Integrating Care for Better Health: State Experience and Future Directions

September 17, 2012

2012 Howard L. Bost Memorial Health Policy Forum
No Wrong Door: Integrating Care for Better Health
Lexington, Kentucky

Mary Takach, MPH, RN
National Academy for State Health Policy
Program Director
NASHP

- 25-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues
Presentation Outline

- We’re in a heap of trouble
- There is a way out
- You can lead the way
Things Don’t Look So Good
# US Healthcare System Falls Behind

## Country Rankings

<table>
<thead>
<tr>
<th>Rank Range</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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</thead>
<tbody>
<tr>
<td>1.00-2.33</td>
<td></td>
<td></td>
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<tr>
<td>2.34-4.66</td>
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<tr>
<td>4.67-7.00</td>
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</table>

## Overall Ranking (2010)

<table>
<thead>
<tr>
<th>Category</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
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</thead>
<tbody>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Effective Care</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Safe Care</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2007</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,588</td>
<td>$3,837*</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,290</td>
</tr>
</tbody>
</table>

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Senior Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov, 2009).

Deaths Preventable with Appropriate Health Care

Deaths per 100,000 population*

* Countries’ age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. See Appendix B for list of all conditions considered amenable to health care in the analysis.

Data: E. Nolte, RAND Europe, and M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files and CDC mortality data for U.S. (Nolte and McKee, 2011).

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.
# Quality in Kentucky

## STATE RANKINGS

<table>
<thead>
<tr>
<th>Category</th>
<th>2009 Scorecard</th>
<th>Revised 2007 Scorecard^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL</td>
<td>45</td>
<td>43</td>
</tr>
<tr>
<td>Access</td>
<td>34</td>
<td>29</td>
</tr>
<tr>
<td>Preventions &amp; Treatment</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Avoidable Hospital Use &amp; Costs</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>Equity^b</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>45</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: The Commonwealth Fund State Scorecard
Kentucky Quality Indicators Cont’d

❖ Bottom Quartile

- Kentucky ranked in the bottom quartile for 14 indicators, 8 of which are in the bottom 5 states
  - Medicare Hospital Admissions for Ambulatory Care Sensitive Conditions per 100,000 Beneficiaries
    - 8,576 in Kentucky – Rank 48
  - Colorectal Cancer Deaths per 100,000 Population
    - 21.0 in Kentucky – Rank 50
  - Percent of Nonelderly Adults (Ages 18-64) Limited in Any Activities Because of Physical, Mental, or Emotional Problems
    - 23.2% in Kentucky – Rank 50

Source: The Commonwealth Fund State Scorecard
State Medicaid Spending is Increasing

Total and State Funds Medicaid Spending Growth
FY 2000 – FY 2012

NOTE: State Fiscal Years.

Our systems thinking is improving
Wisdom in 1990

Access  Quality  Cost

Donkey  (Symbol)  Elephant
Wisdom in 2011

Quality

Access  Cost
What we know about primary care

- Primary care oriented systems:
  - Improve health (improving effectiveness)
  - Keep costs manageable (improving efficiency)
  - Reduces racial disparities

Source: Starfield, Johns Hopkins University
Primary Care Score vs. Health Care Expenditures, 1997

Source: Dr. Barbara Starfield; Presentation at the Blekinge Conference; Ronneby, Sweden; September 19, 2007
What we know about Medicaid spending

- Enrollment is the main driver of Medicaid spending.
- Medicaid spending is concentrated in a small group of high-need beneficiaries.
- Health care cost inflation system-wide also affects Medicaid.

Closer look at inflation

<table>
<thead>
<tr>
<th>Percent Increase</th>
<th>Medicaid Costs Per-Enrollee</th>
<th>Job-Based Insurance Premiums</th>
<th>National Health Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>4.6%</td>
<td>7.7%</td>
<td>5.9%</td>
</tr>
<tr>
<td>2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10%</td>
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</table>

A way out.

Background Image by Dave Cutler, Vanderbilt Medical Center
(http://www.mc.vanderbilt.edu/lens/article/?id=216 &pg=999)
The Road to Integrated Care is Paved with Payment Reform

Medicare Payment Reform Framework: Organization and Payment Methods

Notes: DRG is diagnosis-related group. FFS is fee-for-service.
Patient Centered Medical Home Models

Key features:
- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Data & feedback
- Health Information Technology
- Practice Education

Medicaid Medical Home Payment Models

Multi-disciplinary Team Models

Making room for teams and new services

Key features:

- Multi-disciplinary teams — often shared among several practices
- Payments to teams and payments to qualified providers to work with teams
- Patients and families can be “on the team”
### Select Emerging Community Care Team Payment Models

