through four performance measures.
- » Downside penalties will pay for upside bonuses, making MIPS budget-neutral.
- » There is an additional \$500 million that will be distributed annually to top performers from 2019 through 2024.

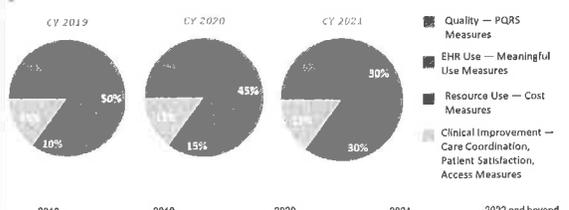
**TRACK 2:**  
APMs — RISK-BASED TRACK

- » Alternative Payment Models (APMs) refer to value-based, non-fee-for-service (FFS) payment mechanisms, such as ACOs. To be eligible, providers must use an EHR, be paid for quality metrics similar to those under MIPS, and bear financial downside risk.
- » Providers must receive a large percentage of revenue through APMs to be eligible for this track.
- » The APM track frees physicians from participating in the MIPS performance metrics.

### I. THE MOVEMENT FROM VOLUME TO VALUE

*MIPS PERFORMANCE EVALUATION*

PQRS, MU and VM will combine into a single payment adjustment under MIPS in 2019.



Year	Quality — PQRS Measures	EHR Use — Meaningful Use Measures	Resource Use — Cost Measures	Clinical Improvement — Care Coordination, Patient Satisfaction, Access Measures
2018	10%	10%	10%	10%
2019	45%	15%	15%	15%
2020	5%	5%	5%	5%
2021	30%	30%	30%	30%
2022 and beyond	7%	7%	7%	7%

### I. THE MOVEMENT FROM VOLUME TO VALUE

Requirements for participation in APMs will increase over time.

2019-2020	2021-2022	2023+
<p>Medicare revenue requirement from APMs: 25%</p>	<p>Medicare revenue requirement from APMs: 50%</p> <p>or</p> <ul style="list-style-type: none"> <li>All payor revenue from APMs: 50%</li> <li>Medicare revenue requirement from APMs: 25%</li> </ul>	<p>Medicare revenue requirement from APMs: 75%</p> <p>or</p> <ul style="list-style-type: none"> <li>All payor revenue from APMs: 75%</li> <li>Medicare revenue requirement from APMs: 25%</li> </ul>

Annual lump sum bonus on fee schedule: 5% (discontinued after 2024)

### II. COMPASS PTN

TCPI is the major national initiative designed to "provide hands-on support to 140,000 physicians and other clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models."

-- HHS Secretary Sylvia M. Burwell

- \$685 million was awarded to 39 national and regional health care networks and supporting organizations to help equip more than 140,000 clinicians to transition to value-based care.
- ENHANCE has joined forces with the Iowa Healthcare Collaborative creating a provider-led, multi-state coalition, known as the Compass Practice Transformation Network (Compass PTN).
- The initiative will support clinical practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies.
- Direct support for clinics will include support from practice transformation consultants, data analytics to help understand opportunities and success, and educational opportunities.

### II. COMPASS PTN-GRANT PARTNERS

Seven partners will carry out the activities of the Compass PTN to assist clinicians in six states.

COMPASS PTN PARTNERS	STATES INCLUDED COMPASS PTN
<ul style="list-style-type: none"> <li><b>Iowa Healthcare Collaborative (IHC)</b> — Serves as the primary contractor with CMS and will lead all Iowa-based activities.</li> <li><b>ENHANCE</b> — Will serve as the Nebraska contractor and lead all Nebraska activities.</li> <li><b>HealthPOINT Dakota State University</b> — HIT regional extension center that will serve as the contractor for all South Dakota activities.</li> <li><b>Georgia Hospital Association Education and Research Foundation</b> — Will serve as the contractor for all Georgia activities.</li> <li><b>The Kansas Healthcare Collaborative</b> — Will serve as the contractor for all Kansas activities.</li> <li><b>OU Physicians and Telligen</b> — Will jointly serve as the contractors for all Oklahoma activities. In addition, Telligen will assist with data collection and analysis services.</li> </ul>	

### II. COMPASS PTN- KEY GRANT ACTIVITIES

The Compass PTN will execute three Plan-Do-Study-Act (PDSA) cycles each year to bring practices through the five phases of transformation.

