CAPITOL ASSOCIATES

Moderator: Bill Finerfrock
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12:00 pm CT

Operator: Good day and welcome to the Rural Health Clinic Technical Assistance National teleconference series, Becoming a Primary Care Medical Home, Why Should RHCs Take This Next Step, conference.

During today's conference, you will have the opportunity to ask questions by pressing star 1. Please be aware that you'll be prompted to record your name at that time and that the recording will be played into the conference prior to your line being opened to ask your question. Also as a reminder, today's call is being recorded.

Now at this time, I'd like to turn things over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator. Thank you, everyone, for participating in today's national teleconference call on becoming a primary care medical home, why RHCs should consider this next step.

My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics. Our speaker today is Mary Takach, Program Director at the National Academy for State Health Policy, and Mary is talking to us today from Portland, Maine.

She is the Program Director at the National State Health Policy where she directs their policy research focused on primary care, specifically patient-centered medical homes, workforce and delivery system issues.

She's also the lead researcher on a commonwealth fund, multi-year project that is helping states advance medical homes in their Medicaid and State Children's Health Insurance Program.

Rural health clinics must be part of our nation's health care delivery system as it moves forward, and it's important for our HC staff to know what is behind the PCMH movement and why becoming a PCMH can be beneficial to clinics, providers and, most importantly, patients.

We're planning a follow-up teleconference on how to become - with a teleconference on how to become a primary care medical home and details on that will follow when they are available.

The format for today's program will consist of a presentation between 30 and 40 minutes and then with the remaining time allotted for your questions. I do want to point out that this series is sponsored by the Health Resources and Services Administration, Office of Rural Health Policy, in conjunction with the National Association of Rural Health Clinics.

The purpose of the Rural Health Clinic Technical Assistance Series is to provide RHC staff with valuable technical assistance and RHC-specific information.

Today's call is the 42nd in the series which began in late 2004, and during that time over 11,000 individuals have participated on the bi-monthly RHC national teleconferences. As you all know, there is no charge to participate in this series, and we encourage you to refer other who might benefit from this information, to sign up to receive announcements regarding dates, topics and speaker's presentation.

The Web site to do that is www.hrsa.gov/ruralhealth/policy/confcall/index.html. During the question and answer period we do as that the callers provide their name and the city and state location before asking your question.

If you have ideas for future topics, please send them to info@narch.org and put RHC Technical Assistance in the subject line. All topics will be considered for a presentation, and we look forward to your ideas.

I want to thank Mary for taking time out of her schedule to be with us today, and Mary, we're all looking forward to hearing what you have to say about patient-centered medical homes. The time is yours.

Mary Takach: Thank you, Bill, and good afternoon, everyone, or good morning to some of you out west. I'm really excited to have been asked to speak with you this afternoon about medical homes and work that NASHP has been doing over the past few years on medical homes.

I really admire the work that rural health clinics do, and I hope that my presentation today provides some opportunities for you to learn about ways to strengthen your mission by connection to state policy initiatives around medical homes.

I'm also hoping that this is a chance for me to learn more about rural health clinics and consider ways that state policies might be strengthened moving forward on medical home initiatives.

And finally, I'm hoping towards the end of the presentation to be able to touch briefly on some funding opportunities that are happening now as well as anticipated opportunties as the Affordable Care Act rolls out around medical homes.

So I'm going to follow the PowerPoint presentation that you were all provided ahead of time. And we'll go ahead and move to our second slide, which is a little bit about NASHP, because I'm going to suspect that most of you don't know much about the National Academy for State Health Policy.

But we were founded by state policy makers over 24 years ago. We are a non-profit, non-partisan organization. We were founded by state policy makers as a way for them to talk to each other across state lines and then inside the state across branches and agencies. And the whole purpose is to advance best practices in health policy.

On slide 3 you can see we've been working on medical home projects now for a number of years, but it's been primarily through the funding of the Commonwealth Fund that we've done most of our work with states.

As you can see, we've worked now with 24 states on medical home initiatives, helping them think about ways to start a medical home initiative or strengthen an existing medical home initiative.

In this current round of technical assistance, which is Round 3, we're working with about 15 states with leading medical home initiatives.

And we're trying to help them think about ways to connect to some of those monies that are available under the Affordable Care Act to expand from pilots into a state-wide program and also to think about expanding perhaps to broader populations.

A lot of these initiatives have started with a small population, for instance complex adults, and now we're trying to help them think about ways to consider adding other populations. It's been really exciting work and we have another year before that wraps up.

I also just wanted to draw your attention to the third bullet which our national cooperative agreement with the Bureau of Primary Health Care, and the purpose of this national cooperative agreement is to inform state policy making decision as it affects community health centers.

Now, I'm saying this as a caveat to you. I have pretty good information around community health centers and haven't had an opportunity to work a lot with rural health clinics.

So I can make some generalizations about rural health clinics. I know payments are pretty similar, but I know that there are a number of notable differences which I hope, perhaps during our questions and answers, you will have a chance to enlighten me about some of the needs and considerations that we should be making as we're moving state medical home initiatives ahead.

So here are the presentation goals as I had mentioned them earlier. Hope we can get this all discussed today. And we'll go ahead and move on to slide 5. This is today's medical home model. As you probably know, the term medical home has been around for decades.

