Initial Models for Health Home Program Development

November 29, 2011; 2-3:30PM (ET)

- For audio, dial: 1-877-668-4490; Meeting/Event Number: 719 105 325
- A video archive will be posted on http://www.medicaid.gov.

For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

Initial Models for Health Home Program Development

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Types of Technical Assistance with Health Home Development

- One-on-one technical support to states
- Peer-learning collaboratives
- Webinars open to all states
- Online library of hands-on tools and resources

SPA Comparison Matrix

- Contains key elements from draft 2703 health home SPAs, including: target population, delivery system, providers, enrollment strategy, payment and geographic area
- Draft SPA information from states working with ICRC, included with state permission and review
- Continuously changing document which will be routinely updated on our website

Themes from Comparison Matrix

- Building upon existing building blocks, initiatives and pilots
- Including all targeted chronic conditions (and then some), and/or targeting SPMI
- Varying in enrollment strategies
- Adopting a per capita payment based on criteria, often tiered
- Varying involvement of health plans
- Varying approaches to geographic reach of program

State-by-State Health Home State Plan Amendment Matrix: Summary Overview

This matrix outlines key program design features from draft health home State Plan Amendments (SPAs) submitted to the Centers for Medicare & Medicaid Services (CMS). This document captures what states have proposed in draft or final SPAs submitted as of January 2012. Note that ***program design changes may be required to address any concerns CMS may have and as such, states are continuously revising their draft SPAs***. For more information about health homes (HH), visit www.integratedcareresourcecenter.com.

State	Target Population	Delivery System	HH Providers	Enrollment	Payment	Geographic Area
	Consistent with definition in statute plus Hypertension	FFS Program	Interested clinics/practices that contain at least one MD, DO or ARNP meeting State standards that align with a PCMH delivery model.	Patient can opt-in when beneficiary presents at HH provider's office	Care management PMPM Performance payment based on quality	Statewide
Missouri CMHC SPA Status: Final SPA approved (10/20/11)	SPMI only Mental health (MH) or substance abuse (SA) disorder plus a chronic condition MH or SA disorder plus tobacco use	Managed care program Fee-for-service (FFS) program State contracting directly with HH providers	CMHC meeting State qualifications CMHCs well-positioned to be HH providers after ongoing investments in recent years (e.g., disease management, care management, electronic health records (EHR), etc.)	Eligible individuals identified, auto-assigned, and notified by State Beneficiary has option to change HH providers or opt out Potential eligible individuals receiving services in emergency department (ED) notified and referred to a health home	Clinical care management per-member-per-month (PMPM) payment Interested in shared savings strategy and performance incentive payment – both for HH providers and for Medicaid - and will revisit after initial approval	Statewide
Missouri PCP SPA: Status: Final SPA approved (12/22/11)	At least two of the following: asthma, cardiovascular disease, diabetes, developmental disabilities (DD), or overweight (BMI >25); *or* One of the previous chronic conditions and at risk of developing another	Managed care program FFS program State contracting directly with HH providers	Designated providers of HH services will be FQHCs, RHCs and primary care clinics operated by hospitals	Eligible individuals identified, auto-assigned and notified by State Beneficiary has option to either change HH providers or opt out of program Potential eligible individuals receiving services in ED notified and referred to a health home	same as CMHC	Statewide

State Presentations

- Missouri
  - Dr. Ian McCaslin and Dr. Joe Parks
  - CMHC SPA approved 10/20/11, 1/1/12 start date
  - PCMH SPA “on the clock”
- Oregon
  - Nicole Merrithew and Ralph Summers
  - SPA “on the clock”

Health Homes in Missouri

Joe Parks, M.D.

Health Homes
Affordable Care Act

- Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide **Health Homes** for enrollees with chronic conditions.
- Missouri is seeking approval from the Centers for Medicare & Medicaid Services (CMS) to be able to provide Health Homes to Missourians who are Medicaid eligible participants with chronic illnesses.

What is a Health Home?

A “Health Home” is a place where individuals can come throughout their lifetimes to have their health care needs identified and to receive the medical, behavioral and related social services and supports they need, coordinated in a way that recognizes all of their needs as individuals -- not just patients.

Missouri's Health Homes

- Missouri is the first state to submit a state plan amendment to implement Health Homes.
- Missouri will have the following types of Health Homes:
  - Primary Care Health Home for Chronic Conditions
  - Behavioral Care Health Home for Chronic Conditions
  - Multi-Payer Medical Home for all covered lives

Missouri's Health Homes

Primary Care Health Home

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Physician practices

Behavioral Care Health Home

- Community Mental Health Centers (CMHCs) & CMHC affiliates

Multi-Payer Medical Home

Partners in Planning

The planning process for Missouri's Health Home model has included stakeholders and has been a collaborative effort between the following:

- DSS, DMH
- MO Foundation for Health
- MO Primary Care Association (PCA)
- MO Coalition of Community Mental Health Centers (CMHCs)
- Consultants: Michael Bailit & Alicia Smith
- Missouri Hospital Association
- Missouri School Board Association

Health Homes

This model is intended to be a means to:

1. Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
2. Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model*; and
3. Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.

