

Innovative Strategies for States to Address Cost and Quality Goals

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Testimony before the Montana Legislature

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Presentation Outline

- ❖ What we know about high performing health systems
- ❖ State strategies to achieve high performing health systems building on medical homes
 - Financing through public-private partnerships
 - Financing through ACA 2703 health homes
- ❖ What we know & don't know about these strategies
- ❖ Options for Montana

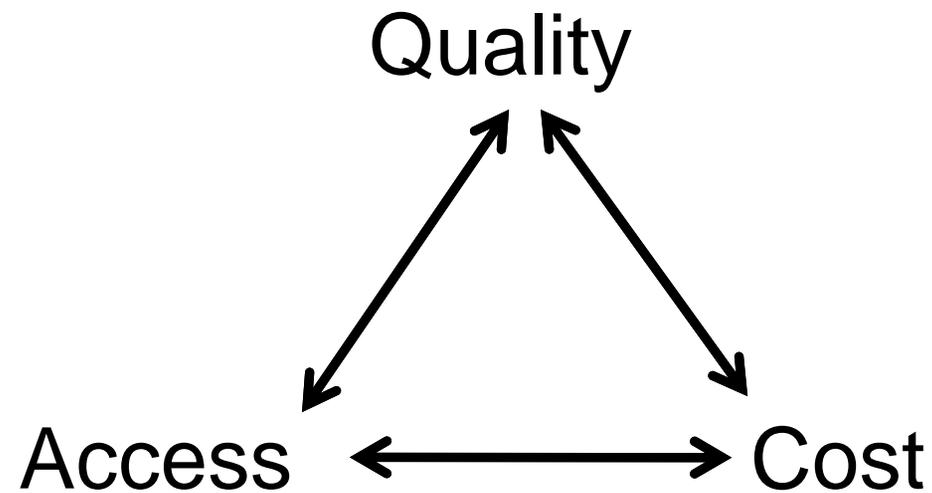
NASHP

- ❖ 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

A Few NASHP Projects Supporting State Medical Homes and Primary Care Initiatives

- ❖ Commonwealth Fund: Advancing Medical Homes in Medicaid/CHIP
 - Round I 2007-2009 (CO, ID, LA, MN, NH, OK, OR, WA)
 - Round II 2009-2010 (AL, IA, KS, MD, **MT** NE, TX, VA)
 - Round III 2011-2012 (AL, CO, MD, MA, MI, MN, NM, NY, NC, OK, OR, RI, VT, WA)
 - Round IV 2012-2014: (**MT**, NE, PA, WV)
- ❖ Centers for Medicare and Medicaid Services
 - With RTI, evaluation for the Multi-payer Advanced Primary Care Practice Demonstration
 - With NORC, interim evaluation to Congress for Section 2703 Health Homes
- ❖ Federal Health Resources and Services Administration 2011-2014
 - National Organization of State and Local Officials Cooperative Agreement to engage Medicaid Directors and HRSA grantees

