pennsylvania
DEPARTMENT OF HUMAN SERVICES

Dear Members:

As chair of the Patient-Centered Medical Home Advisory Council, I am pleased to submit the comprehensive accounting of progress made since recommendations from the Council, dated June 2016, as required by Act 198 of 2014. The Council's ideas, contributions and enthusiasm in recommending effective advancements and innovations to the Patient-Centered Medical Home model are both valuable and inspiring.

I would like to thank the members of the General Assembly for their interest in enhancing the quality of care for Medicaid beneficiaries in our Commonwealth.

In addition to the Patient-Centered Medical Home Advisory Council's 2017 report, a roster of the appointed Council members is enclosed for your records.

Sincerely,

Teresa D. Miller
Secretary

Patient-Centered Medical Home 2017 Advisory Council Report

A. Introduction to Patient-Centered Medical Homes

Pennsylvania's Patient-Centered Medical Home (PCMH) Advisory Council was established by Act 198 of 2014 to advise the Department of Human Services (DHS) on how Pennsylvania's Medicaid program can increase the quality of care while containing costs through the following PCMH model approaches:

1. Coordinate and provide access to evidence-based health care services, emphasizing convenient, comprehensive primary care and including preventive, screening, and well-child health services.
2. Provide access to appropriate specialty care, mental health services, inpatient services, and any evidence-based alternative therapies.
3. Provide quality-driven and cost-effective health care.
4. Provide access to medication and medication therapy management services, in accordance with section 935(c) of the Patient Protection and Affordable Care Act (Public Law 111-148, 42 U.S.C. § 299b-35(c)).
5. Promote strong and effective medical management, including, but not limited to, planning treatment strategies, monitoring health outcomes and resource use, sharing information and organizing care to avoid duplication of services, including the use of electronic medical records (EMR). In sharing information, the protection of the privacy of individuals and of the individuals' information shall be priorities. In addition to any and all other federal and state provisions for the confidentiality of health care information, any information-sharing required by a medical home system shall be subject to written consent of the patient.
6. Provide comprehensive care management to patients to align and assist with treatment strategies, health outcomes, resource utilization and organization of care, and address determinants of health impeding goals of care.
7. Emphasize patient and provider accountability.
8. Prioritize access to the continuum of health care services in the most appropriate setting and in the most cost-effective manner.
9. Establish a baseline for medical home goals and establish performance measures that indicate a patient has an established and effective medical home. These goals and performance measures may include, but need not be limited to, childhood immunization rates, well-child care utilization rates, care management for chronic illnesses, cancer prevention services, and emergency room utilization.

The PCMH Advisory Council met throughout 2015 and made key recommendations for 2016-2017 after thoughtful discussions and planning that reflected the consensus of the council members. The PCMH Advisory Council defined the parameters and components of a PCMH program for Medicaid beneficiaries. It also made the following key recommendations:

1. Integrate physical health (PH) and behavioral health (BH) within the PCMH.
2. Measure individual and family satisfaction within the PCMH.

3. Develop Health Homes for persons with serious persistent mental illness (SMI), substance use disorder (SUD), children with serious emotional disturbance (SED), and patients with two or more complex medical conditions.
4. Further develop Medication Therapy Management (MTM).
5. Continue to implement Telemedicine, Health Information Technology (HIT), and Health Information Exchange (HIE).
6. Define quality metrics and cost data for the PCMH and Health Homes programs.
7. Continue workforce development.
8. Develop alternative payment models.

This report will highlight the initiatives implemented by DHS based on the recommendations of the council. These initiatives were designed in 2016, operationalized in 2016-2017, and continue to evolve as improved methods emerge. DHS' Office of Medical Assistance Programs (OMAP) implemented the components of a PCMH program, as defined by the council, and recommendations 2, 6, and 8 through the Physical Health HealthChoices Managed Care Organization (PH-MCO) contract in 2017. DHS' Office of Mental Health and Substance Abuse Services (OMHSAS) implemented recommendations 3, 6, and 8 through the development of Certified Community Behavioral Health Clinics (CCBHCs). OMAP and OMHSAS jointly implemented portions of recommendations 3, 6, and 8 by developing the Centers of Excellence (COE) program to treat those with opioid use disorder (OUD). Both OMAP and OMHSAS continue to develop or enhance existing programs to address recommendations 5 and 7. This report will provide detailed updates on the progress DHS has made through the following initiatives: the Opioid Use Disorder Centers of Excellence, PCMHs, CCBHCs, MTM, and Telemedicine.

