Patient Centered Medical Home

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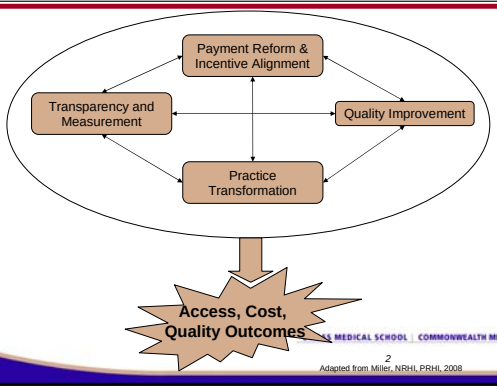
Commonwealth Medicine

UMASS MEDICAL SCHOOL

Applied Knowledge in Public Service

Patient Centered Medical Home

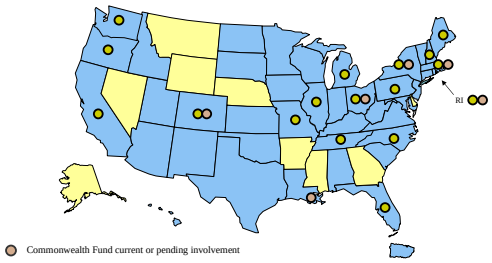


Adapted from Miller, NRHI, PRHI, 2008

Overview

- Demonstrations and Pilots:
  - North Carolina
  - Minnesota
  - Vermont
  - Rhode Island
  - Pennsylvania
  - NYC
  - Massachusetts
  - Medicare (1/2010)
- Payment models
- Evidence Base
- Conclusions

Patient Centered Medical Home Demonstrations/Pilots



Commonwealth Fund current or pending involvement

Multi-payer pilot discussions/activity

Identified pilot activity

No identified pilot activity

Source: Patient-Centered Primary Care Collaborative, July 16, 2008.

Patient Centered Medical Home Pilots/Demonstrations

•Contextual framework

- Infrastructure recognized and enhanced
  - rural community health centers
  - managed care tradition
- Infrastructure undertaken
  - health information technology

•Development

•State models & implementation vary
•Develop in different directions and in unique ways
•Pre-existent factors play an important role

Community Care of North Carolina

- Medicaid program, established and evolving since 1998
- Includes:
  - Disease and care management, population management, utilization management, quality improvement initiatives
- 14 Networks, 3500 physicians, >800,000 Medicaid enrollees
- Network of collaborating providers: hospitals, health departments, departments of social services, PCPs: shared responsibility for care
- Key feature: Network-based care coordination
  - Identify complex, high-cost patients in need of case management
  - Hire local case managers to assist in coordinating care
  - Collect and report patient data to the CCNC statewide office
- Focus on chronic disease management: asthma, diabetes, chf
- Increased access: Medical homes must provide 24/7 coverage

Sources: CNC (http://www.communitycarenc.com); "Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries (2006) American Academy of Family Physicians. Center for Health Care Strategies/Quality Innovations in State Medicaid Programs (November 2007) Community Care of North Carolina http://www.communitycarenc.com/ (Retrieved 29Dec08)

Community Care Networks

- Non-profit organizations
- Includes all providers including safety net providers
- Medical management committee
- Provider networks organized by local providers, physician led
- Evidenced based guidelines are adopted by consensus rather than dictated by the state
- Medical Homes are given the resources for care coordination and get timely feedback on results

Intent: To build local systems of care rather than just changing payment system

Source: Dobson LA Jr. CCNC presentation

Community Care of North Carolina & Medical Home

Payment

- Networks receive $3.00 pm/pm to develop/provide/invest in needed local systems
- PCP receives $2.50 pm/pm to serve as medical home and to participate in Disease Management and Quality Improvement
- NC Medicaid pays 95% of Medicare FFS

Sources: CCNC (http://www.communitycarenc.com); Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries (2006) American Academy of Family Physicians. Center for Health Care Strategies/Quality Innovations in State Medicaid Programs (November 2007). Community Care of North Carolina http://www.communitycarenc.com/ (Retrieved 29Dec08) Dobson, A. CCNC presentation

Minnesota Department of Human Services

Health Care Homes

2008 Health Care Reform Act

- Develop and implement certification standards for health care homes (HCH)
- Develop a payment system to implement HCH
  - Per person risk adjusted care coordination fees; quality incentives
- Focus initially on patients with complex or chronic conditions
- Over 2 years, expand use of HCH and care coordination fees under state health care programs and private sector health coverage
- Share best practices through HCH collaborative

Sources: Jeff Schiff, MD, MBA, Medical Director, Minnesota Health Care Programs http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139315 (Retrieved 29Dec08)