What we know



US Healthcare System Falls Behind

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



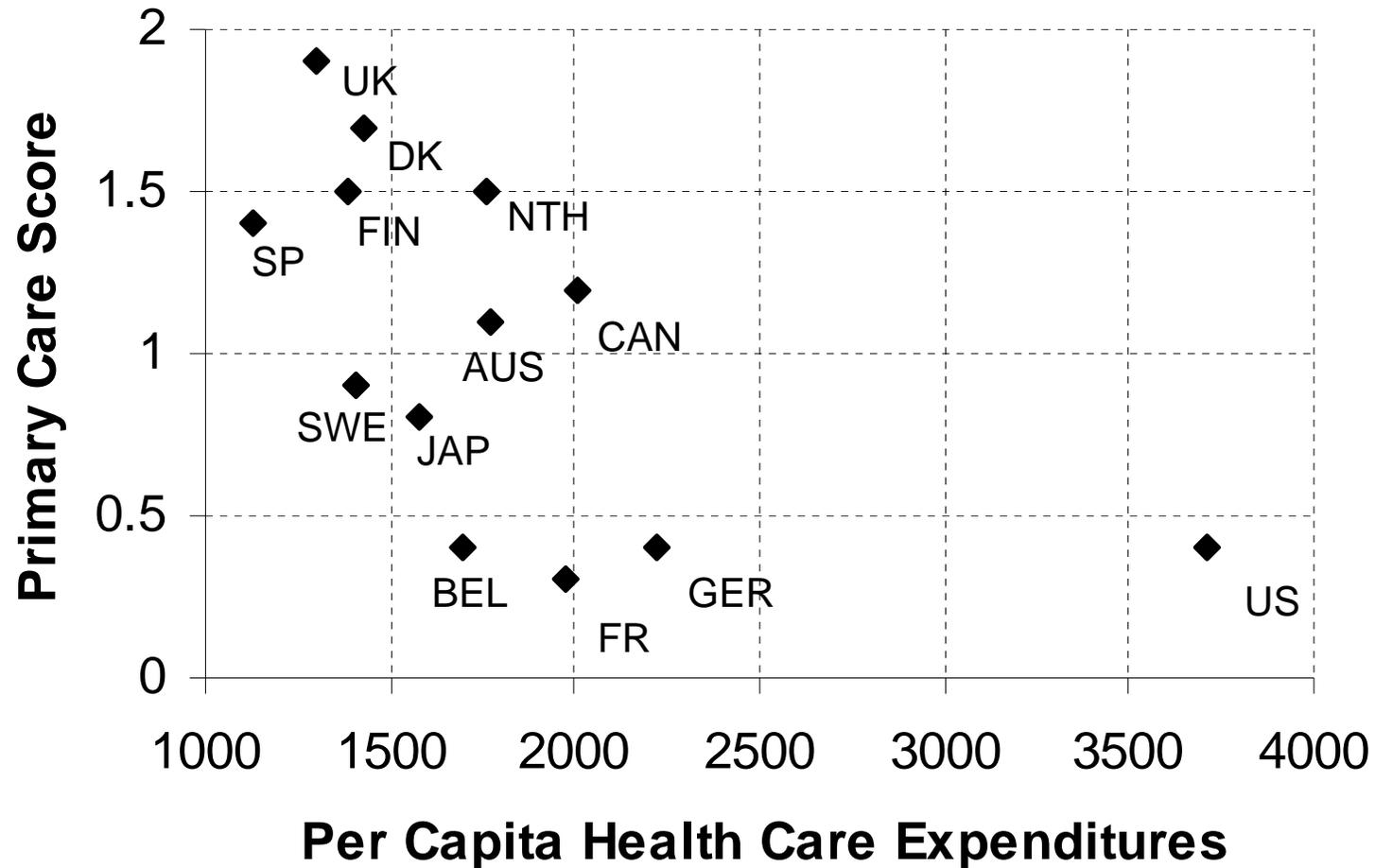
	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

