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Wisconsin Moves Ahead With Medical Homes Initiative

BY RIC GROSS

As healthcare costs have continued to spiral upward nationwide, the patient-centered medical home concept has emerged as the 'flavor of the month,' on the evolving menu of healthcare policy ideas, with Medicaid pilot programs active in 31 states. Now, Wisconsin is stepping up to make it 32 'flavors' in all.

That became the case when Wisconsin Gov. Jim Doyle signed the 2009-11 state budget, which included a requirement that the Department of Health Services develop a PCMH pilot for the state's Medicaid population.

The medical home concept has caught on among providers, patients, insurers and states eager to try something new in the battle against rising costs. The PCMH model centers on a team-based model of care, whereby a primary-care physician provides coordinated care throughout a patient's lifetime. This care includes preventive services, as well as coordinated treatment of acute and chronic illness, and is reimbursed using a combination of indexed capitated payments and outcomes-based payments. Because of the emphasis on outcomes, medical homes are seen as likely to promote greater drug compliance, particularly for treatments of chronic disease.

The medical home is meant "to address the fragmented, uncoordinated episodic care that many Americans receive," according to a report from the National Committee for Quality Assurance, which noted that an estimated 150 million Americans will be living with at least one chronic illness by 2015.

The medical home model has grown increasingly popular in state Medicaid programs. Today more than half are testing the model for at least a portion of their members. According to the National Academy for State Health Policy, some states are doing demonstrations they hope to take statewide, while others are targeting specific populations, such as chronically ill adults. States are looking at solid evidence that primary care can prevent costly hospitalizations and improve outcomes for patients. They're attacking the 80/20 issue: 20 percent of beneficiaries are responsible for 80 percent of costs. By coordinating care for that 20 percent group, costs can be lowered and outcomes improved.

"We are very supportive of the idea that patients across Wisconsin need good coordination of their care," said Department of Health Services Secretary Karen Timberlake. "The question is how do we structure it and drive reimbursements so that we really support that. Also, what is the role of the physician, the primary care office and what is the role of the managed care company in that process. Those are some of the things

that need to be sorted out as we move forward. New [Medicaid HMO] contracts begin in 2010 all across the state, and this will be an active topic of conversation for us.”

Shaping The Legislation In The Badger State

The legislation dictates the pilot increase Medicaid reimbursements while providing a monthly per-patient care coordination fee for participating sites. The most common payment method is a three component system that includes a care management fee, ongoing fee-for-service payments, and some type of performance-based bonus payment.

Larry Pheifer, executive director, Wisconsin Academy of Family Physicians and a strong supporter of the initiative, said his organization has recommended a \$5, \$10 or \$15 case management fee, per member, per month, based on NCQA recognition, as well as an increase of around 4 percent in fee-for-service payments.

“Physician practices think this is really important, but there is a cost to develop infrastructure, etc., and why should they go through the [NCQA] process if they don’t know if the money will be there,” said Pheifer. “Payers have been saying it makes sense, but they want to wait until practices are NCQA certified. We have been trying to bring along both sides. We see this as a tremendous opportunity so there will be some money on the table to [encourage] practices to go through the process.”

Physician practices must be recognized by the NCQA to be deemed as patient-centered medical homes. The NCQA has three levels of certification for medical homes that involve care coordination activities, management of data registries and proactive population-based care. No Wisconsin practices are currently NCQA-certified, although many are far along the curve toward making that happen. “Several going through the process are large, multi-site practices, so they can go through and 11 to 13 sites will receive recognition,” Pheifer said.

Table 5-1: Characteristics Of Medical Home Programs In Selected States

State	Targeted Population/Conditions	Recognition
Colorado	Medicaid/CHIP. Plans to extend to all children in state, covering all conditions Adult pilot: cardiovascular disease, diabetes, low back pain, prevention, depression	Developed own standards for pediatric practices; NCQA PPC-PCMH for adult pilot
Minnesota	Medicaid/CHIP. Plans to extend to all insured state residents in 2010 for those with complex conditions first	Developed own standards
New Hampshire	Medicaid adults with chronic conditions	NCQA PPC-PCMH
North Carolina	Medicaid/CHIP. All conditions	Developed own standards
Rhode Island	Medicaid adults. Multi-payor pilot for adults with diabetes, depression, and coronary artery disease	NCQA PPC-PCMH
Washington	Medicaid/CHIP. Children and adults with disabilities	Developed own standards

Source: National Academy for State Health Policy

Practices may also qualify for inclusion if they perform well with respect to certain aspects of care under a PCMH model or similar coordinated care structure. In that case, Wisconsin could be following the lead of states such as Colorado, Minnesota, North Carolina, Oklahoma, Oregon and Washington, who launched pilots developing their own standards for physician recognition and involvement, according to the National Academy for State Health Policy.

Once details of the three-year pilot are formulated, the DHS must submit it to the Legislative budget-writing committee for approval, after which the pilot will go into effect Jan. 1, 2010. Participating physicians would begin receiving increased Medicaid reimbursements after July 1, 2011.

