REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Chronic Health Care Homes (HJR 82, 2010)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA
RICHMOND
2012

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Delegate Benjamin L. Cline
Chairman

Kim Snead
Executive Director

900 E. Main Street, 1st Floor
P.O. Box 1322
Richmond, Virginia 23218
804.786.5445
804.786.5538 (facsimile)

March 27, 2012

The Honorable Robert F. McDonnell
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, Virginia 23219

Dear Governor McDonnell and Members of the General Assembly:

House Joint Resolution 82, introduced by Delegate Patrick A. Hope and agreed to by the 2010 General Assembly, requested a two-year study by the Joint Commission on Health Care on the feasibility of developing chronic health care homes in the Commonwealth.

In keeping with the requirements of House Joint Resolution 82, this final report of the Joint Commission is enclosed for your review and consideration.

Respectfully submitted,

Benjamin L. Cline

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

Members of the Joint Commission on Health Care

Chairman
The Honorable Benjamin L. Cline

Vice-Chair
The Honorable Linda T. Puller

Virginia House of Delegates
The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Harvey B. Morgan
The Honorable David A. Nutter
The Honorable John M. O'Bannon, III
The Honorable Christopher K. Peace

Senate of Virginia
The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable L. Louise Lucas
The Honorable Ralph S. Northam
The Honorable Patricia S. Ticer
The Honorable William C. Wampler, Jr.

The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources

JCHC Staff

Kim Snead
Executive Director

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Michele L. Chesser, PhD
Senior Health Policy Analyst

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Sylvia A. Reid
Publication/Operations Manager

Preface

This is the final report of the study requested in House Joint Resolution 82 (HJR 82) by Delegate Patrick A. Hope in 2010. HJR 82 directed the Joint Commission on Health Care to complete a two-year study of the "feasibility of developing chronic health care homes in the Commonwealth." (The interim report was published as HD No. 4 – 2011.)

Chronic diseases, the most prevalent, costly, and preventable of illnesses, account for 70 percent of all deaths and more than 75 percent of the nation's $2 trillion in medical care costs, according to the Centers for Disease Control and Prevention. The fragmented way in which medical care is typically delivered means patients with multiple chronic conditions typically receive care from multiple providers working independently and therefore in a less effective, more costly manner. The patient-centered medical home (PCMH) involves a team-based model of care in which a personal physician leads a team of providers responsible for planning and delivering ongoing care for the "whole person."

When HJR 82 was introduced, the concept of a PCMH was just beginning to gain attention. Since that time, there has been substantial growth in the development of PCMH pilot programs, indicating that medical homes may become a useful, sustainable model. As of December 2010, the National Committee for Quality Assurance (NCQA) had recognized 1,506 programs across the country. A number of PCMH initiatives have been undertaken in Virginia: 18 Carillion physician practices in the Roanoke and New River Valley areas are recognized as Level-3 (highest) PCMHs by the NCQA; and an increasing number of practices in the Hampton Roads area are working toward transforming into medical homes including physicians and faculty of Eastern Virginia Medical School and several Sentara practices.

The Department of Medical Assistance Services (DMAS), partnered with the Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carillion to transition a Medicaid primary care program in southwestern Virginia into a medical home pilot. In addition, DMAS recently modified its Medicaid contract language to allow for participation in a PCMH pilot.

At the federal level, provisions of the Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models (including PCMHs) to reduce the rate of growth of Medicare and Medicaid expenditures. In Virginia, an Innovation Center will be established as a nonprofit center hosted by the Virginia Chamber of Commerce to be a resource in Virginia.

Based on the study findings, the Joint Commission on Health Care approved a policy option to continue to monitor the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

Joint Commission members and staff would like to thank the numerous individuals and organizations who assisted in this study, including representatives of the Department of Medical Assistance Services, The Patient-Centered Primary Care Collaborative, The American Academy of Pediatrics, and the Carilion Clinic.

Table of Contents

Chronic Health Care Homes

House Joint Resolution 82 introduced by Delegate Patrick A. Hope, and agreed to by the 2010 General Assembly, directed the Joint Commission on Health Care (JCHC) to complete a two-year study of "the feasibility of developing chronic health care homes in the Commonwealth."

