BANKING, COMMERCE AND INSURANCE COMMITTEE
September 28, 2012

[LR513]

The Committee on Banking, Commerce and Insurance met at 9:00 a.m. on Friday, September 28, 2012, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR513. Senators present: Beau McCoy, Vice Chairperson; Mark Christensen; Mike Gloor; Ken Schilz; and Paul Schumacher. Senators absent: Rich Pahls, Chairperson; Chris Langemeier; and Pete Pirsch.

SENATOR McCOY: Well, good morning and welcome to the Banking, Commerce and Insurance Committee. I think we'll get going this morning. My name is Beau McCoy. I'm from District 39, western Douglas County and Omaha, and I am Vice Chairman of the committee. Chairman Rich Pahls isn't able to be with us this morning. This morning the committee is going to take up LR513, Senator John Wightman's interim study to examine ways in which health benefit policies and contracts could provide coverage for patient-centered medical homes. Our hearing today, as always, is your part of the legislative process. This is your opportunity to express your position on the topic before us this morning. To better facilitate this morning's proceedings, as always, please turn off your cell phones, put them on vibrate...or all other devices. If you are planning on coming up and testifying this morning, if you could move up into these front chairs, would be very helpful to us. Of course, being that this is an interim study, there are no proponents, opponents, or neutral testifiers. We do have a couple of folks who are going to testify behind Senator Gloor this morning, and then we'll open it up to whoever else in the room may want to come up this morning and visit with us. If you could, testifiers, if you could sign in and hand your sign-in sheet to our committee clerk when you come up to testify, that would be very helpful this morning. Very important, if you could, as a lot of you know, spell your name before you testify, would be very helpful in keeping the record for the transcribers. If you do have written materials, they can be distributed by our pages this morning. If you don't have ten copies, if you could, raise your hand and the pages will help make sure that we do have at least ten copies this morning. And with that, I think we'll move to introductions. To my right is Bill Marienau, the committee

counsel; to my left, at the end of the table, Jan Foster, our committee clerk. And then we'll start over on my right and go around the table and do introductions with the senators on the committee.

SENATOR SCHILZ: Good morning. Ken Schilz, District 47.

SENATOR SCHUMACHER: Paul Schumacher, District 22.

SENATOR CHRISTENSEN: Mark Christensen, District 44, Imperial.

SENATOR McCOY: And then Senator Mike Gloor will be opening for us this morning, and he's the senator from Grand Island. Our pages this morning are Amara Meyer from Brule, Nebraska, and Lacey Schuler from Tekamah, Nebraska, if I have it correct. Thank you. And with that, we'll move to the opening on Senator Wightman's interim study, and, again, Senator Mike Gloor is going to open this morning on the legislative resolution.

SENATOR GLOOR: (Exhibit 1) Good morning. Thank you, Senator McCoy. Again, my name is Mike Gloor, M-i-k-e G-l-o-o-r. This is a nice turnout for what I think is a program that kind of flies under the radar but has great potential for the state of Nebraska and healthcare delivery. And I'm excited about the turnout, know how excited you all are to hear this. Go Big Red. That's why we're here. (Laughter) You know, candidly, and I'll start by talking a little bit about the pilot that we have in place that you, as the Legislature, gave authorization for almost four years ago based upon a bill I brought forward, and it's an opportunity for an update and also to talk about opportunities that are out there. Unlike a lot of hearings that we get involved in, this isn't about a problem so much as a program that's doing well, opportunities. And Senator Wightman, in our discussions about this, I think, was willing to carry this resolution forward based upon discussions he was having with constituents, members of the medical community looking at the future and where do we go from here in upcoming years with things like

medical home. You've got a book, I think, in front of you, and you can follow along the PowerPoint I'm going to do; it's labeled...tab "Nebraska Medicaid Pilot." Especially for Senators Schilz and Schumacher, it may avoid a crick in the neck when it comes to the screen, but we'll walk through there. I'm not going to spend a lot of time describing medical home itself. I'm going to talk a little bit about the pilot. But suffice it to say that my years in healthcare brought me to the conclusion, and it's one of the reasons I ran for the Legislature, that we have to change the delivery system. If we really want to control costs, if we really want to focus on quality to patients, good outcomes, we've got to change the delivery system itself. We just can't keep doing the same things the same way we have in the past. And medical home is one of those initiatives that has been brought forward over the past decade--well, it's actually been around longer than that--but with real vigor over the past decade, with some great success stories in a number of states. So we ended up with a pilot program in the state of Nebraska. What LB396, that established the pilot, did was say that we were going to require the department, Health and Human Services, to develop at least one two-year pilot program in an area that wasn't currently covered under managed care contracts. That's primarily a ten-county area in the eastern part of the state. What we ended up with and what the department decided to do, to their credit, were two pilots rather than one. They changed the Medicaid payment structure. There needed to be an evaluation at the end of the pilot, and then at that point in time we'll see whether there is opportunity for expansion, based upon the results that are out there or that come in at that period of time. We had an advisory council that was appointed in October of 2009. That's when the legislation was passed. The plan was to start a pilot before...on or before January 2012. We actually started, excitingly enough, a year earlier than we had intended; so we started in January of 2011. We're going to evaluate it, and it has to be reported back to the Legislature and the Governor by June 2014. Once again, there's every reason to think that we'll be reporting back well in advance of that period of time. There was an advisory council established. It was made up of primary care physicians across the state, with representatives from a hospital. I served as an ex officio on behalf of the Legislature. They were charged with, basically, setting up the criteria, the guidelines, for the pilot,

