Medical Assistance Program Oversight Council

January 10, 2014

Presentation Outline

- Evolution of the Concept of Patient-Centered Medical Home
- A New Model of HealthCare Delivery
- PCMH Program Standards
- PCMH Program – Transforming Health Care
- Participation Requirements
- Potential Benefits of a Medical Home
- Program Support
- Lessons Learned/Program Adaptations Implemented
- PCMH Progress to Date
- Next Steps

Evolution of the Concept of Patient-Centered Medical Home

- Medical Home is not a building but a concept of care
- This term was first used by American Academy of Pediatrics (AAP) in the 1960's to address care coordination for children with special healthcare needs
- In 2007, the AAP, American Academy of Family Physicians (AAFP), American College of Physicians (ACP), joined by the American Osteopathic Association (AOA) further refined elements of the concept to be called "patient-centered medical home"

Evolution of the Concept of Patient-Centered Medical Home (cont.)

- In 2008, the National Committee for Quality Assurance (NCQA) published Standards and Guidelines for Patient-Centered Medical Home

- Agency for Health Care Research and Quality (AHRQ) defines Medical Home:

  The primary care medical home, also referred to as the patient centered medical home, is a promising model for transforming the organization and delivery of primary care. AHRQ believes that health IT, workforce development, and payment reform are critical to achieving the potential of the medical home.

Evolution of the Concept of Patient Centered Medical Home (cont.)

- Several quality organizations have developed programs that recognize and/or accredit various health care organizations as medical homes according to specified sets of standards.

- All share the following Medical Home operational characteristics:
  - A personal provider coordinating all care for patients and leading the team
  - A care team working together with the person

Evolution of the Concept of Patient Centered Medical Home (cont.)

- A whole person approach to providing and coordinating comprehensive care
- Systematic performance of quality improvement activities with a focus on patient safety
- Enhanced access to care through improved scheduling and communication

Person-Centered Medical Home
A New Model of Healthcare Delivery

- As part of the larger health care transformation, DSS, State agencies, CHNCT and an array of stakeholders collaborated to define person-centeredness to serve as the framework for programs within Connecticut

- Person-centeredness focuses on:
  - Providing the Member with needed information, education, and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning;

Person-Centered Medical Home
A New Model of Healthcare Delivery (cont.)

- Supporting the Member, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and

- Reflecting care coordination under the direction of and in partnership with the Member and his/her representative(s), that is consistent with his or her personal preferences, choices and strengths, and that is implemented in the most integrated setting.

PCMH Program Standards

- The Medical Assistance Program Oversight Council in 2010 tasked its PCCM Committee with advising on development of a Person Centered Home initiative

- Throughout 2010 and 2011, the initiative's design had input from an advisory group representing:
  - Consumers
  - Providers
  - Advocates
  - State-Appointed Advisory Groups: PCCM Committee, MAPOC, CDHI Provider Pediatric Workgroup, and others

PCMH Program Standards (cont.)

- The Advisory Group evaluated a number of PCMH recognition programs and chose the National Committee for Quality Assurance (NCQA) to be the initial PCMH standard

- Subsequently in March 2013, the Joint Commission Primary Medical Home Certification option was added to accommodate eligible providers with active Ambulatory Care Accreditation

PCMH Program – Transforming Health Care

The DSS PCMH initiative is transforming healthcare through care delivery reform, payment reform and a new means of practice support.

- Care delivery reform includes practice transformation which supports:
  - Increasing access
  - Using data and metrics for informed decision-making
  - Improving members ability to make informed healthcare decisions

PCMH Program – Transforming Health Care (cont.)

- Payment reform includes the use of performance incentives, such as:
  - Add-on payments for selected primary care services
  - Incentive payments based on health measure results
  - Improvement payments in future years for demonstrated improved performance

- Practice support includes:
  - Glide Path Option
  - ASO team assistance

Who Can Participate as a DSS Person-Centered Medical Home?

- CT Medical Assistance Program (CMAP enrolled) providers with an active unrestricted CT license as an MD, DO, APRN or PA, whose primary care area of specialty is:
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Geriatrics

Who Can Participate as a DSS Person-Centered Medical Home? (cont.)

- Practice Settings:
  - Community-based practices
  - Federally Qualified Health Centers (including School Based Health Centers)
  - Hospital Outpatient Primary Care Clinics

- Providers functioning as primary care providers (PCPs) at least 60% of their clinical time with a panel of attributed patients

Who Can Participate as a DSS Person-Centered Medical Home? (cont.)

