



Medicaid Medical Home Initiatives and the Role of Health Information Technology (HIT)

Presented by:

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Overview

- Introduction to CHCS
- Primary Care Crisis in Medicaid
- Medical Home Efforts in Medicaid
 - Role of Health Information Technology (HIT)
 - Success Factors for Medical Home Efforts
- Emerging Opportunities to Leverage HIT and Invest in Primary Care

CHCS Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

Our Priorities

- Enhancing access and coverage to services
- Improving quality and reducing racial and ethnic disparities
- Integrating care for people with complex and special needs
- Building Medicaid leadership and capacity



Primary Care Crisis

- Primary care crisis persists
 - Primary care providers (PCPs) face an increasingly large patient panel
 - Aging population; escalation of chronic conditions; and increased utilization of preventive services
 - Shortage of PCPs
 - Fewer medical students entering primary care
 - Lower income, greater stress, and higher burnout for PCPs
 - “Hamster-wheel” environment for PCPs with 15 minute, fee-for-service (FFS) visits
- Primary care crisis may be more acute in Medicaid

Changing Environment and the Medical Home

- **Changing primary care practice environment increasingly means practices must meet growing expectations for efficiency, quality, and vitality**
 - Improving care requires improving systems of care (not just “working harder”)—need to tap into HIT resources to do so
 - Systems with strong primary care yield lower costs and higher quality*
- **Medicaid is deploying supports to the point of care to help create transformation to medical homes**

*Starfield, B. et al. Contribution of primary care to health systems and health. Milbank Quarterly 2005; 83:457-502.

Practice Supports for Medical Homes

<u><i>Practice Support</i></u>	<u><i>Description</i></u>
Leadership and Change Management	Coaching and mentoring to depart new skills
HIT	Implementing e-RX, registries, EHRs
Chronic Care Education	Implementing practice-based chronic care tools
Enhanced Payment	Providing up-front enhanced payment
Social Network	Facilitating new social linkages
Data	Providing aggregate and member-level health plan data
Nurse Care Manager	Deploying practice-based care manager
Practice Facilitator	Deploying practice-based quality improvement facilitator

Medical Home and the Role of HIT

- **Adoption and use of HIT(e.g., registries, EHRs, and electronic data exchange, aggregated data warehouses) can help drive success of medical home efforts by**
 - collecting, tracking, and reporting performance information;
 - identifying “missed opportunities” in care;
 - managing and coordinating care of the patient panel;
 - guiding evidence-based decision-making at the point of care;
 - facilitating population-based care;
 - fostering a culture of quality improvement; and
 - spreading use of best practices in care.

Medical Home Efforts in Medicaid

- **Numerous medical home demonstrations across the country**
 - Since 2006, more than 30 states have initiated demonstrations for Medicaid/CHIP beneficiaries.*
 - States are using their purchasing power to promote medical homes among health plans, the private sector, and multipayer collaboratives.
 - Primary Care Case Management Programs (OK)
 - Multiplan Programs (MI)
 - Individual Plan Programs (numerous)
 - Multipayer Programs (ME, RI)
 - Other Programs (NY PCIP)
- **Almost all demonstrations promote adoption and use of HIT.**

*Kaye, N. and Takach, M. Building medical homes in State Medicaid and CHIP programs. 2009. Portland, ME: National Academy for State Health Policy. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Jun/Building%20Medical%20Homes%20in%20State%20Medicaid%20and%20CHIP%20Programs/medicalhomesfinal_revised.pdf. 13 Jan. 2010

PCCM Programs

- **Oklahoma**
 - SoonerCare Choice beneficiaries served by a medical home with a primary care provider
 - Health Management Program (HMP) initiated in 2008
 - “Dual-armed” program: (1) care for high-risk SoonerCare members with chronic conditions; and (2) care delivery redesign at the practice site
 - Adoption and demonstrated use of clinical measures in Care Measures registry is cornerstone of the HMP—first steps towards transformation
 - Practice support is staged and incented:
 - Stage 1: Practice facilitation engagement and assessment (\$500)
 - Stage 2: Pay for reporting via Care Measures registry
 - Stage 3: Pay for improvement

Multiplan Programs

- **Michigan**

- Collaboration between Medicaid agency and six Detroit-based Medicaid health plans to
 - Support six small, high-volume Medicaid practices.
 - Assess practices' needs, challenges, and priorities, including HIT.
 - Help practices select and implement a registry to measure and improve patient care.
 - Designate quality improvement (QI) coaches who help populate registry, interpret results, and develop process for ongoing use.
 - Provide financial support to practices interested in becoming patient-centered medical homes.
- Struggle to provide the practices with sufficient support around “nuts and bolts” of registry technology

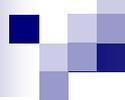
Multipayer Programs

- **Maine**

- Regional QI coalition leads multipayer medical home pilot, collaborating with Medicaid, Medicare, and private health plans.
- Payment model includes: (1) continued FFS payments; (2) up-front PMPM care management fee to practices; and (3) payment contingent on performance using NCQA PCMH recognition standards.
- Intervention strategies for practices
 - PCMH learning collaborative
 - External one-on-one QI coaches for practices
 - Technical assistance from contracted experts for targeted key areas, including HIT
 - Claims-based quality and resource use feedback reports to practices.