It evolved in the 1960s. It was the American Academy of Pediatrics who really coined that term medical home. Back then it was considered a central place for storing a child's health records so that different specialists would have access and they could all be working from one record, though you can imagine that the term medical home has evolved quite dramatically over the decades.

Now, this term - the Joint Principles of a Patient-Centered Medical Home was coined about four years ago, and it was coined using the input of four major primary care physician organizations. So we're talking about the American Academy of Pediatrics, the Family Physicians, Internal Medicine and Osteopaths.

They all got together because they were looking at ways to revitalize primary care. They saw that there is a distinct need to get more people interested in primary care as well as a distinct need to better support primary care.

So they got together and they decided to promote a broad, national movement around getting primary care on the front burner of state agendas and federal agenda. They came up with this Joint Principles of Patient-Centered Medical Home.

You can see, looking at this modern-day medical home house, there are the seven principles that the physician groups came up with and as you can also see, when four physician groups get together and decide who should lead a medical home, they made room only for physicians.

The Joint Principles focus on the physician: personal physician, physician-directed practice. But I do want to tell you that this model has evolved, and although this was the vision four years ago, this group has been open to nurse practitioners and PAs to lead medical homes.

So the patient-centered medical home concept is now much more inclusive. There's room in this house for other kinds of providers to lead the medical home. Also want to say that, I do speak to a lot of practices about about medical homes, and most of them think that they are a medical home and they've been functioning as a medical home for a long, long time.

And I just wanted to comment about what this means, what this medical home means today that is a little different than what it may have meant 10 or 20 years ago. Today’s principles recognize that there is a primary care physician shortage. This primary care physician shortage requires us to consider ways of including more people as part of the medical home, more kinds of providers serving as leaders of the medical home. Which means there are new roles for nurse practitioners and PAs and also expanded roles for others in their practices.

So there needs to be new ways of emphasizing teams or team-based care to a practice because we have such tremendous shortages in our primary care workforce that we need to think about ways that people in a practice can work in expanded capacities, work to the top of their license.

So this medical home model is a way to help us rethink about care delivery. There are new expectations for payers, there are new expectations for providers, and there are new expectations for patients.

So for patients, it's not just having them be the recipient of care, patients are now expected, as part of this medical home model, to be partners in planning their care. They're supposed to be signing their care plans.

Families need to be a part of this process. Patients are supposed to understand what their expectations are as a member of their medical home that they are going to contact their provider before they go to the emergency room.

They're going to take part in their care because the care coordinator is going to connect them to self-management classes to take care of their chronic illnesses. There are new expectations for patients. There's also a great deal of new expectations for providers.

We're trying to raise the bar on primary care. Our primary care model right now is not working. It's not working for many, many reasons, but we need to raise the bar to help providers think about evidence-based care. Half the providers in the country do not use evidence-based practices to deliver primary care.

So having standards that emphasize evidence-based guidelines is a good idea in many respects. Also, planning visits ahead of time such as getting lab work done so that when the patient comes

in, you can make the most of those 15 minutes by reviewing labs with them and talking about the kinds of changes that need to occur.

There's also a distinct emphasis for providers to focus on quality outcomes. This is pretty new for a lot of primary care practices. There hasn't been a lot of emphasis on measuring the outcomes of a practice panel. Is that practice achieving certain quality and cost outcomes?

Are you providing care that meets all the (triple aim) goals? This is where information technology really can come into play –are electronic health records or medical records being used to manage your population?

And then also having information about how your clinic might be doing against a clinic in another area of your state, being able to measure and compare and use that information to improve your work. So there is a really distinct difference in the medical home today and the medical home of yesteryear.

I should also mention to you that there are lots of terms around medical homes. You've probably have heard them all. There's medical home, there's patient - or primary care home or health care home. There's, advance primary care practices.

They're all referring to basically this notion of a new, expanded role for primary care. Now, I'm also going to tell you that I'm going to try very carefully not to use the term health home unless I'm referring to the Affordable Care Act legislation section demonstration on health homes.That's a federal term, it refers to a very distinctive part of the Affordable Care Act.

So we'll go ahead and move on. On slide 6, what have states been doing around medical homes? Well, as you can imagine with 50 states there is a great deal of activity and variation.

Some are starting small, they're starting with sub-populations. Many are targeting high-cost populations -- the 20% of the patients that drive 80% of the cost. But the notion is to, for those states, is start small, show a return on investment and then go state wide.

Most states have state legislative or governor support. Many have state funding, but I will tell you that most do not, particularly the ones that have evolved over the past couple years during state budget deficits. A lot of this legislation that has been passed on medical homes has been with a budget-neutral mandate.

Budget neutrality can be done and is being done. Of course it'd be great to have funding to do it better, but there are states that have some pretty good success stories about being able to re-jigger their primary care delivery system, shifting resources around in order to fund this medical home model.

All kinds of - all delivery systems fit within a medical home model, whether it's free for service or managed care. And I think one of the most interesting developments, that about 1/3 of the states in this country are interested in multi-payer medical home collaborations.

You can see the map on slide 7. This is a great opportunity to really drive change in the primary care delivery system.

If it's just Medicaid patients that practices are receiving payments for and a practice doesn't don't have a very large Medicaid panel, the opportunities for the kind of transformation that is being asked is only limited to a small number of patients.

