

**New Jersey Medicaid**  
**Medical Home Demonstration Project**  
**Report to the Governor and the Legislature**

Second Report

Division of Medical Assistance and Health Services

NJ Department of Human Services

## **Introduction**

In September, 2010 a state law (NJ P.L. 2010, Chapter 74) was passed directing Medicaid to establish a three-year pilot demonstration for medical homes focusing on the frail elderly and those with chronic diseases.

In response to the legislation, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) wrote a Memorandum of Agreement (MOA) requesting that the four Medicaid contracted managed care organizations (MCOs) in New Jersey participate in a pilot to enhance or create infrastructure, within their networks, for medical home services. All four MCOs agreed to participate, signed the MOA, and are presently in various stages of developing patient centered medical homes (PCMH) within their networks.

Additionally, the language from the Memorandum of Agreement was incorporated into the Managed Care Contract; thus making it a required program for all contracted NJ Medicaid MCOs to participate in developing and supporting PCMH practices within their networks.

## **Summary of MCO Activities to Date**

### MCO A

MCO A's Patient Centered Medical Home (PCMH) program began the second half of 2011 with a single practice and 1,600 members. In 2012, an additional PCMH was added. In 2013, the MCO A's Patient Centered Medical Home Program had eight participating practice locations. This represented nineteen participating doctors, and over 5,000 members. The Patient Centered Medical Homes were initially evaluated on 15 quality metrics; an emergency room utilization metric; and one medical cost metric. Additional quality metrics were added to address the health needs of the added member populations. The current practices include:

- Horizon Health Center
- Forest Hills Family Health Associates
- Ocean County Internal Medical Associates
- Farmingdale Family Practice
- Bloomfield Health Center
- Hudson Primary Care Professionals
- Inman Medical Associates
- Joyce Nkwonta

MCO A's model is built on four strategic patient centered pillars:

- 1) Access & Availability of Care** - Patient has access to 24/7 clinical support that the PCMH has arranged through partnerships and relationships. Practices are encouraged to utilize other health professionals (non-physicians) as part of the care team approach.

- 2) **Personalized Care Management** - Patients have a relationship with care teams who take responsibility for holistically managing their care needs. Components include a comprehensive individualized care plan that is aligned with the patients' preferences and includes prevention and compliance monitoring for both wellness programs and chronic conditions.
- 3) **Prevention and Health Status Management** - Patient receives regular updates and communications along with a personalized approach to encouraging compliance with her care plan.
- 4) **Empowered Decision Making** - Patient is educated and counseled with the knowledge and available resources to make the best decisions for her health.

The purpose of the measures and PCMH bonus program is to:

- Reach Goals of Patient Centered Medical Home Program
- Promote high quality, evidence-based care and care team collaboration
- Tie actions to results, tracking clinical decisions and quality performance
- Establish closer payor/provider collaboration
- Support providers to increase affordability
- Encourage patient ownership and responsibility
- Create a single, scalable PCMH model for long-term rollout

MCO A's Medical Home Model aims to drive quality and affordability. The outcomes-based payments focus on care, quality and affordability. Quality improvement will be measured through process, utilization, outcomes, and patient experience. Affordability will be derived from lower costs through savings from reductions in unnecessary ER and inpatient utilization.

The Program supports practices using data and information exchange, care management reports, performance reports on quality, utilization and cost. Reporting procedures include but are not limited to the following:

- Daily Inpatient census and discharges within 7 days
- Monthly Inpatient admits and discharges, Maternity, Disease management program member and pharmacy utilization data
- Quarterly exceptions reports for quality metrics that list members who qualify for a measure and where the measure has been met

Payment to support practice transformation includes:

- Population Care Coordinator (PCC) Subsidy - MCO support for practice-employed care coordinators to achieve improvements in patient care by coordinating care for high-risk patients. PCC subsidy is given for the first two years of the program.
- Quality, patient experience, utilization payments - Payment for improved patient care – high-quality, better patient experience and utilization/cost. Moving from fee-for-service to fee-for-value.