encouraging them, providing some additional feedback to the pilot projects that were out there. These are members of that advisory council. You may recognize some names. And these were the home...medical home pilots that were selected: the Plum Creek Clinic in Lexington--Dr. Miller is going to be the next testifier up--and the Kearney Clinic in Kearney, Nebraska. In the meantime, there has been a Medicare demonstration, and I bring this up only so that, once again as I mentioned, this has got some significant momentum nationwide. And as sort of a disclaimer, this began prior to the Patient...the Affordable Care Act, Obamacare, so this was already something Medicare had under way as demonstration projects across the nation. We're not part of one of the demonstration projects, by the way. This is the definition of patient-centered medical home. We're a little bit off the screen on this. But let me throw in my own definition for purposes of the reason I got excited about this. Excuse me, bad day for voices. We have to change the delivery system. I opened with that comment. It's too easy in our current system for people with routine illnesses, and obviously with an increasing number of people who are uninsured or underinsured, jumping to the emergency room to spend too much of our money on the high end of healthcare as opposed to the primary care, the family physician or the family group end of care. And I go back to, and the reason this resonated with me, is I go back to the days when I grew up in a rural community in Nebraska and you went to your family physician for everything. You got a broken leg in the football game the night before, you went to your family physician that night or the next morning with your injury and they referred you on to whatever specialist. You called your family physician 24 hours a day, seven days a week, if they were in town, and they made sure you got taken care of, including house calls. But the key here is your focus was in, at that point in time, maintaining that relationship with your family physician, and they knew what was going on with your family, your medical condition, and, in many cases, your life. And knowing that they knew about you and what was going on with you got you better care. It really got you better care. We've drifted away from that. We don't have nearly enough primary care physicians. We don't expect them to be on call 24/7 or make house calls the way they did. But patient-centered medical care is about transforming practices, not just physicians, so

that you still have that kind of a relationship with a practice. And it may not be the physician that's on call 24/7, but the practice may be on call 24/7, so maybe you interact with a nurse practitioner or a PA, but you interact with that practice. And it brings our focus back to not just going to emergency rooms or seeing a neurologist for our headaches but interacting with that practice. And that, in its simplest form, for me was patient-centered medical care. Where there have been patient-centered medical homes at work they have not only seen a reduction in costs, they've seen an improvement in quality. And here's a couple of examples. I think this data is from North Carolina. For women over 40 receiving mammograms: almost a doubling in the number of women who get mammograms. So there's a focus on preventive care, screening care. Colorectal cancer screenings, colon cancer screenings: again, a doubling in the number of people who were part of a medical home versus people who weren't part of a medical home. There are clearly cost savings wrapped up in these screenings, catching people early on with problems rather than catching them after they have a diagnosis of colon cancer, as an example. We established accountability in the pilot programs. There are standards and measures that are laid out there. If we're going to evaluate this at the end, we need to measure it against some standards that are out there. And this is where the advisory board came into play, looking at reductions in things like ER visits and use of generic medicines. Part of the reform is how we pay family practitioners. These different tiers represent as they advance, as they get more sophisticated in their practices in these pilots. The PMPM means "per member per month." So Medicare (sic) is paying--Medicaid enrollees who choose this option, and they get a choice, who choose this option--that practice gets paid $2 for each enrolled member per month in addition to getting paid for the actual visit, but that's to help underwrite the expense associated with this closer level of care, monitoring, and oversight, and transitioning the practice. Again, my apologies for corn dust, soybean dust, and whatever else is in the air, not that there's anything wrong with that. Our early reports: showing progress. There is an organization called TransforMED that's been giving us some reports on this also, has provided consulting and oversight for this. When I say mixed results, some of the things that are done are surveys of physicians and patients to make sure that

satisfaction is high, and I think in the early stages some of the reports that came back from the physicians involved in this were mixed because they were overwhelmed. You're changing your entire practice, and that can be a handful. But we'll let Dr. Miller and Dr. Rauner talk about that. Medicaid required medical home in managed care contracts, two per year to a contractor--this is very important. The department itself, on Medicaid, made the decision when it expanded managed care contracting to the remainder of the counties outside the ten that already had managed care contracting, unilaterally made the decision that each one of those contractors, and there are two contractors for managed care for Medicaid outstate, that each would be responsible for developing on their own two medical home pilots per year outstate. Senators, the significance of that is, before we've even got results from the pilots we have, we've already got the department moving to establish even more pilots in the state--very significant. Private payer medical home efforts in Nebraska: Blue Cross Blue Shield is using...we've used the term "patient registry," it's probably more significant or appropriate or correct to say "disease registry style" approach. They're using medical-home-type approaches to looking at a specific diagnosis. With the Blues it's, I believe, diabetes; there may be others. Coventry is using a structure similar to the pilot we established, and United is providing, with its pilot, some technical assistance and a care coordinator. Again, we've got payers that are moving in this direction before the results of our pilot are in. So next steps and challenges: The program and the payment structure is set to end in upcoming months, and then we'll take the months after that to evaluate the data to be able to show and evaluate success, both in terms of quality as well as cost. But here are some of the challenges that are out there. Medicaid is the only participant in these two pilot sites. Obviously, there are a lot of other patients that get care within those practices--Medicare and private insurers. But when you transform your whole practice to be a little different in the way it provides care, all patients are going to benefit from that, whether it's a private insurer, whether it's Medicare. Medicaid is basically helping underwrite the transformation of these practices, and any patient who goes there, even those who are no-pay, charity cases, are going to get the benefits that are out there. That's not fair. That's, I think, one of the main pushes that Senator