**The Fiscal Year 2012 state budget assumes $7.8 million in savings from the Health Home initiative*

Health Home Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on
  - Providing **health and wellness** education and opportunities
  - Assuring consumers receive the **preventive and primary care** they need
  - Assuring consumers with **chronic**
  - **physical health conditions** receive the
  - medical care they need
    and assisting them in managing their chronic illnesses and accessing needed community and social supports

Health Home Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on
  - Facilitating **general hospital admissions and discharges** related to general medical conditions in addition to mental health issues
  - Using **health information technology** to assist in managing health care
  - Providing or arranging appropriate **education and supports for families** related to consumers’ general medical and chronic physical health conditions

Missouri's Goals:

- Reduce inpatient hospitalization and E.R. visits,
- Enhance the amount of primary care nurse liaison staffing and primary care physician consultation available at CMHCs,
- Enhance the behavioral consultation available at primary care centers, and
- Enhance the State's ability to provide transitional care between institutions and the community.

Eligibility

Who is eligible to be served in by a Health Home?

1. Persons covered by Mo HealthNet including those covered through Mo HealthNet's Managed Care Plans;
2. Persons with 2 chronic conditions;
3. Persons with 1 chronic condition who are also at risk for a 2nd chronic condition; and/or
4. Persons who have 1 serious and persistent mental health condition

Chronic Conditions:

Chronic health conditions include:

1. Asthma
2. Diabetes*
3. Cardiovascular disease – including hypertension
4. Overweight (BMI >25)
5. Tobacco use*
6. Developmental Disabilities

* Smoking or diabetes qualifies a person for being at risk of having a 2nd chronic condition

Components of a CMS Section 2703 Health Home

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care including follow-up from inpatient and other settings
5. Patient and family support
6. Referral to community and support services

Components of a Health Home

1. Comprehensive care management

Conducted by licensed nurses and involve:

- Identification of high-risk individuals and use of client information to determine level of participation in care management services; assessment of preliminary service needs;
- Treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
- Assignment by the care manager of health team roles and responsibilities;
- Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
- Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Components of a Health Home

2. Care coordination

- This is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports -- e.g. appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members.

Components of a Health Home

3. Health promotion

- Health promotion services will consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
- Health promotion services also assist patients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

Components of a Health Home

4. Comprehensive transitional care including follow-up from inpatient and other settings

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management.

Components of a Health Home

5. Patient and family support

These service activities include, but are not limited to:

- Advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments.
- Health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition.

Components of a Health Home

6. Referral to community and support services

These services involve providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples.

For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for this service.

Use of Health Information Technology to Link Services

- **CyberAccess:** MO HealthNet ("MHN") maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices and schools.
- **Direct Inform as EMR patient portal:** A module of the MHN comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning.

Use of Health Information Technology to Link Services

- MHN maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MHN (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay.
- MHN and DMH are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a healthcare home. The contractor would then immediately notify the healthcare home provider of the admission.

Who will provide the services?

- Applications were disseminated by the State for primary health care and behavioral health care providers to complete and return to the State for consideration to become Health Homes.
- The applications have been reviewed by Mo HealthNet and Dept. of Mental Health to make the final determination of selected practice sites.

Who will provide the services?

- Sites were chosen based upon the merits of each individual application and upon the CMS requirement that there be statewide geographic representation.
- At least 25% of a provider's patient base must consist of Medicaid patients and/or uninsured patients.

Who will provide the services?

- Health Homes will work to transform their practices over a 2-year period by participating in ongoing training sessions or “learning collaboratives.”
- CMHCs will be required to obtain Health Home certification through nationally recognized Health Home accrediting organizations.
- Primary care practices will be required to obtain NCQA (National Committee for Quality Assurance) Health Home certification.

Who will provide the services?

- DSS is seeking primary care practice sites that are comprised of licensed physicians collaborating with other licensed health care professionals, including nurse practitioners and physician assistants, to serve as Health Homes.
- Because this model emphasizes the integration of primary health care and behavioral health care, the primary care practices will need to establish or enhance the presence of behavioral health consultant staffing at these sites.