- Members are attributed to a Primary Care Practitioner (PCP) by self selection or by claims history

- Attribution by claims history is based on:
  - 15 months of claims history
  - Specific Preventive and Evaluation & Management (E&M) procedure codes
  - Specific Clinic Revenue Codes
  - Providers identified as PCPs in CMAP system

Potential Benefits of Person-Centered Medical Home

- **Member Benefits:**
  - Enhanced personal relationship with a provider
  - Access to a personal care team
  - Improved ability to self-manage
- **Provider Benefits:**
  - Assistance of a team
  - Financial Incentives for participating providers in the DSS Program
  - Assistance with developing quality improvement activities using Evidence-Based Practice

Potential Benefits of Person-Centered Medical Home (cont.)

- **Program Benefits:**
  - Short Term Improvements:
    - Better access to care
    - Reduction in duplicate services
    - Emphasis on quality improvement and Evidence-Based Practice
  - Long Term Improvements:
    - Health outcomes
    - Quality of life
    - Health equity
    - Lower healthcare costs

Program Support

- Regional Network Managers
- Community Practice Transformation Specialists
- Glide Path Option
- Glide Path Process

Regional Network Management Team

- CHNCT provides a statewide team of Regional Network Managers to:
  - Identify and recruit potential practices
  - Evaluate readiness to apply for PCMH
  - Guide providers through the enrollment process for the program
  - Maintain and update a PCMH Provider Enrollment database and coordinate with HP
  - Provide data and analytic support to providers including member specific information

Community Practice Transformation Team

- The Community Practice Transformation Specialist Team (CPTS) are highly trained professionals specializing in NCQA and the Joint Commission Standards to assist Primary Care Providers as they transform their practices into Medical Homes

- The CPTS team consists of staff assigned to specific regions in CT whose responsibilities include:
  - Proactive collaborative outreach to identified and recruited practices to introduce the Glide Path Option to eligible practices

Community Practice Transformation Team (cont.)

- Evaluation of practice readiness to apply to the Glide Path Option
- Provision of Glide Path application support for practices
- Support for the practice and monitoring of their progress throughout all phases of the Glide Path
- Assistance with practice redesign which includes workflow modifications and introduction of care coordination strategies
- Provision of templates to assist practices in policy and procedure development

Glide Path Option

The DSS Glide Path option for practices serving HUSKY Health Members is **unique** in the United States and receiving national attention.

This option provides financial and technical support for eligible practices that are preparing to seek PCMH status. The option includes the following:

- Hands-on, one-on-one technical support through on-site assistance as well as telephonic support by a CPTS
- Assistance to help practices attain their desired recognition level during the Glide Path Phases as well as their NCQA/PCMH processes

Glide Path Option (cont.)

- Resources include, but are not limited to: toolkits, documentation templates and educational presentations
- Financial incentives for eligible Glide Path practices
- Timeframe for completion of tasks is 18 months (three six month phases)*
- Additional option for 6 months of extension without penalty

* *To date most practices have completed the Glide Path within the 18-month timeframe*

Glide Path Process

- ***Eligible Practices seeking Glide Path status are required to:***
  - Complete PCMH and Glide Path applications
  - Meet with a designated CPTS monthly to discuss work plan and task options
  - Complete Gap Analysis (practice's ability to substantiate compliance with standards)
  - Complete Work Plan (contained in Glide Path Application)
  - Provide ongoing documentation for Work Plan
  - Demonstrate progress toward PCMH recognition

Lessons Learned:
Program Adaptations Implemented

- Allow APRN and PA practitioners to participate either if they maintain a panel of members or if they treat members who are part of a supervising physician's panel
- Allow participation of residents under the guidance of a community preceptor (or attending physicians) as a PCMH provider
- Allow participation by eligible non-standard practices, such as homeless shelters, mobile van units, and school based health centers

Lessons Learned:
Program Adaptations Implemented (cont.)

- Develop and conduct a Quality Assurance Annual Review for recognized practices

- Enhance the Glide Path application to include:
  - Standardized work plans
  - NCQA Crosswalk reference
  - Imbedded applicable NCQA standards within work plan

Lessons Learned:
Program Adaptations Implemented (cont.)