Wightman was approached about, on trying to look at a way to get a multipayer approach towards this. How do we encourage, short of legislating it, how do we encourage all payers to climb on board this? And that's one of the things that we've been sitting down and talking about. We've already had meetings with all payers to sit down and talk about a collaborative way to do this before we're faced with a legislative debate about it. It's also, with some of the initiatives brought forward by payers, a bit...not a bit, it's fractionalizing because the registry model, the disease-specific model, doesn't transform an entire practice. It plucks out a specific disease, like diabetes. It's a good thing in general to take a look at specifically...(lawn mower sound)...see, one more thing in the air to give us all challenges. (Laughter) It's not transformational. It's as if you wanted to transform the practice of farming in this state, everything from what you harvest with, how you harvest, seed you use, the bookkeeping approach, transform the entire practice of farming, and somebody comes in and decides just to look at ways to improve a variety of soybean seeds that are out there and harvesting soybeans. That may be significant in that capacity, but it's not transforming the practice of farming. And we're talking about transforming the practice of medicine, specifically primary care medicine. So there's that aspect of it that's a challenge for us. And that's the reason for the hearing, is we're at that step of the pilots are winding up, we've seen some significant success, we're going to be evaluating data and come back with the findings of that data, but what next? And in the meantime, how do we keep ourselves from being fragmented, and how do we get a multipayer approach towards this so it's not just Medicaid that's paying the freight? And with that, I'll leave more specificity to the physicians that are going to follow me, although I'm happy to answer some questions if you've got any questions now or at the end. [LR513]

SENATOR McCOY: Any questions for Senator Gloor? Seeing none, thank you, Senator. Believe we have Dr. Joe Miller who will come testify this morning. Welcome. [LR513]

JOE MILLER: Joe Miller, J-o-e M-i-l-l-e-r. First of all, thank you, Senators, for your time,

even in your off-season to a certain degree. We really appreciate this. I have been the lead physician for the Plum Creek Medical Group with the transformation of practice, and when we talk about transformation, it is quite a few changes that have occurred. Our care coordinator, who is a very key person in this, quoted something like, we have managed to tear down and rebuild the practice while we have our supervisors running departments and doctors and nurses seeing patients and changing all kinds of things that have happened. And yet we were able to do that in a manner in which we were providing better and better quality care for our patients. We talk about access. We talk about continuity of care. Senator Gloor spoke about knowing the patients. I have the advantage of now being in Lexington for 28 years, so many of my patients I have known for a long time. I know not only about their colds but sometimes I know about their grandparents or their children and how those things affect things, and that gives us that relationship that allows us to provide better care than episodic care that is provided in an emergency room. Part of this transformation has included things such as expanding our hours. We are now open from 8:00 o'clock in the morning till 6:30 in the evening, Monday through Friday, and for three hours on Saturday. We know that we want to provide those hours so that our patients do have access. We've tried to set up a system so that they know that they can get ahold of us and not have to come into the emergency room. Our care coordinator, which is a position that was created, and a very important position, contacts every one of our patients that has been to the emergency room and makes sure that they have a follow-up appointment; that they know that if there was something that they went to the emergency room that maybe was not an emergency, that they could access the office at a much less cost to society; and also to make sure that any medication changes and those things are put into our electronic record so that when they do come back to see the physician, that that's done. We've also done that with our hospitalizations. And with this we have seen both a reduction in hospitalization and a reduction in emergency room visits. We have looked at registries, and a registry is looking at all the patients with a specific disease type or problem. The one that we picked first was diabetes because it was one that affects so much. We found that we have 950 diabetics in our practice, approximately. Now some of those

people, when you have a paper chart you don't realize, maybe haven't been seen for a year or maybe even longer, and if they don't, then they come in in crisis. And if we can figure out a way to prevent disease, it is much better. If you look nationally there are three standards set up. One is an LDL, or a bad cholesterol, less than 100; another is blood pressure less than 130 over 80; and one is a hemoglobin A1C, or an average blood sugar of less than...7 or less. Those are set up by the ADA. In the United States we only have 7 to 10 percent of our diabetics hitting all three of those standards. That's horrible. When we first looked at our practice about nine months ago and put together our registry, we were a little over 15. My personal practice now is over 33, and that's not good enough. But we are able to actually look at each of those numbers and see each of those standards rising. Talk about a person, I have about a 50-year-old gentleman in my practice who is mentally challenged, probably has an IQ of about 80 or 85. He was working at Walmart, but he's got type 1 diabetes. He's on insulin. He's got kidneys that don't work real well. And on top of this, he ends up with the worst gout I've seen in 31 years. His uric acid levels are higher than anything I've ever seen, and he's getting gout not in his big toe but in his knee and his elbow and his shoulder besides his big toe. And I don't know if any of you have had gout, but...I have not, but my patients tell me the sheet doesn't even want to touch, it hurts so bad. And trying to keep him out of the hospital because of all these things has been very difficult. But out of this whole thing we have been...and, unfortunately, he's somebody who really wants to work, but we've had to tell him, you can't, because every time he goes back to work for a day or two he ends up flaring up one of his joints. And now with the care coordination, we've been able to help facilitate getting him...keeping him out of the hospital but also getting him on disability and getting him correct food and things that he needs, because there was...there's a gap here where he can't get disability, he can't get Medicaid, and he was kind of in that gap. Out of this also has come not only do we have a care coordinator, but our hospital has understood, figured out how important this care coordination is, and they have now hired somebody to do that from the hospital's standpoint. We have transformed our practice and are still transforming. My senior partner, who is one of the smarter men I know, said, well, Joe, just turn the switch; we all believe in this thing, just