Background

Chronic diseases are the most prevalent, costly, and preventable of illnesses. According to the Centers for Disease Control and Prevention (CDC), chronic diseases are a leading cause of adult disability and death in the United States; accounting for 70 percent of all deaths and more than 75 percent of the nation's $2 trillion in medical care costs. By 2020, the number of Americans with one or more chronic disease is expected to be 157 million, and 81 million will have multiple chronic conditions. By that date, chronic disease will account for 80 percent of all healthcare spending.[1]

Cost of Chronic Diseases. Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room visits, hospitalizations, or costly inpatient and outpatient treatment plans. People with chronic conditions account for 88 percent of all prescriptions filled, 72 percent of all physician visits, and 76 percent of all inpatient stays. In the United States, the CDC reports the direct and indirect costs annually of heart disease and stroke to be approximately $448 billion and of diabetes to be approximately $174 billion. Additionally, smoking-related chronic disease costs are estimated to exceed $193 billion. The cost of chronic disease for Virginia mirrors the national trend. The Virginia Department of Health's 2006 report on chronic disease indicated approximately 2.2 million Virginians were living with a chronic disease at an estimated cost of $24.6 billion in health care.[2]

Fragmented Care. People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As such, chronic disease sufferers often have multiple health care providers, treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual. This lack of communication leads to unnecessary emergency room and hospital admissions. "Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's conditions, medical history, services provided in other settings, or medications prescribed by other clinicians."[3] As a result, the health care delivery system for those with chronic conditions is complex and confusing, and care is often fragmented, less effective and more costly. The fragmented system can be difficult to navigate for anyone but often people who receive care from numerous providers lack the ability to monitor, coordinate or carry out their own treatment plans because approximately 25 percent of those with chronic conditions face limitations with activities of daily living such as walking, dressing and bathing.[4]

---

[1] Robert L. Mollica and Jennifer Gillespie, "Care Coordination for People with Chronic Conditions, "Partnership for Solutions, Johns Hopkins University. January 2003.)
[2] Virginia Department of Health, Division of Chronic Disease, Prevention and Control, "Chronic Disease in Virginia: A Comprehensive Data Report"
[3] Ernest Clevenger, "How Primary Care, America's Best-Kept Secret, Can Reduce Health Care Costs for Self-Funded Employers" HealthWatch, September 2008.
[4] Robert L. Mollica and Jennifer Gillespie. "Care Coordination for People with Chronic Conditions," Partnership for Solutions, Johns Hopkins University. January 2003.

A new study from the Center for Studying Health System Change revealed "widespread acknowledgement that most provider payment methods don't encourage efficient or effective delivery of chronic disease care." And the study indicated that, "optimal care for people with chronic disease involves coordinated, continuous treatment by a multidisciplinary team."

Chronic Disease Prevention. Chronic diseases are the most prevalent and most costly, but they are also the most preventable of illnesses. A growing body of evidence indicates earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs.[5] Preventive care includes interventions such as risk screenings, vaccinations, behavior education, primary care, disease detection, monitoring and treatment. These activities can significantly reduce disease, disability and death.[6] To effectively combat chronic disease, the system must transform from one that reacts to a person's sickness, to one that remains proactively engaged and focused on keeping a person as healthy as possible.[7]

Need for Better Primary Care Systems. Evidence suggests that strong primary care systems lead to better health outcomes at lower costs.[8] However, the United States health system faces a crisis in primary care. An estimated 65 million Americans live in officially designated primary care shortage areas. The United States spends more on specialist care and has more specialists per capita than any other leading industrialized country. The number of medical students entering adult primary care careers in general internal medicine and family medicine is steadily declining. Data reveals that only 27 percent of adults in the United States can easily contact their primary care physician (PCP) by telephone, obtain care or advice after hours, and schedule timely office visits. Fifty percent of patients do not understand what their PCP told them because their office visits are too short. The primary care system is beset with a fee-for-service reimbursement mechanism that rewards quantity over quality, declining numbers of providers, high and rising per-capita costs, and arguably compromised quality.

Patient Centered Medical Home

Many experts believe problems identified with the United States health system can be addressed using the model of a health care home. A health care home, or patient centered medical home (PCMH), is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

A major goal of PCMHs is to avoid duplicate or unnecessary testing and services which could result in better quality care at a more affordable cost. The PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. Within the model, the personal physician remains responsible for the "whole person" and the team coordinates ongoing patient care across the health system and community. A PCMH offers enhanced access to care through open scheduling, expanded hours, and new care options such as group visits.