- Develop a Readiness Evaluation Questionnaire to help assess a practice's readiness to begin the phases of the Glide Path
- Maximize support to the practices with interpreting Joint Commission and NCQA Standards and Guidelines
- Assist practices to develop data/reports from their electronic medical records

PCMH Progress to Date

- Practice Status Update:
  - Practice Participation Status Summary
  - Practice Participation by Region
- Financial Support
- Quality Measures
- Program Investments
- Next Steps

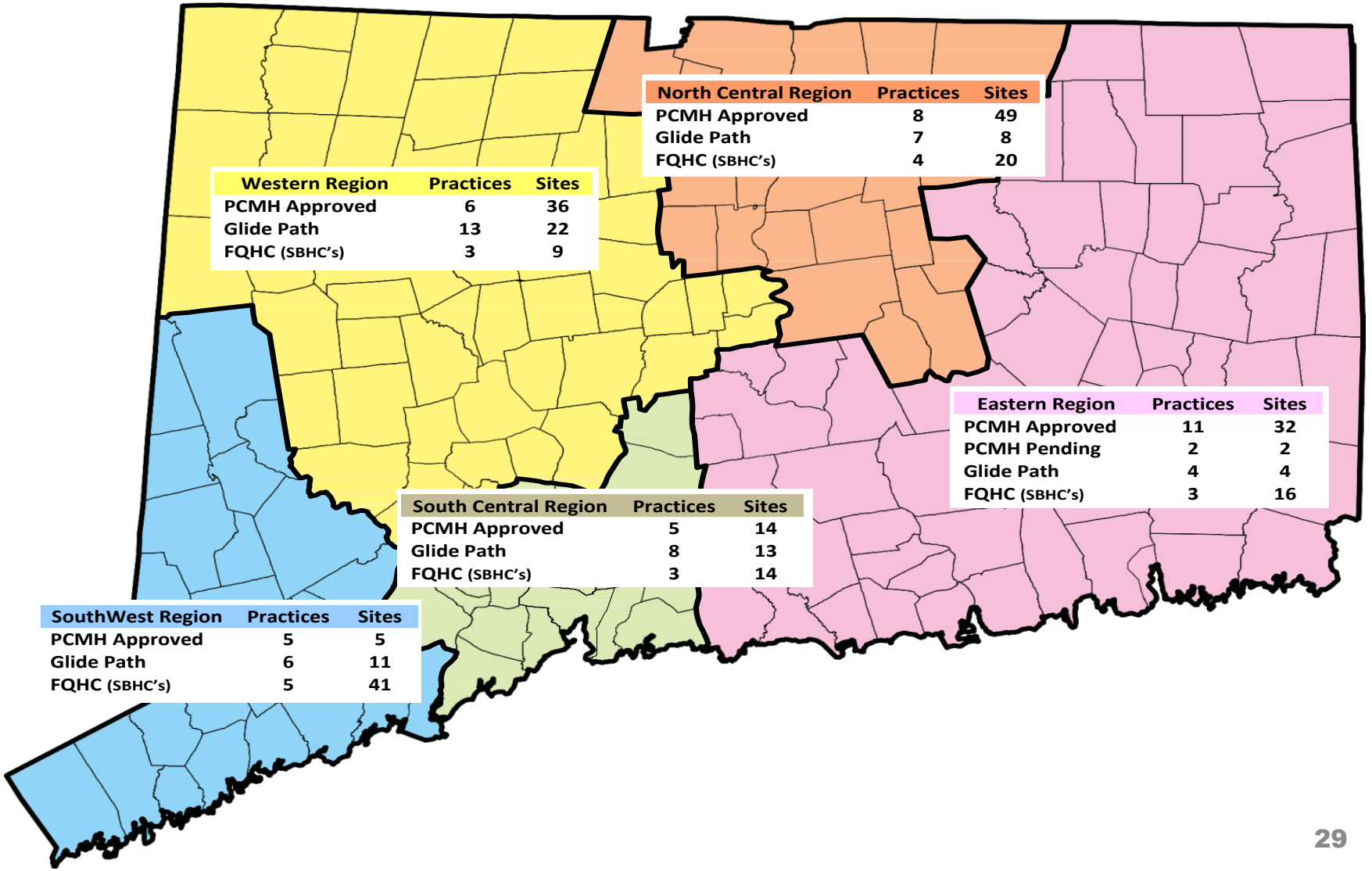
Practice Participation Status Summary - 12/31/2013

Program	Practices*	Sites	Providers	Attributed Members
PCMH Approved	28	136	583	51,571
PCMH Pending	2	2	6	N/A
Glide Path Approved	32	48	158	37,089
Glide Path Pending	2	10	15	N/A
FQHC (includes School Based Health Center sites)	14	100	352	122,546
Total	78	296	1,114	211,206

