Connecticut Health Policy Project

POLICYMAKER ISSUE BRIEF

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Connecticut's Patient-Centered Medical Home Medicare application

An exciting opportunity to improve quality and reduce costs

In August, Connecticut submitted an application to the federal Centers for Medicare and Medicaid Services (CMS) for a patient-centered medical home (PCMH) pilot - what CMS calls the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration – which includes the state employee plan, Medicaid, Medicare and private insurers. The Office of State Comptroller took the lead in drafting the application, which was supported by the Governor's Office and the Department of Social Services. The application attracted broad support from dozens of provider and consumer groups as well as the SustiNet Patient-Centered Medical Home Advisory Committee, not only because of the importance of establishing the PCMH model in Connecticut but also because the collaboration with CMS lays a foundation for comprehensive delivery and payment reforms in Connecticut, such as the development of Accountable Care Organizations. The project is expected to be at least cost neutral; an important goal is to reduce rising costs by improving the delivery of health care.

The plan

The pilot will begin with ProHealth Physicians, a large primary care group that includes 172 physicians at 74 sites across Connecticut. ProHealth is pursuing national PCMH accreditation status and expects to have filed applications for all sites by mid-2011. 235,000 people, eight percent of the state's population, now receive primary care at ProHealth practices. This includes 32,000 Medicare enrollees, 15,000 Medicaid members and 35,000 state employees, dependents and retirees. ProHealth will be providing PCMH care to their entire patient population. Other accredited practices may apply to participate in the future and hundreds have indicated strong interest. Eventually this project could be offered to well over one million Connecticut residents.

On behalf of their state employee members, both Anthem and United HealthCare will participate providing PCMH subsidies, weighted toward performance-based payments. Three other major insurers with significant ProHealth patient populations also have agreements to participate in the project. Medicaid will be participating through the existing Primary Care Case Management program offering advanced primary care to HUSKY Part A patients enrolled with ProHealth providers.

The focus

The PCMH pilot will include the standard functions required for accreditation including care coordination, electronic medical recordkeeping, e-prescribing, team-based care, referral and test tracking, patient self-management, and wellness programs. Each PCMH patient will have an identified care coordinator and primary care provider to help them manage their own care.

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In addition the pilot will include four areas of special intervention to address population health needs.

- **Transitions** in care have been identified as significant factors in both failures of care and as a cost driver. Problems arise when hospital discharge planning is not routinely connected to follow up primary care. The pilot will develop formal protocols for discharging patients out of hospital care linked to primary care through the PCMH. Patients will be intimately involved in development of their own discharge plans and will receive timely follow up from PCMH care managers.
- Primary care in **nursing homes** is critical to preventing serious health problems and hospitalizations. ProHealth physicians serve as medical directors for thirty Connecticut nursing homes. ProHealth will develop protocols to improve access to primary care services within facilities and improve discharge transitions. An APRN or PA will be available on-site at the long term care facility daily.
- An increasing number of patients suffer from **multiple chronic conditions**, making care coordination and self-management a critical focus. PCMHs will identify at-risk patients, provide intensive care management services and personalized self-management tools appropriate to each patient's condition. The expanded care plans and self-management tools will be incorporated into electronic medical records. To facilitate management of chronic conditions, ProHealth is developing formal collaborations with cardiology, orthopedics and behavioral health practices.
- One third of emergency department visits in Connecticut are for non-urgent problems. To address this problem, ProHealth is providing their patients with **expanded access to care** through a growing number of Extended Hour Facilities in each major service area for either scheduled or walk-in care.

Evaluation

Both process and quality measure evaluations are critical components of the PCMH pilot. Parameters include at least twenty HEDIS measures, patient satisfaction and experience of care surveys, and cost control. Physicians will receive individual performance reports. Monthly management reports will allow identification of lagging performance and development of individual improvement plans.

Goals include

- Reducing the percentage of patients with poorly controlled diabetes
- Improving depression screening rates
- Raising screening and immunization rates for children and adolescents
- Better cholesterol and blood pressure management for patients with heart disease or diabetes
- Increasing the rate of colorectal cancer screening
- Expanding use of generic drugs

Multi-state cooperation

Connecticut has also committed to fully participate in a multi-state PCMH collaborative including developing common core evaluation measures across states, sharing data to allow comparative assessments, learning collaborative participation, technical assistance, sharing lessons learned, promising trends and future directions. To date the collaborative includes Vermont, New Hampshire, Maine, Rhode Island, Massachusetts, Pennsylvania, Minnesota and Colorado. Participation in this cooperative among states alone is significant and will provide important tools to Connecticut policymakers as they pursue health care reform.

Bottom Line:

Connecticut's patient-centered medical home plans will reduce rising costs by improving access to coordinated care. If approved, Connecticut's CMS application will bring this important advance to over a million state residents.