turn the switch. The problem is...we have a notebook from...which is our patient-centered medical home notebook of just protocols and things that we've done to change how we're doing things within our office. It's about four inches deep. We know that we're making a difference. We just had a quarterly meeting with the advisory committee, and in that, depending on the quarter, but we've seen a continued improvement of both practices--both Kearney's Kearney Clinic and us--so we're seeing, depending on the quarter, maybe a $40- to $70-per-patient-per-month improvement in costs, decreasing costs. Now that's huge. But that goes along with what places like Community Care in South Carolina has shown, where they've shown a quarter of a million dollars...a quarter of a billion dollars, excuse me, $250 million a year consistently for the last four years, each year, in savings to their Medicaid population, of budgeted costs. The problem is it does take a lot to transform this. I have a passion for this. My partners are saying, how can we keep doing this, how can we keep spending all of this time and energy and money if we're not going to get paid for it? Because not only do the Medicaid patients improve; we're also doing this for all our patients. This is not just for one segment of our population. We're doing this for all of them. And because of that, we really need a multipayer system. We need all the payers to...because all the payers are getting savings, we need them to help pay for the infrastructure that goes into this. So that's why we're here. That's why I've spoken to Senator Wightman about this. And Senator Wightman has been through the process. He understands what we're doing in our office. So thank you for your time. If anyone has any questions... [LR513]

SENATOR McCOY: Thank you, Dr. Miller. Any questions? Senator Schumacher. [LR513]

SENATOR SCHUMACHER: I have a niece, Lauren Schumacher, who is in the audience today, and if I don't ask a question she'll know for sure I don't do anything. (Laughter) How does this differ from just what we normally thought of, at least in smaller communities, the family doctor? I mean what...mechanically how...what is really different, and why do we need to incentivize insurance companies to do something

differently as far as paying? [LR513]

JOE MILLER: I, either at the end of my day the day before or the beginning of that day coming in, I'll take a half-hour to just go through every patient that's coming in and say, okay, this lady needs a mammogram. Now she may be coming in for a blood pressure check, but she hasn't had a mammogram. Or this 55-year-old guy hasn't had a colonoscopy or stools for blood; they haven't had their Zostavax; or we're looking at what it is...and that's on a daily basis that we do that. But what we're also doing, because we now have the power of the computer and the power of electronic record, we're now able to look at our population as a whole and say, okay, these people have not been in. You could never do that with a paper chart. I can't keep in mind who I saw two weeks ago, let alone two years ago, for their diabetes. But we're now able to look at that, and we're also able to say, okay, yeah, they were in, and their hemoglobin A1C was 8.0, and it does not fit standard. So now we're able to say, hey, he hasn't been in in six months; he really needs to come in. We can call him and encourage him to come in. Can we force them? No, but what we find is if we take interest in them, they will take more interest in their own healthcare. What does dialysis cost a year, if we can prevent dialysis? A quarter of a million dollars a year per patient. You know, if we can bring those blood pressures down, if we can bring those sugars down, if we can bring those cholesterols down, if we can prevent a heart attack, if we can prevent a stroke, if we can prevent those things, that saves the system tremendous money but it really changes the lifestyle of that patient. We, when we look at the United States' healthcare system and we look at First World countries, we are 19th of 19 in healthcare efficiency, meaning value for the money. We cost twice as much as anybody else and we're at the bottom of the totem pole as far as quality, and what we're trying to do is bring that quality back up. The best analogy I can give you is, yeah, we got great things here; we got probably some of the best liver specialists in the world down at the University of Nebraska Medical Center. But if you go back...I forget what Olympics it was, but when Jordan was playing and they put all these great guys together and they went out and they were a basketball team at the Olympics, and I think they got beat by Albania because they

weren't a team. What we need to do is we need to be able to pull this together, not only be a patient-centered medical home as a practice but we also need to be a patient-centered neighborhood. And this is a concept that is going to go beyond this, where we actually have agreements with the specialists as far as: these are things that we will do, these are things that you need to do in return to keep our patients healthy, so that we're not doing too many procedures that are costing us money, that we don't need. You know, the incentive is to do procedures because the incentive right now is: everything I do I get paid for. The incentive has never been for preventive care. It's always been for disease care, and that's what we've been practicing in the United States ever since medicine really started, is disease care. We now have the opportunity to practice healthcare and actually keep people healthy and really work at what we can do to prevent the end stages of disease. [LR513]

SENATOR SCHUMACHER: So the basic difference, if I'm trying to jell it out of what you said, is people sign up with one of these homes and then the professionals in the homes keep contacting them? Or I'm... [LR513]

