

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

The patient centered medical home is an approach that provides comprehensive primary care for children, youth, and adults and may have benefits for population health, equity in health, and cost containment. This model of care is garnering support from public and private payers and purchasers, as well as physicians, academics, policy makers, and consumers. This *State Health Policy Briefing* will examine the Southeast Pennsylvania Chronic Care Initiative, Medicare Medical Home Demonstrations, and approaches to evaluations of medical home demonstrations to provide an overview of policies for states to consider to help practices become high functioning medical homes.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

APRIL 2009

Public Payer Medical Home Initiatives

ROHAN BEESLA AND RELJA UGRINIC,
PATIENT CENTERED PRIMARY CARE COLLABORATIVE

During the past 12 months, the patient centered medical home (PCMH) model of care has garnered support from health plans and employer groups, as well as physicians, academics, health policy makers, and consumers. The PCMH is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is predicated on a partnership between an individual patient and/or family and their personal primary care provider, who cares for the whole person and facilitates connections to needed services in the community.

The National Academy for State Health Policy (NASHP) and the Patient Centered Primary Care Collaborative (PCPCC) have partnered on a one-year project to advance medical homes in state Medicaid and CHIP (Children Health Insurance Program). Supported by The Commonwealth Fund, this project includes a series of three web seminars and accompanying State Health Policy Briefings that discuss strategies for states to consider when supporting practices in fulfilling their role as a medical home. This brief is the third and follows the web seminar *State Roles in Multi-Payer Medical Home Pilots*, held on November 12, 2008.

This issue brief summarizes the web seminar by examining the Southeast Pennsylvania Chronic Care Initiative, Medicare Medical Home Demonstrations, and approaches to evaluations of medical home demonstrations. Evaluations are an important component of demonstration projects and address challenges from purchasers of care, including insurers, employers, and states to build an evidence base that will show the extra investments may help translate to improved health outcomes.

The PCMH model has roots in several different models of care, including the American Academy of Pediatrics medical home¹ and the Chronic Care Model.² There is growing evidence that support of the PCMH model of care may have benefits for population health, equity in health, and cost containment.

- A Mercer analysis showed that North Carolina Community Care operations in State Fiscal Year (SFY) 2004 saved \$244 million in overall healthcare costs for the state. Similar results were found in 2005 and 2006,³ and
- Within the United States, adults with a primary care physician rather than a specialist had 33 percent lower costs of care and were 19 percent less likely to die, after adjusting for demographic and health characteristics.⁴

The Patient Centered Primary Care Collaborative (PCPCC) has endeavored to track, monitor and compare the many ongoing medical home pilot projects with a view to providing a consolidated resource and enticing additional participation in these evaluations from payers, physicians, patients, and families. The PCPCC has developed a compilation of private sector PCMH pilot and demonstration projects, which it will periodically republish to capture developing information. Though these projects are loosely described as “private-payer” based, **there are notable instances of participation by state public-payer programs, and the opportunity exists for states to play a role in others if they are so inclined.** Indeed it has been the stated objective of several convening entities to attract public payer participation, which has been met with varying degrees of interest.

One approach to practice transformation is found in Pennsylvania at the Southeastern Pennsylvania (SEPA) Rollout of the Chronic Care Initiative. The Governor’s Office of Health Care Reform (GOHCR) convened a large number of stakeholders, including several commercial health plans with Medicaid managed-care plans to initiate a multi-payer approach to managing the care of chronically ill patients. What began with a state commission—ordered by Governor Ed Rendell—to formulate information systems and payment reform to support the Chronic Care Model led to an incremental implementation plan targeting chronically ill patients. Although the plan specifically begins with those with chronic care illnesses, the hope is to spread the lessons to wider populations.

The first rollout began May 2008 in Southeastern Pennsylvania. It targeted 32 practices serving approximately 230,000 patients, focusing on those with diabetes and co-morbidities as well as pediatric asthma.⁵ Participating practices will be eligible for enhanced reimbursement subject to their recognition using the National Committee for Quality Assurance Physician Practice Connections - Patient Centered Medical Home (NCQA PPC-PCMH) tool. Practices will also receive payment for required technical assistance, practice redesign, and development of care management capacity.⁶ Clinical data for the patients covered will be compiled by the practices monthly, which they will present to one another at learning collaboratives to provide a snapshot of the rollout’s progress.