B. Opioid Use Disorder Centers of Excellence

The commonwealth has shown progress in fighting the epidemic through multiple initiatives which include: growing treatment access through Medicaid expansion, increasing access to medication-assisted treatment (MAT), expanding opioid education and training for health professionals, establishing a Naloxone standing order, and opening a 24-hour help line that connects people to treatment. Pennsylvania averages 13 opioid-related deaths per day. Maintaining a sense of urgency and placing a strong emphasis on continued concerted efforts to combat the opioid crisis remains a top priority.

The Opioid Use Disorder Centers of Excellence (OUD-COEs) were introduced by Governor Tom Wolf in 2016 when he named the opioid epidemic a top administration priority. The OUD-COEs generated immediate, strong interest among the public and providers alike. The announcement of a call for applications for the OUD-COE program yielded 116 applications from providers across the commonwealth. To date, there are 45 OUD-COEs across 27 counties that began with a staggered implementation approach in October 2016 and ended with the final OUD-COE going live in May 2017. The COE program is intended to transform the OUD service delivery system into team-based treatment, whole-person focused care addressing both MH and PH concerns as well as providing assistance in the navigation of care so patients stay engaged in their treatment.

As of September 30, 2017, DHS has seen the following positive results from COE efforts:

1. Over 10,000 individuals with OUD have been touched by the COEs.
2. Over 8,700 individuals have been seen face-to-face by the COEs.
3. Over 7,700 have initiated into treatment for OUD.
4. The average duration of ongoing treatment engagement is 90 days.
5. Of those starting OUD treatment, 92 percent have been referred for drug and alcohol counseling and 75 percent have received counseling services.
6. Of those starting OUD treatment, 26 percent have been referred for treatment of a co-occurring mental health (MH) condition.
7. Over 75 percent of those referred for a MH condition received a MH service.
8. 85 individuals have been referred for pain management with 41 receiving pain management services.

Prior to the introduction of COEs, as few as 48 percent of Medicaid beneficiaries diagnosed with OUD were receiving treatment. Of those receiving treatment, only 33 percent continued treatment for more than 30 days.

Additional information about the COEs can be obtained at the following web site: http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/.

C. Patient-Centered Medical Homes

The concept of a medical home was presented by the American Academy of Pediatrics in 1967 as a primary care model described as "accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective."[1] Both the World Health Organization and the Institute of Medicine adopted the model. By 2002 the Chronic Care Model was introduced by Dr. Edward H. Wagner of the Kaiser Permanente Washington Health Research Institute as a precursor to today's PCMH model and is defined as "an evidence-based framework for health care that delivers safe, effective, and collaborative care to patients"[2] and is commonly acknowledged for its ability to lead health care teams in the treatment and care for chronically ill patients and is promoted as an established technique to improve chronic health care.

DHS leveraged the work of the Advisory Council to set parameters for the PH-MCO adoption of PCMHs with the objective of an improved care model. The PCMH model delivers inclusive primary care for children, youth, and adults in a health care environment that facilitates partnerships between patients and their provider and the patient's family and others when appropriate. Patient care in the PCMH model focuses on the whole person, taking both the individual's PH and BH into account. Patient care is comprehensive, inclusive, and team-based and highlights whole person orientation through appropriately arranging care with other qualified professionals and coordinating care through all stages

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[1] https://www.pcpcc.org/content/history-0
[2] https://www.kpwashingtonresearch.org/our-research/our-scientists/wagner-edward-h/

of life: acute care, chronic care, preventive services, and end of life care. The PCMH model is supported by: EMR, HIE, virtual telemedicine services, and patient registries as well as personal connections through community-based, peer-driven support services. PCMHs must meet certain recognition or certification standards and quality measures. In return, it is expected they be fairly compensated for the cost of providing care through fee-for-service payments, through per member per month payments, and that the PCMHs embrace the move to value-based purchasing.

Based on the above principles and recommendations from the PCMH Council, OMAP required the HealthChoices PH-MCOs 2017 agreements that the PH-MCOs identify and fund PCMHs that serve at least 10 percent of their total membership and at least 20 percent of members that fall within the top 5th percentile of medical costs. For calendar year 2018, this percentage will increase to 20 percent of their total membership and at least 33 percent of members that fall within the top 5th percentile of medical costs.