Other Programs

- **New York Primary Care Information Project (PCIP)**
 - The program supports the adoption and use of EHRs among PCPs in NY City’s underserved communities through a wide-range of services.
 - *“In order to achieve greater health, simply adopting EHRs is not enough... We have to reorient our technology, our care, and our billing system toward an agenda of prevention, with special emphasis on the clinical interventions that have the greatest potential to save lives.” –PCIP Website*
 - Services that the PCIP team provide include
 - Implementation team that helps providers to successfully implement EHRs by sharing best practices in IT.
 - “Super-user” consultants available to maximize efficiency of office operations.
 - Shared network of quality improvement specialists who visit participating practices roughly every 4 to 6 weeks and provide practices with assistance in achieving: (1) workflow redesign; (2) disease-specific quality improvement; (3) office transformation; and (4) PCMH certification.



Role of HIT in Successful Medical Homes

- Sufficient support during selection, implementation, and ongoing maintenance of HIT is critical
 - Particularly during first 6 to 12 months
- Adoption of HIT critical for transformation
 - Can it trigger “conversion”?
- Consolidation of experts deployed to practices
- Medical home practices better positioned for EHR adoption and meaningful use

Evaluating the Impact of Medical Home Efforts and Role of HIT

- **How to move the medical home beyond demonstrations/pilots and disseminate the model among practices on a national level?**
 - Need to build the case for the medical home.
 - Collect data across a strategic set of performance metrics to track and evaluate the impact of medical homes, including
 - Quality/health outcomes measures (e.g., HEDIS, CAHPS)
 - Costs (e.g., input expenditures for program activities)
 - Utilization data (e.g., ED use, inpatient hospitalization, readmissions).
 - Can use such data to conduct return-on-investment (ROI) analysis to compare the economic costs and benefits of medical home programs.
- **HIT will play an important role in evaluating the impact of the medical home.**
 - Practice level, at the point of care, EMRs/EHRs and patient registries to track patient outcomes and care processes
 - State level, for electronically reporting data to CMS and making the case for sustainable financing for medical home efforts

Health Homes: Emerging Opportunity in Health Reform to Invest in Primary Care

- **Section 2703 of Affordable Care Act - State Medicaid Option to Provide Health Homes for Enrollees with Chronic Condition(s).**
 - Medicaid can reimburse a designated provider, team of health care professionals working with a provider, or health team for six **health home services** for patients with chronic conditions:
 1. Comprehensive care management
 2. Care coordination/health promotion
 3. Comprehensive transitional care
 4. Patient and family support
 5. Referrals to community and social support services
 6. Use of HIT to link services
- **Funding:**
 - Appropriated; 90-10 Federal–State match for services for first 8 quarters that SPA is in effect
 - Can use Medicaid funding for planning purposes

Health Homes: Emerging Opportunity in Health Reform to Invest in Primary Care

- **Eligible beneficiaries have**
 - Two chronic conditions
 - One chronic condition and at risk for second
 - Serious and persistent mental health condition
 - Chronic conditions include, but are not limited to, mental health condition, substance abuse, asthma, diabetes, heart disease, or overweight
- **Eligible providers**
 - Designated provider, team of health care professionals working with a provider, or health team (Section 3502 of ACA)
- **Scope of health home**
 - May or may not be provided within the walls of a primary care practice
 - May or may not be incorporated into a medical home initiative

How HIT can Help CMS and States Measure the Success of Health Homes

- **Reporting requirements**
 - States must track and report outcomes (e.g., avoidable readmissions, ER, skilled nursing facility admissions) and calculate cost savings.
 - Designated providers must report quality measures as condition of reimbursement.
 - Health teams must also report patient outcomes and experience.
 - Independent evaluator will survey States on impact of health home services on various cost, clinical, and utilization measures.
- **HIT will play a critical role by**
 - Helping stakeholders to collect data across performance metrics to track and evaluate the impact of health homes.

Questions to Consider

- How do we create a culture of change (a “conversion”) within a practice?
- How can Medicaid transform primary care, not just implement EHRs? And who does this?
- What is the opportunity presented by health homes to spread HIT linkages and vice versa?

Health Reform Implementation

Resources @ <http://www.chcs.org>

Delivery System Reform

- *WEBINAR RESOURCES* - The Affordable Care Act: Opportunities for Medicaid to Advance Ambulatory Care Quality
- *BRIEF* - Models for Improving Medicaid Primary Care: Lessons for Health Reform

Payment Reform

- *BRIEF* - Increasing Primary Care Rates, Maximizing Medicaid Access and Quality
- *BRIEF* - Medicaid Payment Reform: What Policymakers Need to Know About Federal Law
- *BRIEF* - Payment Reform: Creating a Sustainable Future for Medicaid
- *REPORT* - Sound Practices in Medicaid Payment for Hospital Care

Expansion Population

- *BRIEF* - Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States
- *BRIEF* - Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform

Visit CHCS.org to ...

- Download practical resources to help improve the quality and efficiency of Medicaid services.
- Subscribe to CHCS eMail Updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost members.