The learning collaboratives are an important part of the intervention in SEPA. While technical assistance facilitates system redesign, the sharing of anecdotes and data between office staffs helps reinforce the cultural shift proponents of the Chronic Care Model hope to bring to primary care—that it is a more personalized focus on patients that assists them to self-manage chronic conditions, and includes the entire office staff in an organized, team-based approach to care. An outside firm will conduct a comprehensive evaluation 18 and 36 months into the project.

As mentioned, while previous evaluations have tested disparate components of a PCMH, the SEPA project—like most multi-payer demonstrations tracked by the PCPCC—is using the National Committee for Quality Assurance’s PPC-PCMH recognition tool to determine a practice’s eligibility for enhanced reimbursement. It should be noted that many states are developing their own or using other recognition tools for several reasons. There is concern that the cost of NCQA is too high, the burden of certification is too great, and the emphasis on structural measures is insufficient to assess the provision of comprehensive patient centered medical homes services. Improvements in this and other current tools can be expected to further improve the assessment of PCMHs.

Pilots, including those in Colorado and Rhode Island include portions of public (Medicaid and CHIP) program participants. The participation of these programs is crucial. Medicaid and CHIP participation will increase the percent of patients in each practice who are eligible for the intervention (and for whom additional resources are provided to the practice). Therefore, these programs’ participation will spread the cost of making and sustaining practice change, as well as ease the change itself by reducing (or even eliminating)

the need for the practice to vary office procedures by payer. Also, since members of Medicaid tend to have poorer health than the general population⁷ they may benefit more than privately insured patients in the practice's panel.

Although disease-oriented health services are, by definition, not primary care services (which is person- and population-focused and addresses *all* health problems), some payers have decided to enter these pilots by focusing first on those with chronic conditions. Although it may not be possible to generalize the results of such an evaluation of pilots focused on chronic care to the general population of patients associated with PCMH, data from these projects might be able to inform an evaluation of population-based PCMHs.

Medicare is another payer that will be focusing on improving care of chronically ill adults through medical home pilots. Legislation originally passed in 2006 and bolstered in 2008 mandates Center for Medicare and Medicaid (CMS) design a

“medical home demonstration project... to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which—

- (1) care management fees are paid to persons performing services as personal physicians; and
- (2) incentive payments are paid to physicians participating in practices that provide services as a medical home.”⁸

At the writing of this brief, CMS is in the final stages of planning the demonstration project, but has not made a final decision as to which sites will be incorporated into the project.

According to James Coan, Project Officer, Office of Research Development and Information, CMS, the three-year design will include no more than eight states, and will target the enrollment of 400 practices, 2,000 physicians, and 400,000 Medicare beneficiaries.⁹ All patient enrollees must have at least one chronic disease, making approximately 86 percent of Medicare beneficiaries eligible. The beneficiaries will be in Medicare's fee-for-service population, and not Medicare Advantage plans. For practices to be eligible, they must be physician led (by a first contact doctor), and able to transform into a tier 1 or tier 2 medical home.¹⁰ CMS will use a

modified version of the PPC-PCMH to determine the level of medical home achievement by subscribing physician offices.

Case management reimbursement to physicians, per patient, will also be based on the Hierarchical Condition Code (HCC) of that patient. The HCC score is a risk-adjusted approximation of the severity of a beneficiary's health condition. According to CMS, “HCC scores ≤ 1.6 represent beneficiaries who are less ill and require less physician effort to manage. Those with scores ≥ 1.6 are considered more ill and require more physician effort to manage the patient.”¹¹ As such, practices will receive a higher rate of compensation, per patient per month, for patients with higher scores.

As these and other projects reach their evaluatory stage, stakeholders will be eager to see the results of the clinical outcomes and costs of this standardized intervention. Among the questions that Dr. Meredith Rosenthal, a key PCMH evaluator from the Harvard School of Public Health, says evaluations must answer are:

- “Do practices that conform to PCMH criteria deliver:
 - Better quality of care?
 - Better patient experiences?
 - Lower total cost?
 - Improved physician and staff satisfaction?
- What does it take to turn practices in PCMHs?
- Is there a business case for the PCMH – for payers? For providers?”¹²

To help answer these questions, Dr. Rosenthal has outlined a process in the Rhode Island Chronic Care Sustainability Initiative's project to collect information on service utilization, costs, clinical outcomes, and patient experiences. This data will be collected pre-intervention and compared to the same data post-intervention. There will also be a control group that did not receive any intervention.

