

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

November 2012
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 NJ 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 network.

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" currently has contracts with two physician groups with plans to contract with several more by year end. The first PCMH began operations in July 2011 and the second in January 2012. The MCO works with the PCMHs to enhance care coordination, meeting or exceeding quality of care standards and metrics, appropriate use of services and settings and overall medical cost control.

Care coordination activities are supported through several means. First, data is provided by the MCO to the PCMH that allows the PCMHs to care coordinate when the members need it most. Data includes member listings of currently or recently hospitalized members; members who have been to the emergency room (ER) within the past 24-48 hours; pregnant members; and members enrolled in MCOs disease management programs. Information on gaps in care is also shared with the PCMH to ensure timely coordination of services. Second, for Level I PCMHs, the MCO provides a care coordinator to work in the primary care practice to assist with care coordination activities. Level II and III PCMHs are required to support the care coordinator themselves. Third, the MCO provides financial assistance through a monthly per member/per month (PMPM) payment to help defray the costs of care coordination activities.

Each PCMH is measured along 15 quality metric measures. The measures are tied to the Healthcare Effectiveness and Information Data Set (HEDIS) measures of quality and measure facets of preventative and ongoing healthcare services to keep members healthier. PCMHs have the ability to receive incentive payments for meeting or

exceeding the measure thresholds. The MCO works with the PCMH throughout the year by producing reports showing members that may need certain preventative services. As with most HEDIS measures, the measurement requires at least one (1) year of data while several measures requires two (2) years of data collection to evaluate results. In addition to the time period for evaluation of the metric there is also a claims run-out period to ensure adequate time for claims to be received and processed. At this point, enough time since PCMH implementation has not occurred for us to evaluate the quality metrics.

Emergency room utilization is a utilization metric used by the MCO to ensure appropriate settings are used for the delivery of health care. Emergency room use has been one of the areas identified where members receive care that could be delivered in the primary care physicians office and allow improved care coordination through the primary care physician. The metric is evaluated on an annual basis. Only one of the two PCMHs has been active for a full year and will need a claims run-out period to allow evaluation of the metric. The physician can receive an incentive payment for certain reductions in ER care.

The third metric is overall medical cost of the PCMH. Through delivery of quality care and care coordination, this MCO believes overall medical costs can be reduced. The overall medical cost metric measures the PCMH overall medical costs and compares to the physician peer groups in the geographic area. There are adjustments made for member categories such as the Aged, Blind and Disabled population and adults versus children. The metric is measured annually and will be evaluated at a later date to allow for a full year of medical home activity as well as one year for claim submission.

MCO B

MCO "B" began their support of practices and FQHCs through an affiliation with the Camden Coalition of Healthcare Providers in 2011 utilizing a comprehensive interdisciplinary care management model for some of the most challenging patients. That relationship grew through the addition of an Accountable Care Program with CAMCare, a Federally Qualified Health Center (FQHC) associated with Camden Coalition. The intent of the Accountable Care Program is to improve health outcomes by supporting the Patient Centered Medical Home Model. This is accomplished by building proactive teams that engage the primary care practice and hospitals. The Accountable Care Program supports the practice in their effort to help patients become engaged in preventative screening and chronic disease monitoring. The intent of the program is to improve healthcare outcomes while reducing unnecessary ER utilization and hospitalization. Their vision is to support clinical teams in their efforts to measure, monitor and manage access to care and to utilize evidence based care of high risk patients and take action to drive continuous improvement in outcomes for the population overall.

The Accountable Care Communities Shared Savings program provides up front dollars to their practices to build Medical Home capabilities. Contracted practices receive a

negotiated per member per month (PMPM) for the sole purpose of enhancing their resource and technical capability to act as a Medical Home. The MCO expects that practices will conduct follow-up PCP visits with members who visit the ER. They also expect that the practice will arrange for follow-up appointments with members who are discharged from the hospital. As of August 1, 2012 the MCO started supporting CAMcare in this effort. Not only are we encouraging primary care provider (PCP) follow-up but they have also identified high risk patients within the CAMcare practice and have begun to work collaboratively to coordinate services with and through the practice. So far they have developed care plans for many patients and made numerous appointments. Additionally, the Shared Savings program shares the benefit of efficiencies created through this process between the plan and the practice. The amount of savings distributed to the practice is based on their HEDIS scores.

Since their August implementation at CAMcare, a team including a registered nurse has been able to interact on-site with the staff. Together, they engage the members who have been utilizing the ER for their primary care needs to return to the PCMH.

The MCO anticipates that cost savings will be achieved as early as the first quarter after implementation. Currently they are preparing for the first Joint Operating Committee Meeting between CAMcare and the MCO later this month at which time the MCO will analyze both current savings and potential future savings.

In addition, the MCO has been able to identify “care opportunities” in the PCMH patients who have not had critical screenings exam such as mammograms and colonoscopies, as well as other gaps in care which may not have been known to the provider.

The MCO will be looking at hospitalization rates and ER utilization in their vulnerable populations, including our frail elderly, to track not only the usage of such services but the reengagement into the PCMH after discharge.

The MCO will be supporting CAMcare’s efforts to obtain National Committee for Quality Assurance (NCQA) PCMH accreditation through direct interaction and the MCOs shared data program allowing transparency and better communication to build a model of cooperation that the MCO believes is integral to the success of the Patient Centered Medical Home.

MCO C

MCO “C” has executed PCMH letters of agreement with three primary care practices. The health plan has provided the resources of a Medical Practice Consultant (MPC) to guide and assist these practices through the NCQA PCMH recognition process. The practices are currently gathering evidence in support of the standards with a goal submission date of May 2013.