<http://www.chcs.org>



Leveraging Health Information Technology in Pennsylvania's Medical Home Programs

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Outline

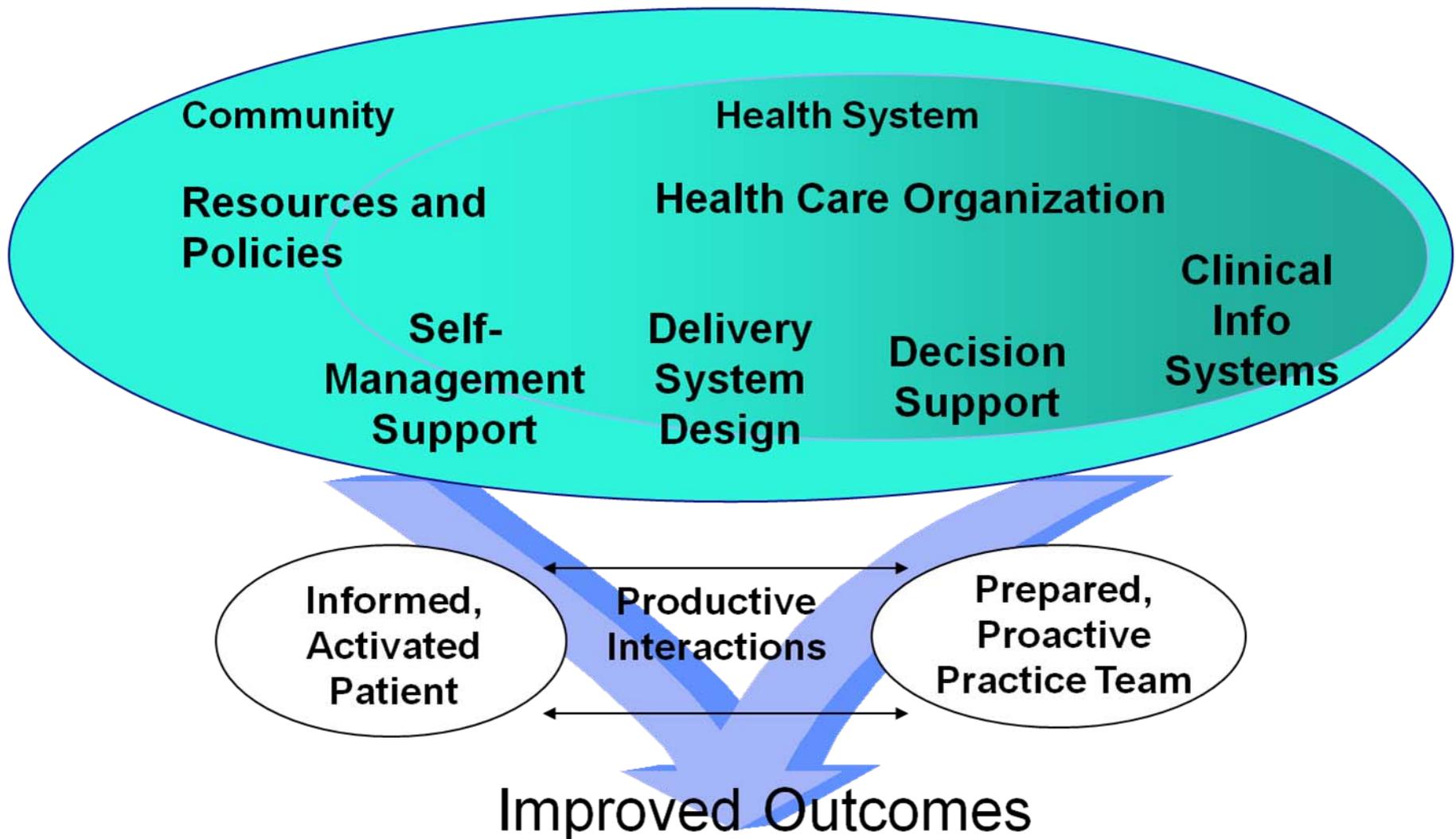
- Chronic Care Model
- Medicaid in Pennsylvania
- Medical home programs
 - Pennsylvania Pediatric Medical Home EPIC Integrated Care program
 - Governor's Chronic Care Commission
 - Reducing Disparities at the Practice Site (RDPS)
 - Connected Care™
 - ACCESS Plus

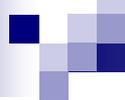


Medical Home Programs

- Leveraging health information technology (HIT)
- Improving care coordination
- Improving quality outcomes
- Reporting financial outcomes