FIVE PHASES OF TRANSFORMATION				
<p>SET AIMS</p>	<p>USE DATA TO DRIVE CARE</p>	<p>ACHIEVE PROGRESS ON AIMS</p>	<p>ACHIEVE BENCHMARK STATUS</p>	<p>THRIVE AS A BUSINESS VIA PAY-FOR-VALUE APPROACHES</p>

Source: Centers for Medicare and Medicaid Services

## II. COMPASS PTN- KEY GRANT ACTIVITIES

Through the initiative, clinicians will be provided with ongoing education and technical assistance to move toward a team-based care delivery model.

### EDUCATION

- » The PTN will plan and host in-person learning sessions in each state annually to reinforce key national transformation topics.
- » The state-based learning sessions will be based on the IHI Breakthrough Series Model.
- » Topics will include leadership, development of community-based peer groups, care coordination, population health management, patient and family engagement, Lean, and medication safety.
- » The Learning Sessions will occur in tandem with each PDSA cycle.

### TECHNICAL ASSISTANCE

- » Local Quality Improvement Advisors (QIA) will be dedicated to assigned practices to assist with transformation efforts.
- » They will assist physician leaders in the development of potential opportunities and improvement plans and assess their progress through the stages of transformation.
- » They will be trained to assist clinics to build capability in adopting QI methods (e.g., PDSA and Lean), developing work plans, and reporting data.

## III. BENEFITS OF ENROLLMENT

The Compass PTN enables providers to be prepared for value-based delivery models and lead the effort in national transformation efforts.

- 1 Optimize health outcomes for your patients
- 2 Promote coordination of care for your patients
- 3 Spend more time caring for your patients
- 4 Be prepared for new and emerging federal policies
- 5 Gain access to dedicated quality improvement advisors to support transformation efforts
- 6 Learn from high performers how to effectively engage patients and families in care planning
- 7 Gain opportunities to be part of the national leadership in practice transformation efforts
- 8 Bear no cost or risk to participate in TCPI or PTN

## III. BENEFITS OF ENROLLMENT

The activities of the Compass PTN are aligned with the Initiatives of ENHANCE

### QUALITY REPORTING

- » ENHANCE has selected reporting metrics that are consistent with the core metrics chosen for the Compass PTN.
- » The metrics were chosen because they are widely used and reported measures among providers.

### QUALITY IMPROVEMENT

- » Education and technical assistance can be used to make improvements in quality and utilization initiatives that practices have already identified.
- » For example, providers can apply the knowledge gained from this grant to improve an existing organizational priority, such as diabetes management.

### PAYOR RELATIONSHIPS

- » ENHANCE is holding discussions with payors to fund activities that complement grant activities.
- » Potential quality or shared savings programs will be consistent with metrics and improvement efforts that are implemented under the grant.

## IV. PARTICIPATION EXPECTATIONS

Once enrolled, practices will be expected to participate in learning sessions and submit data monthly.

- Join the PTN by signing a charter indicating that you will focus on the Initiative's aims
- Progress through the five identified phases of practice transformation over four years using technical assistance and peer-led support
- Identify a PTN point of contact in your clinic to receive and disseminate information to clinicians from the PTN, CMS and other contractors
- Collect and submit data monthly via secure web portal beginning in late 2015/early 2016. Data collection will be tailored to the technological capacity of the clinic.
- Participate in 4-month PDSA improvement cycles coupled with in-person (regional or statewide) learning sessions.
- Participate in educational venues and share experiences

## V. HOW TO ENROLL

Practices should enroll as soon as possible.

Complete the Compass PTN Charter online at:

[www.ihconline.org/CompassPTN](http://www.ihconline.org/CompassPTN)

- Click on "Join the Compass PTN"
- Read the enrollment instructions before completing the form.
- Enrollment can be completed at the practice, rather than individual provider, level.
- For Questions, email Jaime Bland [jbland@enhancehealthnetwork.com](mailto:jbland@enhancehealthnetwork.com)



## Questions & Discussion



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