Medical Homes: Building Blocks to Health System Reform

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NASHP

- 26-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues
Where do you want to go?

Background Image by Dave Cutler, Vanderbilt Medical Center (http://www.mc.vanderbilt.edu/lens/article/?id=216&pg=999)
Patient Centered Medical Homes

Key model features:

- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Practice teams
- Health Information Technology
- Data & feedback
- Practice Education

Graphic Source: Ed Wagner. Presentation entitled “The Patient-centered Medical Home: Care Coordination.” Available at: www.improvingchroniccare.org/downloads/care.coordination.ppt
Practice Level Transformation

- Laying the foundation
  - Committed and aligned leadership
  - Effective strategy for quality improvement
- Building relationships
  - Linking patients to providers and teams
  - Supporting team based relationships
- Changing care delivery
  - Organized, evidence-based care
  - Patient centered interactions
- Reducing Barriers to Care
  - Enhanced access
  - Care coordination
Making medical home payments (29)
Payments based on provider qualification standards (27)
Payments based on provider qualification standards, making payments in a multi-payer initiative (18)
Participating in MAPCP Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)
Participating in CPC Initiative (7: AR, CO, NJ, NY, OH, OK, OR)

As of September 2013

http://www.nashp.org/med-home-map
### Select Care Coordination Payments to Providers in Multi-Payer Medical Home Initiatives

<table>
<thead>
<tr>
<th>State Initiative</th>
<th>Per member per month range</th>
<th>Adjusted for Patient Complexity or Demographic</th>
<th>Adjusted for Medical Home Level</th>
<th>Lump Sum Payment</th>
<th>Financial Incentive Based on Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL (n=9)</td>
<td>$1.20 - $79.05</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>6</td>
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<tr>
<td>Maine*</td>
<td>$6.95 - $7.00</td>
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<tr>
<td>Maryland</td>
<td>$3.51 - $11.54</td>
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<tr>
<td>Massachusetts</td>
<td>$2.10 - $7.50</td>
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<tr>
<td>Michigan*</td>
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<tr>
<td>Minnesota</td>
<td>$10.14 - $79.05</td>
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<tr>
<td>North Carolina</td>
<td>$2.50 - $5.00</td>
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<tr>
<td>Pennsylvania</td>
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<tr>
<td>Rhode Island</td>
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<td>$1.20 - $2.39</td>
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</tbody>
</table>

* Michigan: Payments to Provider Organizations; pass-through to practices that employ care coordinators.
Maine: Commercial insurer PMPM rates unavailable.
Multi-disciplinary teams

Expanding PCMH to make room for new services

Key model features:

- Practice teams—often shared among practices
- Payments to teams and qualified providers
- Patients and families “on the team”
- Teams are based in a variety of settings
Medicaid Supporting Shared Practice Team Models

As of September 2013

- **Green**: Shared Practice Team Programs (9: AL, ME, MI, MN, MT, NY, NC, OK, VT)
- **Yellow**: Planning Activity (3: IA, MD, RI)

Building “Health Home” Neighborhoods using ACA Sec. 2703
## Medical Homes vs. Health Homes

<table>
<thead>
<tr>
<th>Medical Homes</th>
<th>2703 Health Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Designed for everybody</td>
<td>❖ Designed for eligible individuals with a serious mental illness and/or specific</td>
</tr>
<tr>
<td>❖ Primary care provider-led</td>
<td>chronic physical conditions</td>
</tr>
<tr>
<td>❖ Primary care focus</td>
<td>❖ Primary care provider is key, but not necessarily the lead</td>
</tr>
<tr>
<td>❖ No enhanced federal Medicaid match</td>
<td>❖ Focus on linking primary care with behavioral health and long-term care</td>
</tr>
<tr>
<td></td>
<td>❖ Eight-quarter 90 percent federal Medicaid match</td>
</tr>
<tr>
<td></td>
<td>❖ Significant increase in financial support to providers</td>
</tr>
</tbody>
</table>
ACA Section 2703 Health Home Activity

As of June 2013

- **Blue**: Approved State Plan Amendment(s) (12)
- **Orange**: Planning Grant (17)

*Note: States with stripes have both*

http://www.nashp.org/med-home-map
Integrated/accountable care health system models

Key model features:
- High-performing primary care providers
- Emphasis on coordination across providers in the health care system
- Shared goals & risk
- Population health management tools
- Health information technology & exchange
- Engaged patients
State Innovation Models (SIM) Initiative

Model Testing Grants (6)
Model Pre-Testing Grants (3)
Model Design Grants (16)
Oregon Coordinated Care Organizations (CCOs) Payment Model

- Authorized by the legislature in 2012 via SB 1580
- 15 CCOs are operating in communities in Oregon
- Each CCO receives a *fixed global budget* for physical/mental/ (ultimately dental care) for each Medicaid enrollee
  - CCOs must have the capacity to assume risk
  - Implement value-based alternatives to traditional FFS reimbursement methodologies
- CCOs to coordinate care and *engage enrollees* & providers in health promotion
- Meet key quality measurements while reducing spending growth by 2% over the next 2 years

What have we learned? What role can you play?

- Embedded nurse care managers = secret sauce
- Practice transformation takes time and resources
- Data challenges are significant
- States have demonstrated a commitment and a unique role in advancing primary care
- Models are not static, status quo not an option
- Legislation works; leadership cannot be underestimated
- Cost savings are uncertain for now, budget neutrality is often the goal
- Public-private partnerships are critical
- Time is now!
For More Information

Please visit:

- www.nashp.org
- www.nashp.org/med-home-map
- www.nashp.org/state-accountable-care-activity-map
- www.statereforum.org
- www.pcpcc.net