Overview

- Demonstrations and Pilots:
  - North Carolina
  - Pennsylvania
  - Minnesota
  - Vermont
  - Rhode Island
  - Medicare (2010)
- Payment models
- Evidence Base
- Conclusions
Patient Centered Medical Home Demonstrations/Pilots

- Contextual framework
  - Infrastructure: integrated and enhanced primary care, community health centers, managed care reform
  - Technology: information technology

- Development
  - Data models & implementation vary
  - Develop in common direction and in unique ways

Community Care of North Carolina

- Medicaid program, established and evolving since 1996
- Includes:
  - Waivers
  - Care management, population health, quality improvement, health information technology
  - Health reform: provider payment, shared responsibility for care
  - Focus on chronic disease management: asthma, diabetes, and hypertension

- Incentives:
  - Improved care coordination
  - Increased patient satisfaction
  - Increased quality of care
Community Care Networks

- Non-profit organizations
- Include all providers including safety-net providers
- Medical management committees
- Federated networks organized by local providers, physician led
- Evidence-based guidelines adopted by consensus rather than dictated by the state
- Emphasis on health outcomes, resources for care coordination and get timely feedback on results

Intend to build local systems of care rather than just changing payment system

Community Care of North Carolina & Medical Home

Payment

- Networks receive $3.00 per pm to develop and provide +70% in needed medical services
- PCP receives $2.50 per pm to serve as medical home and to participate in Disease Management and Quality Improvement
- NC Medicaid pays 95% of Medicare FFS

Minnesota Department of Human Services

2008 Health Care Reform Act

- Develop and implement certification standards for health care homes (HCH)
- Develop payment system to implement HCH
- Per patient risk adjusted care coordination
- Focus on health outcomes
- Focus on patients with complex or chronic conditions
- Over 2 years, expand use of HCH and care coordination tools under state health care programs and private sector health coverage
- Disease-based practices through HCH collaborative
Vermont Department of Health

Medical Home Project and VDP Blueprint for Health: History
- Medical Home Implementation Project
  - The State of Vermont Medical Home Implementation Project 2008-2010
  - The State of Vermont Medical Home Implementation Project 2009-2011

Vermont Blueprint for Health (VDP): Steps with plans focusing on chronic disease management and prevention
- VDP is a collaborative, multi-stakeholder initiative with goals aimed at improving health care outcomes and reducing cost for Vermonters.
- Ultimate goal: system-wide transformation by 2011

Vermont Blueprint for Health
Integrated Medical Home Pilots

- Financial Reform
  - Payment based on VCOA
  - 2008-2010: 12-23 WPPI
  - 2009-2011: 12-23 WPPI

- Multi-disciplinary Care Support
  - Health care support & coordination
  - Prevention and health promotion

- Health Information Technology
  - EHR implementation
  - Quality improvement

- Evaluation
  - EHR data collection
  - Cost analysis

Rhode Island Chronic Case
Sustainability Initiative: CSI-RI

- All-payer, multi-payer POCM initiative
- 5 sites, all inpatient and outpatient
- 30 physicians, including PCP
- 24-hour primary care network, beginning 2008
- Focus on: CAD, diabetes, depression
- Third party evaluation: HECRI
- Use of registry data for outcome measures

Source: Deborah T. Hever
Office of the Health Insurance Commissioner, RI
CSI-Ri: Commonality Key to Implementation

1. Common Practice Sites
   - All patients will visit the same core group of provider sites in which to practice their jobs. Requires common set of practice
   - Conditions

2. Common Services
   - All patients will have access to services that are a part of the CORE Principles, even if not in the CORE Site
   - Conditions

3. Common Measures
   - All patients will agree to assess patients using the same measures, other than national measurement rate
   - Conditions

4. Compensations
   - Medical staff and nurse practitioners will be contacted across all regions.

CSI Ri: Medical Home Model

- Sites commit to establish Medical Home. Use NCQA standards. Require self-assessment progress to:
  - Level 1, 18 months in
  - Level 2, 12 months in

- Sites agree to go through training in Chronic Care Model (existing program at state level for QIO)

- Sites agree to hire and use Nurse Care Manager

Source: Christopher H. Miller
Office of the Health Insurance Commissioner, NY

CSI Nurse Care Manager

- Located within the site
- Provides services to all patients, regardless of payer
- Case Manager "collaborates" Collaboration of NCMs across sites and with Medicaid NCMs

NCM Activities:
- Initial patient assessment and risk stratify severity of chronic diseases
- Monitor and monitor medical treatment
- Gather and maintain program in medical
- Education of patient on disease and treatment
- Identify quality measures
- Assist with health system requirements
- May work alongside other representatives
CSI-Ri: Payment Model

- Current FFS model remains in place
- Monthly $3 ppm fee to each practice
- Additional allocation to support Care Managers
- Plans and providers agree to attribution methodology
- Commercial claims-based - any one with total visit to
  any in 2 year time period and morbidity at end of
  year
- No shared performance incentives

Source: Christopher F. Halen
Office of the Health Insurance Commonwealth, PA

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

2010 Objectives
- Project participation of 1,000 primary care practices and 7 million patients
- Use a electronic patient self-management tools
- Support PHR is standardized health information exchange
- Use a PHR is collaborative tools for the "Patient Centered Health Home"
- Provide patient education with clinical quality measurements of evidence-based practices
- Provide a reward and recognition program for high-performing practices

Medical Home in Massachusetts
- MassHealth/COIHI initiatives
- 2009 health care legislation
- Commercial payers: contracting
  - BCBS/MA
  - HPSI: disease specific pilots
  - QSC: required plans to include medical home demonstrations
- MA Coalition for Primary Care Reform
- Central Mass试点
High-cost/low-value with high-cost and low-value

- Build on Multi-payer Initiative at CBOs
- 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 PMPM payment (Bridges to Excellence)
7. FFS with lump sum payments, P4P and shared savings
8. Comprehensive payment with P4P

Medical Home: The Evidence Base

- Primary care-oriented health systems generate lower cost, higher quality, fewer disparities (Stafileo)
- 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, 1998)
- Medical Home
- QHealth early pilot results: 20% reduction in all cause admissions and 7% late medical cost savings
Evidence Base: Community Care of North Carolina

- 54% decrease in hospital admissions
- 15% decrease in diabetes-related hospitalizations
- Cost to states-$2.33 trillion yearly (Cost of Community Care Operations)

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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."

Sloane, J. 2006

Conclusions

- PCMH is designed to address problems in health care system – lack of patient coordination, fragmentation, chronic disease management, high costs and inefficiencies
- PCMH learns from failures and service design
- PCMH standards based on joint principles and Chronic Care Model
- Regulatory practice transforms, payment model, innovation
- PCMH is necessary to improve transparency and quality incentive
- PCMH learns from already demonstrated skills in improvement processes
- Demonstrations and pilots among the counties, public and private
- Evaluated by professional societies, physicians, consumers, labor
- Evidence-based in need of evaluation of pilots