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Patient-Centered Medical Homes Sub-Committee

Division of Public and Behavioral Health
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December 8, 2017

Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

PCMH

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Senate Bill 6: PCMH defined in NRS

"A patient-centered medical home means a primary care practice that:

1) offers patient-centered, continuous, culturally-competent, evidenced based, comprehensive health care that is led by a primary care provider and a team of health care providers, coordinates the health care needs of the patient, and uses enhanced communications strategies and health information technology; and,

2) Emphasizes enhanced access to practitioners and preventive care to improve the outcomes for and experiences of patients and lower the costs of health services."

SB 6 amended NRS 439.519(3):

Under the Advisory Council on Wellness and the Prevention of Chronic Disease a majority of the voting members of the Council may:

- (c) Establish an advisory group of interested persons and governmental entities to study the delivery of health care through patient-centered medical homes.
- Interested persons and governmental entities that serve on the advisory group may include, without limitation: (1) public health agencies; (2) public and private insurers; (3) providers of primary care, including, without limitation, physicians and advanced practice registered nurses who provide primary care; and, (4) recipients of health care services."

Certification/Recognition

- **The National Committee for Quality Assurance** for PCMH recognition
- **The Joint Commission** for ambulatory health care accreditation and PCMH recognition
- **The Accreditation Association for Ambulatory Health Care** accreditation and PCMH recognition

* Technical assistance and training for the above recognition processes is supported by Health Resources and Services Administration (HRSA).

	Medicaid Health Homes	Patient-Centered Medical Homes
Target Population	Individuals with chronic conditions	All populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as nurse practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g.. Medicaid, commercial insurance)
How Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care	Team-based, whole person orientation achieved through coordinated care
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

Section 2703 of the ACA

Health Homes are for people with Medicaid who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition
- Chronic conditions listed in the statute including mental health or substance abuse issues, asthma, diabetes, heart disease and being overweight.
- Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

Health Homes Payment Model

- States will receive a 90% enhanced FMAP (Federal Medical Assistance Percentage) for the specific health home services in Section 2703. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a health home.
- The 90% enhanced match is good for the first eight quarters in which the program is effective. A state may receive more than one period of enhanced match, understanding that they will only be allowed to claim the enhanced match for a total of 8 quarters for one beneficiary.

State Plan Amendment (SPA)

- As of May 2017, 21 states and the District of Columbia have a total of 32 approved Medicaid health home models.
- The health homes have enrolled over 1 million beneficiaries, and 20 states have received health home planning funds from CMS.
- AZ, AR, KY, MS, and NV all received planning funds without approved SPAs. NV implemented an 1115 Waiver in lieu of SPA per CMS guidance.
- ID, KS, and OR have all terminated their SPAs under Section 2703

Other States' Health Homes

Populations:

- Chronic Conditions
- Serious Mental Illness (SMI)
- Substance Use Disorder (SUD)
- Serious Emotional Disturbance (SED, children)
- HIV/AIDS

- https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-overview.pdf

PCMH in Nevada (informal)

https://www.pcpcc.org/initiatives/nevada

Public Payer:

- CMS State Innovation Model (SIM) Design Award recipient (statewide)

Private Payer:

- Cigna Accountable Care Program – Healthcare Partners Nevada (LV)
- Anthem Enhanced Personal Health Care Program (statewide)
- MGM Resorts' Direct Care Health Plan (LV)
- Turntable Health-Iora Health (LV)

New York: Adirondack Medical Home Multi-payer Demonstration NCQA-Recognized

- Includes Medicaid, Medicare and seven other regional payers in region
- PMPM payments made on provider's level of recognition in the Demonstration (based on EHR use):
  - Statewide Level 1: $2 PMPM
  - Statewide Level 2: $4 PMPM
  - Statewide Level 3: $6 PMPM
  - Adirondack Medical Home Demonstration: (ADK) $7 PMPM

https://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf

New York (cont.)
Ten Standards of Medical Practice

1. Written standards for patient access and patient communication;
2. Use of data to show standards for patient access and communication are met;
3. Use of paper or electronic charting tools to organize clinical information;
4. Use of data to identify important diagnoses and conditions in practice;
5. Adoption and implementation of evidence-based guidelines for three chronic conditions;
6. Active patient self-management support;
7. Systematic tracking of test results and identification of abnormal results;
8. Referral tracking, using a paper or electronic system;
9. Clinical and/or service performance measurement, by physician or across the practice; and
10. Performance reporting, by physician or across the practice.

New York (cont.)

- Since 2010, the number of PCMH providers in NYS has increased from 633 to 4,461.
- As of mid-2012, over 1.4 million Medicaid managed care (MMC) and CHPlus enrollees are assigned to PCMH providers.
- In 2011, about 75,000 Medicaid fee-for-service (FFS) members had a visit with a PCMH provider.
- For the first six months of 2012, this number increased to 84,000. As this number represents unique recipients and not visits, there is no expectation that the number for the full year will double or increase substantially.
- Since January 2010, NYS Medicaid has provided over $148 million in enhanced reimbursement to providers.

New York: Quality Measures

- An evaluation of quality of care, as defined by nationally recognized measures of care, indicates that PCMH providers have outperformed non-PCMH providers in several domains of care, in particular, management of chronic disease which is essential to improving outcomes, quality of life and lowering costs.
- For example, the management of cholesterol for those treated in PCMHs is twelve percentage points higher than those who are not in PCMHs (59% vs. 47%).
- PCMHs also provided superior care to diabetics with a higher rate of preventive care and testing, as well as, better outcomes such as control of blood sugar and cholesterol.
- PCMH practices also provided better preventive care and counseling such as measurement of BMI and nutrition counseling.
- Children in PCMHs are less likely to have an inpatient hospitalization.

PCMH in the Country

Research from the National Committee for Quality Assurance finds that the number of PCMH incentive programs around the country has increased from 26 in 2009 to over 160 today, a growth of about 82%.

- A more patient-centered approach
- Lower costs and improved outcomes
- Reduction of overutilization of expensive healthcare resources
- Team of providers
- EHRs
- Improving the patient experience

PCMH in NV

- Next steps for the Sub-Committee?
- How do we move forward with our goals and objectives for PCMH in Nevada?
- What further information do we need to progress PCMH in NV?

QUESTIONS?

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