Health Reform Redux: State and Federal Reform Efforts, Medical Home, and HITECH-Fueled Adoption of EMRs and Health Information Exchange

Panelists:

Jay Himmelstein,

Judy Steinberg,

Dennis Dimitri

Family Medicine Retreat March 20, 2010

Panel Outline

- Overview and Introductions
- State and National Reform: Implications for Family Medicine - Dennis Dimitri
- Medical Home Initiatives in Massachusetts: Current Activities and Opportunities – Judy Steinberg
- The Evolving Landscape of Electronic Medical Records and Health Information Exchange – Jay Himmelstein

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Patient Centered Medical Home: *State and National Initiatives*

Judith Steinberg, MD, MPH

March 20, 2010

Agenda

- **MA Patient Centered Medical Home Demos:**
  - Qualis Safety-Net Medical Home Initiative
  - MA PCMHI: Multi-Payer Demonstration
- **MA PCMHI: UMMS role**
- **MA PCMHI: Next steps**
- **National Demos/Pilots**

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Qualis Safety Net Medical Home Initiative

- Five year demonstration
- Support: CWF and other funders
- 5 Regional Coordinating Centers
  - MA, CO, OR, PA, ID
- 64 Health Centers
  - 14 health centers in MA
- MA Kick-off August, 2009
  - Webinars, trainings, practice coaching
  - Learning Collaborative sessions
- Will integrate with the MA PCMHI
- National evaluation: Univ Chicago

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In April 2008, the Fund awarded a grant to Qualis Health in Seattle to run a five-year medical home demonstration project that seeks to transform 68 safety-net primary care clinics within five regions of the United States into patient-centered medical homes.

Following a request-for-proposals, the team selected five regions for participation: Colorado, Idaho, Massachusetts, Oregon, and Philadelphia.

Partners HealthCare (Boston), Blue Cross Blue Shield of Massachusetts Foundation, The Boston Foundation, and Beth Israel Deaconess Medical Center (Boston).

MA PCMHI: Multi-Payer Initiative

- PCMHI Council
  - Developed a framework for a MA PCMHI: White Paper
    - Pillars of a PCMH
    - Practice expectations
    - Payment methodology
    - Evaluation
    - Infrastructure support

http://www.mass.gov/lhqcc/docs/meetings/2009_12_02_white_paper.pdf

- PCMHI Steering Committee

- Working Groups:
  - Consumer engagement
  - Payer
  - Evaluation
  - Data aggregation and shared savings

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MA PCMHI: Practice Selection

- Practices to be collectively, "representative" of primary care practices in MA
- Possibly consider nominations from communities
- Total number of practices to be determined based on the final payment model and the financial commitment each payer is willing to make
- Applicants will be required to meet a set of basic qualifications that indicate that the practice should be able to succeed in medical home transformation as a result of its participation in the PCMHI.

MA PCMHI: Payment Methodology

- Fee for service
- One time payment for start-up costs
  - Time spent at learning collaborative sessions,
  - Practice registry software
  - Initial internal practice team planning meetings.
- Ongoing prospective payment
  - Care management
  - Population management, team meetings
- Shared Savings
  - With quality gate

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Possible plan to evolve over time, reducing fee for service and aligning with MA plans for global payments

MA PCMHI: UMMS Role

- Lead role in:
  - Consumer engagement
  - Practice coaching
  - Technology support
  - Registry development/data aggregation
  - Evaluation
- Supportive role in:
  - Provider engagement
  - Learning collaboratives

MA PCMHI: UMMS Departmental Involvement

- Commonwealth Medicine
  - Center for Health Policy and Research
    - Clinical Affairs
    - MA AHEC
    - Office of Community Programs
    - Evaluation and Measurement
  - Shriver Center
  - CCCPO
- Dept of Family Medicine and Community Health
- Dept of Pediatrics
- UMMS IT

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MA PCMHI: Next Steps

- Gain consensus on payment methodology and other details of the framework
- Practice site procurement
  - RFR due to be released May 2010
  - Practices chosen August 2010
- Pre-work: September through Dec 2010
- First Learning Collaborative: Jan 2011
- Three year demonstration

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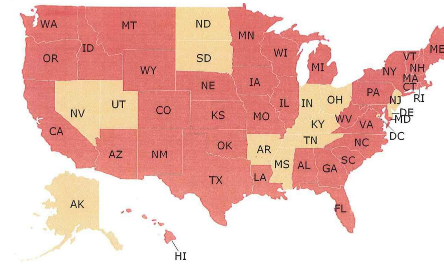
National Demos and Pilots

- Demos across the nation
- CMS initiatives
  - Medicare Medical Home Demonstration Program
    - Authorized by 2006 Tax Relief and Health Care Act legislation
    - Prospective care coordination payments, tiered by patient complexity and medical home scores
    - On hold due to proposed national health reform legislation (House) that would repeal and replace it with pilots
  - Medicare Multi-Payer Advanced Primary Care Practice Demonstration
  - Medicare CHC demo
- Medical Homes and National Health Reform