But then if you start throwing Medicare in there or private insurance companies, if you look at Vermont, all payers are involved in their medical home initiative.

So if you have 100% of payers, you really have an opportunity to see some big shifts in care delivery. Some of you may know that Medicare is now becoming a payer in these pilots and eight states have been selected to be part of a Medicare advance primary care practice multi payer demonstration.

What that means is that there were eight states that had existing multi-payer medical home initiatives on the ground. Medicare is now joining them and offering that opportunity to see if having more payment and payers involved can really push change.

So how does a state go ahead and begin a medical home initiative? Medicaid cannot do this alone. One payer cannot do this alone. You need partners.

And without partners you're not going to be successful. Particularly if you're pushing a Medicaid-only initiative and you don't ask Medicaid providers for their input about new expectations and new payments, then you're not going to get a great deal of buy-in around this.

So planning with providers is extremely important part of the medical home initiative. Community health centers, rural health clinics, provider associations such as the American Academy of Family Physicians and the state Primary Care Associations have been really important partners in planning processes for state medical home initiatives.

To a lesser extent, consumer groups and patients are on these planning committees, but that is beginning to change.

There is a need to develop partners in order to pool resources and expertise. So, states are working with their state quality improvement collaborative to help them design evaluation tools or organize a learning collaborative to help providers come together as a group to learn about ways to better manage their panels.

They are also collaborating internally with each other. That's a great concept. Having Medicaid talk to public health and mental health agencies.

Governors' office and legislators have been important champions of state medical home initiatives. States are also partnering with their foundations and universities. Foundations have been good partners in some states, funding specific aspects of a medical home initiative.

Foundations are not going to fund payment to providers, but they might fund pieces of a medical home initiative, perhaps an evaluation, which is really important: showing this is working, that this an endeavor that should be expanded.

So foundations are a really important part, and universities, too, can be very important partners, again, funding or providing manpower for evaluations or some of the coaching that is required by some states at the practice level.

As I mentioned, states are also joining forces with other payers and purchasers. Public employee benefit purchasers are really good partners, and in some states state employees can number up to 10% of a state workforce.

So you start bringing in your state employee groups into an existing medical home initiative, you really have the opportunity to push for greater transformation.

Go on to the next slide. So how do you tell that a practice is a medical home? As I mentioned, if you polled providers, “are you a medical home?” Many of them would say, yes, I am a medical home. I've been doing this for quite some time.

Well, this isn't enough for payers. Payers, particularly Medicaid payers, have very limited resources, and they want to make sure that their resources - any new payments --are actually going to be met with some new kinds of improvements in a practice.

And so there has been a movement towards making sure that practices are indeed medical homes by qualifying them, by having them pass their criteria to say, yes, you are indeed a medical home because you have passed expectations that let us know that you're operating at a higher level, therefore you qualify for an additional payment.

Now, NCQA has been a very important tool that some states have looked to qualify or recognize practices as a medical home. And NCQA stands for the National Committee for Quality Assurance. The PPCPMCH is the 2008 tool, it's been now replaced with a 2011 medical home tool. So we'll just call this NCQA Medical Home Tool now because that old tool has been replaced.

As you can see, a number of states have found NCQA to be a very helpful way to make sure that practices are recognized as a medical home. I'll go over this a little bit more in the next slide.

But NCQA is not the only qualification tool. You can see that a number of states have decided to adopt their own criteria, their own medical home standards. These standards have been developed mostly by the providers that they've enlisted as partners.

So as you can imagine, if providers are helping to develop the standards, providers really like these standards and there's a great deal of buy-in, not as much pushback of becoming a medical home if providers have had their handprint on their standards.

But developing your own standards a very time intensive kind of initiative. If you look at Oregon, for instance, they've been getting input on their medical home standards through town meetings

across their state now for a couple years. It's something that's not created overnight, and nor should it. It's a very important part of qualifying practices as medical homes.

Let's just take a closer look at the NCQA. This is their 2011 standards. As you can see, there are a number of criteria here, and if you are doing these things under the criteria, you receive points. If you are providing access during expanded - or access - after-hours access, you receive four points towards your total score. These criteria all add up to 100 points.

As you can also see, there are some of these standards or elements that have double stars to it. So those things you have to do. The other things are optional elements and you can pick and choose among them, but you have to do the required must pass elements in order to be scored as a medical home.

So these standards have been improved over the years. The 2008 standards were the first standards that NCQA came out with. Those old standards had received a great deal of criticism because they were very physician focused.

They basically excluded nurse practitioners from becoming medical homes. They said that only physicians could direct medical homes, and this new NCQA tool is more inclusive.

They allow, now, nurse practitioners to become medical homes, but not PAs. The old NCQA tool was also criticized because it was not patient-centered enough, seemed too focused on information technology. And so they have tried to improve this by adding some more patient kinds of care processes to answer that concern.

The good thing about the new standards is that, well, it has those improvements. But also the good thing is that if you pass the NCQA standards, you also meeting meaningful use standards. The federal government provided in the stimulus bill incentives for Medicaid-based practices to

adopt medical records and then receive a payment incentive if they're using it in a meaningful way.

So with the new 2011 standards, if you become NCQA certified, you not only are NCQA certified, so that's a good thing, but you also are eligible to receive federal payment for being a meaningful user of health information technology.