The PH-MCOs requirements for PCMH providers include:

1. Monthly payments to each PCMH based on factors such as clinical complexity, age, medical costs, and composition of the care management team.
2. Collection of key quality metrics.
3. Rewards for PCMHs with quality-based enhanced payments focusing on key performance measures defined by the department.
4. Quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and MCOs in a HealthChoices region.
5. Provision of timely and actionable data to PCMHs.
6. Report annually on the clinical and financial outcomes of their PCMH program.

PH-MCOs must use specific requirements to select the PCMHs within their networks. Providers and practices must meet the following 11 requirements for the MCO to consider them eligible to participate in the PCMH program. Requirements 1, 2, 3, and 5 must be met by the provider or practice in 2017 to participate in the PCMH program. The remaining requirements must be met by at least the end of 2018.

1. Be identified as a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance (P4P) program or a defined set of practices willing to share care management resources.
2. Accept all new patients or be open for face-to-face visits at least 45 hours per week.
3. Have already received a payment in the Medicaid or Medicare electronic health record (EHR) meaningful use program.
4. Join a HIE in order to share health-related data.
5. Deploy a Community Based Care Management (CBCM) team.
6. Collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider P4P program, the Integrated Care Program (ICP), and additional population specific measures defined by DHS.

7. Conduct internal clinical quality data reviews on a quarterly basis, report results, and discuss improvement strategies with the PH-MCO.
8. Measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience.
9. Include as part of the health care team patient advocates or family members to support the patient's health goals and advise practices.
10. See 75 percent of patients within 7 days of discharge from the hospital with an ambulatory sensitive condition.
11. Participate in a PCMH learning network.

The PCMHs are focused on the same quality metrics included in the provider P4P program listed below:

1. Controlling High Blood Pressure
2. Diabetes: HbA1c Poorly Controlled
3. Medication Management for People With Asthma
4. Annual Dental Visit (Ages 2 – 20 years)
5. Well Child Visits, First 15 Months of Life
6. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
7. Adolescent Well-Care Visits
8. Reducing Potentially Preventable Readmissions
9. Emergency Department visits per 1000 member months
10. Prenatal Care in the First Trimester
11. Postpartum Care
12. Frequency of Ongoing Prenatal Care

The PH-MCOs must agree to electronic submission of quality measures and report on their PCMH progress through the submittal of an annual report with quarterly updates. These mechanisms allow the DHS to gauge the progress of initiatives as well as their effectiveness.

Data available as of October 31, 2017 shows that the PH-MCOs have identified approximately 600 unique high-volume practices as PCMHs and about $4 million has been paid to these practices. These identified PCMHs are serving approximately 645,000 members with around 47,000 members falling in the top 5th percentile of medical costs. In addition, the PCMHs are serving approximately 260,000 members with a diagnosis of SMI. Regional face-to-face and webinar Learning Network meetings have occurred starting in July 2017.

Listed below are the HealthChoices PH-MCOs and the number of PCMH practices they have currently identified. Please note that some of these PCMH practices serve more than one PH-MCO and therefore some are duplicated in the counts below.

1. Aetna Better Health: 68
2. AmeriHealth Caritas Northeast: 93
3. AmeriHealth Caritas Pennsylvania: 181

4. Gateway Health Plan, Inc.: 243
5. Geisinger Health Plan: 111
6. Health Partners Plans: 51
7. Keystone First Health Plan: 55
8. UnitedHealthcare Community Plan: 68
9. UPMC for You, Inc.: 14

D. Certified Community Behavioral Health Clinics

CCBHCs ensure access to high-quality, community-based behavioral health care. CCBHCs were introduced on April 1, 2014, when the Protecting Access to Medicare Act of 2014, Pub. L. 113-93, (PAMA) was signed into law. The PAMA included a provision that authorized a CCBHC Demonstration program separated into two parts. This law infused $1.1 billion into community-based health services for Medicaid patients. The commonwealth, through OMHSAS, was one of eight states that received a CCBHC Phase 1 demonstration grant in December 2016 from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant provided approximately $9 to $10 million in an enhanced federal match for CCBHC expenditures. CCBHCs permit patients to access an extensive selection of quality services at one location as well as eliminate the obstacles that traditionally exist across physical and behavioral health systems. The CCBHCs primarily serve adults and children with serious mental illnesses and substance abuse disorders. The increase in coordination and individualized care that the CCBHCs provide have the potential to greatly improve the quality of life for those they assist throughout many facets of their lives.