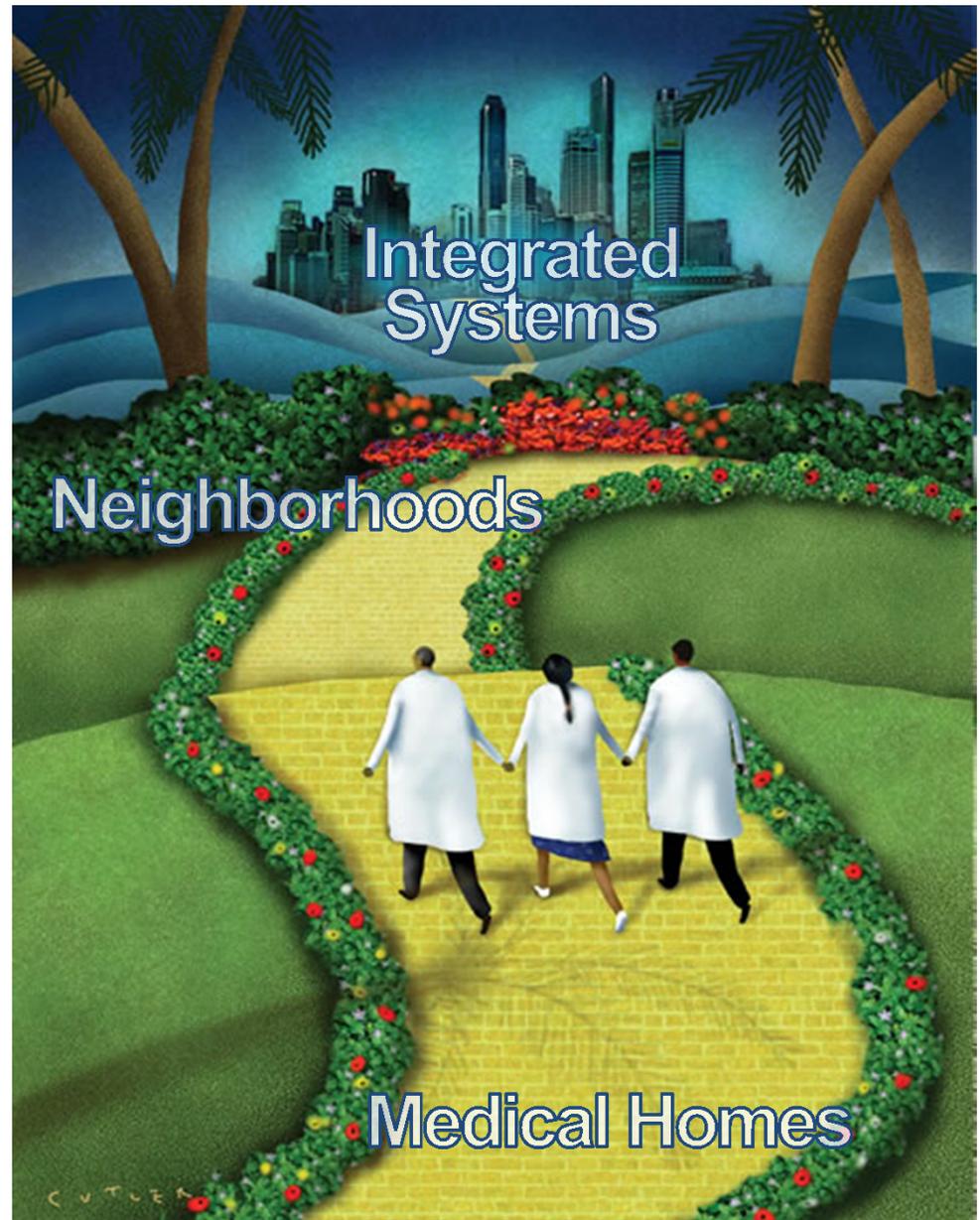
Source: Karen Davis et al. *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally 2010 Update*. The Commonwealth Fund. June 2010.

