

Summary of the National Governor's Association's Best Practices Meeting on Medical Homes

Presented by:

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System Advisory Council

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A Medical Home “System”

- We must create a system to address population needs
 - Won't get there one practice at a time
 - 99.98% of time spent outside the Dr. office
 - Need tools to manage own health
- Health System Reform vs. Health Care Reform
 - Environmental factors, Built environment, and Health System

Five Key Areas of System Development

- Forming Key Partnerships – Coordinating Body
- Defining and Recognizing a Medical Home
- Purchasing and Reimbursement
- Support for Changing Practices – Learning Collaborative
- Measuring Results

Forming Key Partnerships

- Involving providers and consumers in planning
- Working with quality improvement collaboratives
- Partnering with other payers/purchasers
 - Multi-Payer Stakeholder Collaboratives: CO, LA, ME, MI, NH, PA, RI, VT
 - State and public employees: WA, OR
 - “All-in” via legislation: MN, OR, VT

Developing and Recognizing Medical Homes

- Many will adopt or modify criteria and process in NCQA/PPC-PCMH tool: CO (adults), LA, NH, RI, VTOR wants to use Common Measures and avoid to 'burdening providers' with NCQA certification
 - Colorado (child) criteria allows providers to choose: qualify by NCQA or get certified by Medicaid annually
- Minnesota's proposed criteria include: Participating in learning collaborative
 - Use of internal registry for patient population management
 - Keeping updated care plans
 - Including patient/parent on care teams
- Oklahoma PCPs perform self audit to place themselves in 1 of 3 tiers
- PCCM contracts spell out structural components in place (NC, AL)

Developing and Recognizing Medical Homes

- Need for a standardized tool
- If payers are going to provide extra reimbursement, they need an objective determination
- Critical for evaluation across demonstration projects
- Critical for practices since practices may participate in projects for multiple payers

Purchasing and Reimbursement

- Many plan to pay PCPs fee-for-service + PMPM (some tiered) payment for care management
- Many states are implementing or developing pay for performance (some through bonus system)
- Five considering multiple structures, capitation, global fees, risk adjustment...(LA, MN, NH, OR, WA)
- Use purchasing power through health plans to increase access to medical homes (CO, OR, MN)
- Many are considering consumer incentives

Support for Changing Practices

- Provider adoption of good practices
- Learning collaboratives for practices (MN, WA)
 - In office training (CO)
- Four developing means to inform providers about their performance (CO, LA, NH, WA)
- All developing means for giving providers information about individual beneficiary needs/past utilization

Measuring Results

- State-Led Multi-Stakeholder Pilots
- RI: evaluation by Harvard School of Public Health funded by CMWF
 - Did providers adopt components of the PCMH?
 - Did the interventions have an impact on patient outcomes?
 - Are there cost savings?
- VT: evaluation by University of Vermont funded by payers
 - Cohort matched claims based evaluation
 - Clinical outcomes, health status measures, cost savings
- New Hampshire - Practice-level structure and process measures, consistent with Medicare's Physician Quality Reporting Initiative
- Washington: structure, process and outcome measures including primary care provider ability
 - Utilization changes
 - Patient experience

Pennsylvania System Model

- The Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission was established by Governor Rendell's Executive Order in May 2007.
- The purpose of the Commission is to design the informational, technological and reimbursement infrastructure needed to implement and support widespread dissemination of a combination of the Chronic Care and Patient-Centered Medical Home Models throughout Pennsylvania.
- Implementation will be incremental with regional multi-stakeholders collaboratives.

Pennsylvania Model

- Southeastern PA was the first regional rollout, starting May 13, 2008, with three two-day meetings and a year-end one-day data meeting occurring in the first 12 months:
 - 32 Practices
 - 149 Clinical FTE
 - 230,000 patients
- A second round of rollouts will include South Central, Southwestern and Northeast PA
- Total impact of the first phase includes over 500 physicians/CRNPs representing nearly 750,000 patients.
- Rollout framework has flexibility by region as determined by regional steering committee containing multi-stakeholders.
- At 18 and 36 months formal evaluations will assess whether the rollouts are achieving desired quality and cost containment goals, and whether to continue.

Pennsylvania Model

Requirements of PCP Practices

- Attend “Learning Collaborative” meetings
- Team(s) from each practice
 - Seven days in first year
 - Initial focus on diabetes and pediatric asthma
 - Work with an assigned practice coach to transform practice
- Use a patient registry (or EMR) to track patients
- Report data from the patient registry and other sources required for evaluation purposes
- Achieve Level 1 NCQA Recognition within 12 months
- Reinvest funds into the practice site, including staff and technology

Pennsylvania Model Learning Collaborative

- Action-oriented learning
- One-year process with three two-day in-person sessions and a one-day Outcomes Congress
- Teams supported by expert faculty in diabetes and asthma care, QI, IT, self-management support, co-morbid care, and topics related to the overall framework
- Sharing across teams facilitated by conference calls between sessions, listserv, websites for materials

Pennsylvania Model Requirements of Payers

- Three year commitment to fund and support
- Methodology –payments proportionate to revenue from all sources as validated and coordinated through GOHCR
- Payment to IPIP for Practice Coaches
- Payment to PCP Practices are intended to offset costs
 - Infrastructure development
 - NCQA survey tool \$80/practice
 - Data entry to registry \$800/practice
 - Office assistant \$8,000/practice
 - NCQA application fee \$360/clinician
 - Registry license fee \$275/clinician
- Time for practice team to attend learning collaborative
 - Seven days during 1st year\$11,655/team

Pennsylvania Model

Requirements of Payers

- Enhancement to current payer contractual payments
- Annual lump sum payments upon NCQA recognition up to \$4PMPM
 - Prorated for portion of year at each level of recognition
 - Prorated based on PCP/CRNP FTEs in practice
 - Discounted by % of revenue from Medicare FFS and non participating payers
- Pay-for-performance –standard process post first 3 years based on clinical, utilization, satisfaction and financial outcomes
- Negotiate as a state and not at practice level
 - NOTE: Some states REQUIRED payers to participate via legislation or Executive Order

Distinguishing Features of a MH System (Louisiana)

- Rolled out through Medicaid (50-65% Medicaid patients averaged per practice)
- State Government as *convener*
- *Multi-stakeholder participation* in design and implementation
- Transforming care for *all patients*
- Funding methodology *transparent and adequate*
- *Support* for practices
- *Scale* is sufficient to yield reliable results
- *Transferrable*

Policies that can make a difference

- Increased reimbursement for outpatient services performed by physicians and non-physicians, especially for Medicaid.
- Adequate compensation and greater value placed on cognitive services, preventive counseling, patient and family education.
- Improved reimbursement for care coordination services.
- Improved reimbursement for provision of language access services.
- Support and rewards for quality assurance and improvement efforts.
- Payment and support for implementation of health information technology infrastructure and processes.

Lessons Learned in implementation of Medical Home System

- By focusing on the most needy and relatively unmanaged recipients, you can have remarkable success in improving health outcomes and cost savings
- Don't forget about recipient turn-over. It's significant in a Medicaid population
- Program is too small if focused on just chronic disease or one small population



Questions and Discussion