The Chronic Care Model—MacColl Institute for Healthcare Innovation

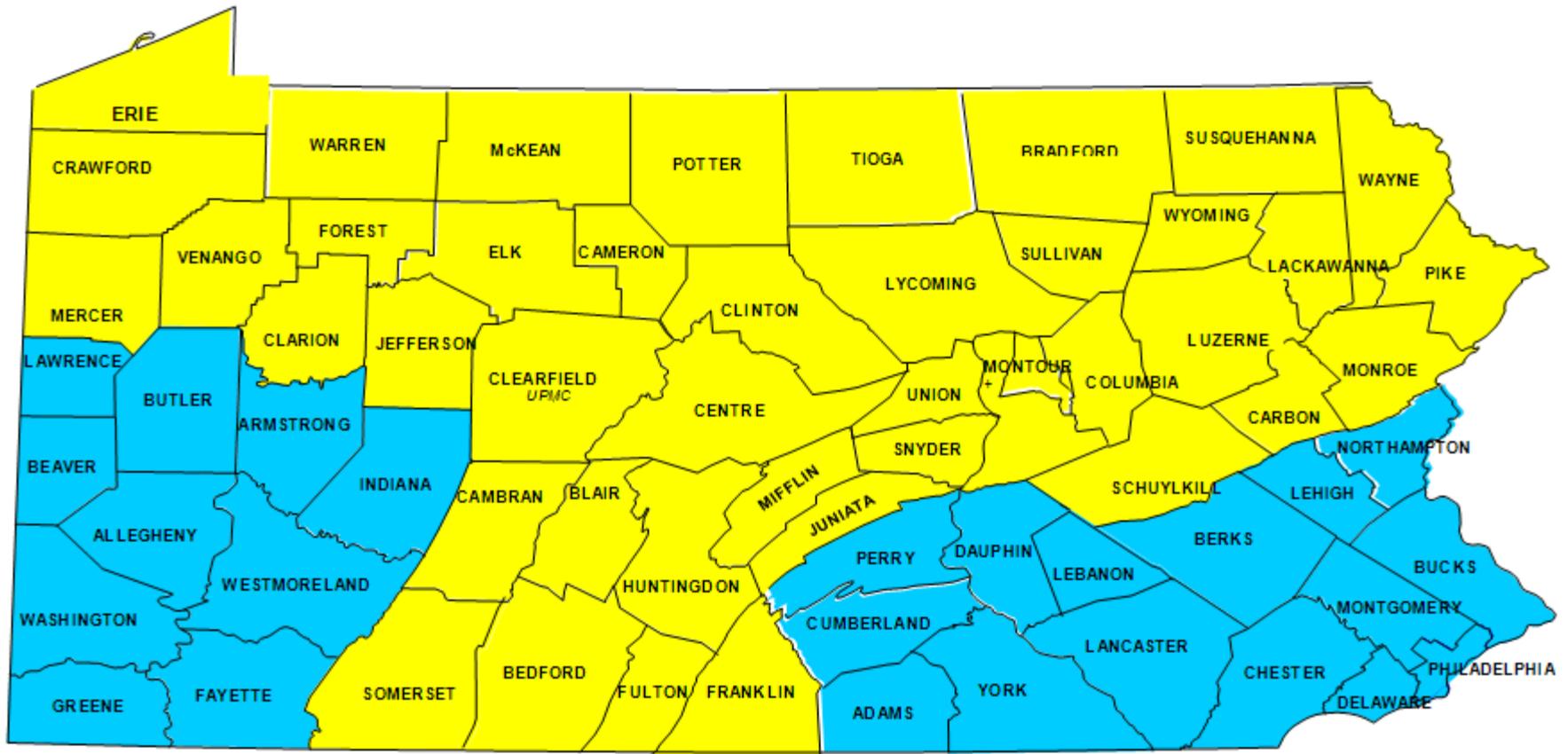




Pennsylvania Medical Assistance

- Provides health care coverage to over 2.1 million consumers (14% of the Commonwealth's population)
- Operates a capitated managed care program—HealthChoices[®]—in 25 urban and suburban counties, covering 1.2 million consumers
- Operates a managed FFS program in 42 rural counties for 320,000 consumers—ACCESS Plus

PA Counties with Mandatory Managed Care or ACCESS Plus and Voluntary Managed Care



 Mandatory Managed Care - HealthChoices

 ACCESS Plus and Voluntary Managed Care (*where available*)

Pennsylvania Pediatric Medical Home Initiative

- Started 2002 and is now funded by Title V (PA DOH)
- Partners: PCPs, PAAP, DOH, DPW, MCHB
- Practices: n=81, 37 counties, 58% suburban /rural, size 1,000–30,000 patients
- Core principles:
 - Support quality improvement/practice transformation
 - Integrate HIT into care coordination, clinical data collection, quality improvement
 - Incorporate family-centered care
 - Promote care coordination
 - Foster high-quality, efficient health care delivery

Pediatric Medical Home—What Works?

- Educating Practices In the Community (EPIC) training
- Patient registry/HIT integration
- Parent partners/consumer engagement
- Policy/payment reform: care plans, P4P, increased EPSDT payments, developmental screening, obesity
- Improved quality, reduced hospitalizations, increased parent/patient satisfaction
- Community partners
 - Resource nights, meet and greet
 - Local work groups
 - Parent youth professional forums
 - Home visiting nurses
 - “Especially for Parents” Web site

Chronic Care Commission Medical Home Program

- Governor's Office of Health Care Reform Chronic Care Commission
- Multipayer model based on each practice's revenue by insurer
- All Medicaid MCOs provide funding
- Practices required to use registry to measure clinical quality focused on asthma and diabetes
- Agreement with providers over 3 years
- Initial pilot of 32 practices in southeastern Pennsylvania (SEPA)
- Now includes 5 regions, 677 PCPs, and over 675,000 patients

