

State Roles in Multi-Payer Medical Home Pilots

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PCMH Projects and Partners: Overview and Drawing in the Private Sector

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Function of the CMD:

Describe the activities of sites developing and implementing patient-centered medical home test projects; share information and best practices about pilots within a collaborative community; and serve as the connector to technical, quality improvement, and education resources to facilitate ongoing demonstrations.



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PCMH Pilot Report



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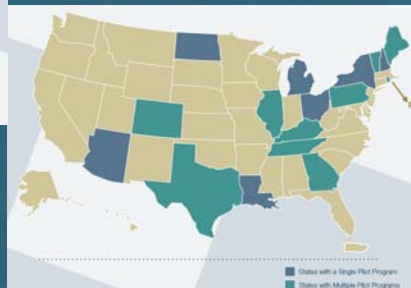


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Overview of PCMH Pilot Activity

UnitedHealth Group PCMH Demonstration Program (AZ)	CDPHP Patient-Centered Medical Home Pilot (NY)
Colorado Multi-Stakeholder Multi-State PCMH Pilot (CO)	EmblemHealth Medical Home High Value Network Project (NY)
Wellstar Health System (GA)	New York Hudson Valley p4p/Medical Home Project (NY)
Quality Quest Medical Home (IL)	Cincinnati Medical Home Pilot Initiative (OH)
Louisiana Health Care Quality Forum Medical Home Initiative (LA)	Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
Maine Multi-Payer Patient-Centered Medical Home Pilot (ME)	Southeastern Pennsylvania Rollout of the Chronic Care Initiative (PA)
Aligning PCMH Stakeholders in Michigan (MI)	Rhode Island Chronic Care Sustainability Initiative (CSI-RI) (RI)
Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)	Memphis Multi-Payer Patient-Centered Medical Home (TN)
CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)	Texas Patient-Centered Medical Home Demonstration Project (TX)
NH Multi-Stakeholder Medical Home Pilot (NH)	Patient-Centered Medical Home—Vermont (VT)
Patient-Centered Medical Home—Diabetes Management (ND)	
MediHome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative (ND)	

- 22 projects
- 16 states



- 12 are Multi-stakeholder
- 10 are Insurer-based



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Challenge: Define the Medical Home

- Recognition tool
- Independent, third party entity
- Alignment with the PCMH attributes
- Flexible
- Road map for practices to evolve over time
- Applicable to practices of different sizes



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Challenge: What Does it Co\$t?

- Varying Assumptions...
 - Future of Family Medicine 2004: Transition costs of \$23,000 - \$90,000 per physician*
 - \$15 PMPM for patients with chronic conditions
 - Ambulatory ICU: \$40-50 PMPM for primary care – but assumes more complex patients
- Deloitte Analysis**
 - Initial investment of \$100,000/FTE
 - Ongoing expenses would increase \$150,000 per year/FTE
- AMA Relative Value Update Committee (RUC)
 - Estimates of work and practice expense values of services to be provided within the Medicare Medical Home demonstration project
- ACP/Commonwealth “Costing the Medical Home Study” – Report Fall 2008
 - Assess the incremental cost of building the medical home based on NCQA PPC-PCMH framework

* http://www.annfammed.org/cgi/reprint/2/suppl_3/s31

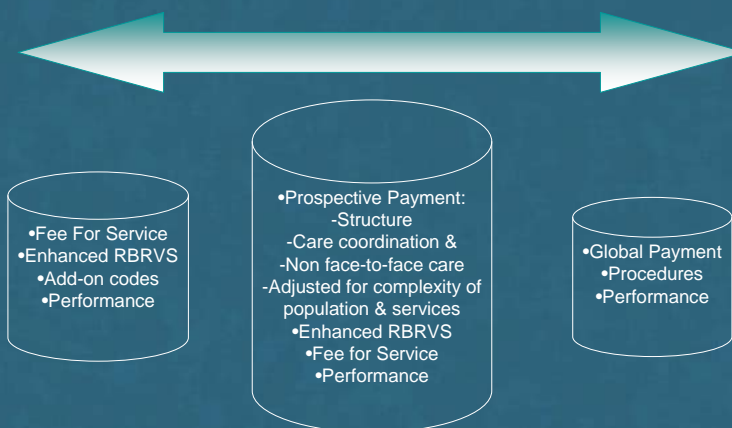
**Deloitte: The Medical Home, Disruptive Innovation for a New Primary Care Model

Accessed at: http://www.deloitte.com/dt/rca/doc/content/us_chs_MedicalHome_w.pdf



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Spectrum of Payment Models for the PCMH



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Approaches to Practice Support

- Assistance with practice assessment/gap analysis
- On-site and remote practice coaching
- Staff support
- Learning collaboratives
- Technology subsidies, advice, and training
- Distribution of toolkits and other educational resources
- Assistance with reporting and data feedback to the practices



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Why Multi-Stakeholder?