Primary Care Sites Chosen

1. 19 FQHCs operating 70 clinic sites
2. 5 Public Hospitals operating 22 sites
3. One Independent Rural Health Clinic

Behavioral Health Care Sites

- DMH is seeking CMHCs with existing Division of Comprehensive Psychiatric Services contracts to serve as Health Homes for Medicaid beneficiaries.
- While some CMHCs have already begun to deliver services based on the Health Home model, the behavioral health providers will be required to:
  1. Better integrate their practices,
  2. Do more outreach and coordination with hospitals and primary care clinics, and
  3. Enhance the amount of primary care nurse liaison staffing available at CMHCs.

- Because addressing general health issues is necessary in order to improve outcomes and quality of care
- Because treating illness is not enough
  - Wellness and prevention are as important as treatment and rehabilitation.

- Health Home Manager
  - Provides leadership in the implementation and coordination of Health Home activities
  - Champions practice transformation based on Health Home principles
  - Develops and maintains working relationships with behavioral health providers and CMHCs
  - Monitors Health Home performance and leads improvement efforts
  - May design and develop health and wellness initiatives

- Health Home Physician
  - Not funded in PMP
  - Provides medical leadership:
    - Participates in treatment planning
    - Guides other team members on specific patient health issues
    - Assists coordination with external medical providers

- Nurse Care Managers
  - Develop wellness and prevention initiatives
  - Facilitate health education groups
  - Participate in the initial treatment plan development for all of their Health Home enrollees
  - Assist in developing treatment plan healthcare goals for individuals with co-occurring chronic diseases
  - Consult with Care Coordinators and Behavioral Health Consultant about identified health conditions
  - Assist in contacting behavioral health providers and CMHCs regarding a patient's admission/discharge from the hospital

- Nurse Care Managers
  - Provide training on medical diseases, treatments and medications
  - Track required assessments and screenings
  - Assist in implementing DMH Net health technology programs and initiatives (such as CyberAccess and metabolic screening)
  - Monitor HIT tools and reports for treatment and medication alerts and hospital admissions/discharges
  - Monitor and report performance measures and outcomes

Behavioral Health Consultant

- Management of psychosocial aspects of chronic and acute diseases
- Application of behavioral principles to address lifestyle and health risk issues
- Emphasis on prevention and self-help approaches
- Build resiliency and encourage personal responsibility for health
- SBIRT for drug, alcohol, tobacco and depression
- Consultation and co-management in the treatment of mental disorders and psychosocial issues

Care Coordinator

- Referral tracking
- Data management and reporting
- Scheduling for Health Home Team and enrollees
- Chart audits for compliance
- Reminding enrollees regarding keeping appointments, filling prescriptions, etc.
- Requesting and sending Medical Records for care coordination

Payment Method

- Providers that meet the Health Home requirements will receive **Per-Member-Per-Month (PMPM)** payments (current est. $75-50) for performing various Health Home activities
- Providers will be required to pay a small PMPM ($2-3) to MPCA for data management, training, technical and administrative support
- The current state plan will be amended in future to add a request for a second payment method so that providers may receive **incentive payments** based on shared savings and relating to performance.

Per Member Per Month

- **Clinical Care Management per-member-per-month payment**:

  Using a methodology developed by DSS and DMH, practice sites will be reimbursed for the cost of staff primarily responsible for delivery of services not covered by other reimbursement (primary care nurses, behavioral health consultants) whose duties are not otherwise reimbursable by Medicaid.

Performance Incentive Payment

- When the state plan amendment is amended in the future, the state will propose that practice sites could be paid for up to 50% of the value of the reduction in total health care per-member-per-month costs for the practice site's attributed MHN patients, relative to prior year experience. Savings will be distributed on a sliding scale based on performance relative to a set of site-specific preventive and chronic care measures generated and reported by the practice and subject to DSS audit.

Goals and Measures

1. Improve primary health care.
2. Improve behavioral health care.
3. Improve patient empowerment and activation.
4. Improve coordination of care.
5. Improve preventive care.
6. Improve diabetes care.
7. Improve asthma care.
8. Improve cardiovascular care.

Goal #1: Improve Primary Health Care

- Ambulatory Care-Sensitive Condition Admission Rate - Ambulatory care-sensitive condition- age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs.
- Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure).
- Care Coordination : % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.
- Hospital Readmission Rate: Hospital readmissions within 30 days.

Goal #2: Improve Behavioral Health Care

- Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days.
- Reduce excessive drinking of alcohol.
- Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers - % members on that class of medication with medication possession ratios (MPR) > 80% .
- % of children 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
- % of patients 18 years of age and older receiving depression screening through the use of a standardized screening instruments within the measurement period.
- % of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary.