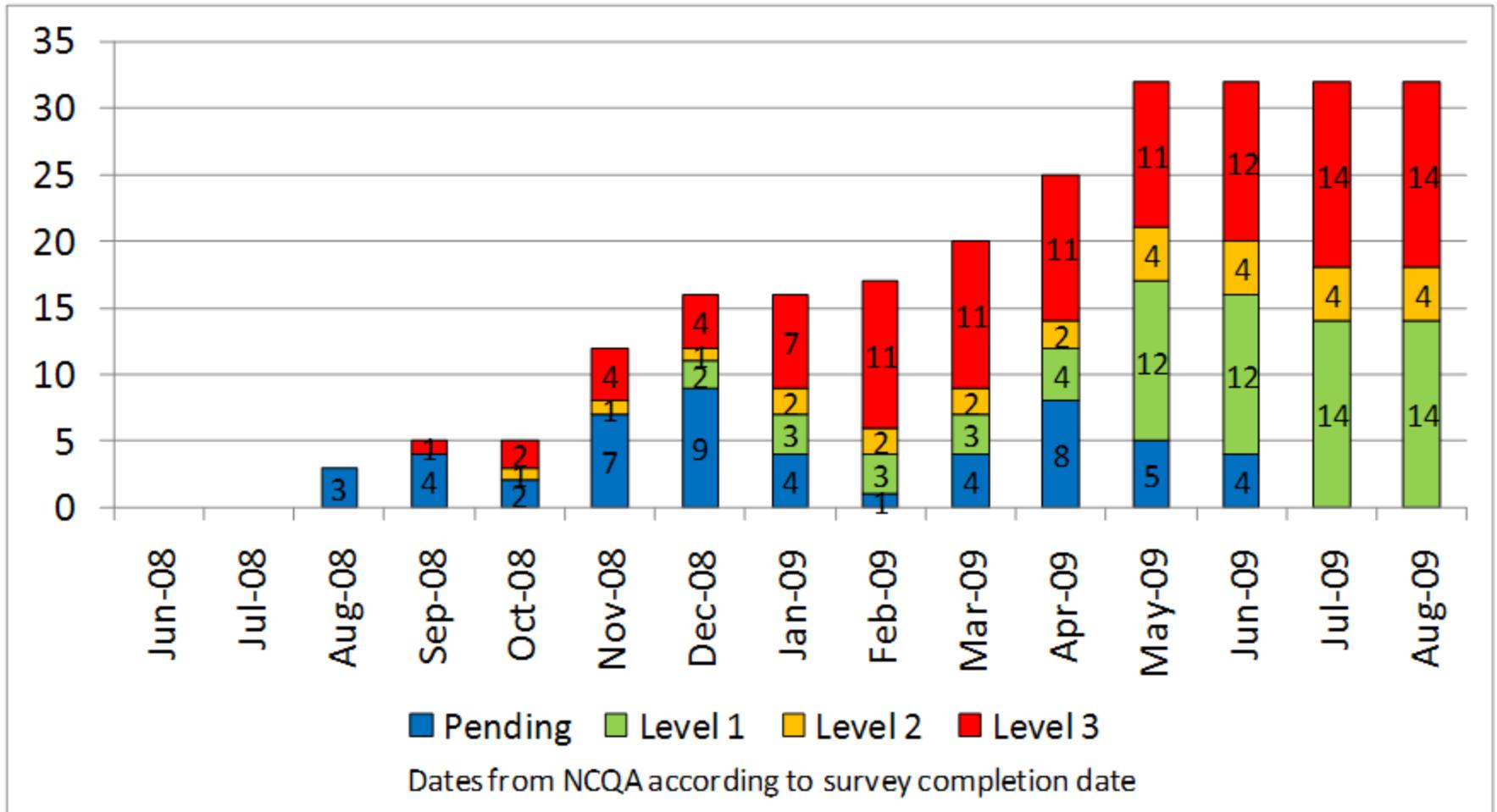
Expectations of Clinicians

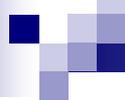
- Obtain Patient-Centered Medical Home (PCMH) **certification from NCQA**
- **Select a team** of at least three people: a physician, nurse, office manager, and other office staff
- Use **rapid change** cycles to implement the Chronic Care Model
- As a team, participate in each of three, 2-day **learning sessions** and a 1-day **annual Outcomes Congress**
- Participate in the **communication learning network**
- **Report** on the required **outcome** measures using a **registry**

SEPA Medical Home Model

- Payments for each practice based on
 - NCQA survey tool and 0.25 office assistant FTE in year 1: \$8,000
 - NCQA application fee and physician involvement in collaborative in year 1: \$12,000
 - NCQA medical home certification
 - Level 1: \$28,000–\$40,000 per FTE
 - Level 2: \$42,000–\$60,000 per FTE
 - Level 3: \$66,000–\$95,000 per FTE

SEPA NCQA PPC-PCMH Recognition





SEPA Diabetes Clinical Outcomes

- Reduced HgA1c and LDL levels
- Improved aspirin use
- Better blood pressure control
- Increased retinal eye exam, foot exam, and nephropathy screening
- One Medicaid MCO reported significant reductions in hospitalizations and ED visits

Reducing Disparities at the Practice Site (RDPS) Pennsylvania Fast Facts

Practice Site Measure	Fast Fact
Practices actively participating	9
Physicians participating	27 Physicians, 7 PAs
Medicaid patients served by the practices	8,254
Diabetic Medicaid patients served	1,721
Patients with improved quality measures	See next two slides
Nurse case managers deployed	0
Practice coaches/facilitators deployed	1
Patients in the registries	1,721
Bonus payments awarded to date	\$225,832

