Stepping up to the Future
NH CITIZENS HEALTH INITIATIVE

October 2008



NH Multi-Stakeholder Medical Home Overview

Reimbursement

- Convened in Summer of 2007 to further the P4P effort initiated in 2006
- Established goals, objectives and tasks associated with a fundamental shift in primary and specialty care reimbursement in NH to:
  - Promote and facilitate the implementation of the Medical Home model across primary care;
  - Create a uniform scorecard of quality measures from national norms with benchmarks for primary, specialty, hospital and ambulatory care;
  - Align reimbursement to promote primary care.

Medical Home Project Team



- The NH Multi-Stakeholder Medical Home Project was initiated in January of 2008 as a joint effort of all NH Payers and representatives of the clinical communities.
- The pilot will commence on 01/01/2009, payment will begin 04/01/2009 and will run until 3/31/2011.
- It is our desire and intent to offer uniformity in patient attribution, reimbursement, technical support and outcomes measurement to deliver the greatest effectiveness possible in program design.

Adopted the Joint Principles



- Personal Physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks
- Enhanced access

Adopted the Joint Principles



Reimbursement should

- Reflect the value of non-face time
- Pay for care coordination
- Support adoption and use of HIT for QI
- Support enhanced communication such as secure email and telephone consultation
- Allow for separate fee-for-service visit payment
- Recognize case mix differences in patient population
- Allow for additional payments for achieving measureable quality improvements

Pilot Decisions

1. Selection Criteria

- Geographic Diversity
- Demonstrated Medical Home Readiness
  - Able to reach NCQA Level-1
- Patient Panel Composition
- Organizational Commitment

NCQA PPC-PCMH



PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

NCQA PPC-PCMH

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements are not Recognized.

NCQA PPC-PCMH



PCMH "Must Pass" Elements

- Written standards for patient access and patient communication
- Use of data to show meeting this standard
- Use of paper or electronic-based charting tools to organize clinical information
- Use of data to identify important diagnoses and conditions in practice
- Adoption and implementation of evidence-based guidelines for three conditions
- Active support of patient self-management
- Tracking system to test and identify abnormal results
- Tracking referrals with paper-based or electronic system
- Measurement of clinical and/or service performance
- Performance reporting by physician or across the practice

Pilot Decisions

2. Pilot Size
    1. 5 to 10 practices with 30k total members
    2. Family Practice, Internal Medicine and General Practitioners
3. Infrastructure & Practice Support Model*
    - Initial vetting and training
    - NCQA preparedness assistance with individualized site visits (3 each)
    - Monthly webinars for collaboration

Pilot Decisions

4. Attribution Method (United & Colorado Model)

- Derived
- Retrospective view of Medical E&M and Rx for 18 months
- Algorithm will select most recent date and will break ties with visit volume and spend
- Quarterly reporting

Pilot Decisions

5. Reimbursement

- NHCHI recommended midpoint $4 PMPM prospective care management fee
- Fee for service
- Existing P4P programs

6. Evaluation

- Proposal for evaluation design is in the process of review

Lessons Learned



- Be as consistent as possible with other active pilots
  - The greater the body of evidence is, the better able we will be to broadly translate successes
- Ensure early funding for facilitation through pilot selection
- Diversify funding
- Get some consensus on major issues before opening the doors
- Stakeholder management is three fourths of the early work
- Beg and borrow – but don't steal – then reciprocate in kind
  - The more efficient we are, the more successful we will be

Questions?

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