JOE MILLER: No. No, actually, no. Senator, what we have done is we have just taken everyone in our practice...and that's part of the whole issue, is we are changing the way we're delivering healthcare in Lexington. We're changing the way we deliver healthcare in our office. If someone calls in that day and needs to be seen, they get seen, okay? We try our best to get every...now if a lady comes...calls in and says, I want my Pap smear at 2:00 o'clock this afternoon, well, that may not happen that morning, okay? But if they have an illness, if they are feeling ill, if they are having a problem with a chronic disease, we try to get them in there today. I know, dealing with a couple elderly parents right now; and trying to get them into healthcare in Omaha is very difficult. The way to access healthcare in the city is go to the emergency room; if you're ill, go to the emergency room. We're trying to make that not happen. We've expanded our hours. We've expanded...trying to make it so that things will happen that way. But it's for our whole patient population. It has nothing to do with whether you're Medicare or Medicaid

or Blue Cross and Blue Shield or United Healthcare or Coventry or now Arbor Health. It has nothing to do--those are the four major players in our state--has nothing to do with who they are. So everybody is getting treated the same, and it's...but we need...if we're going to attract physicians to go to rural Nebraska, if we're going to keep people in primary care...and all the statistics show that the only people that are going to really make a difference in healthcare costs is going to be primary care. And right now we can't get our best of our best to go into primary care. We can't even get as many students as we need to go into primary care. And it really comes down to one thing--dollars and cents. If I'm a medical student and I'm graduating with $300,000 in debt and I can make X being a family physician and I can make 3X or 4X being an "ologist," they may not be math majors but they can kind of figure that out pretty quickly: I think maybe I can pay my debt off and not have to work quite as hard. We really need...and the federal government has a graduate medical education committee, came out in February of 2011 and said, we need to take...we need to improve primary...increase the number of primary care from 32 percent to 40 percent very quickly. Now the problem is they're putting a lot of people into primary care that really aren't there. And if you look at most of the statistics it's probably 25 percent. The rest of the world, those other 19 countries, it's about 50/50. In the United States it's 25/75. [LR513]

SENATOR SCHUMACHER: And then one follow-up question: You indicated that right now there's a tendency in our system to use the emergency room as the first point of contact. We've spent, I guess, since that rule went into effect, what, a couple decades ago, where an emergency room, they had to give free treatment. If that's how we've been training people for the last 20 years or so, what do we need to do to train people to either use a primary care physician or one of these patient-centered medical homes? Instead of saying, well, I'll just go to the emergency room; that's what you do. [LR513]

JOE MILLER: And that's part of...and we are in a retraining process. You know, I talked to you about the care coordinator talking to people. We try to get our patients to

understand. We can take...and I can take better care...I can take better care of my patient than even my partner can. But my partner can sure take a lot better care of my patient with the electronic record and having the records of the patient than somebody who has never seen the patient before or has any access to records. We can provide better care, lower-cost care because we don't have to repeat a bunch of tests. We don't have to do a lot of tests because we know who the patient is, you know. If I know that patient and I have a relationship with them, I'm going to be able to provide better care for them. [LR513]

SENATOR SCHUMACHER: Thank you for your testimony. [LR513]

JOE MILLER: Okay. [LR513]

SENATOR McCOY: Senator Schilz. [LR513]

SENATOR SCHILZ: Thank you, Senator McCoy. Thanks for coming in today, and it really does sound like exciting stuff. You talk about on one side you're saving millions of dollars for the patients, but then on the other side, as you administer that care and you provide that care, is that where your costs...are they increasing there? [LR513]

JOE MILLER: Yeah. [LR513]

SENATOR SCHILZ: Because, first of all, you're not...I suppose that you're not doing as many procedures and... [LR513]

JOE MILLER: We're not able to, if you look at it, timewise, it's going to...you're not going to be able to see as many patients, okay? But you're going to be able to provide better care. You also have the increased costs of some other administrative things, such as a care coordinator, who, you know, nobody pays for that, but that person is very important. This is outside of Medicaid, but Medicare the statistics are 5 percent of the

Medicare population uses 50 percent of the dollars. Now if we can figure out who that 5 percent is or, even better, who 15 percent is going to be that 5 percent and somehow take care of problems to prevent that, we can save tremendous dollars down the road. And that's where care coordination, that's where looking at populations is much different than just seeing whoever walks in the door that day and taking care of that particular problem and not looking at that patient as a whole patient and all the things that they need. [LR513]

SENATOR SCHILZ: Right. And then the other question then that I have is the transition also has to cost some extra, too, to move forward. [LR513]

JOE MILLER: It's a significant amount of money putting all of this together. And he brought up about physicians not being real happy initially. Yeah, all of a sudden you're telling me I can't see as many people because I've got to do all this extra stuff and I'm not going to get paid for it, you know? And so...but as they start understanding that, yeah, we're able to provide better care, that if you look at the studies overall over patient-centered medical home, and Bob will go into some of those, patient satisfaction is huge, much improved. Physician satisfaction, nurse satisfaction, office satisfaction all goes up over time. But change, oh, you know, most of us don't like that thing, and so that really makes it more difficult. [LR513]

SENATOR SCHILZ: Right, sure. Maybe you need to leave a tip jar out. (Laughter) Thank you. [LR513]

JOE MILLER: Okay. Anyone else? [LR513]

SENATOR McCOY: Senator Christensen. [LR513]

SENATOR CHRISTENSEN: Thank you, Chairman. Thank you for coming in. It's been very interesting. As you said, you come in an extra half-hour and you evaluate, look

over the record, see what they haven't had and things that way, cannot the computer eventually be programmed or you have a secretary, somebody that is less expensive, go through that and just you get the alert? [LR513]