RDPS Quality Improvement to Date

PA Administrative Rates: Based on 1,721 Unique Recipients

Metric	CY 2007 Had Test	CY 2007 %	CY 2008 Had Test	CY 2008 %	CY 2009 Had Test	CY 2009 %
HbA1c	640	37.1%	803	46.5% (↑9.4)	906	52.5% (↑6)
LDL	622	36.0%	824	47.7% (↑11.7)	911	52.8% (↑5.1)
Eye Exams	309	17.9%	387	22.4% (↑4.5)	469	27.2% (↑4.8)
Nephropathy	257	14.9%	332	19.2% (↑4.3)	402	23.3% (↑4.1)

RDPS Conclusions

- Practices very engaged in quality improvement despite infrastructure challenges
- Quality process rates improved significantly but lab outcomes decreased because of increased testing
- Practices receptive to registry
- Most practices interested in HIT incentives
- Practices engaged in redesign (both business and quality)
- Very engaged with practice coach/care coordinator

Connected Care™ in Pittsburgh

- Initiative to improve the connection and coordination of care for those with serious mental illness (SMI) among health plans, PCPs, and behavioral health providers in outpatient, inpatient, and ED care settings.
- Based on Patient Centered Medical Home model with integrated care team and care plan to address all medical, behavioral, and social needs.
- Recovery-oriented care model
- Partnership between
 - Center for Health Care Strategies (CHCS)
 - Department of Public Welfare (DPW)
 - UPMC for You
 - Community Care Behavioral Health
 - Allegheny County Department of Human Services





Rationale for Connected Care™

- Historic gap between PH and BH providers
- Occurs regardless of financing mechanism
- Similar to gaps between other specialists and PCPs
- Coordination challenge posed by confidentiality provisions
- Shortened lifespan of consumers with SMIs, primarily due to physical health issues (complications of smoking and weight)

Target Population

- Members qualify for Connected Care™ if they are
 - A UPMC for You and a Community Care member
 - Age 18 or older
 - Live in Allegheny County
 - Defined as having SMI*

* SMI has been defined as individuals who have been diagnosed with schizophrenic disorders, episodic mood disorders, or borderline personality disorder.

Member Stratification

- High PH needs defined as
 - Three or more ED visits in past 3 months, or
 - Three or more inpatient admissions in the past 6 months
- High BH needs defined as
 - Discharged from, history of being served by, or diverted from a State mental hospital
 - Five or more admissions to most restrictive level of care, or readmitted within 30 days
 - Four or more admissions to most restrictive level of care and inpatient or RTF or CTT admission
 - Three or more admissions to the most restrictive level of care and inpatient or two admission to most restrictive level and inpatient and an open authorization for certain services

Care Management Activities

- Joint meetings with PH and BH providers to inform of the program
- Consumer group input on program design and materials
- Using BH providers to help obtain consents
- Approximately 250 new members identified monthly
- In 2009, provided \$25 gift card incentive to 4,400 members who had a visit with their PCP
- 2010 incentive is \$25 gift card to complete consent and enroll
- UPMC for You and Community Care coordination includes:
 - **Focus on Tier 1 members**
 - **Integrated care plan**
 - Weekly multidisciplinary care team meetings held
 - **Daily identification of members with PH or BH admission, and ED visits from key UPMC hospitals**
 - Concurrent case discussions
 - 24 hour/day phone line managed by Community Care to answer member questions regarding the program

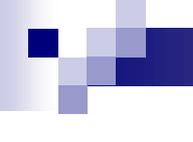


Preliminary Outcomes

- Reduced combined BH-PH admissions from 635/1,000 to 534/1,000 member months
- Reduced combined BH-PH readmissions from 126/1,000 to 76/1,000 member months
- Reduced combined BH-PH ED visits from 1,963/1,000 to 1,875/1,000 member months
- Improved the number of consumers receiving metabolic screening by 3.4%

What is ACCESS Plus?

- Enhanced Primary Care Case Management (EPCCM) medical home model for adults and children started in 2005
- There are 320,000 Medicaid members, excludes dual eligibles but includes ABD, over 50,000 with chronic diseases covered by Disease Management (DM)
- DM program: done by vendor for 21 conditions
- Complex Case Management: manages over 2,500 active cases
- Vendor has guaranteed cost savings, is at risk for DM performance, and responsible for P4P implementation



ACCESS Plus Program Goals

- **Improve access** to primary care and other appropriate health care services
- Provide a **medical home** for children and adults
- **Improve the quality** of health care available to Medical Assistance recipients
- Provide access to **disease management** and **care coordination**
- **Stabilize** Pennsylvania's Medical Assistance spending

ACCESS Plus Redesign

- Focus on broader chronic disease categories
- Expand community-based approach
- Focus on PCP medical home practice redesign
- Focus on BH-PH coordination
- Integrate HIT
- Centralized predictive modeling
- Transition of care program
- Vendor at risk for guaranteed cost savings and 12 quality measures
- Continuation of provider P4P using \$1 PMPM