Goal #3: Improve Patient Empowerment & Activation

- Patient use of personal EHR - either practice EMR patient portal or CyberAccess or its successor
- Patient Satisfaction

Goal #4: Improve Coordination of Care

- Use of CyberAccess per member per month (or its successor) for non-managed care organization enrollees
- % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from primary care physician.

Goal #5: Improve Preventive Care

- % of patients with documented BMI between 18.5–24.9.
- % of children 2 years of age who had 4 DtaP/DT, 3 IPV, a MMR, 3 H influenza type B, 3 hepatitis B, a chicken pox vaccine (VZV) and 4 pneumococcal conjugate vaccines by their 2nd birthday.
- % of patients aged 18 years and older with a calculated BMI in the past 6 mo. or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Adult Weight Screening and Follow-Up.

Goal #6: Improve Diabetes Care

- % of patients 18–75 yrs. old with diabetes (type 1 or 2) who had HbA1c <8.0%.
- % of patients 18–75 yrs. old with diabetes (type 1 or 2) who had:
  - HbA1c >9.0%.
  - BP <140/90 mmHg
  - LDL-C <100mg/dL
  - HbA1c documented in the last 6 months during measurement period (*move to optional after 12 mo.*)

Goal #7: Improve Asthma Care

- % of patients **5-17 years** of age who were identified as having persistent asthma and were appropriately prescribed medication **(controller medication)** during the measurement period.
- % of patients 18-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Goal #8: Improve Cardiovascular Care

- % of patients aged 18 years and older with a diagnosis of hypertension with a blood pressure <140/90 mm Hg OR patients with a blood pressure >= 140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during the most recent office visit within a 12 month period.
- Adherence CVD and Anti-Hypertensive Meds.
- % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).
- % of patients aged 18 years and older with a diagnosis of heart failure who were prescribed ACE inhibitor or ARB therapy.
- % of patients aged 18 years and older with a diagnosis of heart failure and who were prescribed beta-blocker therapy.

Data Management and Analytics

- Clinical Information via MPCA data warehouse
- Hospital and ER utilization from claims
- Notification of Hospital Admit from MHN concurrent authorization system
- Care Coordination via CyberAccess
- Medication Adherence reports

Adherence: Quarterly Reports

- Detailed report of Non-Adherent* patients
  - Patient Name
  - Prescriber Name
  - Medication Name
  - Medication Type
  - Last Fill Date
  - Medication Possession Ratios (MPRs) for prior 90 days

Non-Adherence = Medication Possession Ratio (MPR) <0.8

CMT
Care Management Technologies

Insight and Action in Behavioral Health

Adherence: Quarterly Reports

- Covers Multiple Drug Classes
  - Diabetes Meds
  - Antihypertensives
  - Cardiovascular Meds
  - COPD Meds
  - Antidepressants
  - Mood Stabilizers
  - Antipsychotics

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Insight and Action in Behavioral Health

Adherence: Quarterly Reports

- Delivered via e-mail in password-protected Excel file
- Easily filtered and/or sorted to individual user's needs

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Quarterly Adherence Reports

Centerville Health Clinic

Three month rolling quarter ending 05/2011

PatientId	PatientName	PatientDOB	DrugType	LabelName	DrugMPR	LastFillDate	PrescriberName
			AntiPsychotic	ABILIFY 15 MG TABLET	0.6885	4/1/2011	Duarte-sckell Sandra
			AntiDepressants	LEXAPRO 10 MG TABLET	0.7077	5/25/2011	SUSAN MINCHIN
			AntiDepressants	LEXAPRO 20 MG TABLET	0.7391	5/25/2011	SUSAN MINCHIN
			AntiPsychotic	ABILIFY 20 MG TABLET	0.5978	5/25/2011	SUSAN MINCHIN
			Mood Stabilizers	DIVALPROEX SOD ER 500 MG TAB	0.2391	5/25/2011	SUSAN MINCHIN
			AntiPsychotic	INVEGA ER 9 MG TABLET	0.2283	5/10/2011	Chaganti Surendra
			Anti-Hypertensive	VERAPAMIL 80 MG TABLET	0.6739	5/2/2011	Day Caroline
			Cardiovascular	VERAPAMIL 80 MG TABLET	0.6739	5/2/2011	Day Caroline
			Mood Stabilizers	LAMOTRIGINE 25 MG TABLET	0.7935	5/6/2011	ST LOUIS UNIVERSITY HOSPITAL
			AntiDepressants	SERTRALINE HCL 100 MG TABLET	0.7065	5/19/2011	Fan Baolin
			Anti-Hypertensive	ATENOLOL 50 MG TABLET	0.7065	5/19/2011	Fan Baolin
			Anti-Hypertensive	LISINOPRIL 20 MG TABLET	0.7065	5/19/2011	Fan Baolin
			AntiPsychotic	TRIFLUOPERAZINE 2 MG TABLET	0.7065	5/19/2011	Fan Baolin
			Diabetes	GLIPIZIDE ER 10 MG TABLET	0.5618	5/12/2011	Pachalla Vani
			Cardiovascular	LISINOPRIL 20 MG TABLET	0.7065	5/19/2011	Fan Baolin
			COPD	ADVAIR 250-50 DISKUS	0.4857	5/28/2011	Singh Prithvi