JOE MILLER: And actually that is part of this, and as of the first of the year I hired my own PA that's working with me, and we're doing...because of what we're doing, that has allowed us to see more patients, give better access, because she's able to take off some of the load. And this needs to be physician directed. You're right. We've set up protocols. We've set up protocols for refills. We've set up protocols for immunizations. A lot of the time with the immunizations the nurses have already said, okay, this person needs this, this, this, and this because these all fit what the protocols are. They ask the patient, you know, you haven't had your shingles shot yet. And they've already called back to see--because Medicare doesn't pay for that--to the office person and say, you know, what does their supplement pay on that? So that they can just say...the patient will say whether or not they want it. You know, flu shot time, they know, they walk in the door, they haven't had their flu shot, it's offered. And, you know, each year in Lexington the number of flu shots have gone up tremendously, in fact, probably in the last three years almost doubled. We'll give out over 4,000 flu shots this year. That decreases what we're going to see in January and February. That decreases the hospitalizations that we're going to have due to our old folks getting flu. Just having that herd immunity within the population of Lexington will make a big difference on how much influenza we will actually see during the flu season. [LR513]

SENATOR CHRISTENSEN: So that's what I was hoping to hear from you and you hit on it, that you may be able to see more people by having this more structured. [LR513]

JOE MILLER: Well, it's...the...what it's going to be is we're going to focus on the more chronic things that we are able to deal with. There are...it is a physician-directed--and I think that that's important--practice in which we try to raise our nurses, my PA to the highest level of their license to be able to take care of the things that they can take care

of and do that, really, throughout the practice. Even...what we want our office people to understand is that this is physician-centered...it is not a physician-centered practice, it is not a nurse-centered practice; this is a patient-centered practice. What we want to do is we want to take care of the patients. The patients are our focus, not whether we want to get out of here for lunch or not, not whether or not we can be...we want to make sure that they are taken care of in the best way they can be taken care of. [LR513]

SENATOR CHRISTENSEN: Thank you. [LR513]

JOE MILLER: Okay. [LR513]

SENATOR McCOY: Any other questions? Seeing none, thank you, Dr. Miller. [LR513]

JOE MILLER: Thank you very much. [LR513]

SENATOR McCOY: We have Dr. Bob Rauner. [LR513]

BOB RAUNER: (Exhibit 2) I'm Dr. Bob Rauner; Rauner is R-a-u-n-e-r. Basically, I just have kind of two things I'm going to bring up. One is that I think in 2008 some people said, well, this is a new concept; it's not proven yet. Now, in 2012, that's no longer the case. And I have one handout, which is this. This is a summary, actually seven pages, of successful pilots all over the country. And so we're not at the point anymore where this is of any doubt. And if you look through here, it's on all sectors. It's private insurance led, it's military. You'll see an Air Force and a VA pilot that worked. There's a Medicaid North Carolina project. Some are employer sponsored. Every way you do this it is we're getting great results from it, okay, which I think probably leads you to the question, well, if it's such a great thing, why isn't it just happening? I mean, why doesn't the private sector just say let's all make this happen? And the reason it's happening is actually two issues. One is what you might call a tragedy of the commons issue, and the other is an antitrust issue. Both of those are why you do need some governmental role

in this. Even though we're kind of not a government-control state, there is a role for it here, and it's because of those two issues. So, for example, what's the tragedy of the commons issue? Well, the problem is, the way our insurance contracting works, most insurance contractors stay with a United or a Coventry maybe only two years. That means any investment you make has to pay off within two years because three years from now that patient may belong to another insurer. And the problem you have with medical home is that up-front cost. You have to install electronic records. You have to train your staff. You have to hire a care coordinator. That is an up-front cost. And what the studies show is it takes anywhere from two to five years for that to pay off. It pays off almost every time, but if three years from now that patient is now another...belongs to another insurer, you know, that means Coventry paid the money but now Blue Cross is going to make the savings. And so that tragedy of the commons issue is why it's hard to get others to do it. Now Medicaid is sticking with it because a lot of times Medicaid, if you're dual eligible, you've got them for a long time, so it's easier for them to make the case. Medicare is doing it. Why? Because once you're on Medicare, you're always on Medicare. You don't age out of Medicare. Same with Air Force and VA, once you're a military lot, you may be military forever, and so they see that. And then some of these plans, like, for example, the last one, from Washington, that was led by Boeing. Because Boeing likes to keep its employees for a long time, they're going to invest in that because they see that. So occasionally you'll see a large employer drive that if they have a huge section, but we don't really have that except for in a couple places. So maybe in Sidney, Cabela's employs half the town, they could probably justify that, but other than that in Nebraska it's hard for one employer to drive it. And so part of the problem is, to get it to work and avoid freeloading you have to have everybody do it, not just one. And if one person cheats and doesn't do it, they get to freeload; and Medicaid pays for it and maybe a Coventry pays for it, but UHC and Blue Cross gets the benefit. And that's the issue. You have to get...to make it work you have to get all from that side plus from Joe's side. He doesn't want to give great care to half of his patients and crummy care to the other half. He's going to provide it to all. So he can't do it differently for each of his patients. It just doesn't work logistically. The other issue is an antitrust