Primary Care Score vs. Health Care Expenditures, 1997



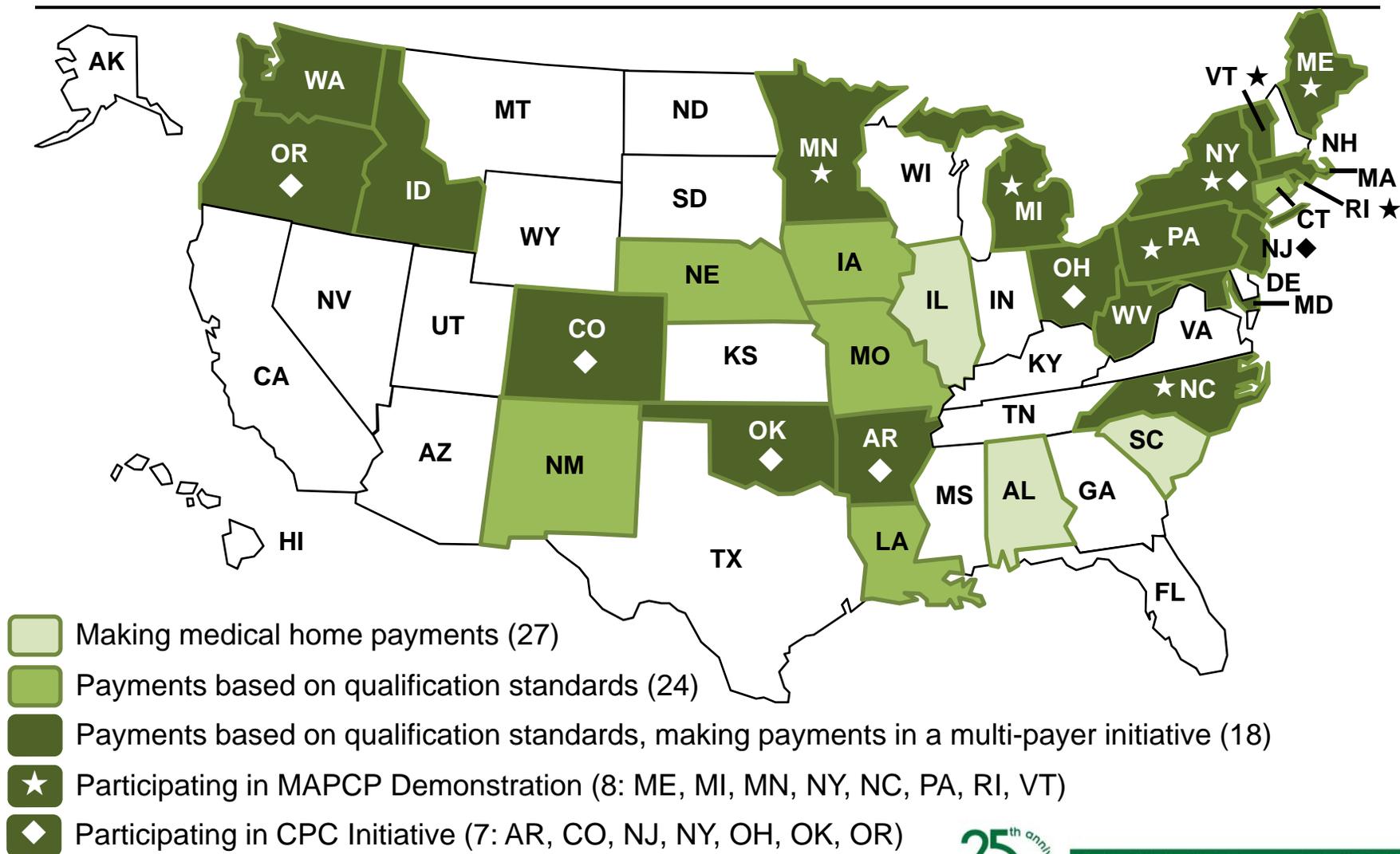
Source: Dr. Barbara Starfield; Presentation at the Blekinge Conference;
Ronneby, Sweden; September 19, 2007

Innovative Strategies that Address Cost, Quality, & Access



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

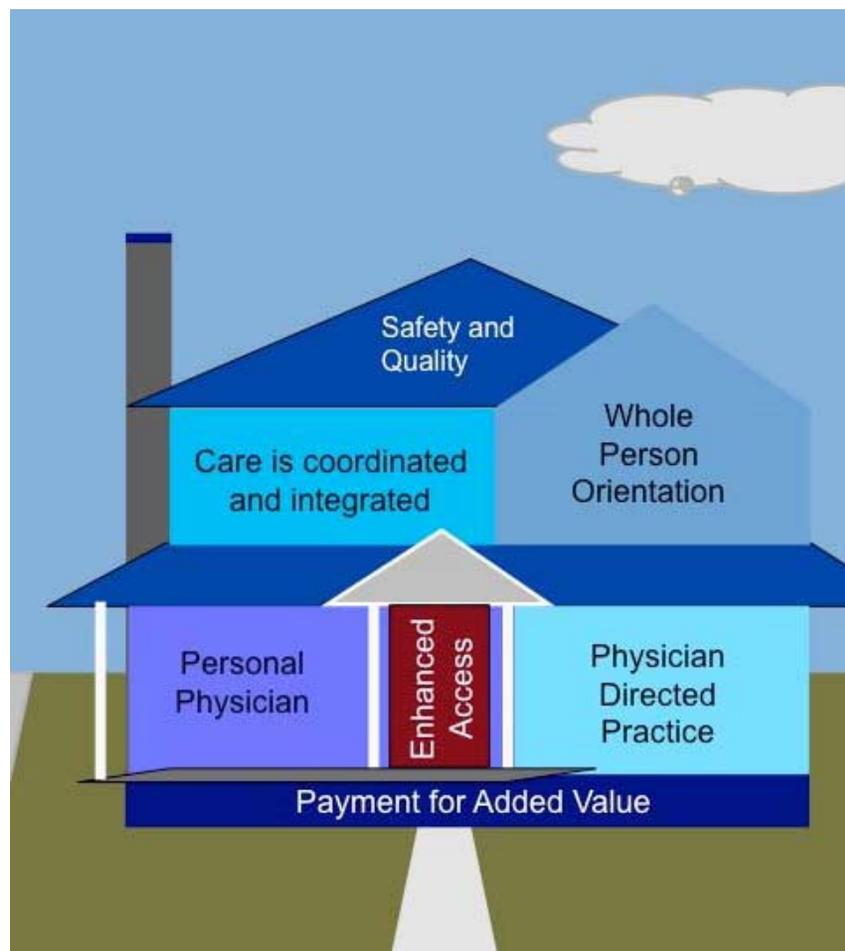
Medicaid Medical Home Payment Activity



- Making medical home payments (27)
- Payments based on qualification standards (24)
- Payments based on 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)