The objective of the CCBHC application process was to assess and select eligible community behavioral health providers who met or strongly demonstrated the future ability to meet all certification criteria established under the federal CCBHC planning grant and program demonstration initiative. Agencies selected for the CCBHC certification process were expected to develop outpatient networks of primary care, mental health, and substance use providers serving all ages, as well as to adopt a common set of tools, approaches, and organizational commitments to treat individuals in a seamless and integrated fashion.

All interested CCBHC hopefuls had to meet several general requirements in order for their application for entry into the program to be considered. The applicant must:

1. Be a nonprofit organization; part of a local government behavioral health authority; an entity operated under authority of the Indian Health Service (IHS), an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act; or an entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (Pub. L. 94-437).
2. Be currently licensed to provide comprehensive behavioral health and licensed drug and alcohol addiction treatment services, with mechanisms in place to ensure the provision of physical health services.

3. Have the ability to serve all individuals, across the lifespan, regardless of circumstances.
4. Have demonstrated ability to be able to meet all CCBHC certification criteria.

There were additional desired, but optional, criteria sought to enhance the ability of the CCBHC applicant to meet all CCBHC certification criteria, which included:

1. Additional state/federal credentialing such as Designation to provide Integrated Outpatient Services, Federally Qualified Health Center (FQHC) or "look alike" status, or IHS.
2. Experience providing an array of behavioral health services and/or addiction treatment services licensed by the Department of Drug & Alcohol Programs (DDAP) related to the Scope of Services outlined in the CCBCH certification criteria.

It is expected that the chosen CCBHCs provide certain fundamental services to patients. These services include:

1. Crisis services.
2. Targeted case management.
3. Outpatient MH and substance use services.
4. Patient-centered treatment planning.
5. Mental health screening, assessment, and diagnosis.
6. Psychiatric rehabilitation services.
7. Peer and family support.
8. Care for veterans and members of the military.
9. Mental health outpatient primary care screening and monitoring.

The CCBHCs must track and submit quality measures to the commonwealth no later than nine months after the first Demonstration Year (DY) is over. DY 1 is defined as July 1, 2017 to June 30, 2018 and DY 2 is defined as July 1, 2018 to June 30, 2019. The commonwealth measures are provided to SAMHSA no later than 12 months after the DY is over. These measures include nine CCBHC measures, six Quality Bonus Payments (QBP) measures, and 13 state measures.

CCBHC measures include:

1. Time to Initial Evaluation (I-EVAL)
2. Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
3. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
4. Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
5. Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
6. Weight Assessment for Children/Adolescent: Body Mass Index Assessment for Children/ Adolescents (WCC-BH)
7. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
8. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
9. Depression Remission at Twelve Months (DEP-REM-12)

QBP measures include:

1. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
2. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
3. Follow-Up After Hospitalization for Mental Illness (Ages 21+) (FUH-BH-A)
4. Follow-Up After Hospitalization for Mental Illness (Child/Adolescents) (FUH-BH-C)
5. Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)
6. Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-BH)

State measures include:

1. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)
2. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
3. Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)
4. Antidepressant Medication Management (AMM-BH)
5. Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-BH)
6. Plan All-Cause Readmission Rate (PCR-BH)
7. Follow-Up After Discharge from the Emergency Department for Mental Health Treatment (FUM)
8. Follow-Up After Discharge from the Emergency Department (FUA)
9. Follow-Up After Hospitalization for Mental Illness (Adult) (FUH-BH-A)
10. Follow-Up After Hospitalization for Mental Illness (Child) (FUH-BH-C)
11. Housing Status (HOU)
12. Patient Experience of Care Survey (PEC)
13. Youth/Family Experience of Care Survey (Y-FEC)

DHS's final selection of CCBHCs includes seven practices, comprised of both rural and urban locations throughout the commonwealth:

1. Berks Counseling Center, Berks County
2. Cen Clear Child Services, Clearfield County
3. Cen Clear Child Services, Jefferson County
4. Northeast Treatment Centers, Philadelphia County
5. Pittsburgh Mercy, Allegheny County
6. Resources for Human Development, Montgomery County
7. The Guidance Center, McKean County

Additional information about the CCBHC program can be found at the following web link: http://www.dhs.pa.gov/provider/mentalhealth/CCBHC/.