Vermont Department of Health

Medical Home Project and VDH Blueprint for Health: History

- ***Medical Home Improvement Project:***
  - Six (6) pediatric practices funded through two grant cycles (2002-2005)
  - Provide tools and resources to 100 PC pediatricians in 40 practices across Vermont (96% of all pediatricians)
- ***Vermont Blueprint for Health (2005):*** State-wide plan focusing on chronic disease management and prevention
  - 2007 Health reform legislation – pilot 3 multi-payer integrated medical homes between 2008 and 2009; focus on adults
  - Ultimate goal system-wide transformation by 2011

Source: Kim Aakre, MD, Medical Director, The Vermont Medical Home Program (http://www.partoparvt.org/03FallMedHome.html#3 (http://healthvermont.gov/blueprint.aspx)

Vermont Blueprint for Health
Integrated Medical Home Pilots

- Financial Reform
  - Payment based on NCQA PCMH standards: range $1.20- $2.39 PPPM
  - Payers sharing costs of Community Care Teams
  - Joint funding from 3 private carriers and Medicaid
- Multidisciplinary Care Support
  - Local care support & population management
  - Prevention specialists
- Health Information Technology
  - Web-based clinical tracking system – HIE network
  - Electronic prescribing
- Community activation and prevention
  - Prevention specialists
  - Community profiles, risk assessment
  - Evidence-based interventions
- Evaluation
  - NCQA PCMH score (process quality)
  - Clinical process measures - health status measures

Source: Susan Besio, PhD, Director, Office of Vermont Health Access, and Director, Health Care Reform Initiative (http://www.hcr.vermont.gov), http: //www.mcph.org/Events/Past_Events/FOCUS/Presentations/9_VT.pdf

Rhode Island Chronic Case Sustainability Initiative: CSI-RI

- All-payer, multi-stakeholder PCMH initiative
- 5 pilot practices, including 1 CHC
  - 28 physician FTEs, 25,000 covered lives,
- 2 year pilot, beginning 10/08
- Focus on: CAD, diabetes, depression
- Third party evaluation: HSPH
  - Use of registry data for outcome measures

Source: Christopher F. Koller
Office of the Health Insurance Commissioner, RI

CSI-RI: Commonality Key to Implementation

1. *Common Practice Sites*
   All payers will select the same core group of practice sites in which to administer their pilot. Requires common set of practice qualifications.
2. *Common Services*
   All payers will agree to ask the pilot sites to implement the same set of new clinical services, drawn from the PCMH Principles.
3. *Common Conditions*
   Pilot sites will not be asked by payers to focus improvement efforts on different chronic conditions
4. *Common Measures*
   All payers will agree to assess practices using the same measures, drawn from national measurement sets.
5. *Consistent Payment*
   Method and intent of incentive payments will be consistent across all payers

Source: Christopher Koller, Office of the Health Insurance Commissioner, RI

CSI-RI: Medical Home Model

- Sites commit to establish Medical Home. Use NCQA PPC standards. Require self audited progress to:
  - Level 1, 9 months in
  - Level 2, 18 months in
- Sites agree to go through training in Chronic Care Model (existing program at state DOH and QIO)
- Sites agree to hire and use Nurse Care Manager

Source: Christopher F. Koller
Office of the Health Insurance Commissioner, RI

CSI Nurse Care Manager

- Located within practices
- Provides services to ALL patients, regardless of payer
- Care Manager “college:” Collaboration of NCMs across sites and with Medicaid NCMs

- **NCM Activities:**
  - Initial patient assessment and risk stratify severity of chronic illnesses
  - Maintain registry/generate reports
  - Gather and maintain educational information
  - Education of patient on disease and treatment
  - Monitor quality measures
  - Access health plan resources

Source: Christopher F. Koller Office of the Health Insurance Commissioner, RI

CSI-RI: Payment Model

- Current FFS model remains in place
- Monthly $3 pmpm fee to each practice
- Additional allocation to support Care Managers
- Plans and providers agree to attribution methodology
  - Commercial: claims based - any one with last visit to site in 2 year time period and member at end of period)
- No clinical performance incentives

Source: Christopher F. Koller
Office of the Health Insurance Commissioner, RI

Pennsylvania Chronic Care Initiative

- Multi-payer, including Medicaid
- Regional roll-out started in 2008
- Practice redesign
  - Participate in learning collaboratives
  - Assigned practice coaches
  - Utilization of patient registry
  - Achieve NCQA level 1 designation in 12 months
- Three year commitment

Pennsylvania Chronic Care Initiative

- Funding:
  - Insurers spending $13m:
    - Learning collaborative time, registry costs, NCQA fees, practice coaches
    - Supplemental payments based on NCQA designation
- Third party evaluation

New York City Department of Health and Mental Hygiene
Medical Home Health Information Technology (HIT)

The Primary Care Information Project is a multifaceted program to support the adoption and use of Electronic Health Records among primary care providers in NYC's underserved communities.

