Evolving Medical Home Payment Models to Better Support Triple Aim Goals

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Welcome and Introductory Remarks

Mary Takach
Program Director
National Academy for State Health Policy
Webinar goals

- Describe how leading states are evolving their medical home programs to further drive system goals
- Focus on three states: where they started, where they are now and where they hope to go
- Discuss how the Affordable Care Act (ACA) is accelerating the adoption of some of these models
Agenda

• Welcome and Introductory Remarks
  Mary Takach, MPH, RN, Program Director, National Academy for State Health Policy

• Colorado’s Accountable Care Collaborative
  Kathryn Jantz and Greg Trollan, Program Performance Specialists, Colorado Department of Health Care Policy and Financing

• Questions and Answers

• The Rhode Island Patient Centered Medical Home All-Payer Initiative
  Deidre Gifford, MD, MPH, Medical Director, Rhode Island Executive Office of Health and Human Services
  Debra Hurwitz, MBA, BSN, RN, Project Co-Director, CSI Rhode Island

• Vermont’s Blueprint for Health
  Hunt Blair, Deputy Commissioner, Division of Health Reform, and State HIT Coordinator, Department of Vermont Health Access

• Questions and Answers

• Closing Thoughts
  Mary Takach, MPH, RN
NASHP Medical Homes Projects
Supported by The 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
Follow the road to reformed delivery systems
Patient Centered Medical Homes

Key model features:
- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Data & feedback
- Practice Education
- Health Information Technology

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

www.improvingchroniccare.org/downloads/care_coordination.ppt
Medicaid medical home payments

- Making medical home payments (26)
- Payments based on qualification standards (22)
- Payments based on qualification standards, making payments in a multi-payer initiative (12)
- Participating in MAPCP Initiative (8)
## Select Care Coordination Payments in 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>
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</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>$1.50 - $3.00</td>
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<tr>
<td>Maine</td>
<td>$3.00 - $7.00</td>
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<tr>
<td>Maryland</td>
<td>$4.68 - $8.66</td>
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<tr>
<td>Massachusetts</td>
<td>$2.10 - $7.50</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>Oklahoma</td>
<td>$2.93 - $8.41</td>
<td>▲</td>
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<tr>
<td>Pennsylvania¹</td>
<td>$1.68 - $6.56</td>
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<tr>
<td>Rhode Island</td>
<td>$5.00 - $6.00</td>
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<tr>
<td>Vermont</td>
<td>$1.20 - $2.39</td>
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<tr>
<td>Washington</td>
<td>$2.00 - $2.50</td>
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</tbody>
</table>

¹ Reflects payment model for Northeast and Southeast roll-outs of the Chronic Care Initiative
Multi-disciplinary team models

Making room for teams and new services

Key model features:

- Practice-based services
- Teams are often shared among practices
- Dedicated care coordinators
- Integrated primary care/behavioral health services
- Patients and families “on the team”
## Select Emerging Shared Team Models

<table>
<thead>
<tr>
<th>Eligible Organizations</th>
<th>Scope</th>
<th>Payment</th>
<th>Key Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alabama: Patient Care Networks of Alabama</strong></td>
<td>Newly created entities</td>
<td>3 care networks, 135 PCPs, 80,000 eligible patients</td>
<td>$5 per-member-per-month (PMPM) for ABD Medicaid, $3 PMPM for Medicaid, plus startup expenses</td>
</tr>
<tr>
<td><strong>Maine: Community Care Teams</strong></td>
<td>Include home care providers, hospitals and FQHCs</td>
<td>8 care teams, 214 PCPs, 150,000 eligible patients</td>
<td>$3 PMPM for Medicaid, $2.95 PMPM for Medicare, $0.30 for privately insured</td>
</tr>
<tr>
<td><strong>Montana: Health Improvement Program</strong></td>
<td>FQHCs and tribal health centers</td>
<td>14 centers, 32.5 FTE care managers, 3,500 patients receiving care management (5% of all eligible)</td>
<td>$3.75 PMPM</td>
</tr>
<tr>
<td><strong>New York: Adirondack Region Medical Home Pilot Pods</strong></td>
<td>Three pods: One based in an FQHC, two based in hospitals</td>
<td>3 pods, 194 PCPs, 103,116 eligible patients</td>
<td>Enhanced PMPM payment to providers who contract with pods: Pod payment range $1.10 - $3.50 PMPM</td>
</tr>
</tbody>
</table>
Neighborhood (health home) models

Key model features:
- Focus on chronic conditions
- Qualification standards must include: coordination between providers, comprehensive transition care, behavioral health & long term services integration, use of health information technology
- Robust community & social services linkages
- Individual & family support resources
## Select 2703 Health Homes Payment Models

<table>
<thead>
<tr>
<th>SPA</th>
<th>Payment Model</th>
<th>Payment</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri - Behavioral Health</td>
<td>Care Management Fee</td>
<td>$78.74 Per Member Per Month</td>
<td>Community Mental Health Centers</td>
</tr>
<tr>
<td>Missouri - Physical Health</td>
<td>Care Management Fee</td>
<td>$58.87 Per Member Per Month</td>
<td>FQHCs, RHCs, Hospital Clinics</td>
</tr>
<tr>
<td>New York</td>
<td>Care Management Fee (Adj. for geog. &amp; case-mix)</td>
<td>$75 - $390 Per Member Per Month</td>
<td>FQHCs, Hospitals Clinics Managed Care Plans, etc.</td>
</tr>
<tr>
<td>Rhode Island - Children and Youth with Special Health Care Needs</td>
<td>Flat Service-based Rates</td>
<td>$347 - $397; $9.50 - $16.63 per 15 minutes for additional services (based on provider education level)</td>
<td>Rhode Island CEDARR Family Health Centers</td>
</tr>
<tr>
<td>Rhode Island - Behavioral Health</td>
<td>Monthly Case Rate</td>
<td>$446.51</td>
<td>Community Mental Health Organizations</td>
</tr>
</tbody>
</table>

Approved SPAs as of 03/12/12
Community integrated system models

Key model features:
- High-performing primary care providers
- Central hub linked to community or regional networks
- Population health management tools
- Health information technology & exchange
- Shared goals & risk
- Engaged patients
The ACA provides resources to help states reach delivery system goals.
For more information

- http://nashp.org/med-home-map
- www.statereforum.org
- www.pcpcc.net
- mtakach@nashp.org