[5] *Available at* www.aha.org.
[6] *Available at* www.aha.org
[7] *Available at* www.improvingchroniccare.org.
[8] Barbara Starfield, Leiyu Shi, and James Macinko, " Contribution of Primary Care to Health Systems and Health", The Millibank Quarterly, VOl. 83, No. 3. 2005 (pp. 457-502).

The payment structure for the PCMH recognizes this enhanced value provided to patients. Typically providers who adopt the medical home model receive additional compensation to reflect the change in the delivery of health care services. Some receive fee-for-service payments for all services they provide plus additional payments to provide care coordination. Others are rewarded for managing patient care and for meeting or exceeding quality and performance standards, such as implementing electronic health records, e-prescribing, coordinating medication management with pharmacists, tracking tests and referrals, providing telephone access after business hours, and the percentage of children who receive well-child visits.

Joint Principles for Patient-Centered Medical Homes. In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association came together to identify a set of joint principles for PCMHs at the request of health care purchasers. These principles[9] emphasize access to a personal physician who directs a medical team responsible for the patient's care and emphasize that patient care has a whole-person orientation, is coordinated across the health care system, and is focused on quality and safety, as well as enhanced access to care. The Joint Principles also stress that payment should recognize the added value that physicians and other care providers add.

Standards Developed by the National Committee for Quality Assurance. Standards developed by the National Committee for Quality Assurance (NCQA), a private, 501c3, not-for-profit organization dedicated to improving health care quality, are most often used to identify which primary care practices have achieved designation as a medical home. The standards allow for

[9] Specifically the Joint Principles of the PCMH are: "***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. ***Quality and safety*** are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement; It should support provision of enhanced communication access such as secure e-mail and telephone consultation; It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements." *Available at* www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

recognition as a PCMH at three different levels and include 30 elements, of which 10 are considered mandatory or "must pass". [10] To achieve Level 1 recognition, practices must successfully comply with at least five of the Must-Pass Elements. Achieving Level 2 or Level 3 depends on overall scoring and compliance with all 10 must-pass elements. As of 2010, more than half of NCQA recognized practices had achieved Level 3 status. Practices that achieve NCQA's PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs. NCQA updated its standards and published new guidelines in January 2011 and focus more on Health Information Technology (HIT). These new guidelines align more closely with the meaningful use requirements promulgated by the Centers for Medicare and Medicaid Services (CMS), which reward physicians for using HIT to improve quality. HIT that supports high quality patient care, electronic record keeping, online disease registries, internet communication with patients and electronic prescribing is crucial to a fully functioning PCMH. Practices do not need electronic medical records to be recognized as Level 1. However, Level 2 or 3 recognition depends upon e-prescribing, advanced electronic communications with members and electronic management support.

PCMH Pilot Programs and Demonstration Projects. As of March 1, 2010, NCQA had reviewed and recognized approximately 450 practices in 24 states and the District of Columbia as medical homes. By the end of 2011, more than 7,600 clinicians at more than 1,500 practices across the country had earned PCMH Recognition. Additionally, across the country, public and private payers, purchasers and clinicians have created pilot and demonstration programs. Many programs provide financial incentives, such as pay for performance and reimbursement for services beyond the patient visit, which have motivated primary care practices to engage in the transformation that leads to NCQA PCMH recognition.

The Patient-Centered Primary Care Collaborative (PCPCC) also has PCMH demonstration programs.[11] The PCPCC recently released a report that summarized findings from PCMH demonstrations and concluded that "investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization…Several major evaluations show that patient centered medical home initiatives produced a net savings in total health care expenditures for the patients served by these initiatives."

[10] PCMH Recognition is based on meeting specific elements included in *nine standard* categories: Access and Communication; Patient Tracking and Registry Functions; Care Management; Patient Self-Management and Support; Electronic Prescribing; Test Tracking; Referral Tracking; Performance Reporting and Improvement; and, Advanced Electronic Communication. The NCQA *"Must Pass"* Elements require: Written standards for patient access and patient communication; Use of data to show standards for patient access and communication are met; Use of paper or electronic 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 3 chronic or important conditions; Active support of patient self-management; Systematic tracking of tests and follow up on test results; Systematic tracking of critical referrals; measurement of clinical and/or service performance; and, performance reporting by physician or across the practice.