The outcome-based payments will focus on care quality, patient experience and utilization.

*Quality Measures:*

- Adolescent Well Care Visits
- Adults' Access to Preventive/Ambulatory Health Services
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combo 2)
- Comprehensive Diabetes Care – Eye Exam
- Comprehensive Diabetes Care – HbA1c <8%
- Comprehensive Diabetes Care – LDL <100mg
- Use of Appropriate Medications for People with Asthma
- Use of Imaging Studies for Low Back Pain
- Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
- Lead screening

*Utilization Measures:*

- Emergency Room Utilization

*Medical Cost Measures:*

- Medical cost targets are established based on medical cost for a specific geographic area and member population

*Additional Quality Measures for the Comprehensive Primary Care Initiative (CPCI):*

- CAHPS Clinician/Group Survey
- Controlling High Blood Pressure
- Tobacco Use: Screening & Cessation Intervention
- Influenza Immunization
- Ischemic Vascular Disease: Complete Lipid Profile and LDL Profile <100
- Hospital-Wide All-Cause Unplanned Readmission Measure for the Aged, Blind and Disabled without Medicare Population

PCMH models are newly developed and therefore conclusions cannot be drawn from early results at this time.

In 2014 MCO A will pursue a collaborative approach to expand the PCMH model in parallel with their commercial counterpart leveraging their experience with practice transformation, transformation coaching, and internal Population Care Coordinators across all populations. From this experience, MCO A will identify best practices to scale PCMH models for the Medicaid population throughout New Jersey.

The 2014 proposed pilots are not finalized, but include a combined member attribution for:

- Patient-Centered Medical Homes - Cooper Healthcare System
- Accountable Care Organizations - Horizon Liberty ACO

- Low-Risk Pregnancy and Delivery Episode of Care program – Targeting three large OB/GYN practices in New Jersey.

In addition, MCO A’s Medical Home Model includes participation in the Comprehensive Primary Care (CPC) Initiative. The CPC is a four-year multi-payer program designed to foster collaboration between public and private health care payers to strengthen primary care.

Highlights of the CPC Initiative:

- A CMS Innovation Center program operating in seven regions;
- Multiple health plans offer bonus/care coordination payments to primary care practices
- Includes five participating plans in New Jersey;
- Participating primary care practices are given resources to better coordinate primary care for their full patient population;
- Includes 70 participating practice locations with 272 providers in New Jersey. .

MCO B

MCO B currently has two active accountable care communities located in Camden and Millville/Bridgeton serving 4,402 and 4,320 patients respectively. Each “community” has two practices that address the entire population in the practice and does not focus on any particular chronic condition. The four pillars of performance focused on: improving access to care, reducing unnecessary emergency department use, reducing avoidable inpatient admissions and close management of the high risk population. Predictive modeling is a tool used to stratify the populations and identify those at greatest risk for hospitalization. The practice works closely with these identified members to ensure timely physician visits and to close gaps in care based on evidenced-based medicine. As the momentum for these programs continue to escalate, MCO B plans to continue to expand their efforts in support of physician transformation in 2014 by doubling their number of medical homes.

Results thus far show ED visits per 1,000 at one site dropped from 880 to 773 and at the other site dropped from 759 to 568 (risk-adjusted). Admission rates per 1,000 dropped from 49 to 40; and the readmission rate decreased from 8.5% to 4.2%. The second site had a risk adjusted admission rate per 1,000 drop from 59 to 51 and the readmission rate decreased from 15.2% to 9.2%. There are no patient satisfaction data or cost savings estimates available at this time.

Screening rates for the first site are as follows:

Annual Dental Visit	44.33%
Use of Appropriate Medications for People with Asthma	75.61%
Comprehensive Diabetes Care	72.06%
Childhood Immunization Status (Combination #3)	40.28%
Well Child Visits in the First 15 Months of Life (6 or more visits)	39.77%

There are no screening rates for the second site since they are still in their first quarter.