* Total Unique Practice count is 73. Five Practices have sites in both PCMH and Glide Path categories

Attributed Members	PCMH	Glide Path	FQHC	Total	Percentage
Children (Under 21)	27,934	31,241	61,448	120,623	57%
Adults (21 and Over)	23,637	5,848	61,098	90,583	43%
Total	51,571	37,089	122,546	211,206	100%

Practice Participation Status by Region 12/31/2013



Western Region	Practices	Sites
PCMH Approved	6	36
Glide Path	13	22
FQHC (SBHC's)	3	9

North Central Region	Practices	Sites
PCMH Approved	8	49
Glide Path	7	8
FQHC (SBHC's)	4	20

Eastern Region	Practices	Sites
PCMH Approved	11	32
PCMH Pending	2	2
Glide Path	4	4
FQHC (SBHC's)	3	16

South Central Region	Practices	Sites
PCMH Approved	5	14
Glide Path	8	13
FQHC (SBHC's)	3	14

SouthWest Region	Practices	Sites
PCMH Approved	5	5
Glide Path	6	11
FQHC (SBHC's)	5	41

Financial Support

Connecticut sought and CMS approved three PCMH payment reforms:

- **Add-on payment for Glide Path and PCMH**
  - Physicians have an add-on percentage to 81 primary care procedure codes
  - Hospital Outpatient Primary Care Clinics have an add-on percentage to specific revenue center codes
  - Percentage amounts increase based on the provider type and practice site level of participation

Financial Support (cont.)

- **Incentive Payment**
  - Lump Sum PMPM payment based on performance results for practices approved as PMCH for one full calendar year
  - Specific set of PCMH Adult and Pediatric metrics used to measure performance
- **Improvement Payment (future years)**
  - Additional lump-sum PMPM payment for demonstrated improved performance measurement results compared with the previous measurement year
  - Specific set of PCMH Adult and Pediatric metrics used to measure performance

Financial Support (cont.)

Please note: *Federally Qualified Health Centers (FQHCs) were initially eligible for the payment reforms,however the 2012 deficit reduction measures rescinded these payments.*

PCMH Quality Measures

Quality metrics were chosen to align with the State Employee Health Plan PCMH effort

- **Child/Adolescent Measures:**
  - Well-Child Visits in the First 15 Months of Life
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
  - Adolescent Well-Care Visits
  - Annual Dental Visit
  - Asthma Patients with One or More Asthma-Related ED Visit
  - Developmental Screening
  - ED Visits Ages 0-19
  - Use of Appropriate Medications for People with Asthma
  - PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

PCMH Quality Measures (cont.)