[11] The PCPCC is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians and many others who have joined together to develop and advance the PCMH. The Collaborative has over 900 members.

Study Findings for Several Primary Care Medical Home Models

Geisenger Health System PCMH Model (Pennsylvania)

Example of an integrated delivery system model.

- Demonstrated an 18% reduction in hospital admissions relative to controls.
  - 257 admissions versus 313 admissions (per 1,000 members per year).
  - 7% reduction in total per member/per month costs relative to controls.

BlueCross BlueShield of South Carolina

Example of a private payer-sponsored initiative.

- Demonstrated 10.4% reduction in inpatient hospital days (from 542.9 to 486.5 per 1,000 enrollees per year among PCHM patients).
  - Number of inpatient days 36.3% lower among PCMH patients than among control patients.
- 12.4% reduction in emergency department visits (from 21.4 to 18.8 per 1,000 enrollees per month).
  - Emergency department visits 32.2% lower among PCMH patients than among control patients.
- Total medical and pharmacy costs per member per month 6.5% lower among PCMH patients than among control patients.

Community Care of North Carolina (CCNC)

Example of a Medicaid-sponsored initiative.

- Consists of 14 regional networks providing medical homes for 1.1 million Medicaid enrollees.
  - Each network serves as a virtual integrated health system that includes a medical management committee of local doctors who develop best practices, as well as a medical director and a clinical pharmacist.
  - Number of inpatient days 36.3% lower among PCMH patients than among control patients.
  - Networks and participating physicians receive at least $2.50 PMPM to coordinate care.
- 95% of primary care physicians in North Carolina participate in CCNC
- CCNC saved the state nearly $1.5 billion in health care costs between 2007 and 2009 (according to Treo Solutions), due mainly to reduced hospital admissions and readmissions as well as improved management of chronic conditions.
  - A new pilot program, First in Health, established to extend the cost savings and improvements outside the state's Medicaid program.
  - Community care medical homes to be offered to North Carolina's state employees as an optional enhanced benefit within their existing health coverage at a cost of $2.50 per member per month.

Source: The Patient-Centered Primary Care Collaborative and Community Care of North Carolina websites.

PCMHs and Health Care Reform. Federal health care reform encourages testing of the PCMH model to improve health outcomes, preserve or enhance the quality of care, and reduce costs. The Department of Veterans Affairs, the nation's largest health system, has begun shifting its clinics to the medical home model, with transition expected to be complete by 2015. The Patient Protection Affordable Care Act (PPACA) also created the Center for Medicare and Medicaid Innovation to test innovated payment and service delivery models to reduce the rate of growth of Medicare and Medicaid expenditures. Among the models to be tested are those that promote "broad payment and practice reform in primary care, including PCMH models for high need individuals, medical homes that address women's unique health care needs, and models that

transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment."

The Department of Health and Human Services (HHS) has the authority to expand the use of PCMHs within Medicare or Medicaid, if it has been shown that these models reduce spending or the growth in spending without reducing quality, or can improve patient care without increasing spending. Additionally, states have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home (Section 2703 of PPACA). Patients enrolled in Medicaid, with at least two chronic conditions are allowed to designate a provider as a "health home" to help coordinate medical treatments. States may receive 90 percent of the funding for their health home services in the first two years of operation from the federal government (Section 5301 of PPACA). In addition, federal grants are available to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority for receiving the grants will be given to programs that educate students in team-based approaches to care, including the PCMH.

Furthermore, federal stimulus funding provided under the American Recovery and Reinvestment Act includes incentives to invest in electronic health records (EHRs). Beginning in 2011, hospitals and eligible professionals may be able to receive incentive payments under Medicare and Medicaid if they make "meaningful use" of EHRs. As indicated earlier, the new NCQA standards for PCMH recognition align with these incentives.

Multi-payer Advanced Primary Care Practice Demonstration. In June 2010, HHS invited states to apply for participation in the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP), an initiative in which Medicare, Medicaid and private insurers will use the medical home model to assess improvements to the delivery of primary care and in lowering health care costs. The first eight states chosen to participate were Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota. The demonstration will ultimately include as many as 1,200 medical homes serving up to one million Medicare beneficiaries.

PCMH Initiatives in Virginia

When HJR 82 was introduced in 2010, the concept of a PCMH was just beginning to gain attention. Since that time, there has been substantial growth in the development PCMH pilot programs, indicating that medical homes may become a useful, sustainable model. A number of initiatives are underway in the Commonwealth.