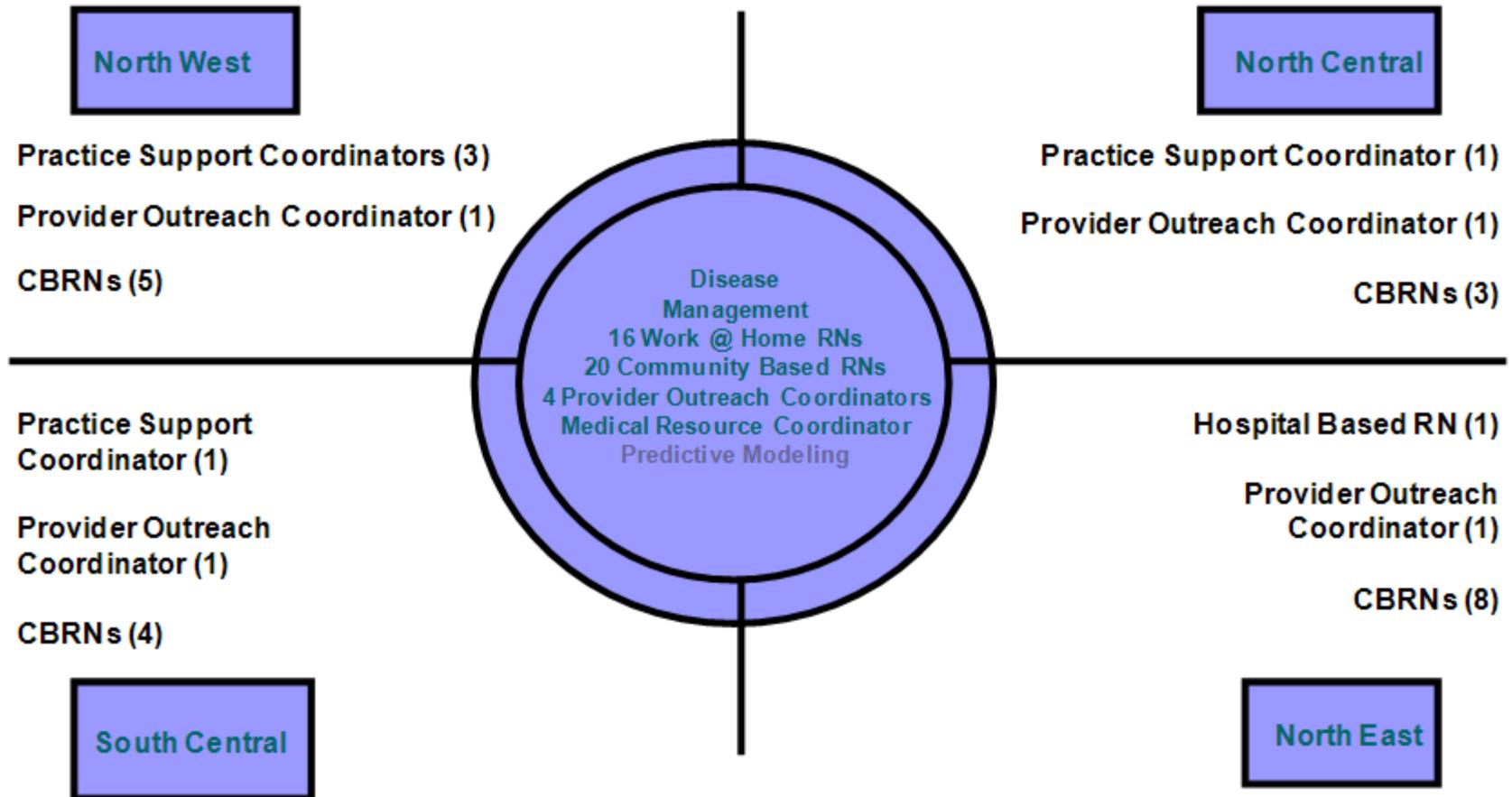
Program Enhancements For Enrollees

- Medical home for children and adults
- Enrollment Assistance Contractor to assist with enrollment
- Enrollee hotline
- Increased access to PCPs
- PCP directories
- Consumer empowerment/education
- Consumer input through Regional Advisory Committees
- Assessment of health care quality
- Assessment of consumer satisfaction
- Disease Management
- 24-hour nurse call line
- Complex Care Management
- Care Coordination: dental and specialty referral, transportation