Adherence: Lapsed Refill Alerts

- Online Notification of Lapsed Medication Refills
- Updated daily
  - Flags lapses as quickly as one day past due
- Detailed Report of Patients with Lapses
  - Patient Name
  - Prescriber Name
  - Medication Name
  - Medication Type
  - Refill Date
  - # Days Late
  - Medication Possession Ratios (MPRs) for prior 90 days
  - Gap Analysis of prior lapses in refills

CMT
Care Management Technologies

Insight and Action in Behavioral Health

Adherence: Lapsed Refill Alerts

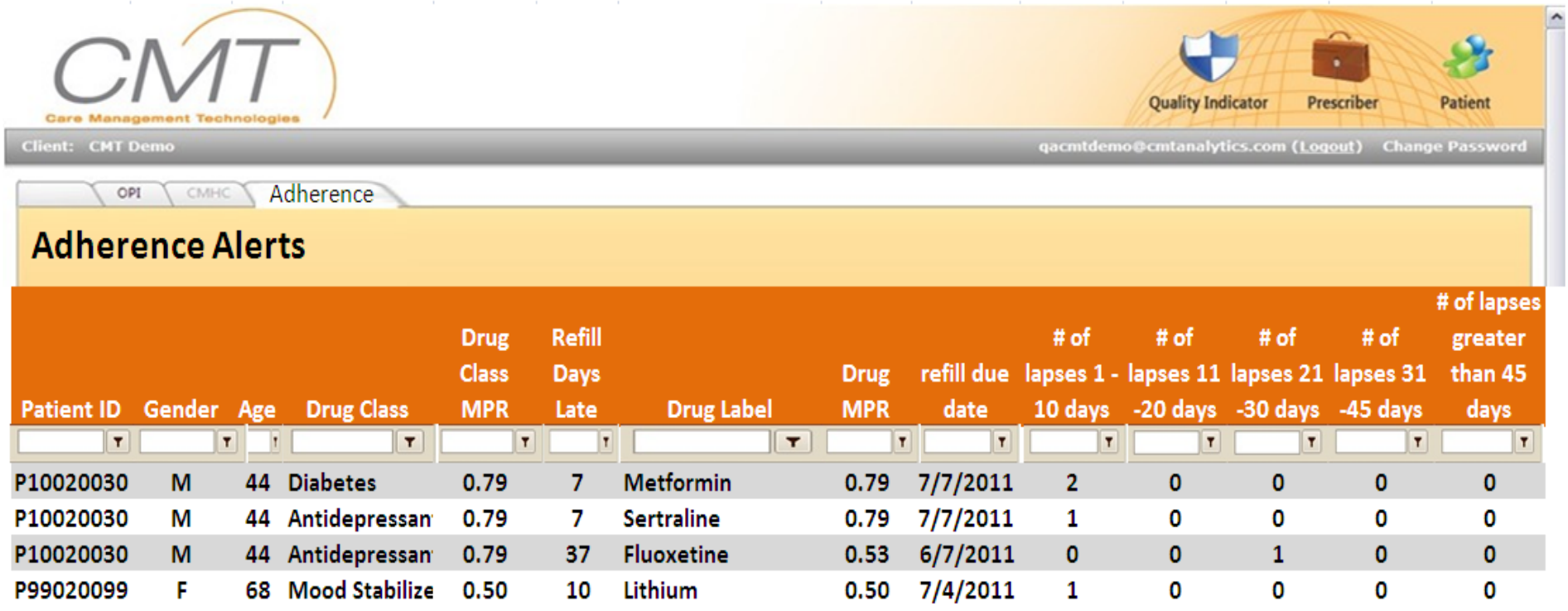
- Covers Multiple Drug Classes
  - Antipsychotics
  - Antidepressants
  - Mood Stabilizers
  - Diabetes Meds
  - Antihypertensives
  - Cardiovascular Meds
  - COPD Meds

CMT
Care Management Technologies

Insight and Action in Behavioral Health

Adherence: Lapsed Refill Alerts

- Immediately Actionable information
  - Care managers can intervene immediately to get patient restarted on medication, avoiding costly deterioration or hospitalization
- Delivered online via *Online Analytics*