National Academy of State Health Policy Grants. In September 2009, the National Academy of State Health Policy (NASHP) awarded eight states, including Virginia, with a grant from The Commonwealth Fund to develop and implement policies that increase Medicaid and CHIP program participants' access to high performing medical homes. DMAS partnered with Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carillion to determine whether a Medicaid primary care case management program in southwestern Virginia could transition into a medical home pilot. The medical home pilot would provide primary care, behavioral health, disease and case management, and other services with a targeted population that would include the aged, blind and disabled as well as low-income families with children. As of November 2011, DMAS had modified its managed care contract language to support managed care participation in a PCMH pilot.

Virginia Innovation Center. A Virginia Innovation Center, established as a nonprofit center hosted by the Virginia Chamber of Commerce "will serve as a resource in Virginia by:

- Researching and disseminating knowledge about innovative models of health promotion and health care to Virginia employers, consumers, providers, health plans, public purchasers, and communities;
- Developing multi-stakeholder demonstration projects aimed at testing innovative models of health promotion and health care; and,
- Helping Virginia employers, providers, purchasers, health plans, and communities accelerate their pace of innovation for the benefit of Virginians."[12]

Virginia Primary Care Physicians. Medical home initiatives are being undertaken by physician practices across Virginia. The Family Medicine Group in Vinton was the first practice in Virginia to be certified as a PCMH. Now, 18 Carillion physician practices in the Roanoke and New River Valley areas are recognized as NCQA Level-3 (highest) PCMHs. Additionally, an increasing number of practices in the Hampton Roads area are transforming themselves into PCMHs. Physicians and faculty of Eastern Virginia Medical School and several Sentara practices are in the application process for recognition as a medical home.

Policy Options and Public Comment

Two policy options were presented for JCHC-member consideration.

Option 1: Take no action.

Option 2: Continue to monitor the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

No public comment was received regarding the policy options.

Subsequent Action by the Joint Commission on Health Care. Based on the study findings, JCHC members approved Option 2.

JCHC Staff for this Report
Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

[12] Description sent to JCHC staff by Health and Human Resources Secretariat staff in August 2010.

Attachments

ENROLLED

HOUSE JOINT RESOLUTION NO. 82

Directing the Joint Commission on Health Care to study feasibility of developing chronic health care homes in the Commonwealth. Report.

Agreed to by the House of Delegates, February 8, 2010
Agreed to by the Senate, March 9, 2010

WHEREAS, chronic diseases can have a profound physical, psychological, and emotional impact on an individual, his caregiver, his family, and society; and

WHEREAS, the Centers for Disease Control and Prevention reported that approximately one half of all Americans were affected by chronic health problems and that chronic health disorders accounted for approximately 1.7 million deaths, or 70 percent of all deaths in the United States in 2005; and

WHEREAS, the Virginia Department of Health's Division of Chronic Disease Prevention and Treatment reported, in 2006, approximately four million cases of the seven most common chronic diseases, including cancer, diabetes, heart disease, hypertension, stroke, pulmonary conditions, and mental health disorders; and

WHEREAS, the enormous cost associated with chronic diseases lead to unnecessary and preventable visits to hospital emergency departments, hospitalization, and lost work productivity; and

WHEREAS, health care homes have been shown to improve the quality of care, improve patient outcomes, and reduce costs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study the feasibility of developing chronic health care homes in the Commonwealth.

In conducting its study, the Joint Commission on Health Care shall review available information including information about programs in other states to develop recommendations related to: (i) standards for chronic health care homes which emphasize (a) the use of a range of primary care practitioners and other professionals including care coordinators to provide high quality, patient-centered care, including development of individualized comprehensive patient care plans, use of patient decision-making aids that provide patients with information about treatment options and associated benefits, consistent contacts between patients and care teams, and systematic patient follow-up, (b) the use of health information technology, (c) the use of evidence-based health care practices, and (d) incorporate quality outcome, and cost-of-care measures; (ii) standards for certification of health care facilities as chronic health care homes including ongoing reporting requirements for chronic health care homes; (iii) development of a chronic health care home collaborative to provide opportunities for chronic health care homes and state agencies to exchange information related to quality improvement and best practices; (iv) enrollment of state medical assistance recipients with chronic health problems in chronic health care home programs; and (v) costs associated with implementing a successful demonstration program to test whether chronic health care homes can improve health care quality and patient outcomes, and reduce costs associated with chronic health problems.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Healthy Living/Health Services Subcommittee

