

Medical Homes: Two Approaches to Consider

Introduction

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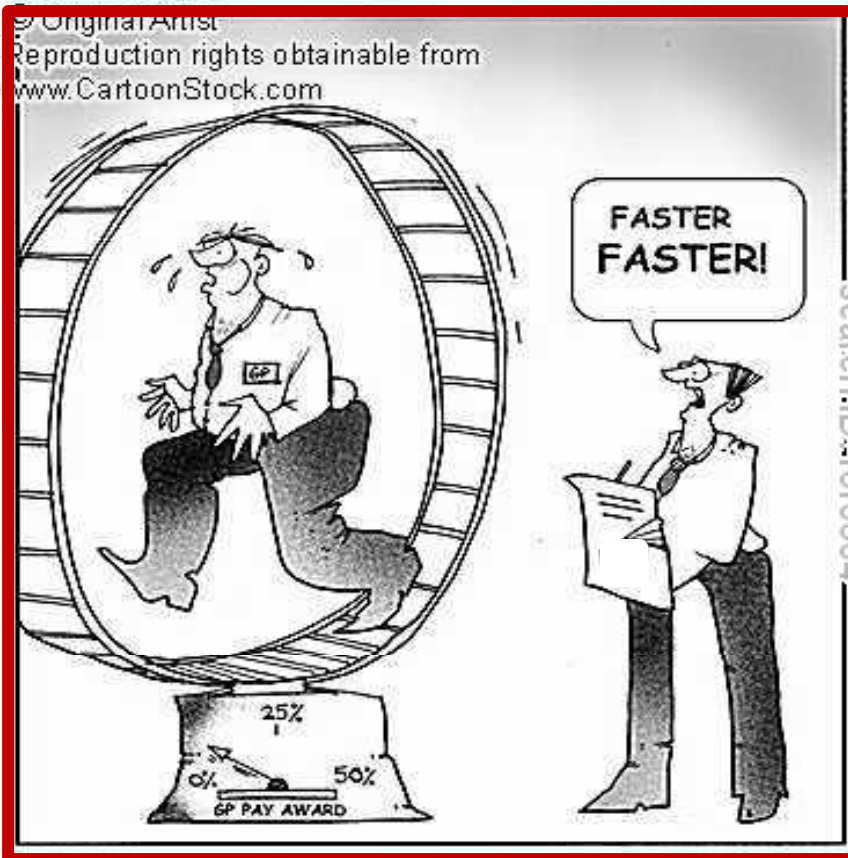
Healthcare Trustees of New York State

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Why PCMH?