Although the evaluation of the multi-payer demonstration projects is several years away, evidence of earlier studies that evaluated elements of the PCMH provide good cause for other interested parties to collaborate and form partnerships and start similar efforts. The importance of public/private partnerships in PCMH efforts are critical and likely result in widespread adoption of care that is more attentive, personalized, and coordinated primary care and yields better health outcomes and more efficient utilization.

ACKNOWLEDGEMENTS

The National Academy for State Health Policy and the Patient Centered Primary Care Collaborative would like to thank several parties for making this report possible. First, thanks to The Commonwealth Fund and Melinda Abrams, for their support of the NASHP-PCPCC Partnership. Appreciation also goes to the members of the NASHP-PCPCC advisory group for their guidance in developing the Web seminar on which this brief is based and their review of the draft brief. Thanks also go to our Web seminar speakers: James Coan of CMS, Shari Erickson of American College of Physicians, Phil Magistro of Pennsylvania Governor's Office of Health Care Reform, and Meredith Rosenthal of Harvard University. In particular, appreciation goes to: Dawn Bazarko of United Healthcare, Paul Grundy of the PCPCC and IBM, Deborah Kilstein of the Association for Community Affiliated Plans, JoAnn Lamphere of the AARP, MaryAnne Lindeblad, Washington state, Stephen Saunders, Illinois, Barbara Starfield of the Johns Hopkins Bloomberg School of Public Health, and Fan Tait and Judy Dolins of the American Academy of Pediatrics. Finally, the authors thank Edwina Rogers of the Patient Centered Primary Care Collaborative and Neva Kaye and Mary Takach of NASHP for their tireless research and thoughtful review of these materials.

ENDNOTES

- 1 2008. American Academy of Pediatrics. <http://www.medicalhomeinfo.org/>
- 2 2009. GroupHealth. MacColl Institute for Healthcare Innovation. <http://www.centerforhealthstudies.org/maccoll/maccoll.html>
- 3 2009. Community Care of North Carolina. <http://www.communitycarenc.com/Publications.htm>
- 4 Starfield B, Shi L, and Macinko J., Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood)*. 2001;20:64-78;ions of Primary Care to Health Systems and Health, *Millbank Quarterly*, 2005;83:457-502; Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006
- 5 Magistro, Philip. AcademyHealth State Health Research and Policy Interest Group. The Pennsylvania Chronic Care Initiative. February 3, 2009. <http://www.ahsrhp.org/interestgroups/shrp/2009/Magistro.pdf>
- 6 The PPC-PCMH was developed by NCQA to be specifically based on the PCMH's Joint Principles, and was created in concert with key PCPCC stakeholders, including primary care groups and large employers. As of now, out of the 22 private sector demonstration projects recently identified in the PCPCC's compilation of projects, 16 are using some form of the PPC-PCMH. Patient Centered Medical Home- Building Evidence and Momentum, A compilation of PCMH pilot and demonstration projects
- 7 The Henry J. Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. Medicaid: A Lower-Cost Approach to Serving a High-Cost Population. March 2004. <http://www.kff.org/medicaid/upload/Medicaid-A-Lower-Cost-Approach-to-Serving-a-High-Cost-Population.pdf>
- 8 Section 204(b) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b-1 note)
- 9 Coan, James. American College of Physicians. Medicare Medical Home Demonstration: Overview. October 28, 2008. http://www.acponline.org/running_practice/pcmh/demonstrations/design.pdf
- 10 Ibid
- 11 Ibid
- 12 Rosenthal, Meredith, PhD. National Academy for State Health Policy. Evaluation of Patient Centered Medical Home Initiatives. November 12, 2008. http://www.nashp.org/Files/Rosenthal_MultiPayerPilots.pdf

NATIONAL ACADEMY for STATE HEALTH POLICY

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice.

As a non-profit, non-partisan organization dedicated to helping states achieve excellence in

health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

Citation:

Beesla, Rohan and Ugrinic, Relja
Public Payer Medical Home Initiatives (April 2009, Portland, ME: National Academy for State Health Policy).

Portland, Maine Office:

10 Free Street, 2nd Floor, Portland, ME 04101
Phone: [207] 874-6524

Washington, D.C. Office:

1233 20th Street NW, Suite 303, Washington, D.C. 20036
Phone: [202] 903-0101