***Primary Care Information Project* (PCIP)**

Eligible practices receive:

- •eClinicalWorks EHR applications and licenses.
- •2 years worth of maintenance and support costs.
- •Extensive training for all levels of staff.
- •Interfaces to common laboratory and billing systems.
- •NYC DOHMH Take Care New York customizations, encompassing public health functionalities:
  - Immunization registry, school health, disease reporting, preventive guidelines
- •Evaluation planned: process, outcomes, ROI, patient satisfaction, health disparities

New York City Department of Health and Mental Hygiene
Medical Home Health Information Technology

2010 Objectives

- •Extend prevention-oriented EHRs to 2,500 primary care providers and 2 million patients
- •Provide a million patients with self-management tools
- •Support PCPs in standardized health information exchange
- •Implement a quality improvement collaborative tied to the "Patient-Centered Medical Home"
- •Provide participating practices with clinical quality scorecards for evidence-based practice
- •Pilot a reward and recognition program for high-performing providers

Source: NYC DOHMH Primary Care Information Project http://www.nyc.gov/html/doh/html/pcip/pcip.shtml. (Retrieved 26Dec08)

Medical Home in Massachusetts

- MassHealth/EOHHS initiatives
  - 2008 health care legislation
- Commercial payers: contracting
  - BCBSMA
  - HPHP- disease specific pilots
  - GIC- required plans to include medical home demonstrations
- MA Coalition for Primary Care Reform
- Central Mass pilots

MassHealth/EOHHS Medical Home Initiatives

CHCs	DCF Kids	High cost / need
14 sites selected for CWF/QUALIS grant Multi-payer Focus	Sites with large number of DCF kids	Sites with MassHealth members with high costs and "intervenability"

- Build on Multi-payer Initiative at CHCs
- Expand to approximately 50-100 practices
- Practices may "qualify" for participation based on multiple categories

Eight PCMH Payment Models

1. Fee-for-Service (FFS) with discrete new codes
2. FFS with higher payment levels
3. FFS with lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment (Bridges to Excellence)
7. FFS with lump sum payments, P4P and shared savings
8. Comprehensive payment with P4P

Bailit Health Purchasing, Feb, 2009

Medical Home: The Evidence Base

- Primary care-oriented health systems generate lower cost, higher quality, fewer disparities (Starfield)
- The Chronic Care Model has been heavily evaluated and found to improve quality. There has been fewer evaluations of cost and utilization impact, but most findings have been positive (Wagner, RAND)
- Medical Home:
  - Geisinger early pilot results: 20% reduction in all cause admissions and 7% total medical cost savings

Sources: Bailit Health Purchasing Feb, 2009
Wilhide S, Henderson T. CCNC. AAFP 2006,
Paulus RA, et al. Health Affairs 2008.

Evidence Base: Community Care of North Carolina

- 34% decrease asthma admissions,8% lower ED use
- 15% increase in diabetes quality measures
- Cost to state:$8-20 Million yearly (Cost of Community Care Operations)

Savings (in $Millions)

Fiscal Year	Compared to Prior FY	Compared to FFS
03	$60	$205
04	$124	$245
05	$81	$229
06	$161	$299

Source:Dobson slide presentation: (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)

Medical Home: The Evidence Base

"Despite considerable enthusiasm favoring widespread implementation, information to date suggests that the PCMH remains a promising approach to chronic care that awaits more data. How well current and future pilots address its **definition, scalability and cost savings**, remains to be seen."

Sidorov, JE. Health Affairs 2008

Conclusions

- PCMH is designed to address problems in health care system – lack of patient centeredness, fragmentation, chronic disease management, high costs and inefficiencies
- CHC's have the foundations through their mission and service design
- NCQA standards based on joint principles and Chronic Care Model
- Requires practice transformation, payment reform/incentive alignment, measurement/transparency and quality improvement activities
- CHC's have already demonstrated skills in improvement processes
- Demonstrations and pilots across the country, public and private
- Endorsed by professional societies, purchasers, consumers, labor
- Evidence-base is awaiting evaluation of pilots

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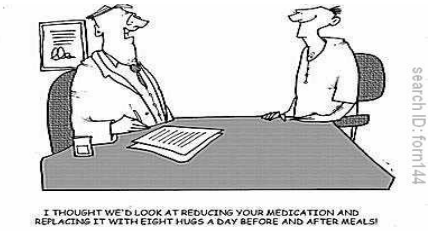

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Acknowledgements

- David Netherton, MS, MA, UMMS CommonwealthMedicine
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- Bailit Health Purchasing, Payment Models slide set, Feb, 2009 and website
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