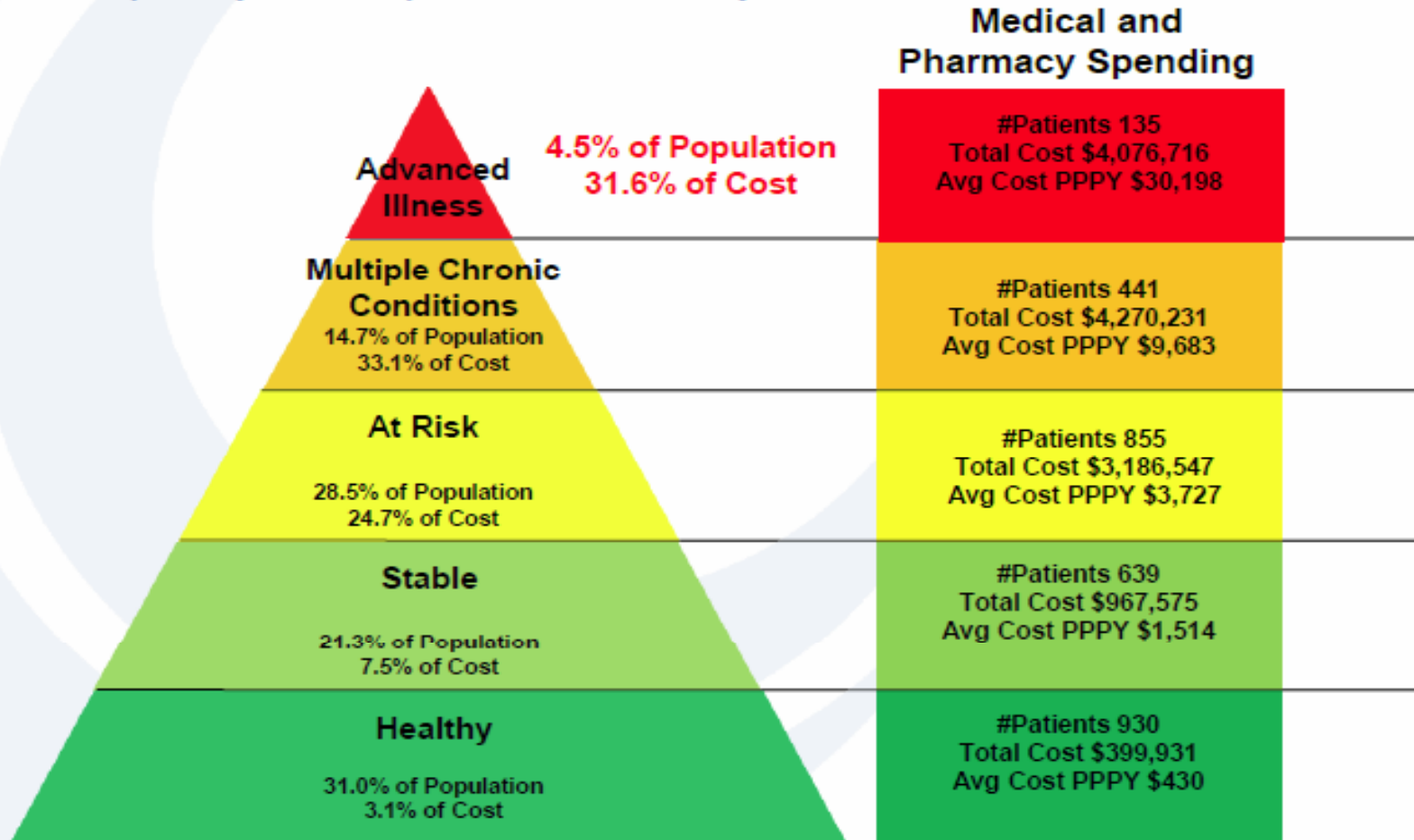
Some Problems With Current System



- **Primary Care Physicians**
 - *Unsatisfying work*
 - *Poorly paid*
 - *Unable to spend time with patients*
- **Patients**
 - *Access*
 - *Relationships*
 - *Fragmentation*
- **Purchasers/Payers**
 - *Costs (esp. chronically-ill)*
 - *Quality*
 - *Experience*

The Populations Served

A Typical Panel of 10 PCPs...
with 3,000 patients, \$12.9M total spend



Note: This practice has an older, sicker population with a significantly higher percentage of its patients in the top bands

What is PCMH?

- *Primary care practice that has achieved recognition (generally NCQA) as a Patient-Centered Medical Home by putting in place elements that “transform” primary care delivery:*
 - *Major changes to the “production process”*
 - *Levels of recognition: Levels 1, 2, and 3*
 - *Different “degrees of difficulty” (largely EMR-related)*
- *Addresses needs of different patient/populations:*
 - *The “well”: Access, prevention and wellness*
 - *The acutely-ill: That, plus care coordination and care transitions*
 - *The chronically-ill: All that, plus the Chronic Care Model*
- *Paid differently, to do all this:*
 - *P4P, for population care management, health improvement*
 - *capitation, or enhanced fees*

What Can a PCMH Do?

Improve Performance in Key Dimensions:

- *Access*
- *Quality*
- *Continuity*
- *Care Management*
- *Patient Engagement*
- *Experience of Care*
- *Cost-Effectiveness*

How Does a PCMH Do It?

- ***Access***
 - *Extended hours*
 - *Teams*
 - *Patient portals*
- ***Use of EMR, HIT***
 - *Patient registries*
 - *Track labs, tests and referrals*
 - *CPOE and e-prescribing*
 - *Advanced e-communication*
- ***Continuity***
 - *Care management*
 - *Coordinating care across continuum*
 - *Transition management*
- ***Quality Improvement***
 - *Decreasing variability*
 - *Reinforces use of EBM*
 - *Performance reporting*
 - *Quality, cost, experience*
- ***Redesigned, planned visits***
 - *Focus on patient needs*
- ***Patient Engagement***
 - *Patient/family education*
 - *Empowering patients*
 - *Utilizing team-based care*
- ***Cost-effectiveness***
 - *Focus on the “preventables”*
 - *Admissions, readmits, ED visits*

***Payers are giving PCPs additional, redesigned payments for
PCMH infrastructure
Care management***

Who's Doing It?