SOURCE: National Academy for State Health Policy. "Medical Home and Patient-Centered Care." Available at: www.nashp.org/med-home-map

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

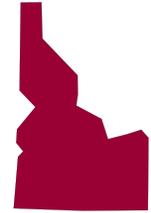
Graphic Source: Ed Wagner. Presentation entitled "The Patient-centered Medical Home: Care Coordination." Available at:

www.improvingchroniccare.org/downloads/care_coordination.ppt

Select Care Coordination Payments to Providers in Multi-Payer Medical Home Initiatives

State Initiative	Per member per month range	Adjusted for Patient Complexity or Demographic	Adjusted for Medical Home Level	Payments to Support Teams or Networks	Financial Incentive Based on Quality
Idaho	\$15.50 - \$42.00				
Maine	\$3.00 - \$7.00	▲		▲	
Maryland	\$4.68 - \$8.66	▲	▲		▲
Minnesota	\$10.14 - \$79.05	▲		▲	
North Carolina	\$1.50 - \$5.00	▲	▲	▲	
Pennsylvania	\$2.10 - \$8.50	▲			▲
Rhode Island	\$5.00 - \$6.00				▲
Vermont	\$1.20 - \$2.39		▲	▲	
Washington	\$2.00 - \$2.50				▲

Multi-Payer Case Study: Idaho



- ❖ **Pilot:** Idaho Medical Home Collaborative
- ❖ **Launch:** January 1, 2013
- ❖ **Authority:** Executive Order 2010-10
- ❖ **Convener and Governance:** Oversight provided by Idaho Department of Insurance (DIO), project management at Medicaid; Collaborative members appointed by the Governor
- ❖ **Anti-Trust:** Executive Order 2010-10; oversight from DIO
- ❖ **Funding for Pilot Administration:** Legislature allocated funds to Medicaid in 2011; also sought funds from grants, such as through the Safety Net Medical Home Initiative
- ❖ **Qualification standards:** Basic requirements for participation include: Practices must attain NCOA 2011 Level 1 recognition by the end of Year 2 of the Pilot; practices must also achieve 11 “critical elements of PCMH”, meet data reporting requirements, and utilize a disease registry. Additional requirements vary by payer.
- ❖ **Payment:** Payment amounts vary by payer (\$15.50 - \$42.00)
- ❖ **Website:** <http://imhc.idaho.gov/default.aspx>

Multi-Payer Case Study: Maine



- ❖ **Pilot:** Maine Patient-Centered Medical Home Pilot
- ❖ **Authority:** Maine Quality Forum, a co-convenor of the pilot, was established by the Governor and Legislature as part of Maine's Dirigo Health Agency in 2003; the Legislature's Commission to Study Primary Care Medical Practice (2007-2008) recommended developing a pilot.
- ❖ **Convener and Governance:** Convened jointly by Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition
- ❖ **Anti-Trust:** Due to anti-trust concerns, payments are negotiated between commercial payers and practice sites individually.
- ❖ **Funding for Pilot Administration:** Convening organizations, MaineCare (Medicaid), private grants; as of January 2013, participating practices are also required to contribute
- ❖ **Qualification standards:** Practices must attain NCQA 2011 Level 1 recognition; practices must also meet 10 "core expectations"
- ❖ **Payment:** Payment amounts vary by payer (\$3.00 - \$7.00), with a proportion being paid to practices and the rest to Maine's Community Care Teams.
- ❖ **Website:** <http://www.mainequalitycounts.org/page/2-712/pcmh-program-information>

Building the Neighborhood Using ACA Sec. 2703 Health Homes



Key model features:

- ❖ Standards requiring coordination between providers
- ❖ Emphasis on behavioral health and primary care integration and long term services and supports
- ❖ Robust community & social services linkages
- ❖ Individual & family support resources
- ❖ Data sharing & information exchange

