Overview of Medical Home Projects and Demonstrations to Date

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Medical Home Projects and Demonstrations

- There has been a tremendous amount of activity in the past few years to test the PCMH concept.
- This presentation reviews the framework of a sample of some of the first initiatives across eight states:

North Carolina
New Jersey
Pennsylvania
Rhode Island
New York
Colorado
Vermont
Michigan

Community Care of North Carolina

- Origins: Small rural practices linking with local hospital and other safety net providers to form Medical Home Network.
- Later: Statewide Medicaid managed care program in all regions of the state and serving all women, children and persons with disabilities.
- Not designed as a Medical Home initiative, per se, but now considered to be one of the first and longest standing demonstrations,

Community Care of North Carolina

- Practice requirements include:
  - Create a medical home
  - Give data to the state
  - Address four quality improvement program areas:
    - disease management;
    - high-risk and high cost patients;
    - pharmacy management; and
    - emergency department utilization
  - Use local network funds to support local case and disease management activities (e.g., initially case managers, then also clinical pharmacists)

- Payment Model: payments made to both providers & networks = $5.50 PMPM (larger for population of persons with disabilities)
  - $2.50 is paid to the PCP
  - $3.00 goes to the network (for case managers, clinical pharmacist)

Community Care of North Carolina continued

- Started in 1998
- Participating: 13 networks -- 3000 Physicians
- Internal and Family Medicine, Pediatrics
- Medicaid program statewide
- Project Evaluation: Mercer Human Resource Consulting Group -- documented savings of $124M when compared to anticipated program costs in SFY04 if no program existed.

Horizon BCBS of New Jersey continued

- State of NJ Health Benefits Program focused on employees and dependents with diabetes in partnership with Partners in Care, an MSO owned by United Medical Group
  - Began as a single insurer initiative
  - Now a multi-payer initiative
- Practice Transformation Support: Practices receive consultative support from Partners in Care nurses, physicians & administrative staff
  - Complement to Horizon's disease management program
- Payment Model: Practices paid for additional time spent performing tasks associated with medical home (e.g., chart review when apt is not scheduled; MD-MD call regarding referral; office staff follow-up with patients that have not received ordered tests, etc.). Paying for additional codes, rather than a case management fee.

Horizon BCBS of New Jersey continued

- Started 2007 as a 1 yr pilot; subsequently expanded
- Participating: > 400 practices and 8,000 patients
- 30,000 covered lives

- Project Evaluation: Third party evaluation planned
  - One-year pilot substantially increased compliance with several key evidence-based care measures and preliminary results indicated medical cost reductions

Pennsylvania Chronic Care Initiative

- Initiative of the Governor, his Chronic Care Commission and the Governor's Office of Health Care Reform, with strong collaboration by providers, payers and physician professional organizations. Four planned regional rollouts of the Chronic Care Initiative to date:
  - Implemented: Southeast (5/08), South Central (2/09)
  - Planning in progress: Southwest, Northeast

- Summary: The Chronic Care Commission called for implementing the Chronic Care Model, developed by Dr. Ed Wagner and colleagues in Seattle across the Commonwealth. The initiative incorporates the NCQA PPC-PCMH standards as a validation tool that practices are transforming their care delivery to effectively manage chronically ill patients.

Pennsylvania Chronic Care Initiative continued

- Practice Transformation Support: Partnered with the PA chapter of Improving Performance in Practice (IPIP) to provide practice coaches and a patient registry to the practices. State plans and staffs an IHI-model learning collaborative.

- Payment Model: Varies by region. Payments are made for Year 1infrastructure costs and in recognition of achievement of PPC-PCMH Levels 1(+), 2 and 3 (except in the Northeast).

Pennsylvania Chronic Care Initiative continued

- Initial 3-year implementation -- started 5/08 in Southeast
- Participating: 32 Practices -- 149 clinician FTEs (SE); 21 Practices – approx. 70 clinician FTEs (SC)
- Internal and Family Medicine, Pediatrics, NPs
- Commercial, Medicare Advantage, Medicaid Managed Care

- Project Evaluation: RFP to be released, 3/09

- Types of Data to be Collected: Clinical Quality, Cost, Utilization, Patient Experience/Satisfaction, Provider Experience/Satisfaction
- Additional efforts at spread already underway

Rhode Island Chronic Care Sustainability Initiative (CSI-RI)

- Broad multi-stakeholder process, funded by a grant from the Center for Health Care Strategies to the RI Office of the Health Insurance Commissioner, who has served as facilitator.