Chronic Health Care Homes (HJR 82-2010)

September 19, 2011

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

HJR 82 Study Mandate

- HJR 82 – 2010 (Delegate Hope) directed JCHC to review "programs in other states and to develop recommendations related to:

(i) standards for chronic health care homes which emphasize

(a) the use of a range of primary care practitioners and other professionals including care coordinators to provide high quality, patient-centered care, including development of individualized comprehensive patient care plans, use of patient decision-making aids that provide patients with information about treatment options and associated benefits, consistent contacts between patients and care teams, and systematic patient follow-up,

(b) the use of health information technology,

(c) the use of evidence-based health care practices, and

(d) incorporate quality outcome, and cost-of-care measures;

HJR 82 Study Mandate (Cont.)

- (ii) standards for certification of health care facilities as chronic health care homes including ongoing reporting requirements for chronic health care homes;
- (iii) development of a chronic health care home collaborative to provide opportunities for chronic health care homes and state agencies to exchange information related to quality improvement and best practices;
- (iv) enrollment of state medical assistance recipients with chronic health problems in chronic health care home programs; and
- (v) costs associated with implementing a successful demonstration program to test whether chronic health care homes can improve health care quality and patient outcomes, and reduce costs associated with chronic health problems.

The Joint Commission on Health Care shall complete its meetings for the *first year* by November 30, 2010, and for the *second year* by November 30, 2011."

Study Background

- Last year we presented the background information addressed in HJR 82, so we will not present that information in detail today.
- At the time this study was introduced, the concept of a PCMH was just beginning to gain attention.
  - However, discussions surrounding new and better ways to provide medical care and a proliferation of demonstrations and pilot programs, indicate that the medical home may become a useful, sustainable model.
- So, we are in the fortuitous position of not having to recommend the creation of any demonstration projects, but to actually monitor what is already happening in the public and private sector.
- This presentation will highlight what is already happening nationally and in Virginia in the medical home arena.

Chronic Disease Statistics

- Chronic diseases are a leading cause of adult disability and death in the US.
- Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room visits, hospitalizations, or costly inpatient and outpatient treatment plans.
- The medical care costs for people with chronic diseases account for more than 75% of the nation's $2 trillion in medical care costs. By 2020, that is expected to rise to 80% of overall health spending.
  www.cdc.gov/nccdphp/overview.htm
- People with chronic conditions account for 88% of all prescriptions filled, 72% of all physician visits, and 76% of all inpatient stays.

5

Prevention of Chronic Disease

- There is a growing body of evidence that earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs. (www.aha.org)
- Chronic diseases are the most prevalent, most costly and most preventable of illnesses.
  - Prevention includes interventions such as risk screenings, vaccinations, education on behavior, primary care, disease detection, monitoring and treatment.
    - These activities can significantly reduce disease, disability and death. (www.aha.org)
  - Transforming the system from one that reacts when a person is sick, to one that is proactive and focused on keeping a person as healthy as possible. (www.improvingchroniccare.org)

6

Fragmentation

- People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery system for those with chronic conditions is complex and confusing, and care is often fragmented, less effective and more costly.
- People who receive care from numerous providers often lack the ability to monitor, coordinate or carry out their own treatment plans.
  - Often have multiple health care providers (HCPs), treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual; resulting in unnecessary ER and hospital admissions.
  - About 25% of those with chronic conditions face limitations with activities of daily living such as walking, dressing and bathing.

Source: Robert L. Mollica and Jennifer Gillespie. "Care Coordination for People with Chronic Conditions," Partnership for Solutions, Johns Hopkins University. January 2003.

7

Fragmentation

- "Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's conditions, medical history, services provided in other settings, or medications prescribed by other clinicians." Ernest Clevenger, "How Primary Care, America's Best-Kept Secret, Can Reduce Health Care Costs for Self-Funded Employers" HealthWatch, September 2008.
- A new study from the Center for Studying Health System Change revealed:
  - "widespread acknowledgement that most provider payment methods don't encourage efficient or effective delivery of chronic disease care."
  - And, "optimal care for people with chronic disease involves coordinated, continuous treatment by a multidisciplinary team."