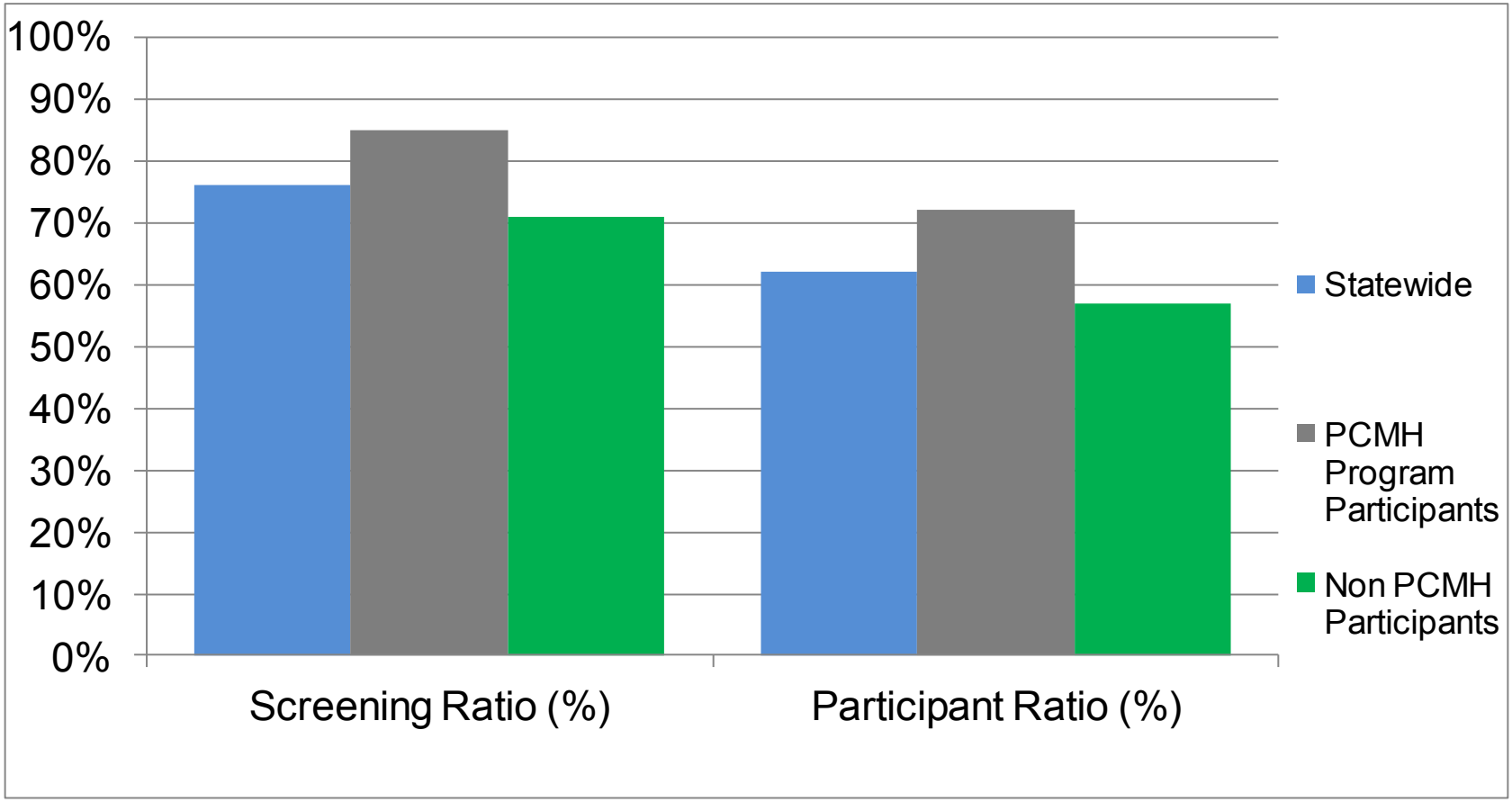
- **Adult Measures:**
  - Adult Diabetes LDL-C Screening
  - Adult Diabetes Eye (retinal) Screening
  - Post Hospitalization Follow-up
  - Follow-up after New Mental Health Diagnosis with /Medication Prescription
  - Cholesterol Management for Patients with Cardiovascular Conditions
  - ED Usage
  - Use of Appropriate Medications for People with Asthma
  - Readmission Rate - 30 days
  - PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Statewide Quality Measures Performance Comparison CY 2012 Results

Quality Measure	Statewide	PCMH Program Participants*	Non-PCMH Participants
Adolescent Well Care	52.7%	56.2%	45.6%
Well-Child Visits in the First 15 Months of Life 6 or More Visits	57.7%	63.9%	58.7%
Well-Child Visits in the Third, Fourth, Fifth & Sixth Years of Life	70.4%	76.2%	63.5%
Adult Access to Preventive Health Services	82.3%	93.7%	74.1%
Annual Dental Visit	72.6%	74.2%	70.5%
Developmental Screening In the First Three Years of Life	21.1%	19.0%	22.1%
Asthma Patients with One or More Asthma Related ED Visits	12.9%	13.3%	12.7%
Use of Appropriate Medications for People With Asthma	86.4%	86.0%	87.4%
Ambulatory Care - ED Visits per 1000 Member Months	79.7	95.6	65.0
Comprehensive Diabetes Care - Eye Exam	48.8%	49.9%	48.6%
Comprehensive Diabetes Care - LDL Screen	67.2%	73.3%	63.7%

*PCMH Program Participants includes practices that are PCMH Approved, Glide Path and FQHCs

EPSDT Statewide Screening & Participant Ratio Comparison Children Ages 0-20 – FY 2012*



