Medical Homes: Building Blocks to Health System Reform

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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
Where do you want to go?

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
Making medical home payments (30)
Payments based on provider qualification standards (28)
Payments based on provider 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)

As of June 2014

Multi-payer planning activity underway (3)
Multi-payer payments to medical homes underway (18)
Participating in Multi-payer Advanced Primary Care Practice Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)
Participating in Comprehensive Primary Care Initiative (CPCI) (7: AR, CO, NJ, NY, OH, OK, OR)

As of June 2014
Where do you want to go?

Multi-disciplinary teams

Expanding PCMH to make room for new services

Key model features:
- Practice teams—often shared among practices
- Payments to teams and qualified providers
- Patients and families “on the team”
- Teams are based in a variety of settings
Medicaid Supporting Shared Practice Team Models

As of June 2014

Shared Practice Team Programs (11: AL, IA, ME, MI, MN, MT, NY, NC, OK, RI, VT)


Where do you want to go?

Integrated Delivery Systems
Health Home Neighborhoods
Multi-Disciplinary Teams
Medical Homes

Background Image by Dave Cutler, Vanderbilt Medical Center (http://www.mc.vanderbilt.edu/lens/article/?id=216 &pg=095)
Medical Homes vs. Health Homes

**Medical Homes**
- Designed for everybody
- Primary care provider-led
- Primary care focus
- No enhanced federal Medicaid match

**2703 Health Homes**
- Designed for eligible individuals with a serious mental illness and/or specific chronic physical conditions
- Primary care provider is key, but not necessarily the lead
- Focus on linking primary care with behavioral health and long-term care
- Eight-quarter 90 percent federal Medicaid match
- Significant increase in financial support to providers

As of June 2014

States with stripes have both


ACA Section 2703 Health Home Activity

As of June 2014

- Approved State Plan Amendment(s) (15)
- Planning Grant (19)

Where do you want to go?

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

Integrated/Accountable Care Health 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
- 16 CCOs are operating in communities in Oregon providing ACO-like arrangements to coordinate care for Medicaid across multiple services
- CCOs must have capacity to assume risk. Each CCO receives a fixed global budget. These budgets include:
  - Capitated PMPM for physical, mental, and dental services
  - Transformation incentive payments
  - Medicare funding to blend with Medicaid funding for dual eligibles
- Expected to implement value-based alternatives to traditional FFS reimbursement methodologies (e.g. shared savings, bundled or episode-based payments, and global payments)
- CCOs to coordinate care and engage enrollees & providers in health promotion
- Meet key quality measurements while reducing spending growth by 2% over the next 2 years
Key Cost & Quality Drivers

✧ **Patient Care Networks of Alabama (early results)**
  - Early results from 2012¹
    - Per member per month costs down 7.1% compared with rest of the state
    - ER Utilization down 15% compared with rest of the state
    - Providers encouraged

✧ **Oklahoma SoonerCare Choice**²
  - Independent evaluation for period of 01/2009-06/2012 found that 30-day hospital readmission rate decreased by 26%
  - ER utilization declined significantly after the introduction of the PCMH model in 2009
  - Positive feedback from both providers and patients


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Key Cost & Quality Drivers

✧ **Minnesota Health Care Homes (HCH)**³
  - Program Evaluation (2010-2012)
    - Report found that HCHs outperformed non-HCHs on various clinical quality measures, including asthma care and diabetes care (statistically significant results)
    - Medicaid enrollees’ average per-capita cost was 9.2% lower for those attributed to a HCH

What have we learned?

- States have demonstrated a commitment and a unique role in advancing primary care
- Practice transformation takes time and resources
- Models are not static, status quo not an option
- Legislation works; leadership cannot be underestimated
- Data challenges are significant
- Cost savings are uncertain for now, budget neutrality is often the goal
- Public-private partnerships are critical
- Still a long road ahead!

For More Information

Please visit:
- www.nashp.org
- http://www.nashp.org/med-home-map
- www.statereforum.org
- www.pcpcc.net

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