- Need: Investment in New Delivery Systems at the Practice Level (not at Health plan or Provider level) – which requires:
 - Enough market share of the participating payers/purchasers to have significant practice penetration
- Leading to: Fundamental Changes in Care Delivery (The PCMH)
- Resulting in: Improved Quality, Reduced Costs, Stronger Primary Care

Special thanks to Deidre Gifford (Quality Partners of RI) for some of the content of this slide.



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Multi-Stakeholder PCMH Projects: Who is (or should be) at the table?

- **Physician organizations** – ACP, AAFP, AAP, AOA, local medical and primary care associations
- **Providers** – physician groups, hospitals, health centers, specialists
- **Health plans** – commercial, Medicaid, SCHIP, Medicare
- **Purchasers** – employers, business groups, Chambers of Commerce
- **Consumers** – advocacy groups and consumers themselves
- **Academic and research organizations** – medical centers, universities, private research entities
- **Multi-stakeholder coalitions/initiatives** – PCPCC, regional, local
- **State and local government** – Medicaid, employee benefits offices, Governor's office, department of insurance, public health
- **Quality improvement/practice and technical support and recognition organizations** – NCQA, QIOs, IPIP, vendors, others
- **Foundations** – The Commonwealth Fund, RWJF, regional and local



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Private Sector Multi-Stakeholder PCMH Pilots Involving Medicaid

- Colorado
- Louisiana
- Maine
- New Hampshire
- Rhode Island
- Vermont



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How to Get Started?

- Evaluate Community Readiness
- Use Your Resources
- Identify Key Local and National Stakeholders
- Establish a Convening Organization
- Kick Off Meeting

Special thanks to Julie Schilz (Colorado Clinical Guidelines Collaborative) for the content of this slide—and several others included in this presentation.



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How Do You Engage Those Key Stakeholders?

- Many of them are already at the table
- Get involved with the PCPCC – Talk to others doing similar work, share what you are doing
- Reach out to the primary care societies – locally and nationally
- Use the other connections and resources you have in your state



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Major Decision Points in Defining PCMH Pilots

- Who's In
- Guiding Principles
- Study Design
- Project Goals and Expectations—Specific Measures (Quality, Cost, ROI, Provider/ Patient Satisfaction) and Data Needed
- Evaluation Plan
- Reimbursement Approach



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Major Decision Points in Defining PCMH Pilots

- Technical Assistance—Practice Redesign and Health Plan Support
- Health Plan Operational Issues
- Administrative Details
- Other Partner Sites?



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The Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission

November, 2008

The Governor's Chronic Care Initiative

- 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 the Chronic Care Model throughout Pennsylvania
- The Commission presented its Strategic Plan to the Governor and the Speaker of the House on February 13, 2008
- The Plan provides a business case and framework for implementing the Chronic Care Model across the Commonwealth
- Implementation will be incremental
- Diabetes (with co-morbidities) and pediatric asthma will be the focus of the initial rollout

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Implementation of the Chronic Care Model in PA

- Southeastern PA is 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 PA – February 11-12, 2009
 - South Western PA – March -4, 2009
 - North East PA – April 21-22, 2009
- Each regional rollout shall persist for at least three years from the start date.
- Rollout framework has flexibility by region as determined by regional steering committee
- At eighteen and thirty-six months a formal evaluation will assess whether the rollouts are achieving desired quality and cost containment goals, and whether to continue.