So you can see there's a bunch of points here. So if you go on to the next slide, you add up your points and then that places you in a level. And they actually made the levels a little tougher with the new standards. 25 points use to earn the first level, so now it's a little harder to get to the first level. You need 35 points.

And the levels go up. The levels are important to consider because many states have tied their medical home payments depending on what NCQA level you are. So the higher level you are, the greater your payment is.

As you can see, there are those must-pass standards, the very last column, that you have to pass these must-pass standards that are 50% performance levels. I will tell you that some states thought that that's not strong enough.

For instance, in a couple states they've actually put the performance standards at a 75% or 100% level that you actually have to comply with those elements all the time or at least most of the time.

So what are other states doing around qualifying practices as medical homes? As I mentioned, some states might modify NCQA to make it a little harder or to emphasize elements that they think are more important or might have been excluded.

Maine is an example of a state that requires their practices in their medical home pilot to not only meet NCQA criteria, but also an additional ten other standards. I've given you an example of some of the ten standards. I want you to take a look at one of the bullets towards the bottom of that list. All practices need to have a quality improvement project. This is part of their recertification as a medical home. And that quality improvement project must be focused on cost containment and waste reduction activities.

If states are not able to show that their medical home pilots are saving money, or at least flattening the rate that Medicaid costs have been increasing over the years, these projects are not going to be supported in the future.

So focusing on cost containment projects, usually on inappropriate utilization of hospital services is a very common element you will see across these projects.

Oklahoma is one state that decided to develop their own medical home standards. They had medical advisory task force - a group of physicians that gave them input on their criteria - and developed a three tier process- very similar to NCQA, but not as focused on information technology, because a lot of practices in Oklahoma do not have access to HIT.

Having standards that focused on HIT criteria was a non-starter in Oklahoma. So they made up three tiers of criteria that don't cost the practices a thing to be Oklahoma certified. NCQA does cost - there is a cost for downloading the tool and then sending your paperwork in to NCQA.

And it costs time to fill out NCQA kinds of paperwork. It costs practice time, it costs time for them to pull a lot of documentation to show that you are actually meeting criteria.

And that takes staff time and that is money, whereas some of the other state developed standards don't costa the practices, and sometimes the states will come in and actually help

practices become certified. States will audit, as a check, but also as an opportunity to help practices think about ways to become medical homes.

So what do practices get for all that work to become certified? Well, they get payment. All these initiatives follow with an extra payment. Mainly they're getting a monthly care management payment on top of the fee for service kind of payment.

Now, for FQHCs and rural health clinics, this is a payment on top of your visit-based or PPS payment. So I have in the next slide some of the example of kinds of payments - or the payment range, but monthly care payments are by far the most popular way of paying for medical home services.

This is intended to pay for that extra time that it takes to do that care coordination, those non-billable kinds of exercises that physicians and nurse practitioners and PAs have to do to organize care better and provide that care coordination to really be a medical home.

Some states also, in addition to those monthly care management payments, provide a lump sum payment, an upfront fee in the beginning to really help a practice, jumpstart their initiative.

This payment may help pay them hire a care coordinator or to buy an EMR or to actually fund lost practice time that to attend a learning collaborative.

So that allows them to shut the clinic doors for a day and go attend a learning collaborative. Some states can't process that monthly care management payment, and so they have enhanced their fee for service visit rates for certain fee for service payments.

Sometimes rural health clinics and community health centers are left out of this payment. For instance, Colorado thinks that rural health clinics and FQHCs are already paid an enhanced rate and they just need to enhance the rate for the fee for service providers.

But paying enhanced visit rates is only happening in one or two states. Some states are paying for new visit codes, such as opening up same-day behavioral health and primary care visits codes. Some states are giving pay for performance kinds of incentives.

And states that have managed care, which, as you know, are a lot of states, are (renegotiating) managed care contracts to make sure that managed care organizations are living up to medical home expectations.

If we move on to slide 14, you can see the payments that go to practices. This is just a sample of the kinds of payment ranges that a practice might receive. You can see that they kind of fall in the range of $3 to $4 per member per month. The payment might be adjusted if a patient is very complex.

You can see Minnesota's payment is quite high. And that's because their whole initiative is aimed at those very sick populations, so that higher payment is for patients that have multiple diagnoses.

Some states adjust their payment and give a higher care management payment if you are a higher medical home level. So if you're an NCQA Level 3, you would be paid towards the top of that range. Or if you're an Oklahoma Level 3 provider, you'd be paid at a higher end of that payment range.

But it's not all about payment. Payment is really good. Let's move on to slide 15. There's other kinds of supports that are really critical in medical homes.

For instance learning collaboratives—this is where providers leave their officers, take their staff and they go learn about better ways to reengineer their practices, make sure that that same-day scheduling can really be done, think about ways to organize visits more efficiently. Lots of things going on in a learning collaborative.

The HRSA health disparities collaborative really began this whole notion of learning collaboratives.

Often states send in practice coaches - this is onsite, practical assistance to help practices think about ways to better provide care.

Often there are conference calls-- for particularly those in rural areas, that can't get to a learning collaborative or a practice coach can't get to them-- these conference calls and check-ins help make sure that practices doing well as well as answer their questions. Sometimes care coordinators just have those calls so that they can support each other and share best practices.

