NH Medicaid Patient Centered Medical Home Pilot

Policy Day For Legislators
Conference on Health Payment Reform
May 11, 2009
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**

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<th>NCQA level</th>
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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
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