- *More than 3,700 primary care physicians in practices across NYS have achieved NCQA recognition as a PCMH*
 - *Level-1 875*
 - *Level-2 274*
 - *Level-3 2,592*
- *Primary care physicians in different settings and contexts*
 - *Solo, small primary care group*
 - *Larger multi-specialty groups*
 - *Hospital-employed physicians*
 - *Freestanding clinics and FQHCs*
 - *Hospital OPDs*
 - *Physician-Hospital Organizations*
 - *IPAs and new types of physician groups*

Who's Paying For It?

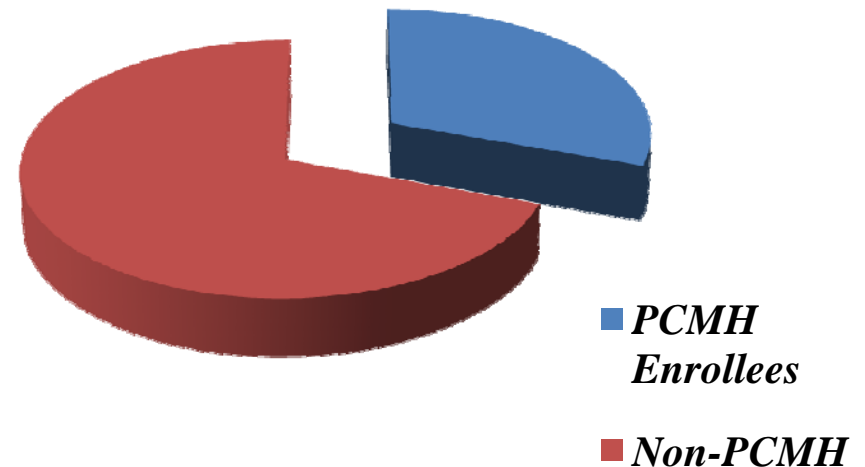
- *Payers participating in PCMH demos in:*
 - *Adirondacks*
 - *Hudson Valley*
 - *Albany*
 - *Syracuse*
 - *Rochester*
 - *Buffalo*
 - *New York City*

Medicaid Payment Incentives

Medicaid Providers Pursuing PCMH Recognition

- *NYS Medicaid incentive payments to providers who achieve NCQA recognition*
 - *\$2 PMPM for level 1*
 - *\$4 for level 2*
 - *\$6 for level 3*
- *Safety net providers have incentive to*
 - *Pursue PCMH*
 - *Enhance their services*

**30% of All NYS
Medicaid Managed Care
Members Have an
NCQA-recognized
PCMH PCP**



Health Homes

NYS Medicaid Initiative

- **ARRA Provision:**
 - Support for most complex patients
 - 90% Federal match, two years
- **Focus: Highest-Cost Enrollees**
 - Population: 975,000
 - Composition:
 - Multiple chronic conditions
 - Medical/behavioral
 - Long-term care
 - OPWDD
- **Common Themes:**
 - Very complex population
 - Exceedingly high-cost
 - Need care management that
 - Exceeds capacity of most providers
 - Is closely-connected to patients
 - Spans medical, BH, social

Health Homes RFP

- **Requirements**
 - Core service: care management
 - Assess, stratify, manage care for high-need, complex patients
 - To replace MATS, TCM, COBRA
 - Established, formal network
 - Medical, Behavioral, Community
- **Regional Approach: NYS Will**
 - Select, approve health homes
 - “Assign” enrollees based on care relationships
 - Hold them accountable for care management, service and costs
- **Payments: Paid for Care Mgmt., Only**
 - Per-person, per-month payment
 - Processed through MCOs
 - Based on complexity of Pts. being served
 - Low, medium, high
 - \$60 /mm → \$300+/mm