E. Medication Therapy Management

The HealthChoices PH-MCOs emphasize the importance and implementation of the care delivery services of medication therapy management. Many Medicaid patients take a wide variety of medication for various health concerns or chronic diseases and it is essential that their medication usage be closely monitored to ensure the best possible care and outcomes. MTM provides patients with many benefits and affords them invaluable information that is crucial to their health and well-being. The definition of medication therapy management by the American Pharmacists Association is extensive and well-worded and is as follows: "Medication therapy management is a service or group of services that optimize therapeutic outcomes for individual patients. Medication therapy management services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs, and many other clinical services. Pharmacists provide medication therapy management to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing, and resolving medication-related problems."[3]

The focus for this initiative is on medication adherence for diabetes, HTN, asthma, HIV, Hepatitis C, and antipsychotic medications. While improving medication adherence for these conditions is an essential role of MTM, DHS expects the PH-MCOs to help implement MTM across populations with other conditions. Six PH-MCOs implemented MTM in 2017 with the remaining two PH-MCOs implementing MTM in 2018.

Aetna has no MTM initiative in 2017, but is rolling out an Integrated Care Program (ICP) Community Health Worker (CHW) initiative with several program goals in mind. These goals include: the improvement of medication adherence in the adult population with Serious and Persistent Mental Illness (SPMI) and the reduction of avoidable hospital utilization with a 10 percent improvement goal each year with at least 750 members managed in care management.

AmeriHealth Caritas has three concurrent MTM programs that will continue into 2018. Their Pharmacy MTM (contracted with both Outcomes MTM and Penn State Health St. Joseph) is designed to improve collaboration among pharmacists, prescribers, and other health care professions, enhance communication between patients and their health care team, and optimize medication use for improved patient outcomes. Finally, the Transition of Care Program (Perform RX) optimizes medication regimens for members during the transition from hospital to home. The goal is to engage members while admitted and provide case management activities in addition to member specific medication education.

Gateway has partnered with the Pennsylvania Pharmacist Care Network for their MTM program. Their program goals include: optimize medication use and promote positive patient outcomes and improve the quality of patient care while lowering overall health care costs. In 2018, Gateway intends to embed four pharmacists at several high-volume practices that see over 25,000 Medicaid recipients.

Health Partners Plan employs one in-house pharmacist to provide pharmacy support with the goal of providing consultative services related to medication adherence and reconciliation, which may include attendance at practice rounds and physician and member consultation and training related to

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[3] http://www.pharmacist.com/mtm

pharmaceuticals. In 2018, Health Partners intends to use 1.5 pharmacists to provide MTM to 15 high volume Medicaid practices.

Keystone has a MTM contract with Outcomes MTM that is designed to improve collaboration among pharmacists, prescribers, and other health care professions as well as to enhance communication between patients and their health care team and optimize medication use for improved patient outcomes. They plan to target 20,000 members in 2018.

United Healthcare works with Access Matters HIV on care management and medication adherence to accomplish HIV medication adherence and improved outcomes.

UPMC has a regional pharmacist for Washington and Fayette counties. The goals for pharmacy collaboration encompass increasing the face-to-face and/or telehealth opportunities for members, whether in their communities, homes, or provider practices to assess and resolve medication-related issues.

F. Telemedicine

The use of telemedicine has continued to expand the number of visits for both physical and behavioral health conditions. The number of telemedicine visits paid by both the physical and behavioral health MCOs increased rapidly from 2011 to 2016. Several impressive data points include:

1. Physical health visits increased from 1,684 in 2011 to 12,968 in 2016.
2. Behavioral health visits increased from 3,873 in 2011 to 41,201 in 2016.
3. In 2011, 70 percent of visits were behavioral health which increased to 76 percent of telemedicine visits in 2016.
4. In 2011, 58 percent of visits occurred in rural counties which decreased to 46 percent of telemedicine visits in 2016.
5. In December 2016, there were over 5,700 telemedicine visits.

DHS expects the upward trend of telemedicine visits to continue throughout 2017 and 2018. OMHSAS is currently reviewing its telemedicine bulletin for behavioral health services to make possible revisions to the current process. OMAP has not planned any specific revisions to its current bulletins but has encouraged the PH-MCOs to work with providers to expand sites of service such as inpatient intensive care units, stroke units, and emergency departments.

G. Conclusion

During late 2016 and throughout 2017, DHS has worked to implement three new programs that will have an impact on hundreds of thousands of Medicaid recipients: COEs, PCMHs, and CCBHCs. DHS will continue to monitor the early successes and challenges of these new programs. These programs focus on health delivery redesign, advancement in access to care, improvement in quality, and alternative payment design. DHS has continued to see the expansion of MTM and telemedicine services for those with both physical and behavioral health conditions.