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Partner Organizations in SEPA Collaborative

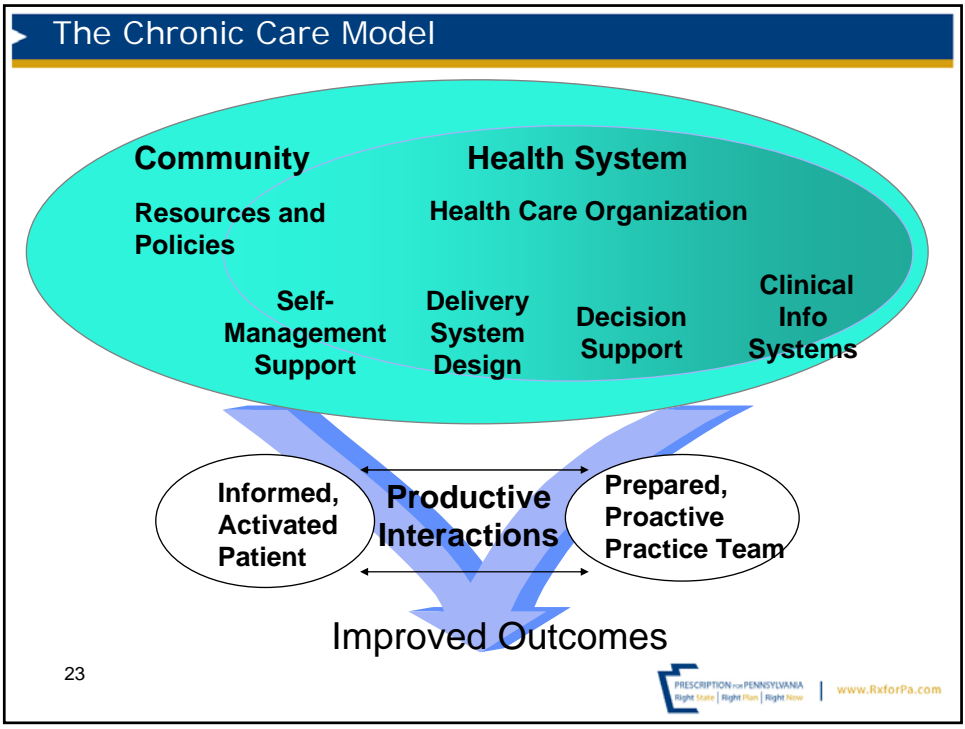
- GOHCR
- Governor's Chronic Care Commission
- Payers
 - Independence Blue Cross
 - Capital Blue Cross
 - Aetna
 - Keystone Mercy
 - Health Partners
 - Cigna
- Provider Organizations
 - Temple University Health System
 - Jefferson Health System
 - University of Pennsylvania
- Professional Organizations/Societies
 - Improving Performance in Practice (IPIP), PA
 - ABIM
 - ACP
 - PAFF

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The Chronic Care Model

- Developed by Ed Wagner, MD, MPH, Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound
- Identifies fundamental areas making up a system that encourages high-quality chronic disease management.
- Can be applied to a variety of chronic illnesses, health care settings, and target populations

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- ### The Learning Collaborative
- Action-oriented learning
 - One-year process with 3 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, listservs, websites for materials
- 24
- PRESCRIPTION in PENNSYLVANIA
Right State | Right Plan | Right Now | www.RxforPa.com

Expectations of the Commonwealth

- Provide leadership, coordination and partial funding for three, two-day Collaborative learning sessions and a one-day Outcomes Congress, a reporting structure, data analysis, marketing and promotion, technical support to teams and communication methodologies
- Create a framework that will permit payors to help practices defray the cost of transforming to the Chronic Care Model
- Provide a web-based patient registry to track a number of interventions and clinical parameters important in chronic disease management and provide alerts if there are problems
- Work with other organizations to arrange for practice coaches to assist with implementing the action steps required in practice settings

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Expectations of Clinicians

- Sign a Participation Agreement with GOHCR with a three year minimum commitment
- Apply for Patient-Centered Medical Home (PCMH) recognition from NCQA and give results to GOHCR
- Select a team of at least three people: a physician or nurse practitioner, nurse, office manager and other office staff
- As a team, participate in each of three, two-day learning sessions and a one-day Outcomes Congress
- Commit by the end of the first twelve months to attaining PCMH Level 1 certification along with the High Value Elements identified by GOHCR (PCMH Level 1 PLUS)
- Report on the required outcome measures of the Collaborative

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Integration of the Patient Centered Medical Home

- Used as validation tool to confirm practice transformation
- Incorporate additional requirements beyond NCOA scoring levels
- Recognition triggers incentive payments to practices
- Extended to nurse-managed centers as well as physician practices

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Financial Incentives

- Designed to reduce financial barriers to participation
- Incentives to include:
 - Payment for technical infrastructure and related costs
 - Payment for resources required for care management functions
 - Payment to achieve NCOA PCMH Level 1 PLUS recognition
 - Payment for NCOA PCMH Level 3 recognition
- Payments to practices will be proportionate from participating payers
- Existing P4P programs remain in place
 - By May 2010 GOHCR will establish a common set of outcome measures to be used by carrier pay-for-performance programs with participating rollout practices