Really important part of all these initiatives is to provide information to providers on their patient panel. This helps providers to not only look at their own panel but compare themselves to other practice panels to see how they're doing, how they measure up.

There's also some funding that's been provided through a number of initiatives for HIT by providing registries to do patient tracking. Also electronic prescribing is another way that states are providing to practices. But the really important part of this entire change package is the resources that are being provided around care coordination.

Some states are funding care coordinators right at the practice level. Other states, particularly - you see the four states noted on the community-based care coordination bullet.

Rural states have found that that is not practical to put a care coordinator in everybody's practice. It makes sense to share care coordinators and to have them be a part of a community health team or a community network in order that practices might have a care coordinator in their office maybe, once a week, maybe a couple times a week.

Also these networks and health teams may have access to other kinds of team members like behavioral health specialists or a nutritionist, other kinds of people that would really help that practice be a medical home.

So it's shared access to support is something that we are seeing growing. There's money in the Affordable Care Act to promote this kind of infrastructure. Some states have provided more Medicaid-based care coordinators to provide practices with some support.

And this patient family based bullet here, what this is referring to is that these three states make sure that patients are included in developing care coordination resources, that patients are a part of the advisory groups for practice teams so that they're giving input to make sure that policies are really patient-centered.

Moving on to slide 16, does this all work? The short answer to that question is I don't know, and we won't know really whether or not all of these initiatives are really going to pay off and improve patient outcomes and lower costs and provide greater satisfaction among patients and providers.

Most initiatives that I summarized today are less than two years old. Now, most of them have very robust evaluations, but those reports won't be out for another year or so.

What we do have claims level data. This is not the most robust data, but it's what we have and I think it's important because it shows a trend that is very satisfying if you're a state legislator and

trying to decide whether or not, a medical home initiative is what your legislature should pass next year.

So we'll take a quick look at some of these findings. The Colorado Medical Home Initiative has been going on since 2006. All children in Colorado's Medicaid program are covered and Medicaid has saved money. And this is a really encouraging sign because this was done under a shoestring budget.

They were able to provide enhanced fee for service rates for private physicians to be medical homes for kids and they are seeing some nice reductions in cost growth. And also I should tell you that there are improved outcomes. I didn't have that on this slide.

Oklahoma, another state that's been implemented their medical home initiative on a budget-neutral basis. They shifted funds into enhanced per member per month payments, crossing their fingers hoping that they would see a return on investment by the next year. And indeed, it really did work out that way that they did get a decline in per member costs and they are getting great feedback from providers and patients on this initiative.

And Vermont is a program that we're all watching with great anticipation because they have - all payers involved in their medical home initiative, their initiative is pretty young. Their first blueprint community, saw some declines in cost. The second blueprint community showed some mixed results.

One of the most important findings about a couple of these initiatives are improvements in access--these initiatives are enrolling a whole lot more physicians.

So 2014, it's here sooner than you know it, but there are lots of resources besides funding coverage. There is also lots of money around improving delivery systems.

I'd like to focus on slide 20, providing new models of care, because I think this one would probably affect you the most. And let's just take a really quick look at 2703, which is the state option to provide health homes for enrollees with chronic conditions.

So, I'm on now slide 21. This is the federal health home initiative, section 2703. It's providing a 90/10 Medicaid match. That is quite an incentive to Medicaid programs to apply for a new state plan. It's only for two years, but it's a 90/10 match. There are three distinct kinds of providers that are eligible to be health homes under this federal program.

And rural health clinics is one of the designated providers. And also I want you to take a look at number 2, a team of health care professionals. That's that community health team, a community network. This is another group of providers that is eligible to be a health home.

And let's take a look at some of the standards that the federal government expects all Medicaid programs to adhere to if they are to get the 90/10 match.

You can see this list of standards -- all are things that you would tend to support, too. They all sound good.

So think about it – under this option a Medicaid's agency's task is to make sure their providers can qualify as a health home. If they can't do this, then they're not able to receive that 90/10 match. So state Medicaid programs are working right now - thinking about ways to connect rural providers to behavioral health services, to care management services, helping them to use HIT to link and better coordinate. This is the work that's being done in states and this is quite exciting.

As I mentioned, there are other sources of federal funding out there. The meaningful use standards are aligned very nicely with patient-centered medical home standards. On the very last

slide there are lots of opportunities for rural health clinics. Federal support is an important opportunity right now. I invite you to go to our Web site, take a look at our medical home map. Take a look at it, click around and see what's going on in other states. It's really important to know what's going on in other states in order that you may think about what are the possibilities in your state.

Very last slide, there's contact information. Please feel free to contact me if you have any questions. Visit our Web site. We have lots of information on medical homes at pcpcc.net, an important source for you to know about if you have a large number of commercial payers as part of your payer mix.

This pcpcc.net tracks private medical home pilots and I'll end there right now.

Bill Finerfrock: Well good, Mary, thank you. That was a lot of information. You did a great job. And I certainly learned a lot. Operator, do you want to give the instructions for folks who want to ask questions? And then I have a few things while we're waiting for the queue to fill that I'd like to ask Mary about. Would you give the instructions?