8

Patient Centered Medical Home

- A number of experts believe that many of the problems identified with the U.S. health system can be solved using the model of a health care home.
- A health care home, or patient centered medical home (PCMH), is an approach in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.
- A major goal of PCMHs is to reduce costs by avoiding duplicate or unnecessary testing and services and result in better quality care at a more affordable cost.

9

Components of Patient Centered Medical Home

- Team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.
- Components include:
  - Each patient receives care from a personal physician who leads a team of providers who are responsible for planning ongoing care;
  - personal physician responsible for "whole person";
  - patient care coordinated across health system and community;
  - enhanced access to care offered through open scheduling, expanded hours, and new care options such as group visits;
  - payment structure recognizes enhanced value provided to patients.

10

Patient Centered Medical Home

- Typically providers who adopt the medical home model receive additional compensation to reflect the change in the delivery of health care services. Some:
  - Receive fee-for-service payments for all services they provide plus additional payments to provide care coordination.
  - Receive additional payments for managing patient care and for meeting or exceeding such quality and performance standards by:
    - implementing electronic health records,
    - e-prescribing,
    - coordinating medication management with pharmacists,
    - tracking test and referrals,
    - providing telephone access after business hours, and the percentage of children who receive well-child visits.

11

Joint Principles

- In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association came together to identify a set of joint principles for PCMHs at the request of health care purchasers.

- These principles emphasize:
  - Access to a personal physician who directs a medical team responsible for the patient's care.
  - Patient care that has a whole-person orientation, is coordinated across the health care system, and is focused on quality and safety, as well as enhanced access to care.
  - Payment should recognize the added value that physicians and other care providers add.

12

National Committee for Quality Assurance Standards

- Standards developed by the National Committee for Quality Assurance (NCQA) are most often used to identify which primary care practices have achieved designation as a medical home.
- The standards allow for recognition as a PCMH at 3 different levels and include 30 elements, of which 10 are considered mandatory or "must pass."
- Practices that achieve NCQA's PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs.
- NCQA updated its standards and published new guidelines in January 2011.

PCMH Programs

- By the end of 2011, more than 7,600 clinicians at more than 1,500 practices across the country had earned PCMH Recognition.
- Across the country, public and private payers, purchasers and clinicians have created pilot and demonstration programs.
  - Many programs provide financial incentives, such as pay for performance and reimbursement for services beyond the patient visit, which have motivated primary care practices to engage in the transformation that leads to NCQA PCMH recognition.

Patient-Centered Primary Care Collaborative (PCPCC) Pilot Programs

- The PCPCC recently released a report that summarized findings from PCMH demonstrations and concluded that "investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization…Several major evaluations show that patient centered medical home initiatives produced a net savings in total health care expenditures for the patients served by these initiatives.
- Studies have demonstrated that PCMHs improve access and reduce unnecessary medical costs.

15

Geisenger Health System PCMH Model

Example of an integrated delivery system model.

- Demonstrated an 18% reduction in hospital admissions relative to controls:
  - 257 PCMH admissions vs. 313 "control" admissions per 1,000 members per year.
- 7% reduction in total per member/per month costs relative to controls.

16

BlueCross BlueShield of South Carolina

Example of a Private Payer Sponsored PCMH initiative

- 10.4% reduction in inpatient hospital days (from 542.9 to 486.5 per 1,000 enrollees per year among PCMH patients).
  - Inpatient days were 36.3% lower among PCMH patients than among control patients.
- 12.4% reduction in emergency department visits (from 21.4 to 18.8 per 1,000 enrollees per month among PCMH patients).
  - Emergency department visits were 32.2% lower among PCMH patients than among control patients.
- Total medical and pharmacy costs per member/per month were 6.5% lower in the PCMH group than the control group.

17

Community Care of North Carolina

Example of Medicaid-Sponsored PCMH Initiative

- Consists of 14 regional networks providing medical homes for 1.1 million Medicaid enrollees.
- Each network serves as a virtual integrated health system:
  - Medical management committee of local doctors who develop best practices, a medical director, and a clinical pharmacist.
  - Networks and participating physicians receive at least $2.50 per member/per month to coordinate care.
- Community Care of NC saved the state nearly $1.5 billion in health care costs between 2007 and 2009, according to Treo Solutions, due mainly to reduced hospital admissions and readmissions and improved management of chronic conditions.

