

## **“Transforming Primary Care to ‘Medical Home’ Initiatives to Restructure Care for Patients with Chronic and Complex Illness”**

Prepared for the Transformation Task Force

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The Minnesota Department of Human Services, Minnesota’s Medicaid agency, has begun a process to transform healthcare delivery in the primary care setting. Legislation passed in both 2007 and 2005 and a Medicaid Transformation Grant have combined to create a unique opportunity to work with providers and patients to change the structure of primary care delivery.

Our vision is to create a “medical home” for patients served by public programs specifically by supporting the transformation of primary care to a system that proactively works in a team with patients and families to manage health and reduce the burden of chronic disease. Expected outcomes of this work are improved health concomitant with reduced costs. In this vision, patients and their families are active and engaged partners in care. Care fulfills the medical home principles of being family-centered, compassionate, culturally-competent, accessible, continuous, comprehensive, and coordinated. Care is coordinated across all of the patients’ illnesses including both physical and mental health. Medical care is coordinated with community support systems. Duplicative care is eliminated. Expensive services are reduced. Patient and family preferences are an essential part of all care planning.

Specifically, DHS will put payment structures and an infrastructure in place to support this transformation. In this payment structure, primary care providers will receive a new care coordination payment to actively and prospectively coordinate the care of patients with complex or chronic illness. Payment will be adjusted to reflect the complexity of the patient’s needs. This payment will be different from the current payments made for individual service encounters. It will require fundamentally different work than that which is routinely provided at this time. Payment for performance, a third payment mechanism, will follow and reinforce the expected outcomes from these projects. Payment for performance is already beginning for enrollees in public programs consistent with the governor’s Qcare goals for care of patients with diabetes and cardiac disease.

The key components that have come together to create this opportunity are:

- Provider Directed Care Coordination legislation passed by the 2007 Minnesota Legislature
- Communication and Accountability in Primary Care Systems (CAPS)- Medicaid Transformation Grant – awarded to Minnesota by CMS
- Intensive Care Coordination pilot project including the development of a risk adjusted predictive modeling tool passed by the 2005 Minnesota Legislature

Provider Directed Care Coordination (PDCC) was passed by the 2007 Legislature and awaits approval by the Center for Medicare and Medicaid Services (CMS). In PDCC the department will pay a per member per month fee (average \$50) to providers coordinating care for patients with complex illness in our fee for service population. (Of the ~670,000 patients in the publicly supported Minnesota Health Care programs, ~120,000 are in our fee for service program. Most of these fee for service patients are disabled citizens.) The criteria for participation as a PDCC provider and the threshold for patient complexity are being developed by the department in conjunction with the medical community. This process is discussed further below.

Communication and Accountability in Primary Care Systems (CAPS)- Medicaid Transformation Grant will provide an electronic interface between the department and providers focusing on care coordination. At the present time the Department processes claims, but receives precious little information about the clinical status of those in public programs. Conversely, providers are not able to receive any information in the department's records that would help providers optimize the care they deliver. Claims records from the department containing diagnoses, procedures, and medication histories are not available to support patient care decisions. The CAPS grant will create that interchange. Providers will be able to submit to the department key care plan information on patients actively being managed in the PDCC project and receive key information from the department's database to support the care of that individual. At all times privacy will be protected and concerns will be thoroughly addressed. Data obtained by the department from the CAPS project will provide an unprecedented opportunity to evaluate the effectiveness of the PDCC program and plan for future enhancements.

The Intensive Care Coordination program passed by the 2005 Legislature is designed to provide an intensive level of care coordination by a provider organization for individuals in our public programs with the highest resource needs. As part of that grant, the grantee, Axis Health, is to develop a predictive modeling risk adjustment system to identify patients whose intensive needs will continue. From this group, Axis will create strategies to intervene to improve health and bring down cost for the most complex 300 individuals. In the creation of this contract, the department specifically expanded the scope of the modeling component. This grant and surrounding work will now create a mechanism to stratify the medical care coordination needs of patients served by the fee for service component of Minnesota Health Care Programs. By creating this stratification, the department will be able to move from a threshold criterion for payment of care coordination only for the patients with more complex needs (commensurate with the \$50 PMPM fee) to a dynamic gradation of care coordination rates to reflect the complexity of coordination required for any patient. This stratification will not be immediately available at the start of PDCC, but will be modeled as the program develops.