Patient ID	Gender	Age	Drug Class	Drug Class MPR	Refill Days Late	Drug Label	Drug MPR	refill due date	# of lapses 1 - 10 days	# of lapses 11 -20 days	# of lapses 21 -30 days	# of lapses 31 -45 days	# of lapses greater than 45 days
P10020030	M	44	Diabetes	0.79	7	Metformin	0.79	7/7/2011	2	0	0	0	0
P10020030	M	44	Antidepressan	0.79	7	Sertraline	0.79	7/7/2011	1	0	0	0	0
P10020030	M	44	Antidepressan	0.79	37	Fluoxetine	0.53	6/7/2011	0	0	1	0	0
P99020099	F	68	Mood Stabilize	0.50	10	Lithium	0.50	7/4/2011	1	0	0	0	0

- Focus on overall health with Behavioral Health/Primary Care Integration
- Improved Clinic processes (may include)
  - Enhanced scheduling
  - No show/cancellation policies
- Significant increase in data reporting and outcomes
- Increased patient input processes
- Increased Treatment planning

- Multi-stakeholder initiative to promote medical home transformation to increase access, and to improve quality of care and efficiency of care.
- Council composed of public and commercial payers, primary care clinicians, hospital systems, employers, consumer reps, and academic researchers are doing planning
- Convened by MFH and oversight provided by MO HealthNet
- Interest in expanding into Kansas City, MO area

Who Applied to be a Medical Home?

- MO HealthNet
  - 28 Practices representing 102 sites
- Multi-payer Initiative
  - 10 Practices representing 41 sites
- CMHC
  - 28 Practices representing 50 sites
- Final practice selection and notification in next 10 days

Learning Collaborative Structure

- Learning Collaborative is series of training initiatives, involving:
  - Pre-work activities
    - Develop EMR or patient registry capability to produce performance measurement data
    - Conference calls/webinar trainings on Medical Home concepts
    - Perform pre-work tasks, such as forming care team, mapping process flows, doing Medical Home gap analysis
  - Learning Sessions
    - 9 all-day training sessions – 7 in the first 12 months and 2 in second 12 months
    - Care team attendees: clinical champion, other clinician and non-clinical support person, trainer (if necessary)

Learning Collaborative: Example Curriculum Topics

- Patient Centered Medical Home (PCMH) principles
- Leadership
- Interdisciplinary Care Teams
- Quality Improvement Basics
- Population Management
- Care Coordination
- Complex Care Management
- Behavioral Health-Primary Care Integration

Learning Collaborative: Example Curriculum Topics continued

- Empanelment
- Evidence-Based Decision Making
- Providing Self-Management Support
- Care Transitions
- Prevention and Health Promotion
- Managing Community Partnerships
- Health Literacy and Culture
- Engaging Patients

Learning Collaborative Timing

- Four Learning Collaborative series will be held, tentatively scheduled for:
  - Learning Collaborative in St. Louis area, beginning in December 2011
  - Learning Collaborative in Mid-Missouri area, beginning in January 2012
  - Learning Collaborative in Kansas City for MO HealthNet practices, beginning in February 2012
  - Learning Collaborative in South County St Louis area, beginning in March 2012

MHMC: Types of Payments

1. For Medical Home Activities - $1.50 PMPM
   - Payment for traditionally non-reimbursed activities such as developing patient care plans, care coordination, self-management skill development, care team meetings
   - Begins month one
2. Clinical Care Management Services
   - $0.60 PMPM for patients less than 18 years old
   - $1.50 PMPM for adult between 18 and 64 years old
   - $6.00 PMPM for patients 65 and over
   - Begins once CCM is identified and continues so long as services are provided
3. Shared Savings – methodology still being refined

- Enhanced payments
  - PMPM payments for services not generally reimbursed (team meetings, patient outreach, etc.)
  - PMPM payments for clinical care management (care management for highest risk patients)
  - Opportunity to earn up to 40% of net savings
- 9-day Learning Collaborative over 2-years
  - Tentative locations: St. Louis, Columbia, KC
  - 50 practice sites per Collaborative plus trainers
- Monthly coaching conference calls
- Monthly feedback on performance

Aligning with MO Health Net Health Home

- Sharing Learning Collaborative resources
- Efforts to align data reporting requirements
- Similar practice application format and requirements
- Similar practice transformation requirements

- Awaiting payer response
- July – practice solicitation RFP released
- August – practices submit applications
- September – leadership interviews
- October – practices notified of selection

CSI Overview

- Leading consulting firm supporting innovation in health care
- Diverse experience base supporting Collaborative initiatives nationally
- CSI Principals serve on technical expert panels and advisory panels for the Commonwealth Fund, the National Association for Community Health Centers, the Center for Health Care Strategies, HRSA, Agency for Healthcare Research and Quality