Select Approved ACA Section 2703 Health Home State Plan Amendments

State Plan Amendment	Target Population	Payment Description	Providers
Missouri – Behavioral Health	SPMI and individuals with other behavioral health conditions	\$78.74 PMPM	Community Mental Health Centers
Missouri – Physical Health	Individuals with chronic physical health conditions	\$58.87 PMPM	FOHCs Hospital-based Clinics Rural Health Clinics
New York	SPMI and individuals with chronic physical health conditions	\$18.71- \$23.27 Per Member Per Month Base Rate (multiplied by risk score)	Partnerships between PCPs, FOHCs/Hospitals/Clinics, Managed Care Plans, and Community Providers
Ohio	SPMI (Adults) SED (Children)	PMPM determined by actual cost to health home	Community Behavioral Health Centers

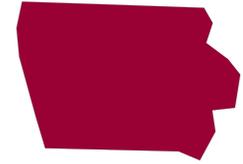
Health Home Case Study: Idaho



- ❖ **Approved:** November 2012
- ❖ **Target Population:** Severe mentally ill; select physical chronic conditions
- ❖ **Eligible Conditions:** SPMI; Asthma; Diabetes
- ❖ **Payment:** \$15.50 PMPM
- ❖ **Eligible Providers:** Physicians, Clinical Practices, Rural Clinics, Community Health Centers, Community Mental Health Centers, and Home Health Agencies (not exhaustive)
- ❖ **Team Composition:** Primary Care Physician, Behavioral Health Professional, Registered Nurse, Medical Assistant, Clerical Staff
- ❖ **Qualification standards:**
 - NCQA PCMH (Level 1) within 2 years
 - Connecting physical and behavioral health systems through telemedicine, co-location, or referral and enhanced coordination

Note: Provides funding for Medicaid's participation in multi-payer Idaho Medical Home Collaborative.

Health Home Case Study: Iowa



- ❖ **Approved:** June 2012
- ❖ **Target Population:** Individuals with behavioral health and/or select physical chronic health conditions
- ❖ **Eligible Providers:** Primary care practices; Community Mental Health Centers; FQHCs; Rural Health Clinics (not exhaustive)
- ❖ **Payment:** \$12.80-76.81 PMPM
 - Tiered based on patient complexity
 - Bonus payments begin in July 2013 based on outcome measures and total cost of care.
- ❖ **Eligible Conditions:** Mental Health Conditions; Substance Use Disorders; Asthma; Diabetes; Heart Disease; Hypertension, BMI >25 (adult), BMI over 85th percentile (pediatric)
- ❖ **Qualification standards:**
 - TransformMED self-assessment
 - PCMH accreditation (NCQA PCMH or similar) within 1 year
 - Adoption of electronic health record and (eventual) meaningful use of health information technology.

Note: One serious mental illness is not an automatic qualifier.

Integrated 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

Oregon Coordinated Care Organizations (CCOs) Payment Model

- Authorized by the legislature in 2012 via SB 1580
- 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
- 13 CCOs are operating in communities around Oregon as of 9/2012. Pending final approval, 3 more CCOs will begin enrolling clients on 11/2012
- Meet key quality measurements while reducing the growth in spending by 2% over the next 2 years
- <http://www.oregon.gov/OHA/OHPB/health-reform/ccos.shtml>

Does it work?



Summary of key cost & quality outcomes for Medicaid medical home programs

❖ Colorado State Programs for Children

- Median annual costs \$215 less for children in medical home practices due to reductions in emergency department visits and hospitalizations
- Median annual costs \$1,129 less for children with chronic diseases in a medical home practice than those without such care

❖ Oklahoma

- Per-capita member costs declined \$29 per-patient/per-year from 2008-2010 with increases in evidence-based primary care including breast and cervical cancer screening.
- Positive feedback from both providers and patients

North Carolina

❖ **Community Care of North Carolina (CCNC)**

- Community Care is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care.
- Adjusting for severity, costs are 7% lower than expected. Costs for non-CCNC patients are higher than expected by 15 percent in 2008 and 16 percent in 2009.
- For the first three months of FY 2011, per member per month costs are running 6 percent below FY 2009 figures.
- For FY 2011, Medicaid expenditures are running below forecast and below prior year (over \$500 million).
- More than \$700 million in state Medicaid savings since 2006.