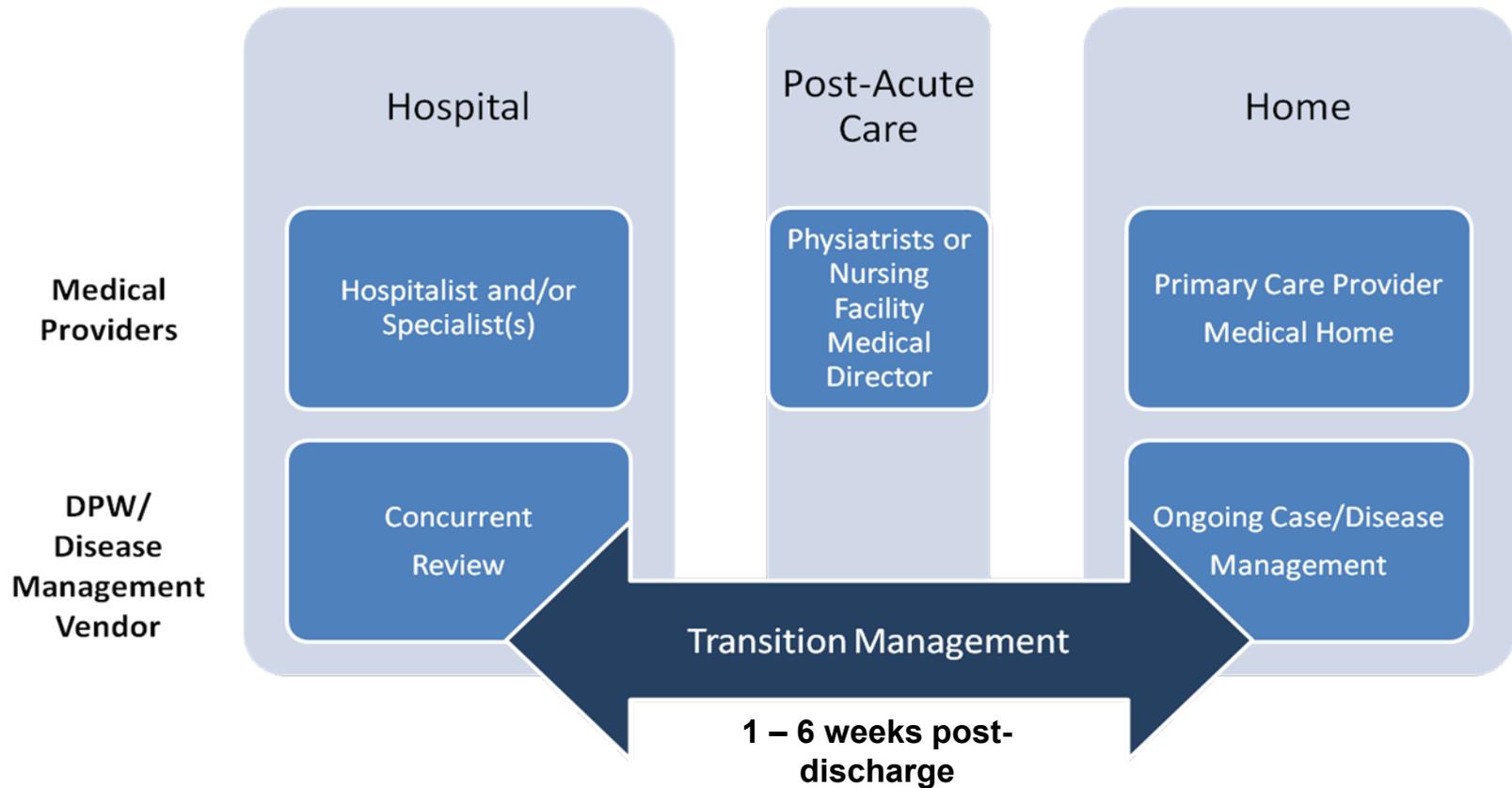
Program Enhancements For Providers

- Access to community-based nurses
- Coordinated Disease and Case Management services
- Community-based nurses and provider service representatives
- Resources for coordination with BH and dental providers
- Access to consumer education and action plan materials
- Provider education and guideline-based charting tools
- Care gap identification
- Provider Call Center
- Input through participation in Regional Advisory Committee
- Provider incentive opportunities
- Fees increased for primary care services (EPSDT and E&M codes)

DM Staff Distribution



ToC Program Goal and Focus



Clinical Quality Improvement Results

- **Asthma- controller medication use increased from 79.5% to 91.2%**
- **Diabetes**
 - HgA1C performed: 78.1% to 84.6%
 - HgA1C poor control: 43.3% to 34.1%
 - LDL<100: 25.3% to 37.5%
- **CAD**
 - Beta-blocker post MI: 78.7% to 94.2%
 - LDL performed: 64.2% to 82.5%
 - LDL<100: 18.7% to 45.9%
- **Controlling hypertension: 59.1% to 76.0%**
- **Dental visits for children: 38.7% to 50.6%**

ACCESS Plus Results

- Over \$87 million saved in the first 4 years of the PCCM program
 - Reduced admissions for those with chronic disease
 - Reduced ED visits
- Quality performance measures from 2005 to 2009:
 - Well-child visits ages 3 to 6: 61.1% to 74.7%
 - Adolescent well-child visits: 34.9% to 58.9%
 - Ongoing prenatal care: 67% to 76.9%
 - Cervical cancer screening: 55% to 67%
 - ED visits: 61.1/1,000 to 41.7/1,000
 - Dental visits children: 38.7% to 50.6%



ACCESS Plus Results

- Clinical quality improved
- Clinical access improved
- Consumer satisfaction improved
- Expanded P4P program focused more on outcomes not just process
- DM program provided cost savings



How Can HIT Be Leveraged?

- Help PCPs build a better medical home by targeting providers with ARRA HITECH incentives
- Identify care gaps and electronically share those gaps with providers and consumers
- Stratify/identify consumers who can be impacted by care management programs
- Improve BH-PH integration
- Coordinate transitions of care
- Measure quality by using electronic health records

Questions?