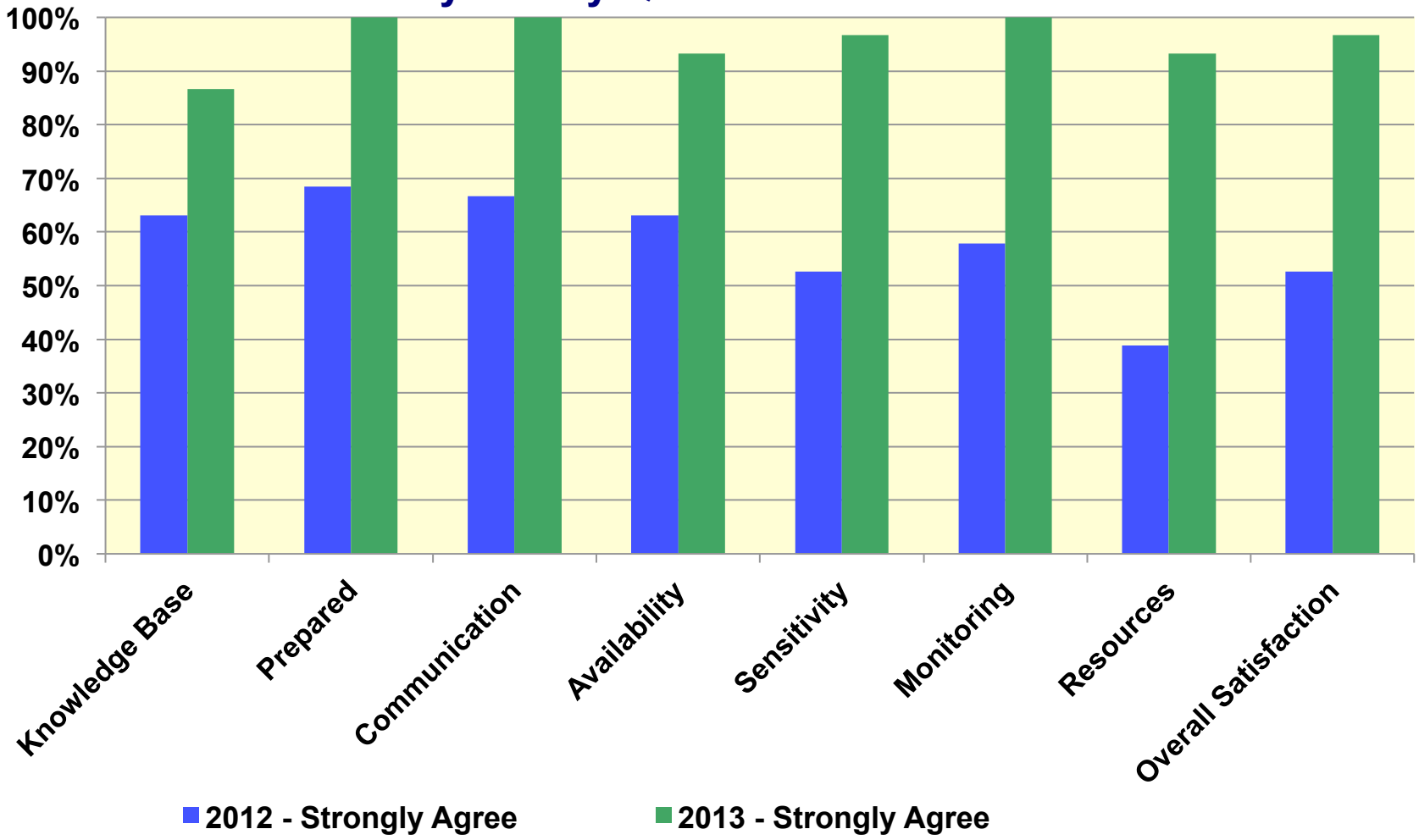
*Reported in Fiscal Year 2013

Early Signs of PCMH Program Success 2013 Member Satisfaction Results*

Category	Respondents	Positive Survey Results Compared to non-PCMH Practices Types
Scheduling Appointments	Adults and Respondents for Children	Less wait time for an appointment with their provider when care is needed right away
Scheduling Appointments	Adults and Respondents for Children	A higher rate of making appointments for a check-up or routine care with their provider
Seeing a Specialist	Adults	Seen a specialist more often in the past twelve months for a particular health problem more often/high rate
Visits	Respondents for Children	Child's provider more often listened carefully
Visits	Respondents for Children	Child's provider more often seems to know important information about the child's medical history
Visits	Respondents for Children	Important conversations occur more often with the child's providers with 99% confidence

*Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)

Community Practice Transformation Specialist Provider Satisfaction Survey Results Comparison By Survey Question - 2012 vs 2013



2012 Program Investments

- The investment for PCMH in 2012 was:
  - $2.4 million in enhanced payments made to:
    - 15 PCMH approved Physician practices and
    - 1 Hospital Outpatient Primary Care Clinic
  - $575,000 in enhanced payments made to:
    - 17 Glide Path approved Physician Practices

Some Next Steps

- Training and rollout for provider use of the Data Analytics Tool
- Future program enhancements:
  - Health Equity
  - Rewards To Quit

Questions or comments?