Wisconsin Landscape Built Around Managed Care

Wisconsin’s healthcare system seems almost ready-made for the medical home model, as it has so many home-grown, regional provider-based managed care plans. Wisconsin relies almost exclusively on managed care for its Medicaid population, with care coordination elements already in place.

“I think the medical home concept is something that has become a hot item, as many see it as a way to increase reimbursement for primary care and to emphasize primary care,” said Phil Dougherty, senior executive officer for the Wisconsin Association of Health Plans. “A number of our health plans are working on pilots.”

For instance, two provider-owned health plans in Wisconsin have seen their parent affiliates launch medical home initiatives of late. In Madison, Dean Health Systems, whose insurance subsidiary is local market leader Dean Health Plan, is instituting a medical home pilot at five physician locations within the Dean Health System network.

“We are in the process of activating those now,” said Robert L. Palmer, CEO of Dean Health Insurance, parent of Dean Health Plan. “There are many different definitions of what a medical home is. That is one thing we want to do—determine exactly what we want to define as a medical home. We also want to determine how a medical home will vary from an urban to a rural setting. While in Dane County [the Madison area] we have a pretty significant urban population, most of our geography is rural. We are not expecting the same configuration of medical home will work equally well in the city as in the country.”

Table 5-2: Potential Savings From Medical Homes

Nationally, patient-centered primary care would save \$29B

» Congestive heart failure	\$8.3 billion
» Bacterial pneumonia	\$7.0 billion
» Diabetes	\$3.5 billion
» Diabetes-related complications like kidney damage and amputations	\$2.6 billion
» Chronic obstructive pulmonary disease	\$3.4 billion
» Urinary tract infection	\$2.0 billion
» Asthma	\$1.4 billion
» Dehydration	\$1.4 billion
» High blood pressure	\$509 million
» Angina not involving a procedure	\$435 million

Source: AHRQ

Palmer said all participants will be patients of the Dean Clinic, with about 60 percent likely being Dean Health Plan members. “We are slating the pilot to run about a year, and if it appears successful, we may take this as a health plan and use the model with certain modifications in the non-Dean parts of our network, typically the more rural areas.”

Meanwhile, Affinity Health System, owner of Menasha-based Network Health Plan operating in a 16-county area in eastern Wisconsin, has launched a medical home at the Koeller Street clinic in Oshkosh and the Kaukauna Fieldcrest Drive clinic in Menasha. Personalized care teams at both Affinity clinics will consist

of one or more physicians partnered with a nurse practitioner or physician assistant, a nurse specialist who will coordinate disease management, a behavioral health resource, a patient service representative and health care associate such as licensed practical nurse, medical assistant or certified medical assistant. It is likely some of the patients will be Network Health Plan members, though not all.

While Anthem Blue Cross and Blue Shield in Wisconsin is not operating a medical home pilot of its own in the state, its charitable giving arm—the Anthem Blue Cross and Blue Shield Foundation—last summer awarded a \$99,000 grant to the Milwaukee Health Care Partnership to be used in its medical home delivery model. The Milwaukee Health Care Partnership is a public-private consortium sponsored by five Milwaukee health systems, four community health centers, the Wisconsin Department of Health Services, and the Milwaukee County Department of Health and Human Services to provide care for the uninsured.

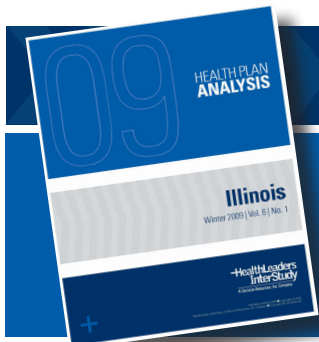
Badger State Can Look To Others For Examples

Wisconsin will be signing new contracts with its Medicaid HMOs for 2010, so the PCMH pilot specifics are likely to be built in. When designing pilot parameters, Wisconsin could look to neighboring Minnesota for ideas. Minnesota last year laid the groundwork for statewide implementation of chronic-care medical homes for all beneficiaries of Medicaid and the Children’s Health Insurance Program, as well as for state employees and the privately insured. Details are still being worked out, but the legislation mandates that by Jan. 1, 2010, all health plans must include medical homes in their networks, while by July 1, 2010, all insurers must pay a care coordination fee to certified medical homes.

Ideas could also come from Massachusetts, a state that—like Wisconsin—relies heavily on the use of provider-owned HMOs for its Medicaid population. Officials there are laying the groundwork for a coordinated, multi-stakeholder statewide initiative. The seeds were planted in the FY 2009 budget, when \$5 million was designated to the MassHealth (Medicaid) program to launch a medical home demonstration project.

Outlook

It is no surprise that Wisconsin has climbed aboard the medical home bandwagon, and it does make sense to examine the possibilities. The state’s DHS is in the midst of rebidding for HMO contracts in the Milwaukee area, and could build in some elements of this pilot. It would be a good place to start, as many HMO patients in the southeastern Wisconsin area have headed to the emergency room when a visit to a primary-care physician was in order. A medical home pilot built into the contracts could help stave this off. ■



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