## MCO C

MCO C's Patient-Centered Medical Home Program is a pilot program that supports and provides incentives to their participating primary care providers to improve the quality of care for their members by becoming PCMHs. Support for appropriate and interested practices will come in the form of incentive payments and care management fees.

The initial engagement included three primary care practices and two more were added in 2013 as part of a separate medical home initiative. Of the participating practices, three serve 3,629 patients and one has achieved National Committee for Quality Assurance NCQA Level III recognition; the two remaining practices are working on their submission. The focus populations of these PCMHs include HIV patients via the Ryan White program and a homeless population with a history of behavioral health and/or substance abuse issues.

Results for the one NCQA-recognized site show emergency department visits per 1,000 have decreased from 776.4 to 627.9; however, the readmission rate within 30 days for any condition showed an increase from 5.0% to 11.1%. Patient satisfaction results from 218 surveys show the majority of patients rated "great" on communication with their provider, coordination of care, access and self-management support. Cost savings estimates for the three initial practices overall show a cost savings of \$250,000.

Screening rates for the one site are as follows:

Annual Dental	42.40%
Childhood Immunization Combination #2	23.08%
Lead Screening	69.23%
Breast Cancer	39.29%
Cervical Cancer	50.00%
Chlamydia	30.00%
Appropriate Pharyngitis Testing	90.91%
Appropriate URI Treatment	97.62%
Asthma	77.78%
Diabetes HbA1c Testing	56.25%
LDL-C Screening	56.25%
Retinal Eye Exam	56.25%
Neuropathy	56.25%

MCO C plans on expanding their PCMH program and will begin recruiting potential practices in the first quarter of 2014.

## MCO D

MCO D began an initial design for a Medical Home using a sponsor hospital and one of their associated clinics staffed by salaried physicians who do primary care. The plan envisioned a Patient Centered Medical Home that would have family practitioners as the central provider type. The hospital was to pursue certification for the first level of Patient Centered Medical Home. The plan included a quality incentive compensation model that awarded the providers based on achievement of HEDIS-like quality metrics.

The design for this approach followed the same model used by MCO D for a large multi-site primary care practice in Bergen and Hudson counties for the calendar year 2011 and 2012. That pilot arrangement allowed the MCO to gauge the impact of a quality incentive program on PCPs who were caring for an established panel of members. In that particular arrangement, the results for 2011 dates of service showed a marked Improvement in meeting quality metrics for this large multi-site primary care practice panel compared to their 2010 results. Their results were above the average of other comparable primary care physician practices.

Issues related to contract MCO D's negotiations with the sponsoring hospital delayed the design and development of the Medical Home initiative and caused MCO D to pursue other options for Medical Home during 2013. A decision to sell selected MCO D's assets to another MCO impeded their ability to proceed with the initiative at all.

MCO D continues to fulfill the contract requirements including a full Quality Assurance/Performance Improvement (QAPI) work plan to address gaps in care for their various populations by working with contracted Primary Care Providers and other practitioners.

## **Summary**

It has been a little more than two years since the first PCMH began operations. Three of the four contracted MCOs have established medical home programs with plans for expansion, while the fourth MCO will be leaving the NJ market before the end of the year. Preliminary results are showing decreases in ED visits and readmission rates; however, several screening rates show results below acceptable levels. Patient satisfaction results at one site are showing positive results in several areas. Although cost savings estimates may be early to ascertain, one MCO is showing a modest savings thus far. In addition to the medical home model, the Division of Mental Health and Substance Abuse (DMHSA) continues its development of a behavioral health home model in collaboration with DMAHS. DMAHS maintains its commitment in support of innovative integrated care models that provide appropriate care in the appropriate setting while controlling cost.