Operator: All right, certainly. Thank you. And ladies and gentlemen, if you would like to queue up to ask a question at this time, please press star 1 on your touch-tone telephone keypad. Once again, you will be prompted to record your name and your recording will be played into the conference. Once again, that is star 1 if you'd like to ask a question at this time. And we will pause for a moment to assemble our queue.

Bill Finerfrock: Okay. While we're waiting, I noticed during the listing of some of the criteria for designation under the NCQA methodology, one of the criteria is same-day access. And this is a question I've gotten from different folks before. What does that mean and does that mean that folks have to be open 24 hours a day, seven days a week, which obviously is impractical?

Can you elaborate a little bit on this whole issue of same-day access and what that means?

Mary Takach: Well, I think NCQA would probably be the best source of knowing what meets their same-day access requirement. For states, I think there's a lot of interpretation about what same-day access can mean.

It could mean that a provider is giving a patient an opportunity to visit another primary care provider, not an emergency room, to receive their care, that might meet the threshold under some state's standards.

This is probably, for Rural Health Clinics and for federally qualified health centers, one of the hardest criteria to meet. It's a tough standard and you can understand why it's an important standard to be a medical home, but I would say that the interpretation of this might vary, at least from the state's point of view.

From NCQA, I'm not exactly sure how they would measure same-day access, what their bar is for same-day access.

Bill Finerfrock: Okay. And you mentioned that - I believe you said nurse practitioners can be medical home - or patient-centered medical home providers, but PAs cannot. Can...

Mary Takach: Yes, that's (what) I believe. The NCQA did make room in their PCMH standards for nurse practitioners to lead medical homes. PAs I believe will still have to operate under a physician's license and I don't believe that they are able to receive NCQA certification.

Bill Finerfrock: It's the leadership. And I guess that makes sense given that PAs, by definition, have to have a supervising physician in every state in which they practice. There's always going to be a

PA who is linked to a physician, whereas in a number of states nurse practitioners have an independent practice. That may explain.

So it doesn't (exclude) PAs from being part of that care team, it's just that there would continue to have to be a physician when - it would be a physician PA team with a physician as the lead, whereas a nurse practitioner could be the lead on a team that would include PAs and physicians presumably.

Mark Takach: That's how I understand it.

Bill Finerfrock: Okay. All right. Operator, do we have some questions?

Operator: There are no phone questions at this time, but once again, ladies and gentlemen, that is star 1 if you would like to queue up to ask a question.

Bill Finerfrock: And if there are any folks out there who are already primary - or patient-centered medical homes that have achieved that, if you'd like to make a few comments, you know, add or clarify or anything with respect to things that Mary said, feel free to chime in as well.

Mary, some of the folks that, you know, in my reading about it, folks who have said, well, this is a dressed up version of managed care we saw back in the late '80s and early '90s. How is this different than what people might think of as managed care?

Mary Takach: Well, first of all a lot of these initiatives are going on in states with no managed care—other states are doing this through a fee for service payment stream. But the focus is on good primary care.

So it's supposed to be driven from the - the bottom up. They are trying to get input from the from practices, from patients, all stakeholders, to help raise the bar on primary care.

So I think a lot of the managed care nightmares came from, when the direction is coming from the top down. This is more of a collaborative effort to help raise the bar on primary care.

Part of the accountable care organization debate is exactly this point—people feel that it's just another way of delivering managed care, like déjà vu all over again. But, you know, medical homes is different in the sense that this is starting at the practice level and changing and helping them do their job better.

I think we can all relate to the fact that primary care practices are stressed, they're overworked. We're going to be flooding their practices with more Medicaid enrollees in 2014. How can we help them better do their job? This is the kind of model that a lot of primary care providers signed up for.

This is what they wanted to do when they went to school to become a primary care physician or an NP or PA and yet, you know, they get into the real world and they can't do it because they don't have the resources. They don't have the time. And we're trying to make, you know, this is all about trying to give them resources to do their job better and to be more effective.

So I think that is a big change.

Bill Finerfrock: And I would agree with you. And I've heard from a lot of folks who say, well, I'm already a medical home, what do you mean I need to get certified now to be one?

Mary Takach: Right, yes. There are people who have been operating their practices for years and years and don't believe they have to change—and some don't. And that is for sure.

But then if you look a little closer at a lot of other practices, and look at for instance, how are they measuring improvements and care—and how are they using the data to improve care processes?

And that's why - one of the reasons why our health care system is pretty bad on outcomes in the long run. We don't use our data very well.

Bill Finerfrock: Operator, any questions?

Operator: Yes, we actually did just have several callers queue up to ask questions.

Bill Finerfrock: Why don't we open up the lines for a few minutes?

Operator: All right. Great. And we'll take our first caller. Caller did not record their name, so caller, please go ahead.

Bill Finerfrock: If you could let us know what your name is and where you're calling from, it'd be appreciated.

(Tammy): My name is (Tammy), I'm calling from Missouri.

Bill Finerfrock: Go ahead, (Tammy).

(Tammy): Initially when I listened several months back to a conference call, it seemed that you had to be a medical home so that patients could choose you and then if you weren't going to be a medical home, then they wouldn't be able to come to you. Or if they did, you would not be paid at all. Is that maybe a misconception or did I get information that was wrong?

Mary Takach: Well, not being a part of that call, I'm not exactly sure what you're referring to, but I will tell you that, in most of these programs, providers voluntarily become medical homes.