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Evaluation

📌 Learning Collaborative Evaluation

- Practices report monthly
 - Data
 - Narrative
- IPIP aggregates data and provides dashboard report to collaborative members
- State Wide Collaborative Director manages review process

📌 Initiative Evaluation

- Outside firm will evaluate each learning collaborative and entire initiative
 - 18 months
 - 36 months

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Additional Information

Link to the Chronic Care Commission's Strategic Plan

<http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf>

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Evaluation of Patient Centered Medical Home (PCMH) Initiatives

Meredith B. Rosenthal, PhD
November 12, 2008

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PCMH Initiatives Are Proliferating

- PCPCC reports more than 20 private sector-initiated PCMH pilots
- Medicare demonstration
- Numerous existing and emerging Medicaid initiatives
- Very high aspirations for impact:
 - On access
 - On quality
 - On cost

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What is the Evidence Base?

- Body of literature on value of primary care (see, for example, Starfield review)
- Published studies of impact of Wagner's Chronic Care Model
- Reports of successful initiatives that shared some elements of current PCMH
 - Community Care of North Carolina
 - Geisinger Health System

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What is missing?

- Previous studies lacked standardized definition of the intervention – most initiatives are now trying to adhere to the Joint Principles and use the NCQA PPC-PCMH to measure “medical homeness”
- Rigorous attempt to isolate the impact of the PCMH from other factors: most of the current data are cross-sectional
- Answers to a much richer set of research questions

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Some Key Research Questions Current Evaluations Will Address

- Do practices that conform to PCMH criteria deliver:
 - better quality of care?
 - better patient experiences?
 - lower total cost?
 - Improved physician and staff satisfaction?
- What does it take to turn practices in PCMHs?
- Is there a business case for the PCMH – for payers? For providers?

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The Rhode Island Chronic Care Sustainability Initiative (CSI)

- Multi-stakeholder collaboration, funded by Center for Health Care Strategies: 2006-2008
- Led by RI QIO and Health Insurance Commissioner, with all RI Payers, primary care providers, large employers participating (67% of covered lives represented)
- Goal: Develop and test a sustainable model for improving delivery of primary care with focus on chronic disease

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CSI RI: Program Summary

- 2 year, all payer, all product payment pilot (Medicare Advantage pending)
- 26,000 patients, 28 providers, 5 sites in intervention group
- Practices receive care management resources, plus current FFS, plus PMPM fee to implement PCMH services
- Collect data on clinical quality, plus NCQA PPC measures. Focus on diabetes, CAD and depression.
- Practices receive PCMH training/support from outside resources

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Rhode Island Study Measure Categories

- Utilization rates and the mix of services
- Health care spending
- Clinical quality of care
- Health outcomes
- Patient experience of care
- Effects of implementation on primary care practices

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Evaluation Data Sources

- Utilization, quality, and patient experience
 - Billing data
 - Clinical registries
 - Patient survey
- Implementation
 - NCQA-PPC
 - Site interviews

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Analysis Plan

- Changes in clinical quality, utilization and costs
 - pre/post with and without comparison population
- Trends in health outcomes (e.g., HbA1c control)
 - pre/post with and without comparison population
- Comparison of patient experience
 - pilot sites vs. other practices in Rhode Island
- Qualitative assessment of implementation process, barriers, lessons, physician and staff views on the experience

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Challenges for Evaluation

- Selection of outcome measures is complicated by:
 - High level of aspirations for the PCMH
 - Differing views among stakeholders on what the PCMH should and can deliver
 - Relatively short time frame of most pilots
- Interventions will evolve as experience grows (moving target)
- Valid comparison groups may be hard to identify
- Most pilots are relatively small (Medicare, the exception)

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Selecting Meaningful Measures

- If we look for cost savings, dramatic improvements in patient experience, outcomes right away we will set unreasonable expectations
- Need a more fully developed logic model of what the PCMH implies for:
 - what physicians and other staff will do differently
 - how patients access care, manage their own health
- We need to identify “leading indicators” of beneficial changes: e.g., time to first ambulatory visit after a hospitalization

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Opportunities in the Current Landscape

- Support of PCMH by a broad group of stakeholders
- Most pilots have evaluations built in
- Evaluators have formed a collaborative under the auspices of the Commonwealth Fund
- Common measures may permit meta-analysis across pilots to increase ability to find effects
- Variety of evaluation contexts will increase generalizability of findings