issue. We have actually been working...and in this other thing, this core principles document, I started working on that in 2008. It went through Nebraska Academy of Family Physicians in '09 in the spring. We got all the other primary care specialties and Nebraska Medical Association to approve it in the fall of 2009. And we've been meeting with the private insurers for the last three years using this as our starting document. Unfortunately, we've only made progress with one insurer, and that's actually Nebraska's Blue Cross pilot, which is actually listed in here and it is working too. The problem is we can't get them all to work together, and the problem you run into is an antitrust issue, that if some band against the other you can have antitrust violations, and that's scary enough and can be expensive enough that it really limits what you can do just as a gentlemen's agreement in a room. And so what you're finding over and over again that what happens in other states to make this happen, you have to have some governmental umbrella. It doesn't have to be mandated, it could just be Senator Gloor or some of you guys bringing all of us into the room and agreeing to agree. Short of that, though, if you have a bad actor, you may just have to push it. And what's happened in a couple other states, they've had to resort to that. Rhode Island, it got pushed under the Insurance Department. Their health insurance commissioner, Chris Koller, has led that. We actually had him come out and speak at our conference, and I think he met with some of the insurance people to explain that, why that works. And we were able to get him here because his mom is a south Omaha gal originally. Other states, they've had to have the legislature step in and say, look, this is the common standard. And I think the way to look at it is it's kind of like the railroads. In the old days, the railroads actually had different widths of track, and for obvious reasons that was a pain if you wanted to go from one place to another. And so the...so they basically set a standard width of the railroad. It lowered everybody's costs, it made everything more efficient. Or like in the old days with ATM cards, some of you may remember when we had Cirrus cards and Nortel cards and you had to go to one versus the other. Well, now it's all one because it was simpler, it was more efficient, it was more convenient for everybody involved. And so what this actually was to try and do is to get them to all use the same system, okay, because if they all do it differently, it's not going to work either.

And so what we're trying to do is get the insurers to agree, this is how we'll define it. And, really, our outcome is we want to just have four things. One, we want to have a definition of what a medical home is so we're paying for the same product. We'd prefer that it be the Nebraska Medicaid definition because it's already working in Lexington and Kearney. One other insurer is looking at using that definition. The other ones are also good but they cost tens of thousands of dollars, and why add that extra expense and pass that on to consumers when you can just have the Nebraska Medicaid one, which I think is good enough? The second is there has to be some "per member per month." It's that management fee that pays for Joe's care coordinator. Because if he decreases his office volume because he made people less (sic) healthy and they didn't get sick and come in, he's going to lose money, not make money, by doing this. And so you need a management fee to pay for that out-of-office care, because what you find is a lot of things actually don't need you to come in and see me. You know, some of your blood pressure checks, you have...you could do a blood pressure monitor at home and just e-mail it to me or with secure messaging. You wouldn't have to come to the office. Right now there's no way to get paid for that, where if you have a management fee, well, I can just cover it that way and then I can see you and it's more convenient for everybody involved. The third thing we need is a common definition of what our goal is, because you don't want people to decrease volume and get worse care. You want to make sure that this care is still being decent. So like Joe said, you want to define diabetes care--what blood pressure goal, what cholesterol goal, what should it be--and you want everyone using the same one so we can compare everybody. Because what happens, you'll find, is that, you know, Blue Cross wants to use a blood...an LDL cholesterol of 100 and this one might want 70 and this one might want 30. Well, you can't run your forts three different ways all the time, and so one thing we want is a common definition. And then the last thing is if we can get a multipayer pilot, Medicare will also jump in on this. Medicare already believes that they're already doing it. We were locked out of those applications because they won't do it unless others are doing it, because they know the freeloading issue too. They don't want to pay for it all themselves. And so we want whatever we have to meet the Medicare criteria for a

multipayer so it's not just our own local dollars paying for it, we have Medicare as well. And so that's kind of where we're at right now. So I'm hoping we can have this happen with just an umbrella and not need legislation, but that could be necessary; and that's kind of what we're in the process of right now. [LR513]

SENATOR McCOY: Questions for Dr. Rauner? Senator Schumacher. [LR513]

SENATOR SCHUMACHER: Thank you, Senator McCoy. Doctor, I'm trying to put this in the context of...on the assumption that the Affordable Health Care Act survives the election. If that happens and if it's proceeded with, how does this sit into that framework? I mean, do we, as a state, have any way to plug that in as some kind of essential healthcare benefit? Do we...should we look at plugging that in as something that is mandatory on the exchange? If we do, who picks up the bill for it if it's a Medicaid kind of bill? I mean, how does this all fit together with that, or will some of this be rendered moot if that goes into effect? [LR513]

BOB RAUNER: Honestly, I don't think the Affordable Care Act makes that big a difference one way or the other. [LR513]

SENATOR SCHUMACHER: Okay. [LR513]

BOB RAUNER: There are some incentives in the Affordable Care Act that do incent medical home, mostly because of Medicare payments, basically, so the Medicare portion could be affected. I don't think it would make a big difference on the private payer side, though. Now I think there are things you could put into the state health insurance exchange that actually could facilitate this well, by actually using those same requirements in the exchange, so that anybody who's going to be on this exchange, any plan, as long as they have this medical home with this common definition, common targets, that could be facilitated by the exchange. But I think it actually is...it's kind of moot. It can happen one way or the other. I think it would be really good to have some

common data system. A lot of states have what they call as an all-player claims database, so you can pull in the claims from everybody in one place and then you, as a government or an independent body, can say who's doing the best job, honestly. Is Blue Cross doing a better job getting those cholesterols controlled versus Coventry, versus United Healthcare, versus Medicaid? It's a way to basically give, I think, consumers a better choice, and other states are doing that. Minnesota has what I think is an excellent plan, where you can actually go on the Web site, look at...they had a diabetes D5 initiative where they had these five things that every diabetic should have. Those insurers in Minnesota have pooled all their claims, and you can go in, as a consumer, and look at the clinics and see which ones are doing best. And, I mean, as a patient, I'd like to see that. As an employer buying insurance, one insurance company versus another, maybe you'd want to have that. But we don't have any, as far as I know, any all-player claims databases like that where we can do that. Other states do that, and I think they're ahead of us on that one. Could that then be incorporated into the state exchange? Probably at least for the insurers that are part of the exchange, or the state could do an all-player claims database at some point, which I do think would be good. It would be kind of like having a consumer reports of healthcare for Nebraska, and other states do have that. But that's another cost and maybe kind of beyond this discussion. [LR513]