<table>
<thead>
<tr>
<th>Eligible Organizations</th>
<th>Scope</th>
<th>Payment</th>
<th>Key Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alabama:</strong> Patient Care Networks of Alabama</td>
<td>Newly created entities</td>
<td>3 care networks, 135 PCPs, 80,000 eligible patients</td>
<td>$5 per-member-per-month (PMPM) for ABD Medicaid, $3 PMPM for Medicaid, plus startup expenses</td>
</tr>
<tr>
<td><strong>Maine:</strong> Community Care Teams</td>
<td>Include home care providers, hospitals and FQHCs</td>
<td>8 care teams, 214 PCPs, 150,000 eligible patients</td>
<td>$3 PMPM for Medicaid, $2.95 PMPM for Medicare, $0.30 for privately insured</td>
</tr>
<tr>
<td><strong>Montana:</strong> Health Improvement Program</td>
<td>FQHCs and tribal health centers</td>
<td>14 centers, 32.5 FTE care managers, 3,500 patients receiving care management (5% of all eligible)</td>
<td>$3.75 PMPM</td>
</tr>
<tr>
<td><strong>New York:</strong> Adirondack Region Medical Home Pilot Pods</td>
<td>Three pods: One based in an FQHC, two based in hospitals</td>
<td>3 pods, 194 PCPs, 103,116 eligible patients</td>
<td>Enhanced PMPM payment to providers who contract with pods: Pod payment range $1.10 - $3.50 PMPM</td>
</tr>
</tbody>
</table>
Health Neighborhood Models

Key features:

- Emphasis on coordination between providers, comprehensive transition care, behavioral health & long term services integration, use of health information technology
- Data analytics, quality improvement
- Robust community & social services linkages
- Individual & family support resources
- Community Care of North Carolina provides robust example
## Select 2703 Health Homes Payment Models

<table>
<thead>
<tr>
<th>SPA</th>
<th>Payment Model</th>
<th>Payment</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri - Behavioral Health</td>
<td>Care Management Fee</td>
<td>$78.74 Per Member Per Month</td>
<td>Community Mental Health Centers</td>
</tr>
<tr>
<td>Missouri - Physical Health</td>
<td>Care Management Fee</td>
<td>$58.87 Per Member Per Month</td>
<td>FQHCs, RHCs, Hospital Clinics</td>
</tr>
<tr>
<td>New York</td>
<td>Care Management Fee (Adj. for geog. &amp; case-mix)</td>
<td>$75 - $390 Per Member Per Month</td>
<td>FQHCs, Hospitals Clinics Managed Care Plans, etc.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Care Management Fee (Adj. for Medical Home Tier)</td>
<td>$10-24 Per Member Per Month</td>
<td>FQHC’s, Hospital Clinics, etc.</td>
</tr>
<tr>
<td>Rhode Island - Behavioral Health</td>
<td>Monthly Case Rate</td>
<td>$446.51</td>
<td>Community Mental Health Organizations</td>
</tr>
<tr>
<td>Iowa</td>
<td>Care Management Fee (Adj. for # and severity chronic illnesses)</td>
<td>Per Member Per Month</td>
<td>FQHC’s, Hospital Clinics</td>
</tr>
</tbody>
</table>
Integrated System Models

Key model features:
- Central hub linked to community networks
- High-performing providers
- Contractual agreements between providers
- Shared goals & risk
- Population health management tools
- Health information technology & exchange
- Engaged patients
Oregon Coordinated Care Organizations (CCOs) Payment Model

- Each CCO will receive a *fixed global budget* for physical/mental/ (ultimately dental care) for each Medicaid enrollee
  - CCOs must have the capacity to assume risk
  - Implement value-based alternatives to traditional FFS reimbursement methodologies
- CCOs to coordinate care and engage enrollees/providers in health promotion
- 13 CCOs are operating in communities around Oregon as of 9/2012. Pending final approval, 3 more CCOs will begin enrolling clients on 11/2012
- Meet key quality measurements while reducing the growth in spending by 2% over the next 2 years
The ACA may help the way.

Background Image by Dave Cutler, Vanderbilt Medical Center
(http://www.mc.vanderbilt.edu/lens/article/?id=216&pg=999)
Provider Payment rates: Medicaid-To-Medicare Provider Fee Ratios for All Services

U.S. Average = 72% of Medicare fees

NOTE: Tennessee does not have a fee-for-service component in its Medicaid program
ACA Multi-payer medical home demos

<table>
<thead>
<tr>
<th>Comprehensive Primary Care Initiative (CPCi)</th>
<th>State Innovation Model Initiative (SIMi)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>Multi-payer model drawing from both public and private payers</td>
</tr>
</tbody>
</table>
| **Scope** | 500 Primary Care Practices in 7 Regions  
- Statewide: AR, CO, NJ, OR  
- Regions: NY, OH/KY, OK | Model Testing Awards: 5 states  
Model Design Awards: 25 states |
| **Payment** | -1st 2 years: PMPM = $20;  
-3rd and 4th years: PMPM=$15  
-shared savings option | TBD |
Innovation Center (CMMI)

- State Innovation Models Initiative (Accountable care models)
- Health Care Innovation Awards
- State Demonstrations to Integrate Care for Dual Eligible Individuals
- Medicare-based models: Medicare Shared Savings Program, Pioneer, Bundled Payments
- More to come...
Where do you fit in?

- Why/how would you sell an untested model?
- There are many steps along the way.
- Public & private payers, foundations, & ACA can be leveraged.

What this means for you:
- Stakeholder participation is necessary and is occurring!
- Buy-in needs to occur at multiple levels.
- Consumer/patient engagement is central.
- Sleep is for the weak.
For More Information

Please visit:

- www.nashp.org
- http://nashp.org/med-home-map
- www.statereforum.org
- www.pcpcc.net

Contact:
mtakach@nashp.org
SAVE THE DATE

NASHP's 25th Annual State Health Policy Conference
October 15-17, 2012
Baltimore, MD

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