CSI Supported Collaborations

CSI has supported more than 30 Collaboratives. Examples include:

- HRSA Collaboratives (Health Disparities, Patient Safety, HIV/AIDS, Rural QI, Finance and Redesign, Healthy Weight)
- West Virginia Multi-Payer Medical Home Collaboratives
- Ontario Ministry of Health Family Health Team Collaboratives
- Indian Health Service Improving Primary Care Collaboratives
- Wellmark Pay for Performance Collaborative
- Washington State Workplace Wellness Collaboratives
- West Virginia Hospital Readmission Reduction Collaborative
- ENACCT Cancer Collaboratives
- Beacon Communities Collaboratives

Missouri Foundation for Health Supported Collaboratives

- Designed through a multi-stakeholder process
- Promoting a Patient Centered Medical Home model in the context of a broader Health Home environment
- Opportunity for collaboration across primary care and behavioral health practice settings
- Selection announcements expected in the next two weeks
- Pre-work for the first collaborative expected to begin this October
- Current plans are for four regional Collaboratives all launching over a four month period

The collaboratives…

- Each will include between 25 and 40 teams
- Each will include a 6-8 week pre-work period, 9 face to face days of learning sessions over an 18 month period, and monthly teleconferences and action steps during the intersession periods
- Will require team-based participation by each practice
- Will require practice reporting on a standard set of process and outcome measures
- Will be evaluated based on the measures reported by practices, claims-based utilization and cost data, practice self-assessment on medical home characteristics, patient/ family feedback, and care team feedback

Update

- The State Plan Amendment for the Behavioral Health model was re-submitted to CMS on July 19, 2011.
- CMS has 90 days to respond/comment.
- Primary Care State Plan Amendment will be submitted to CMS in near future.
- Prompter approval is anticipated due to the PC SPA being 80% identical to the CMHC SPA
- CMHCs planned to start December 1.

Questions?

- Please visit our Health Home website: http://dmh.mo.gov/about/chiefclinicaloffice r/healthcarehome.htm

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ACA Section 2703:

An Overview of Oregon's Proposed Health Home State Plan Amendment

November 29, 2011

Oregon Health Authority

Presentation Objectives

- Identify the building blocks and provide context for Oregon's Health Home SPA development
- Highlight key program features
- Discuss lessons learned during the SPA development process

Building Blocks for Oregon's SPA

- HB 2009 established the Patient-Centered Primary Care Home (PCPCH) program within the Office for Oregon Health Policy and Research
- Key Functions:
  - Develop PCPCH Standards
  - PCPCH Recognition
  - Technical assistance development
  - Communication and provider outreach
  - Coordination across OHA divisions and health reform initiatives
- Resources available on the PCPCH Program website
  - http://www.primarycarehome.oregon.gov

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Primary Care Home Standards Advisory Committee

- 15 members, 6 ex-officio content experts
- Multiple stakeholders (patients, providers, plans, employers, health authority, public health)
- 7 public meetings Nov 2009 - Jan 2010
- Reviewed past work in Oregon, other state, federal and private efforts across the country
- Three principle products
    - PCPCH Core Attributes and Standards
    - PCPCH Measures
    - Guiding Principles for Implementation
- Reconvened second group in Fall 2010 with focus on pediatric and adolescent populations

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Oregon Patient-centered Primary Care Home Attributes and Standards

CORE ATTRIBUTE: ACCESS TO CARE
"Be there when we need you."

Standards:
- In-Person Access
- Telephone and Electronic Access
- Administrative Access

CORE ATTRIBUTE: ACCOUNTABILITY
"Take responsibility for making sure we receive the best possible health care."

Standards:
- Performance Improvement
- Cost and Utilization

CORE ATTRIBUTE: COMPREHENSIVE WHOLE PERSON CARE
"Provide or help us get the health care, information, and services we need."

Standard:
- Scope of Services

CORE ATTRIBUTE: CONTINUITY
"Be our partner over time in caring for us."

Standards:
- Provider Continuity
- Information Continuity
- Geographic Continuity

CORE ATTRIBUTE: COORDINATION AND INTEGRATION
"Help us navigate the health care system to get the care we need in a safe and timely way."

Standards:
- Data Management
- Care Coordination
- Care Planning

Core Attribute: PERSON AND FAMILY CENTERED CARE
"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."

Standards:
- Communication
- Education and Self-Management Support
- Experience of Care

Different Levels of Primary Care "Home-ness"

- Advance Primary Care Home
  - Proactive patient and population management
  - Accountable for quality, utilization and cost of care outcomes
- Intermediate Primary Care Home
  - Demonstrates performance improvement
  - Additional structure and process improvements
- Basic Primary Care Home
  - Foundational structures and processes

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Primary Care Home Measures *(Access to Care Example)*

ACCESS TO CARE – *Be there when we need you*

- In-Person Access

  Appointment Access Measures

  Tier 1 – Practice surveys a sample of its population on satisfaction with in-person access to care.