- Like PA, based on Chronic Care Model. Practices report quarterly from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease and depression

- Practice Transformation Support:
  - Insurers funding for a dedicated, on-site nurse care manager for each pilot site who will see patients of any/all insurers.
  - Quality Improvement Organization and Dept. of Health providing practice training and mentoring for nurse care managers.

Rhode Island Chronic Care Sustainability Initiative (CSI-RI) continued

- Payment Model: FFS with enhanced PMPM payment for PCMH structural measures and for performance on 10 HEDIS measures
  - $3 PMPM for all patients utilized a standardized patient attribution methodology
  - direct-to-practice payments for Nurse Care Manager salary and benefits. Pilot sites reimbursed by the health plans for the services of a Nurse Care Manager:
    - who will be an employee of the practice,
    - be based in the practice and will see patients of any and all insurers.

Rhode Island Chronic Care Sustainability Initiative (CSI-RI) continued

- 2 year pilot – started 10/1/08
- Participating: 5 Practices - 28 Physicians (3-8 MDs per practice)
- Internal and Family Medicine
- Commercial, Medicare Advantage, Medicaid Managed Care, Medicaid PCCM -- 28,000 Covered Lives (All RI payers except FFS Medicare)

- Project Evaluation: Meredith Rosenthal, MD, MPH and Eric Schneider, MD Harvard School of Public Health

- Types of Data to be Collected: Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction
- Insurance Commissioner proposing expansion to additional practices in 2008 as part of a broader initiative to support state's primary care infrastructure as a strategy for reducing health care costs

New York Hudson Valley P4P/Medical Home Project (THINC RHIO P4P)

- NYSDOH P4P grant, THINC RHIO matches health plans dollar for dollar to a total of $1.5 million dollars. Multiple health plans servicing the Hudson Valley.

- Summary:
  - Facilitates EHR implementation in offices practices of the Hudson Valley, with interface with regional HIE.
  - Uses standardized measures to provide performance incentives from multiple payers
  - Financial incentive for private practice physicians who reach Level II of NCQA's PPC-PCMH standards

- Practice Transformation Support
  - Funding from RHIO supplements physician EMR subscription fees to cover basic EMR costs (e.g., software, maintenance, implementation, training, etc.).
  - RHIO and PO both provide funding to cover transformation services and support provided by MedAllies, MassPro, IPRO, and TransforMED.
  - PO covers NCQA fees and provides administrative support.

New York Hudson Valley P4P/Medical Home Project (THINC RHIO P4P) continued

- Payment Model: Maximum bonus amount for the total pool of participating physicians will be $3 million dollars. Incentive payments include two components:
  - (1) process and outcomes measures derived from aggregated administrative data received from all health plans participating in the project (20%) and
  - (2) structural component determined by achieving Level 2 Medical Home recognition using the NCQA PPC-PCMH assessment tool (80%)

New York Hudson Valley P4P/Medical Home Project (THINC RHIO P4P) continued

- 5 year pilot - started in 2008
- Participating: 100 to 500 Physicians (avg. 4 MDs per practice)
- Internal and Family Medicine, Pediatrics
- Commercial, Medicare Advantage, Medicaid Managed Care – approx. 1 million covered lives

- Project Evaluation: Weill Cornell Medical College -- Clinical data will be collected from EMR and chart reviews. Utilization data will be derived from aggregated claims data. Patient and provider surveys will be done throughout the evaluation.

- Types of Data to be Collected: Clinical Quality, Cost, Patient Experience / Satisfaction, Provider Experience / Satisfaction

Colorado Multi-Stakeholder Multi-State PCMH Pilot

- Colorado partnering with the Health Improvement Collaborative of Greater Cincinnati in Ohio for a coordinated evaluation

- Practice Transformation Support:
  - Colorado Clinical Guidelines Collaborative provides technical assistance to support pilot practices to achieve NCQA PPC-PCMH Certification and “Medical Homeness”
  - Quality Improvement Coach (QIC) provide practice level support to help practices implement consistent and reliable processes. Methods and support tools utilized include the Chronic (Planned) Care Model, Lean Training Principles and the Model for Improvement
  - Learning Collaborative Sessions will supplement In-Office Coaching. This model is consistent with the framework of the National Improving Performance in Practice (IPIP) Program

- Payment Model: Three-Tiered Reimbursement Methodology: FFS, Care Management Fee which increases with higher levels of NCQA PPC-PCMH achievement payment begins at Level I, and P4P bonus