Medical Home Demos across the US

- 37 states with medical homes demos that meet the following criteria: (1) program implementation (or major expansion or improvement) in 2006 or later; (2) Medicaid or CHIP agency participation (not necessarily leadership); (3) explicitly intended to advance medical homes for Medicaid or CHIP participants; and (4) evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff. (NASHP)



- Approx 27 multi-stakeholder pilots are underway in 20 states. (PCPCC)

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Medical Homes and National Health Reform

- President Obama's and Senate proposals:
  1. **Support the development of training programs** that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for 5 years beginning in fiscal year 2010)

  2. **Create an Innovation Center within the Centers for Medicare and Medicaid Services** to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)

Kaiser Family Foundation http://www.kff.org/

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Medical Homes and National Health Reform

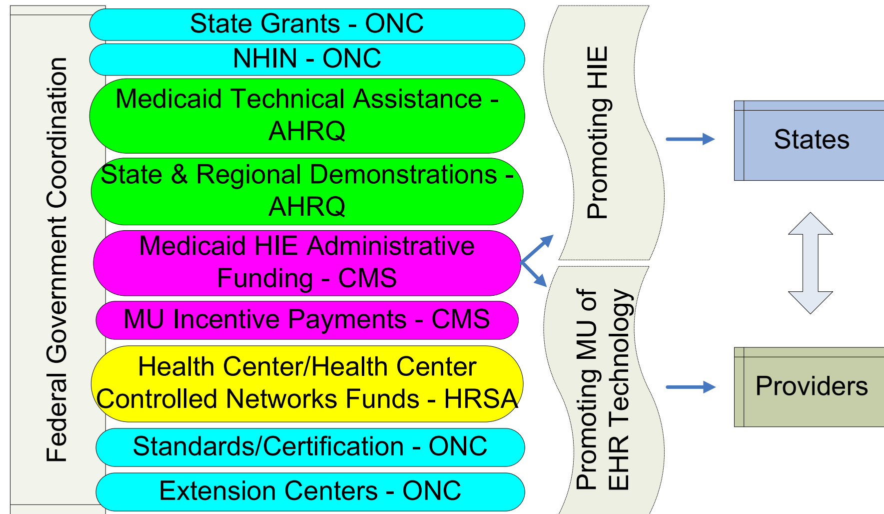
- President Obama's and Senate proposals:
  3. **Allow providers organized as accountable care organizations (ACOs)** that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- House proposal:
  - Repeals CMS Medical Home Demonstration
  - Authorizes two medical home pilots – Medicare and Medicaid

The Evolving Landscape of Electronic Medical Records and Health Information Exchange

- HIT and American Recovery and Reinvestment Act (ARRA): Implementing an infrastructure for better primary care delivery
- Importance of “Meaningful Use” of Electronic Medical Records
- “HIT enabled Health reform”

American Recovery and Reinvestment Act of 2009

- Codified National Coordinator for HIT and Policy & Standards Committee
- $44.7B estimated incentive payments from Medicare and Medicaid and administrative funds to support planning
- $600M to plan and implement sustainable State-Level HIE (All states governments. required to have an HIT Coordinator)
- $600M to support Regional "HIT Adoption" Extension Centers
- Additional Funds for:
  - Broadband and telehealth
  - Community health center and Indian health infrastructure
  - Social Security Administration


Overview of Federal HIT Programs
Federal Government Coordination
State Grants - ONC
NHIN - ONC
Medicaid Technical Assistance - AHRQ
State & Regional Demonstrations - AHRQ
Medicaid HIE Administrative Funding - CMS
MU Incentive Payments - CMS
Health Center/Health Center Controlled Networks Funds - HRSA
Standards/Certification - ONC
Extension Centers - ONC
Promoting HIE
Promoting MU of EHR Technology
States
Providers
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Importance of "Meaningful Use":

- It is the articulation point between the underlying technology and the healthcare improvements we seek;
- It is the standard that doctors and hospitals must achieve to qualify for Medicare and Medicaid incentive payments;
- It will likely be the central organizing principle for the very important work of the Office of National Coordinator, the HIT Policy Committee, and the HIT Standards Committee; and
- It will have a major influence on the activities of the Commonwealth through the Massachusetts eHealth Institute and the MassHealth program.
- It will become a dominant consideration for EHR vendors as they upgrade the functionality of their products.