And so by that fact, their patients would be automatically enrolled, and be a part of that medical home's services. In other states like Oklahoma and North Carolina and Colorado where there are state-wide medical home initiatives, a practice wouldn't get paid an extra payment bump if you decided not to become certified or meet certain standards of a medical home.

I haven't heard of, patients being only driven to those who have received NCQA certification. I will tell you, though, that I wouldn't be surprised if there is going to be a trend towards that because, you know, payers do want a higher standard of care.

They do want efficient practices. They want practices that are delivering on outcomes. Payers may want to steer their patients towards those providers that have reached certain standards around medical homes, particularly as we start to get some data that supports this whole model.

Bill Finerfrock: Okay. All right.

(Tammy): Thank you.

Bill Finerfrock: Thanks, (Tammy). Next caller?

Operator: And next caller, go ahead, please.

(Marilyn Odin): (Marilyn Odin) from Oneonta, Alabama.

Bill Finerfrock: Hi (Marilyn), go ahead. What's your question?

(Marilyn Odin): Okay. My question is how is this going to affect reimbursement for rural health clinics that have a cap rate? Will it enhance the cap rate that we get from Medicare and Medicaid if we are a patient-centered medical home?

Mary Takach: I can only speak from the Medicaid point of view. You know, I don't track federal Medicare pilots or initiatives unless they're married to state medical home pilots. So I can only speak from a state point of view.

And what we're seeing so far is that for most states, there is a payment - a per member per month payment-- on top of your visit based rates. And I'm not aware of any cap on Medicaid payment. I'm not that familiar enough with the rural health clinic payment policy to know if there is - there are Medicaid caps.

Bill Finerfrock: Well, much like the FQHCs, they have a perspective payment or per visit rate that's established by the Medicaid program for that RHC.

So if, for example, my Medicaid rate was established at $100 a visit, and I become a patient-centered medical home, what - and they made available $3 per every Medicaid patient that was enrolled with my practice, would I get that $3 in addition to my regular Medicaid reimbursement for services provided to Medicaid patients?

Mary Takach: For most states - most states are providing that additional per member per month to rural health clinics and FQHC.

Bill Finerfrock: Right.

Mary Takach: Not all, but most.

Bill Finerfrock: Yes, and I think that speaks to, you know, in order to get people to do it, part of the reason states are saying is we recognize that - Mary, and I think you said that you're taking on additional responsibilities, you're taking on additional work, you're providing services that are not normally within the realm of things that have historically be defined as a covered service.

And in order to compensate you for that, they're using this kind of a per member per month management fee or whatever you want to call it to encourage you to provide those additional services.

Mary Takach: Correct.

(Marilyn Odin): Thank you.

Bill Finerfrock: Okay, thanks. Next question?

Operator: All right, thank you. Next caller, go ahead, please.

(Gayle Nickerson): (Gayle Nickerson).

Bill Finerfrock: Hey, (Gayle). Where you from?

(Gayle Nickerson): From California. As you...

Bill Finerfrock: Hi.

(Gayle Nickerson): ...can see on the slides, there's not much happening yet out here.

Mary Takach: Not yet, but coming soon. I'm quite optimistic about that.

(Gayle Nickerson): I wanted to say that we are trying to get ready for that. We have about 30 clinics here in the state of California and recently at one of the NARCH meetings there was somebody who talked about patient-centered medical homes and introduced us to the TransforMED Web site.

And there is a free analysis that clinics can do for themselves to see where they are standing in the process. And so we've taken that on, it's called the Medical Home Information Quotient, I think, MHIQ.

Anyway, I just wanted to suggest to people that they might be interested in Googling that and trying it out to see where their clinic would rate in the process.

Mary Takach: How was that for your clinic? Was it eye-opening or were you - did you find that a tedious process?

(Gayle Nickerson): No, it was not tedious. Obviously we have lots of people in those 30 clinics to do this work. So we asked each clinic to rate themselves. It was interesting to see that many of our clinics were well on the road, but some of them were not.

But some of them were, you know, maybe has rose-colored glasses. But, you know, we're trying to figure out where we are so that we can figure out what we need to do and get there.

Mary Takach: Yes, that's an excellent suggestion. A lot of states actually hire TransforMED as their change agents—call-in coaches in to actually work with practices to become medical homes. So that's a great resource. And it's a good place to start.

(Gayle Nickerson): Yes, we thought so. Thank you.

Bill Finerfrock: Thanks, (Gayle). That was great. Next question, operator?

Operator: All right, thank you. Our next caller, go ahead.

(Cathy Schwartz): (Cathy Schwartz). Oh hi, we're from rural Oregon and I think the lady from Alabama had the same question we had. Although to add to that, I wasn't quite understanding the 90/10 match that you spoke about. Could you elaborate a little bit on that and whether or not that would be a benefit to rural health clinics?

Mary Takach: Well, it could be a benefit to rural health clinics depending on who the state enlisted as their health home providers. This 90/10 match is provided to states that apply for a new state plan amendment to provide health homes in their Medicaid program and it's going to for chronically ill Medicaid enrollees. You have to have certain conditions to qualify for this 90/10 match.

And the state gets enhanced funding to administer their health home program. And the whole idea is, you know, that the state's going to use this 90/10 match to support providers in a better way to become health homes.