Colorado Multi-Stakeholder Multi-State PCMH Pilot continued

- Kick-off 1/09
- 16 practices with 17 sites (2-5 providers per practice)
- Internal and Family Medicine
- Commercial, Medicare Advantage, Medicaid Managed Care -- 30,000 Covered Lives

- Project Evaluation: Meredith Rosenthal, MD, MPH, Harvard School of Public Health
  - A Matched Comparison Group Methodology will be used to evaluate the effectiveness of PCMH qualities on cost, quality and satisfaction for both provider office and patient

- Types of Data to be Collected: Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

Vermont Blueprint for Health

- "Systems-based approach to health care transformation"
  - Integrated approach involving three commercial payers, state health benefit programs, Department of Health, consumers, employer groups, and providers
- Participating practices in each community will be provided with the infrastructure and financial incentives to operate a Patient-Centered Medical Home
- Pilot practices will operate with enhanced payment based on meeting nationally recognized quality standards, local multidisciplinary care support teams including prevention specialists, a web-based clinical tracking system with eRx, and a health information exchange
- Costs for these pilots will be shared, testing a public-private approach

Vermont Blueprint for Health continued

- Patient Centered Medical Home (PCMH)
  - **Physician, Nurse Practitioner, Physician Assistant, Staff**
- Multidisciplinary care support teams (Community Care Teams)
  - **Nurse Practitioner, RN, MSW, Dietician, Behavior Specialist, Community Health Worker, VDH Public Health Specialist**
  - **Local care support & population management**
  - **Prevention specialists**
- Community Activation & Prevention
  - **Prevention specialist as part of the CCT**
  - **Community profiles and risk assessments**
  - **Evidence-based interventions**
- Practice Transformation Support: Health Information Technology
  - **Web-based clinical tracking system (DocSite)**
  - **Visit planners and population reports**
  - **Electronic prescribing**
  - **Health information exchange network**

Vermont Blueprint for Health continued

- Payment Model:
  - Payment based on NCQA PPC-PCMH standards, using a sliding scale point system
  - Shared costs for Community Care Teams
  - Medicaid and commercial payers
  - Blueprint is subsidizing Medicare

Vermont Blueprint for Health continued

- Integrated pilots in three communities (two operational so far)
- Non-integrated pilots in three other communities (no CCT or enhanced payment)
- Internal and Family Medicine, Pediatrics

- Project Evaluation:
  - NCQA PCMH score (process quality)
  - Clinical process measures
  - Health status measures
  - Multi-payer claims database-derived measures

- Types of Data to be Collected: Clinical Quality, Patient Experience/Satisfaction, Provider Experience/Satisfaction

BCBS Michigan Physician Group Incentive Program (PGIP)

- BCBSM uses incentives, aggregated among physicians in POs, to support infrastructure development, allowing each PO, and each physician office, to build component capabilities of the PCMH model as best they see fit, given the state of their own practice at the outset. As physicians' offices reach a reasonable minimum level of capability with regard to PCMH domains of function, then BCBSM begins to alter payment.

- Practice Transformation Support: Learning collaboratives for providers

- Payment Model:
  - BCMSMI pays T-Codes for practice-based care management, including: services by RN, dietitian, diabetes educator, MSW, clinical pharmacist, or respiratory therapist, and patients with care plan in medical record and diagnosis of persistent asthma, COPD, HF, diabetes, CAD, or major depression.
  - In mid-2009, BCBSMI will begin implementation of differential E&M reimbursement (10% higher) for practices that meet criteria for BCBSMI designation as a Basic PCMH.

BCBS Michigan Physician Group Incentive Program (PGIP)continued

- Pilot started in 2005 and initiative continues in expanded form
- Participating: 35 Practices & 6471 Physicians (focused on POs)
- Internal and Family Medicine, Pediatrics, Other
- Commercially insured population
- Project Evaluation: University of Michigan Center for Healthcare Research & Transformation
  - Effectiveness measured by increased access to care/decreased fragmentation of care, reduced cost and use, improved health care processes and outcomes, increased satisfaction (patients/providers

- Types of Data to be Collected: Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction)

Summary

- These examples represent some of the earliest efforts. Many additional models are in development.
- Models are continuing to be refined in many ways, e.g.,
  - Supporting practices with patient information to help them achieve their objectives
  - Changing care for all, but targeting care management
  - Shared savings
- The large number of initiatives provide a great national learning opportunity.