Nebraska State Legislature

SENATOR MIKE GLOOR

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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
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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

Senator Mike Gloor

Senator John Wightman

MD
Blue Cross Blue Shield of Nebraska

Nebraska Academy of Family Physicians

VP Medical Affairs
Coventry Health Care of Nebraska

MD
Nebraska Medical Association

Medical Director Arbor Nebraska Plan.
Arbor Health Plan

MD FAAP
Nebraska Chapter of the American Academy of Pediatrics

Judith D Stark V.P. Health Management
CoOportunity Health

Matthew W. Milam
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
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 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 inducted 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)

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? ☐YES ☐NO		TOBACCO COUNSELING RECEIVED? ☐YES ☐NO
EXPOSURE TO ENVIRONMENTAL SMOKE? ☐YES ☐NO		COUNSELING FOR EXPOSURE TO SMOKE? ☐YES ☐NO

PREGNANCY INFORMATION & HISTORY

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