The integration of these three efforts will create a payment support infrastructure for transformational change in primary care - a risk adjusted care coordination capitation. The existing model of payment only for treatment of acute episodic illnesses and face to face preventative service visits will be replaced by proactive care planning and management with the patient and families.

Several challenges are easily apparent in this transformation. Most importantly, primary care systems will have to restructure to partner with their patients in this new manner. Practices will need to transform to “medical homes” where care of chronic illness is prospectively coordinated in conjunction with the patient and family. This will require a refocus at the clinic level. Where most primary care has been an individual provider effort, the creation of efficient care coordination systems will require the development of practice level teams. Providers and allied health professionals have little expertise in this type of teamwork and planning. Support via efforts such as learning collaboratives will be needed and is funded in the legislation.

The experience of the Minnesota Medical Home Learning Collaborative has been illustrative in this regard. The Collaborative is a combined effort of the Minnesota Department of Health, the Minnesota chapter of the American Academy of Pediatrics, and the Minnesota Department of Human Services. Funding is supplied via a grant from the federal DHHS’s Maternal Child Health Bureau. In the collaborative, teams of a pediatric provider (pediatrician, family practitioner, or pediatric nurse practitioner), a clinic based care coordinator, and the parents of two children with special health care needs work together to plan the medical home improvements in that practice. These teams meet regularly (one to two times per month) in the practice setting to plan and implement improvements. The collaborative meets regularly (three times yearly) to share information, reinforce medical home implementation principles and plan future practice based improvements. These teams have been effective in creating practice transformation. Initial care improvement results have shown much more effective coordination of care and initial utilization outcome results have shown a significant decrease in expensive services while maintaining or increasing preventative services.

A similar, but differently focused effort is organized by the Institute for Clinical Systems Improvement’s DIAMONDS project. This project focuses care coordination at the practice level for the identification and treatment of depression in adults. Like the Medical Home Learning Collaborative, DIAMONDS focuses on the creation of a care coordination team at the practice level, in this case to create a specific care product.

From these collaboratives, it is recognized that up front support to change practices beyond payment reform is likely to be needed.

A second challenge will be in the creation of the specific measurable criteria for payment for care coordination. Criteria such as the creation of an individualized care plan and access to a practice based care coordinator with dedicated time for that role will be keystones of these requirements. Other criteria that have proven useful in the Medical Home Learning Collaborative such as the presence of patients on practice planning teams and the use of learning collaboratives are reflective of a successful transformational process and will be considered as requirements.

This fall the department will host informational and working sessions involving patients, providers, and health plans to develop recommendations for these criteria. We recognize

that a conversation about these efforts that should be an inclusive community endeavor to serve as a milestone for the entire community. To that end the process is being developed to be inclusive and potentially cosponsored by constituencies representing the breadth of health care stakeholders.

A third challenge will be the creation of an equitable system of payment for care coordination services. This payment should compensate providers for their work, while expecting, measuring, and rewarding clinical outcome improvements. From the macrosystem vantage point care improvement should be measurable across the population and costs should be saved or increases mitigated. Value should be increased.

To create such an equitable system, the risk adjustment methodology must identify both the medical and social/demographic factors associated with medical care coordination. To date most risk adjustment methodologies only look at medical factors. Furthermore, care must be taken to avoid the “year two” problem. Such a problem exists when a provider successfully manages their patients to better health only to be penalized by a reduction in payment because the improved utilization of that panel of patients in the second year of participation decreases the disease burden in the risk calculation.

A last challenge for a risk adjustment system will be the addition of clinical data. Currently data about management is most often inferred from the claims stream. For example, patients with high blood pressure are assumed to be compliant if their prescriptions for antihypertensives are filled. Actual blood pressure measurement is only available if chart audits are conducted. As CAPS is developed and other electronic medical records are linked, the faucet drip of clinical information will turn into a fire hose torrent. The incorporation of this data to enhance the system and create value is a challenge that must be prospectively addressed. (DHS and the medical community have begun to address this in a proposal to create a Minnesota Health Information Value Exchange, MN-HIVE not specifically addressed here.)

Healthcare is entering a period when the opportunities for payment reform will multiply. A balance will need to be achieved amongst payment for direct service; a clinical results oriented, but disease specific pay for performance system; and the process orient patient risk adjusted care coordination process being developed here. The dynamics of that balance will be fluid for some time.

We believe that primary care reform is among key challenges of health care transformation now. As outlined here, we as the Minnesota health care community are well poised to make the next steps on this journey. Improvements envisioned in primary care will go a long way to healing the health care system and improving the health of our population.