18

Community Care of North Carolina

- The program has worked so well, they initiated a new pilot program, First in Health, to extend the cost savings and improvements outside the state's Medicaid program.
  - GlaxoSmithKline, retail pharmacist Kerr Drug, and the health plan for NC state employees will offer Community Care medical homes to workers as an optional enhanced benefit for their existing health coverage.
  - $2.50 per member/per month.
  - Most new participants won't need to find new doctors because 95% of primary care physicians in NC already participate in Community Care of NC.

Federal Health Reform

- The Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation:
  - Will test innovative payment and service delivery models to reduce the rate of growth of Medicare and Medicaid expenditures.
    - Among the models to be tested are those that promote "broad payment and practice reform in primary care, including PCMH models for high need individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment."
  - Preserve or enhance the quality of care.

Demonstration Projects

- PPACA authorized the Department of Health and Human Services (HHS) to test medical homes.
  - In June 2010, HHS invited states to apply for participation in the Multi-payer Advanced Primary Care Demonstration Project in which Medicare, Medicaid and private insurers will use the medical home model to assess improvements to the delivery of primary care and lowering health care costs.
    - Eight states were chosen to participate: Maine, Vermont, Rode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota.
    - The demonstration will ultimately include approximately 1200 medical homes serving as many as 1 million Medicare beneficiaries.
  - The Department of Veterans Affairs, the nations largest health system, has begun shifting its clinics to the medical home model, with transition expected to be complete by 2015.

Federal Health Reform

- Provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. (Sec. 2703)
  - Allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a "health home" to help coordinate treatments for the patient.
  - Provides an opportunity for states to get 90% of the funding in the first 2 years from the federal government.
- Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority give to programs that educate students in team-based approaches to care, including the PCMH. (Sec. 5301)

Federal Health Reform

- Federal HHS has the authority to expand the use of PCMHs within Medicare or Medicaid if it has been shown that these models reduce spending or the growth in spending without reducing quality, or can improve patient care without increasing spending.
- Additionally, federal stimulus funding included incentives to invest in electronic health records (EHRs).
  - Beginning in 2011, hospitals and eligible professionals were allowed to receive incentive payments under Medicare and Medicaid if they make "meaningful use" of EHRs.
  - The new NCQA standards for PCMH recognition are closely in line with these incentives.

Virginia Department of Medicaid Assistance Services (DMAS)

- DMAS is partnering with the Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carilion in order to transition a Medicaid primary care case management program in southwestern Virginia into a medical home pilot.
- The medical home pilot, which received a technical assistance grant from the National Academy of State Health Policy and the Commonwealth Fund, will provide primary care, behavioral health, disease and case management, and other services.

Virginia Innovation Center

- In Virginia, an Innovation Center will be established as a nonprofit center hosted by the Virginia Chamber of Commerce.
- While many of the details of how the Center will operate have not been determined as the projected start date for the Center is January 2012, "the Innovation Center will serve as a resource in Virginia by:
  - Researching and disseminating knowledge about innovative models of health promotion and health care to Virginia employers, consumers, providers, health plans, public purchasers, and communities;
  - Developing multi-stakeholder demonstration projects aimed at testing innovative models of health promotion and health care; and,
  - Helping Virginia employers, providers, purchasers, health plans, and communities accelerate their pace of innovation for the benefit of Virginians."
- (Description sent to JCHC staff by Health and Human Resources Secretariat staff in August 2011.)

Virginia Primary Care Physicians

Medical home initiatives are being undertaken in Virginia.

- Eighteen Carilion physician practices in the Roanoke and New River valleys are recognized as Level-3 (highest) PCMHs by the National Committee for Quality Assurance.
  - The Family Medicine Group in Vinton was the first practice in Virginia to be certified as a PCMH.
- An increasing number of practices in the Hampton Roads area are transforming themselves into PCMHs.
- Physicians and faculty of Eastern Virginia Medical School will soon apply for recognition as a medical home.
- Several Sentara practices are also in the application process.

Policy Options

- **Option 1:** Take no action.
- **Option 2:** Continue to monitor the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

27

Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on October 6, 2011.
- Comments may be submitted via:
  - E-mail: jhoyle@jchc.virginia.gov
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218
- Comments will be summarized and reported during the October 17th meeting.

28

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218
804.786.5445
804.786.5538 (fax)

Website: http://jchc.virginia.gov