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MEDICARE MEDICAL HOME DEMONSTRATION (MMHD):

OVERVIEW

Centers for Medicare &
Medicaid Services
Baltimore, MD

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Authorization

- Tax Relief and Health Care Act Balanced Budget Act (TRHCA) of 1997, Section 204
- Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, Section 133

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Specifics

- 3-Year Demonstration
- No more than 8 States
- High-Need Population
 - **Individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.**

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Demonstration Design

- Reviewed statutes, literature (especially of the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA)), and experiences of others
- CMS consulted with ACP, AAFP, and American Geriatrics Society (AGS)
- AMA/Specialty Society Relative Value Scale Update Committee (RUC) estimated work relative value units (RVUs), office expenses, and insurance costs
- Drafted MMHD design
- Drafted the Physician Practice Connection (PPC-PCMH-CMS)

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Tiered Structure

- Two tiers of medical homes
 - Tier 1: "Typical" medical home services, basic care management fee
 - Tier 2: "Enhanced" medical home services, full care management fee

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Tier 1 Requirements

- 17 required capabilities, for example:
 - Discuss with patients the role of the medical home
 - Establish written standards for patient access
 - Use data to identify/track patients
 - Use integrated care plan
 - Provide patient education/support
 - Track tests/referrals

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Tier 2 Requirements

- Tier 1 requirements
- Use electronic health record (EHR), certified by the Certification Commission on Health Information Technology (CCHIT), to capture clinical information (for example, blood pressure, lab results, status of preventive services)
- Have systematic approach to coordinate facility-based and outpatient care
- Review post-hospitalization medication lists
- 3 of 9 additional capabilities (for example, use e-prescribing, collect performance measures)

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Practices That Start as Tier 1 Can Later Apply for Tier 2

- Practices that choose to qualify as Tier 1 initially may still apply to qualify as Tier 2 practices in subsequent years
 - Complete the PPC-PCMH-CMS
 - Provide documentation of Tier 2 capabilities
- Applications accepted Oct. – Nov. 2010 and Oct. – Nov. 2011
- Implementation contractor will review the additional documentation in December of the year of submission
- Once Tier 2 qualification is established, the practice can receive the Tier 2 care management fee

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Which Practices Are Qualified?

- Physician-Based practice
- Must be able to provide medical home services
 - Oversee development & implementation of plan of care
 - Use evidence-based medicine & decision-support tools
 - Use health information technology to monitor & track health status of patients
 - Encourage patient self-management Capabilities qualify as Tier 1 or Tier 2 as measured by PPC-PCMH-CMS Version

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Which Physicians Are Eligible?

- Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) practices providing ambulatory health care, including federally qualified health centers (FQHCs) and small-, medium-, and large-sized practices
- MD/DO board-certified
- Provide first contact and continuous care
- Eligible: General internist, family practice, geriatrics, most other specialties
- Not eligible: Radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, chiropractors, psychiatry, and surgery

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Which Patients are Eligible?

- Medicare fee-for-service beneficiaries
- At least one eligible chronic condition (86% of beneficiaries)
 - Refer to adapted Hwang et al. list (*Health Affairs* 2001) on CMS website
- At Enrollment:
 - Part A and Part B coverage
 - Not in:
 - Medicare Advantage
 - Hospice
 - Long-term nursing home
 - Treatment for end-stage renal disease
 - Another Medicare demonstration

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Location and Sample Size

- 8 sites (A site is a state or a part of a state.)
 - CMS has not yet selected the sites
 - Will include urban, rural, medically underserved sites
- Sample across all 8 sites (not each site):
 - 400 practices
 - 2,000 physicians
 - 400,000 Medicare beneficiaries

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What Are the Benefits to Practices?

- Care management fee
- Share in savings
- Ability to provide better quality care to patients
- Improved practice work flow
- Improved job satisfaction

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What Is the Care Management Fee?

- Based on RUC work RVUs, practice expenses, and insurance
- In addition to activities already reimbursed by Medicare
- Risk-adjusted, based on hierarchical condition categories (HCC) score of the patient

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What Is the Care Management Fee?

Per Member Per Month Payments			
Medical Home Tier	Patients with HCC Score <1.6	Patients with HCC Score ≥1.6	Blended Rate
1	\$27.12	\$80.25	\$40.40
2	\$35.48	\$100.35	\$51.70

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Comments and Additional Questions

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