SENATOR SCHUMACHER: Well, then assuming that we have to struggle with the issue of an exchange and whether to include these things into it, have you heard...one of the choices, I guess, before us, whether it's a hybrid exchange, a regional exchange, a state exchange, a federal exchange, with one of the options being talked about being the federal exchange, is there any discussion at the federal exchange level? Or is this a reason for us to try to do a state exchange thing? [LR513]

BOB RAUNER: I guess (inaudible) I don't think the exchange makes that big a difference one way or the other. I mean, like a lot of folks, I think I'd much rather have it be a Nebraska-based exchange than a federal exchange. I work, on my other job,

as...on an electronic record grant that helps get electronic records, and what they've set up...they don't understand how healthcare works in rural areas, from D.C., and it frustrates the heck out of me. And I think they would do the same thing if they tried to set up our exchange for us. They don't understand that if you're in Valentine, Nebraska, there's no cardiologist there and that sometimes, if there's an ice storm, you can't get out. You just got to take care of that patient. You can't just send them down the road. You know, a helicopter can't fly because it's snowing, and it's too icy to send them on an ambulance. They don't understand that, really. And so I really would prefer that it be state based just for a lot of those common reasons. You know, they don't understand that Valentine might not have the same broadband access that Lincoln does. You know, one backhoe can cut off Valentine sometimes. So they don't get those things. [LR513]

SENATOR SCHUMACHER: Thank you for your testimony today. [LR513]

BOB RAUNER: Yes, you're welcome. [LR513]

SENATOR McCOY: Any other questions? Thank you, Doctor. That concludes the individuals that were lined up to speak initially this morning. Are there any others that would like to testify this morning? Seeing none, would you like to close, Senator Gloor? [LR513]

SENATOR GLOOR: Thank you, Senator McCoy. Thank you, members, for your patience today and for your ears and for your questions. Let me address just a few of the issues that came up, again, from a standpoint of why I got interested in this. Senator Schumacher, who is a very wise senator, by the way, asks great questions, and if he has any relatives interested in healthcare they should consider Grand Island as a place to practice. (Laughter) You know, the reduction in ER visits is a great question, really, sincerely. And an example of how you might reduce ER visits generally is--go back to my comment about in the old days--you know, when I had a family physician, you didn't think about going to the emergency room. You called your family doctor. Well, in this

case we're talking about developing a relationship, which clearly will take some time and trust and interaction, but before somebody visits the ER for their headache they've had for the past three days, they call their medical home. They call their practice. So there's savings there. But I think some of the more dramatic savings, examples that were given to me--and this gets to some of the added-cost questions that come up and why you pay for a medical home a little more than you'd pay for routine office visits and whatnot--an example that sticks in my brain from some of the early years when we were talking about this: following diabetics. And, you know, we all fall off the wagon when it comes to our diets around the holidays, and if you're, in your practice, monitoring your diabetics, one of the practices that I remember hearing about, with the ability of technology in this day and age, had the opportunity for blood sugar levels to be monitored from home through telephone lines. I mean, it's a relatively easy technology now for that information, that blood test to be done in somebody's home and sent in to a physician practice. And the kind of money that can be saved by having that diabetic not get into crisis, collapsing at home, having to be brought in by ambulance to the emergency room, hospitalized for a day or two until their blood sugars get back to normal levels and then dismissed, we know that's going to be thousands and thousands and thousands of dollars, as opposed to monitoring these diabetics perhaps a little more aggressively, but not reactively--proactively. And that technology is going to cost a little money, and the added dollars that go into that practice might allow it to spend some of its money not just on personnel but also on some of the technology that's out there so that they can be proactive in monitoring. We haven't talked about that with the pilots, but that's an example of some of the transformation and some of the proactive approaches towards this. So, again, there are a lot of opportunities out there, I think, and everybody is making, I think, a concerted effort to make sure these pilots are successful. And I want to give kudos to the department. I mean, Medicaid has been very supportive from the git-go. This doesn't move anywhere if Medicaid isn't supportive. And whether it's assigning staff, providing the backup and support necessary, ultimately we're going to be crunching numbers, Medicaid has been very supportive. As I said, they've now built into the managed care contracts in outstate expansion of pilots by those contracting

entities. And even the payers themselves, even though we're trying to figure out a way to get everybody to march in lockstep, even the payers themselves have been willing to come to a meeting to sit down and begin discussions on this. And we've got another meeting scheduled later in October (fire alarm sounding) to do this very thing. So kudos to those folks, but we have a ways to go yet. And that actually was where I was going to finish up. (Laughter) Thank you. [LR513]

SENATOR McCOY: Any other questions for Senator Gloor? With that... [LR513]

SENATOR GLOOR: You know where you can find me. [LR513]

SENATOR McCOY: ...this will conclude. Thank you. [LR513]