MCO D

MCO “D” had a partnership with St. Joseph’s Independent Practice Association (IPA) in Passaic County to implement a PCMH demonstration project. The primary point of contact at the IPA was terminated and St. Joseph’s was unable to carry the demonstration project forward. They are currently in the process of re-establishing their medical home project. The three options being considered include a family practice teaching clinic at St. Joseph’s; a family practice clinic in the south; and a special needs physician practice.

Behavioral Health Homes

New Jersey has two fully functioning Behavioral Health Home programs funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) initiative. The project that is located in the Northern region of the state offers complete primary health care, behavioral health care, dental care, lab services, a fitness center, and an onsite pharmacy. Another grantee is located in the central region of NJ. That organization utilizes a lead agency in partnership with a local FQHC and three other behavioral health care agencies in the region. The FQHC provides primary care services for mental health consumers served by the lead agency and its three behavioral health care partners. Together the FQHC and the behavioral health centers provide integrated and coordinated care to patients served by the program.

In 2008, through a philanthropic anonymous donation, the University of Medicine and Dentistry/University Behavioral Health Care (UBHC) established a primary care/behavioral health care project. Currently the project operates in two locations and provides integrated and coordinated primary and behavioral care for UBHC consumers in the northern and central areas of NJ.

These models of Primary Care and Behavioral Health care integration are examples of work underway in NJ and they serve as an innovative foundation that could be leveraged to develop Behavioral Health Homes across the state.

Section 2703 of the Affordable Care Act offers a State Option to provide Health Homes for Enrollees with Chronic Conditions. Section 2703 adds section 1945 to the Social Security Act (the Act) to allow States to elect this option under the Medicaid State plan. This provision is an important opportunity for States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. The Act defines health home services as “comprehensive and timely high quality services,” and includes the following health home services to be provided by designated health home providers or health teams; comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized

representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate. State would be eligible for an enhanced federal medical assistance percentage (FMAP) of 90% on the services listed above for the first eight quarters the state plan amendment (SPA) goes into effect.

Upon examining the many integration activities as well as the Behavioral Health services system transformation, NJ has decided to focus the proposed Health Home SPA on the development of Behavioral Health Homes (BHHs). NJ plans to serve those individuals with a (1) Severe Mental Illness or those individuals with a (2) Substance Use Disorder and a chronic medical condition or (3) a substance use disorder and risk of a chronic medical condition. Among the group of individuals meeting this diagnostic criterion, services will be targeted to individuals who are high utilizers of medical and behavioral health care services. Final determination of eligibility criteria for the BHH service will be set using a thorough data analysis.

BHHs will be implemented in geographic regions according to need and availability of fiscal resources. Priority will be given to areas with demonstrated high need and strong readiness of local providers to develop BHH capacity. Once geographic areas are identified and fiscal resources are in place, NJ will submit a SPA for federal review.

Behavioral health agencies licensed through the NJ Department of Human Services as either mental health or addiction treatment agencies will be eligible providers. Agencies may choose to provide services at their fixed site, or develop a mobile model of service delivery.

Upon federal approval of a New Jersey Health Home SPA, New Jersey will work with interested providers to support their capacity building efforts and to develop the initial BHH provider network. Initially, Behavioral Health Home providers will be certified by the state of NJ. However, the provider agencies will be given one year to become NCQA certified.

New Jersey Behavioral Health Homes will be administered by New Jersey's Behavioral Health Administrative Service Organization (ASO). The ASO will be responsible for managing both the consumer's Behavioral Health and Health Home services. The consumer's physical health claims will continue to be paid and managed through one of the state's four MCOs.

Implementation of the BHH will be timed to coincide with the startup of the ASO scheduled in 2013 or some time thereafter. The NJ ASO would be responsible for identification of individuals eligible for the BHH on the basis of client utilization and other data gathered from the ASO and the MCOs. In addition, the collaboration with the MCOs will include receiving referrals from the MCO and providing a warm hand off to the BHH service.

The ASO will be contracted to provide care management services to behavioral health consumers. However, NJ will assure that care management services provided by the ASO will be complementary and not duplicative of that provided by the BHH.

Role of Behavioral Health Home in the Statewide System of Behavioral Health Care

Unlike many Patient Centered Medical Homes which enroll a mix of relatively well patients with those with higher needs, NJ has conceptualized this service as targeted to those with high intensity need. Given the level of complexity of the eligible BHH consumer needs, a relatively high service utilization pattern is anticipated.

The BHH in NJ will be a new service added to the existing continuum and targeted to high utilizers and those who are at risk of becoming high utilizers. It is not designed to replace any of the existing behavioral health services in the current continuum.

Culminating with the implementation of the first regional BHH service, the State will study individual and system level outcomes as well as costs. Analysis of the results from the first region will determine how the service is expanded in the state. However, at the time of this submission, NJ anticipates that the service will be expanded by geographic area through subsequent SPA submissions.

Other Endeavors

Comprehensive Primary Care Initiative

New Jersey was one of seven regions selected to participate in Medicare's Comprehensive Primary Care (CPC) initiative. CPC is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. Three of the four Medicaid MCOs are participating in this initiative. Practices throughout NJ have submitted applications to participate and are currently contracting with the participating plans. The practice kickoff meeting is scheduled for mid-November. The NJ workgroup is currently working together on alignment of quality metrics, plans for cost sharing and utilization information to be shared with practices and community stakeholders.

Summary

Since the first PCMH began its operations in July 2011, it is premature to determine whether cost savings and metrics such as rates of health screening, outcomes and hospitalization rates have been impacted. In addition, most outcome metrics require a minimum of one year's worth of data, plus the time allotment for claims processing. All four of Medicaid's contracted MCOs continue to develop their medical home initiatives and work within their networks to develop medical home services that reflect their population and its needs. DMAHS is committed to the Patient Centered Medical Home model and fostering integrated services for those they serve.