And this will likely mean a new payment to providers, and states can list who their providers are--the federal legislation listed the entire realm of providers. It really is quite inclusive of who could be a health home provider. And then states must meet other conditions, provide certain kinds of services and abide by those criteria that I outlined in the slide.

A state can roll out their plan one region at a time across the state. They can be state wide. They have a lot of flexibility in designing their health home.

And this is important opportunity for states like, California-- this is going to be their first toe in the water on how to create health homes, how to reinvigorate their primary care delivery system. Very important part of the federal legislation.

Bill Finerfrock: Yes, let me just also add to that - the match or clarify. States typically, under the Medicaid program is a federal state combined program. On average the federal government puts up about 55% of the cost of Medicaid. So for every dollar that the state spends normally on Medicaid, the federal government reimburses them 55 cents out of that dollar.

What this means is that if a state wants to do a home health - or a patient-centered medical home initiative, for every dollar that the state spends on that initiative, as long as they meet the various criteria that Mary was talking about, the federal government will reimburse the state 90 cents out of every dollar.

So it allows the state to get more money from the federal government, which would create - free up more state dollars to do some things that they might not otherwise be able to do.

But that 90/10 match is that the federal government will reimburse the state's 90 cents for every dollar that they spend setting up this patient-centered medical home initiative through the Medicaid program.

Mary Takach: Yes. Thank you, Bill.

(Cathy Schwartz): And so is a health home very similar to a medical home? They're just...

Mary Takach: Yes, actually it's a - I've heard people call it a medical home on steroids. It kind of takes the medical home principles and then kind of expands it to include other kinds of services.

So behavioral health services, for instance, making sure there's a connection to behavioral health care and making sure there's a connection to long-term care services and support, something that some of the traditional medical homes have not been great about. They've wanted to, but they haven't been great about making those connections. The federal government, now with this 90/10 match is providing them with the support to make those connections to that broader health home.

Bill Finerfrock: Operator, how many more questions do we have?

Operator: Looks like we still have three questions left in the queue.

Bill Finerfrock: All right. Mary, do you have some time? I know both Mary and I need to get onto another conference call.

Mary Takach: Probably one more question and then I probably should get off.

Bill Finerfrock: Okay, why don't we take one more. I apologize. If you want to submit - if you don't get your question in, send it to info@narhc.org and I will get it to Mary and we'll get you back an answer. But we'll take one more question on the phone lines.

Operator: All right. Great, thank you. And our next caller, please go ahead. They did not record their name, though.

Bill Finerfrock: Go ahead caller.

Operator: And caller go ahead, your line is open.

Bill Finerfrock: Make sure you don't have your phone on mute.

(Julie Anderson): This is (Julie) ((inaudible)) from Wisconsin.

Bill Finerfrock: I'm sorry, (Judy)?

(Julie Anderson): (Julie Anderson) from Wisconsin.

Bill Finerfrock: Great, go ahead, (Julie).

(Julie Anderson): So this is a follow-up question to the one that was just from Oregon. So when we're talking about the 90 cents that goes to the state in regards to 2703, what's the benefit to the Rural Health Clinics? Is that - so it's not direct funds (from) Medicaid patients, is it more support from the state to become a medical home? Or how does that work?

Mary Takach: Correct. It's up to the state to decide their reimbursement to their providers, their health home providers. If you take a look at the some of the existing medical home programs, I would imagine that a lot of states are going to mirror what they already have in place.

But for the new states that haven't done this, they might design a health home program to look a whole lot like some of the ones that we already have on the ground. So that 90/10 match would go to getting one off the ground and helping to shore up those providers through enhanced funding to become health homes.

Could be a new per member per month could be an upfront payment. I know Missouri, for instance, is a state that's looking at ways to give a big payment bump in the beginning to help practices hire staff that's needed to do that care coordination because this is a complex population that the federal government is targeting.

These may be people with chronic mental illnesses and other kinds of diseases. So, you know, it's hard to say how that 90/10 match is actually going to get translated at the state level, but it's a guarantee that those providers who are health home providers are going to receive an increase in payment if they meet the criteria that the state has adopted for health homes.

States might adopt the NCQA, they might develop their own, but they do have to, as I mentioned on that one slide, all state initiatives have to meet those federal criteria that was outlined on that one slide.

Bill Finerfrock: Well, Mary, thank you so much for all of the time you've taken to be with us today. We really appreciate it. Thank you to all of our listeners and our questions. I'm sorry we didn't have time to get to those. As I said, if you have some questions that you were not able to ask, please send them to info@narhc and we'll try to get you an answer.

I'm mentioned at the outset that we're going to try and set up another call on - actually going through the process, probably talking a little bit about this TransforMED mechanism so you can perhaps take a look at where you are.

Today's call was recorded and a copy of the recording and a transcript will be available as soon as we are able to get through all the technical parts of that process to make sure it's an accurate transcript, et cetera. And we will get information out on the next call.

I want to thank the Office of Rural Health Policy for their support for this information. I want to thank, again, Mary and the National Academy for State Health Policy for the work that they're doing in this area and taking the time to be with us.

I want to wish everyone a great weekend and a great rest of August, and thank you for participating.

Operator: Great. Thank you very much. Well, again, ladies and gentlemen, that does conclude today's conference.

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