Missouri's Medical Home: Background and Considerations

MO HealthNet Oversight Committee

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Goals for Today

Review elements of envisioned medical home model.

Will not discuss in detail today the concurrent model for DMH-affiliated entities

Lay out the basic structure Missouri is planning based upon Section 2703 of the Affordable Care Act (ACA).

Open discussion, questions, next steps

Our Over-Arching Goals

- Support high quality, cost-effective primary care for those with chronic conditions
- Financially support transformation of primary care practices
- Build on principles of team-based care
- Help support partnerships among providers, patients, and families

Our Strategic Goals

- Maximize federal match from new funding streams in order to support primary care.
- Develop basis for future multi-payer collaborations driven by new payment models
- Develop experience in preparation for development of ACO opportunities

Anticipated Elements at the Practice Level

- Personal physician
- Expanded access – open scheduling, after-hours availability, alternative communication tools
- Team practice – at the **Practice Level**
- Coordinated care
- Health IT and analytical tools – must have EHR
- Practice coaches
- Learning collaboratives

Section 2703 Summary

- Under the ACA, by mid-2011, states can apply for federal funding to provide “health homes” to Medicaid participants with chronic illnesses.
- Eligible for 90% Federal funding for two years for defined medical home related services
- Our model subject to CMS approval – under construction

Section 2703
Healthcare Home Components

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care including follow-up from inpatient and other settings
- Patient and family support
- Referral to community and support services
- Use of health information technology to link services

Eligible Individuals

- Covered by Medicaid
- Persons with two chronic conditions
- Persons with one chronic condition who are at risk for a second chronic condition
- Persons who have one serious and persistent mental health condition
- Potential to include managed care patients

Chronic Conditions

- Serious Mental Health Conditions
- Substance Use Disorders
- Asthma
- Diabetes
- Heart Disease
- Overweight (BMI>25)
- Developmental disability
- Smoking or diabetes as “at risk of” triggers

Key Parameters of the Statute

- Hospital Referrals. Hospitals must establish processes to refer eligible individuals who seek treatment in a hospital emergency department to designated health home providers
- Coordination. Must coordinate treatment between physical health and substance abuse and mental illness
- Monitoring.
  - States must track avoidable hospital readmissions and calculate savings, same for ED visits.
  - Proposal for use of HIT to improve coordination and care management.

One View of Structure

- Eligible entities identified based on interest, experience, Health IT capability, sufficient Medicaid volume, and sufficient chronic illness burden
- “Start-up” seed funding to each site
- Monthly administrative PMPM base payment
- Performance PMPM for sites that hit benchmarks.
- Ongoing monitoring of outcomes with range of both incentives and disincentives based on performance.
- **Program will not change existing reimbursement for regular office visits and procedures**
  - **Pays a “wrap-around” payment for additional care manager(s) for patients with chronic disease.**

Federal Matching Opportunities

Note Only for Medicaid-covered Patients

- 10% state match earns 90% federal match
- Opportunity to maximize federal participation using Intergovernmental Transfers (IGTs)
- Key point – payments made direct to outpatient primary care provider (physician or clinic)

Provider certification process

- **NCQA**
  - Full price: $500 per physician, max of $3k for practice.
  - Discounts for grouped applications: $400 per physician if jointly sponsored and $250 per physician if jointly owned—max of $1500 per practice for multiple practices under joint ownership.
  - May be special pricing arrangements to come under 2703.

How NCQA Defines Medical Home

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	4
B. **Uses data to show it meets its standards for patient access and communication****	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	6
E. **Uses data to identify important diagnoses and conditions in practice****	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. **Actively supports patient self-management****	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. **Tracks referrals using paper-based or electronic system****	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. **Measures clinical and/or service performance by physician or across the practice****	3
B. Survey of patients' care experience	3
C. **Reports performance across the practice or by physician ****	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

NCQA Measuring quality. Improving health care.

NCQA “Must-Pass” Elements

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management Support
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement

Patient Assignment

- Give patients an opportunity via mail to select health care home with provisional assignment based on claims history. If no selection is made, auto-assignment.
- Patients will have ongoing choice of health home
  - What elements of "lock-in" are needed from provider perspective?

- We are proposing for CMHCs to be health home for patients with serious persistent mental illness

- Practices need capacity to take referrals from hospital emergency departments.
- Hard to reach patients:
  - How can we support clinic-hospital communication?
  - What best practices and resources will support practices to engage hard-to-reach patients?

Cost Modeling

- Detailed Analysis not Performed yet pending CMS Guidance as to Allowable Spend
- Oklahoma paying about $3-$9 PMPM based on clinical status.
- Pennsylvania paying $1.50 PMPM plus shared savings—for all patients.
- We are open to going higher on PMPM if it is tied to high-cost patients and accountability for outcomes.
- We need to discuss cost of care management elements.

Outcomes Measures

- CMS-demanded Emphasis on outcomes and not just process.
- Statute requires measurement of avoidable hospitalizations and ED utilization.
- Measures with emphasis on primary care outcomes and common chronic disease management:
  - HEDIS measures well-validated
- MO HealthNet Performance Improvement Committee identified set of measures tied to diagnosis—on next slide.

Sample Clinically Important Measures

1. Use of Inhaled Corticosteroids in asthma and COPD.
2. Use of ARB or an ACEI in CHF
3. Use of Beta Blockers in CHF
4. Lipid profile for CAD
5. Statins for CAD
6. Attempt to Step-down H2A or PPI Therapy for GERD.
7. HbA1c performed for diabetics
8. Retinal Exam performed for diabetics
9. Microalbumin performed for diabetics

Capturing Cost Outcomes

- Important to not only measure cost outcomes for individuals identified as high cost.
- Discussion: how to capture valid pre vs. post cost outcomes.
  - For Performance PMPM or shared savings calculation
  - For CMS-contracted external program evaluation

Reality Check

- We see Section 2703 as a great opportunity to aid a number of practices and clinics reach medical home goals
- We Have Limited Funds with Which to Work
- All Stakeholders will Need to Demonstrate an “all-in” Commitment
- Conversion of a practice site to medical home by any definition is:
  - Hard work
  - Costly
  - Requires significant workflow restructuring
  - Strong clinical leadership

Timeline – Pending CMS Guidance

August 2010 to present: Internal planning and Stakeholder Consultation.

June 2011: Specific plan completed and announcement made to state primary care practices, including application

July 2011: State plan submitted to CMS

July-August 2011: Application evaluation, interviews, final selection

September 2011: Selected practices notified

December 2011: Initial Learning Collaborative