  Tier 2 – Practice surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools and reports on results on the access to care domain.

  Tier 3 – Practice surveys a sample of its population using one of the CAHPS survey tools, reports results on the access to care domain, and demonstrates improvement with patient satisfaction in access to care.

- Telephone and Electronic Access
- Administrative Access

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OHA PCPCH Initiative

Goals:

- All OHA covered lives receive care through a PCPCH
  - Includes Medicaid, public employees, Oregon educators, Oregon high-risk pool, Family Health Insurance Assistance Program, and Healthy Kids
- 75% of Oregonians have access to care through a PCPCH by 2015

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Key Program Features

- Target population
  - PCPCH Program target: All Oregonians
  - Sec. 2703 SPA target:
    - Individuals with one or more chronic condition
    - Individuals with one chronic condition and at-risk of another
    - Individuals with a serious mental illness
- Delivery system
  - Over 80% Medicaid Managed Care
    - 14 FCHPs, 2 PCO
    - 10 MHO
    - 8 DCO
  - Restructuring delivery system to Coordinated Care Organizations beginning July 2012

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Coordinated Care Organizations

- Key elements of CCOs:
  - Local control
  - Coordination
  - Global budgets and shared savings
  - Metrics/Performance measures
  - **Patient-Centered Primary Care Homes**

Key Program Features

- Beneficiary enrollment
  - FFS Providers submit patient lists identifying ACA vs. non-ACA qualified individuals
  - Medicaid MCOs provide patient lists of ACA Qualified individuals that are assigned to a PCPCH
  - Patient engagement required within 6 months of assignment
  - Patient opt-out available

Key Program Features: Health home services

- **Comprehensive Care Management**
  - Develop action plans for exacerbations of chronic illnesses and end- of-life care, when appropriate
  - Develop goals for self management, preventive and chronic illness care
- **Care Coordination**
  - Emphasis on continuity with the PCPCH provider or team
  - Develop a person-centered care plan
  - Track tests and result notification, track referrals ordered by its clinicians, and direct collaboration or co-management with specialty providers
  - Co-location of behavioral health and primary care is strongly encouraged
- **Health Promotion**
  - Promote the use of evidence based, culturally sensitive wellness and prevention
  - Link enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences
  - Promote patient/family education and self-management of the chronic conditions

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Key Program Features: Health home services

- **Comprehensive Transitional Care**
  - Hold written agreements and/or procedures in place with its usual hospital providers, local practitioners, health facilities and community based services to ensure notification and coordinated, safe transitions
- **Individual and Family Support Services**
  - Provide patient and family education, health promotion and prevention, self management supports, and information and assistance obtaining available non-health care community resources, services and supports
  - Use peer supports, support groups and self care programs to increase the client and caregivers knowledge about the client's individual disease
- **Referral to Community and Social Support Services**
  - Provide referral to community and social support services, such as patient and family education, health promotion and prevention, and self management support efforts, including available community resources, housing, nutrition, etc.

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Key Program Features: Provider standards

- Patient-Centered Primary Care Home (PCPCH) model
- Six Core Attributes
  - Access
  - Accountability
  - Comprehensive Whole Person Care
  - Continuity
  - Coordination and Integration
  - Person- and Family-Centered Care
- Each attribute has corresponding standards and measures
- Practices recognized as Tier 1, 2, or 3 depending on how advanced the PCPCH is

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Key Program Features

- Payment methodology
  - Automated PMPM payment
  - Member engagement must be documented in Medical Record
  - Payment for ACA Qualified Members available to FCHP's/PCO's
  - Medicaid FFS, PCPCH Fee Schedule
  - ACA Qualified Members
    - Tier 1 $10 PMPM
    - Tier 2 $15 PMPM
    - Tier 3 $24 PMPM
  - Non-ACA Qualified Members*
    - Tier 1 $2 PMPM
    - Tier 2 $4 PMPM
    - Tier 3 $6 PMPM

***NOT included in Section 2703 SPA**

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Lessons Learned

- Challenges
  - Flexibility around payment reform may be limited
  - Challenging to effectively align “competing” initiatives
  - Provider burn-out, initiative fatigue
  - Targeting an entire delivery system sector instead of a smaller intervention
- Successes
  - Targeting an entire delivery system sector instead of a smaller intervention
  - Opportunity to move forward with Oregon health reform
  - Stakeholder buy-in is critical

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Contact

http://primarycarehome.oregon.gov

http://health.oregon.gov

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