NH Medicaid Patient Centered Medical Home Pilot

Policy Day For Legislators

Conference on Health Payment Reform

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Katie Dunn, RN, MPH

State Medicaid Director

Overview

- Why do a PCMH pilot in Medicaid?
  - History of incremental approaches to achieving the goal of sustainable, integrated care that supports maximizing the purchasing power of limited resources & drives towards a healthy Medicaid population via a focus on quality.
  - Belief in the Center for Medical Home Improvements' philosophy that health care should be:
    - Accessible, Continuous, Coordinated, Family-Centered,Comprehensive, Compassionate and Culturally-competent.

Profile of NH Medicaid Recipients

Medicaid Recipients Have Higher Burden of Illness than Privately Insured Individuals

Medicaid recipients have greater burden of illness compared to commercial insured population:

- 1.8 times the prevalence of asthma
- 3.8 times the prevalence of Chronic Obstructive Pulmonary Disease (COPD)
- 5 times the incidence of lung cancer
- 2 times the prevalence of coronary artery disease
- 3.5 times the incidence of stroke
- 5 times the prevalence of heart failure
- 2 times the prevalence of hypertension
- 2 times the prevalence of depression
- 2 times the prevalence of mental health disorders in children
- 2 times the ambulatory sensitive hospital admission rate when compared to NH Commercial
- 4 times the ED utilization of NH commercial

Common Themes

- Chronic diseases require a patient/provider partnership in order to be successful in engaging patient in daily management of risk factors and compliance with treatments.
- Avoid "too many cooks in the kitchen".
- Assure access to primary care services in less expensive site of service and with guaranteed follow up.

Citizens' Expectations

- Citizens expect more from the public sector including Medicaid
  - Transparency
  - Accessibility
  - Efficiency
  - Accountability
  - Maximize the use of technology
- NH Medicaid relies on the NH health care providers to care for beneficiaries and meet CMS requirements.
  - Want to be as consistent as possible with the private sector to diminish the administrative burden on providers especially in light of low reimbursement rates.
  - Follow evidence-based medicine – proven strategies.

Progress to Date

- Oct 2009
  - Commonwealth Grant Safety Net Medical Home planning
- Jan 2009
  - OMBP Internal Workgroup
    - Determined “must have” components for the State
    - Engagement with the NH Citizens Health Initiative MH Project
- Feb/Mar 2009
  - State Budget and ARRA Discussions
- Apr/May 2009
  - Where we are today...

Recruited Partner Practices

- Community Health Centers
  - Littleton, Dover, Berlin, Portsmouth, Franklin, Colebrook, Newmarket, Manchester, Plymouth
- Dartmouth Hitchcock Clinics
  - Keene, Concord, Manchester, Nashua, Lebanon

Provider Participation Requirements

- NCQA (Nat'l Committee For Quality Assurance) recognition-required
- Individual practice site evaluation
  - Center for Medical Home Improvement
- Learning collaborative for pilot participants in collaboration with NH CHI Project.
- Provider agreements

Patient Enrollment and Attribution (Assignment to a Primary Care Provider)

- Under consideration:
  - Management of
    - Initial enrollment
    - Ongoing enrollment
    - Disenrollment
      - Transfers within the pilot
      - Drop from the pilot
  - Reconciliation of patients to PCP
    - Process
    - Data management through a secure database
    - Periodicity

OMBP Financial Support
Two Components

- Prospective payments (PMPM)
  - OMBP must have elements:
    - Tiered payments
    - Highest payments to adults with complex illness

OMBP Financial Support
Per Member Per Month Prospective Payment

NCQA level	Pediatrics	Adults
1	$1.00	$1.75
2	$2.00	$3.25
3	$3.00	$6.00

OMBP Financial Support
Retrospective Payments

- Retrospective payments (P4P)
  - OMBP must have elements
    - Improved appropriate utilization of ED visits, reduction in avoidable hospitalizations
    - Improved health status for Medicaid patients
    - Improved dental access
  - Under Consideration
    - Health outcomes for chronic disease

Reporting and Evaluation Multiple Components

- Reporting
  - Level of report
    - Practice site level
    - Individual practitioners' level
  - Routine reporting-content, periodicity, etc.
- Pilot evaluation
  - Clinical outcomes
  - Costs and utilization
- Look at issue of risk adjustment
- Define the use of reports for quality improvement & creation of Medicaid Report Card

Reporting and Evaluation, cont.

- OMBP must have elements
  - Cost: Total cost/patient, Total cost/patient/ practice site
  - Utilization: ED use, avoidable hospitalizations
  - Dental access metrics
- Discussion elements
  - ? Include usual chronic care measures
  - Want to assure connection to national measures as well as the NH CHI Medical Home measures for consistency.

Next Steps & Timeline

- PCMH program rollout timeline
  - Spring 2009
    - Stakeholder discussions
    - Final decision making
  - Summer 2009
    - Database development
    - Practice assessments
    - Communications to providers and patients
    - Finalize Reporting and Evaluation
  - Late Fall/Winter 2009
    - Rollout

Contact Information

- Katie Dunn, NH Medicaid Director
  - 603-271-5254
  - Kdunn@dhhs.state.nh.us
- Doris Lotz, MD, NH Medicaid Medical Director
  - 603-271-5254
  - dlotz@dhhs.state.nh.us