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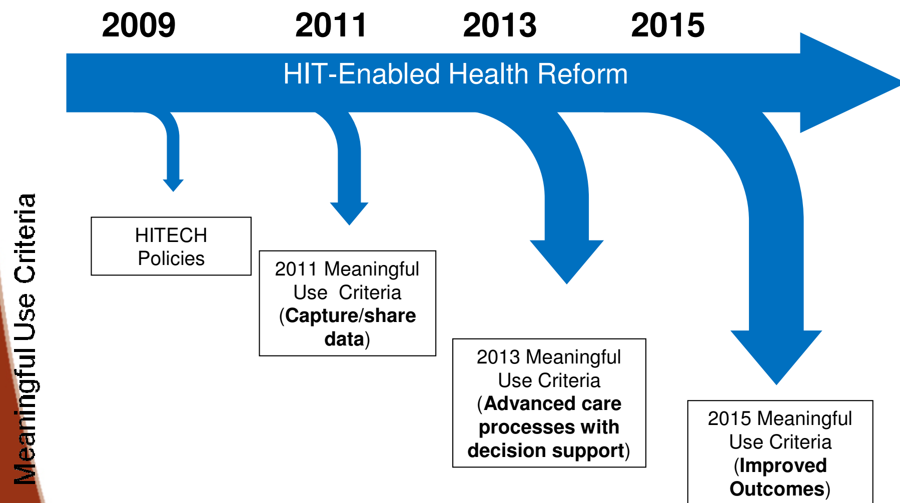
The Meaningful Use Matrix

The Meaningful Use Matrix is built around five “Health Outcomes Policy Priority” areas taken from the work of the National Priorities Partnership convened by the National Quality Forum:

- Improve quality, safety, efficiency, and reduce health disparities;
- Engage patients and families;
- Improve care coordination;
- Improve population and public health; and
- Ensure adequate privacy and security protections for personal health information.

For each priority area there are overarching “Care Goals,” and then more specific “Objectives” and “Measures” established for 2011, 2013, and 2015.

HIT-Enabled Health Reform
Achieving Meaningful Use



Source: Meaningful Use Workgroup Presentation, July 16, 2009

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Meaningful Use Objectives for EPs and Eligible Hospitals

1. Use Computerized Provider Order Entry (CPOE)
2. Implement drug-drug, drug-allergy, drug-formulary checks
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®
4. Maintain active medication list
5. Maintain active medication allergy list
6. Record demographics
7. Record and chart changes in vital signs
8. Record smoking status for patients 13 years and older
9. Incorporate clinical lab-test results into EHR as structured data

Meaningful Use Objectives for EPs and Eligible Hospitals

10. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach

11. Report ambulatory quality measures to CMS or the States

12. Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules

13. Check insurance eligibility electronically from public and private payers

14. Submit claims electronically to public and private payers

15. Provide patients with an electronic copy of their health information upon request

16. Capability to electronically exchange key clinical information among providers of care and patient-authorized entities

Meaningful Use Objectives for EPs and Eligible Hospitals

17. Perform medication reconciliation at relevant encounters and each transition of care

18. Provide summary care record for each transition of care and referral

19. Capability to submit electronic data to immunization registries and actual submission where required and accepted

20. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice

21. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

Meaningful Use Summary

Eligible Providers

- 25 Objectives and Measures
- 8 Measures require ‘Yes’ or ‘No’ as structured data
- 17 Measures require numerator and denominator

Eligible Hospitals and CAHs

- 23 Objectives and Measures
- 10 Measures require ‘Yes’ or ‘No’ as structured data
- 13 Measures require numerator and denominator
- Reporting Period –90 days for first year; one year subsequently

Clinical Quality Measures

2011 – Providers required to submit summary quality measure data to CMS or States by attestation

2012 – Providers required to electronically submit summary quality measure data to CMS or States

EPs are required to submit clinical data on the 2 measure groups: core measures and a subset of clinical measures most appropriate to the EP's specialty

Eligible hospitals are required to report summary quality measures for applicable cases

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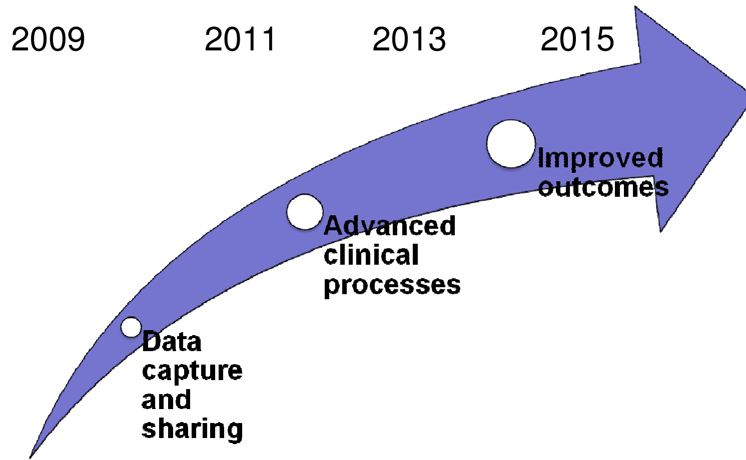
The Future Direction of Meaningful Use



Source: Meaningful Use Workgroup Presentation, July 16, 2009

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Implications for Practice in Central Massachusetts

- Financial rewards (and penalties!) for adoption and meaningful use of EMRs by providers and hospitals
- Effective medical home initiatives and payment reform supported by effective statewide health information exchange
- Example of clinical implications – see excerpt from YouTube video on Maine health-infonet: see http://www.youtube.com/watch?v=sXJXg4vNbOM

Discussion