Summary of key cost & quality outcomes for Medicaid medical home programs (cont.)

❖ Vermont Blueprint

- In one Blueprint community, in-patient use and related per month costs decreased by 21 and 22 percent, respectively
- Emergency department use and related per person per month costs decreased by 31 and 36 percent, respectively
- Mixed results for another Blueprint community.

❖ Patient Care Networks of Alabama (early results)

- One network functioning for 7 months / the other two functioning for 6 months
 - Per member per month costs down 7.1% compared with rest of the state
 - ER Utilization down 17% compared with rest of the state
 - Providers encouraged

Yes, but...

- ❖ AHRQ study reviewed 498 studies between 1/2000-9/2010 on U.S.-based interventions
- ❖ 14 evaluations met inclusion criteria
 - (1) tested a practice-level intervention with 3 or more of 5 key PCMH components and
 - (2) conducted a quantitative study of one of the triple aim outcomes or of healthcare professional experience.
- ❖ "We found some promising results across all 3 triple aim outcomes; *however, the majority of findings were inconclusive.*"

Roles for Legislators—lessons from other states

- ❖ Authorizing language for pilots including convening entity, stakeholder committees
- ❖ Articulating the need for pilot activity including collaboration among payers, providers (particularly hospitals), purchasers (i.e. state employee benefits)
- ❖ Providing Anti-trust protection
- ❖ Appropriating funds: project management, Medicaid's role (leverage federal match), practice transformation efforts
- ❖ Funding Health Information Technology Infrastructure

Implications for Montana

Delivery system assessment:

- Is your health care system meeting costs and quality goals?
- Do Montanans have access to high performing primary care providers?
- What models can be adapted for Montana?

Financing innovation:

- Can partnerships, ACA, &/or foundations be leveraged?
- Don't underestimate need for practice payments, training and infrastructure support
- Don't give away new dollars: Align new payments with new expectations around achieving costs and quality goals

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- Specific Populations

PROGRAMS

- ABCD Resource Center
- Behavioral Health Evidence-Based Practices & Medicaid
- Children's Health Insurance
- Community Health Centers
- Maximizing Enrollment
- Medical Home & Patient-Centered Care**
- State Health Access Program (SHAP)

TOOLBOXES

- Patient Safety Toolbox
- State Quality Improvement Partnership Toolbox

QUICK LINKS

- NASHP Projects & Programs
- NASHP Publications by Category
- NASHP Publications by Date

Medical Home & Patient-Centered Care



Development and ongoing updates of this webpage would not be possible without the generous support of The Commonwealth Fund

A medical home is an enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care. First advanced by the American Academy of Pediatrics in the 1960's, the concept gained momentum in 2007 when four major physician groups agreed to a common view of the patient-centered medical home (PCMH) model defined by seven "Joint Principles." (For more information on the "Joint Principles" please go to www.pcpcc.net.) Since 2007, NASHP has been tracking and supporting state efforts to advance medical homes for Medicaid and CHIP participants. NASHP's medical home map allows you to click on a state to learn about its efforts. Our work is supported by The Commonwealth Fund.

As of January 2012, 41 states have adopted policies and programs to advance medical homes. Medical home activity must meet the following criteria for inclusion on this map: (1) program implementation (or major expansion or improvement) in 2006 or later; (2) Medicaid or CHIP agency participation (not necessarily leadership); (3) explicitly intended to advance medical homes for Medicaid or CHIP participants; and (4) evidence of

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MEDICAL HOME STRATEGIES

- Forming Partnerships
- Defining and Recognizing Medical Homes
- Aligning Reimbursement & Purchasing
- Supporting Practices
- Measuring Results

MEDICAL HOME WEBINAR ARCHIVE

- Building Medical Home Neighborhoods through Community-Based Teams: Lessons from Three States with Emerging Programs
Wednesday, April 18, 2012
- The Power of Integrated Care: Implementing Health Homes in Medicaid
Tuesday, February 15, 2011

more

MEDICAL HOMES PUBLICATIONS

- Building Medical Homes: Lessons from Eight States with Emerging Programs
December 2011
- State Innovations to Transform and Link Small Practices
December 2010

Please visit:

- www.nashp.org
- <http://nashp.org/med-home-map>
- www.statereforum.org
- www.pcpcc.net

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