Review/Approval Process

Apply by 10/3/2011

Operational by 11/1/2011

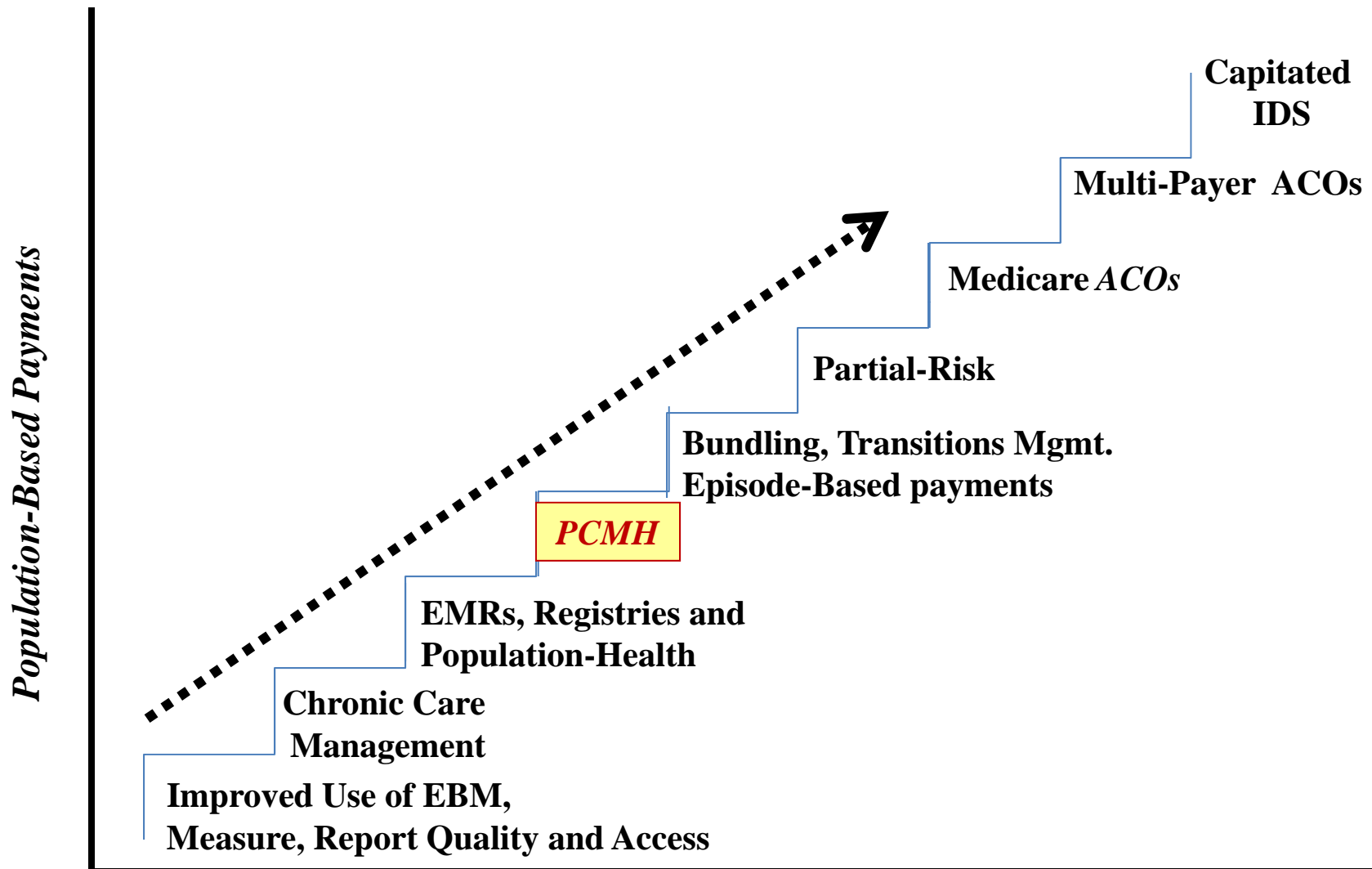
Why Should Hospitals Be Interested?

- ***Primary care is your foundation:***
 - *Main point of longitudinal contact for patients and populations*
 - *Source of referrals to specialists and hospitals*
- ***Evidence that PCMH is effective:***
 - *In improving quality and experience, and*
 - *In reducing preventable utilization and costs (that's a good thing, right?)*
 - *The key to the “next big thing”: population health management*
- ***But, there are real problems:***
 - *Primary care base is already threatened in many areas*
 - *Threatens access, particularly for the under-served*
 - *Primary care in general is under-performing vs. the triple aim*
 - *Particularly in managing high-cost chronically-ill*
 - *Hospital OPDs provide a LOT of primary care, often sub-optimally*

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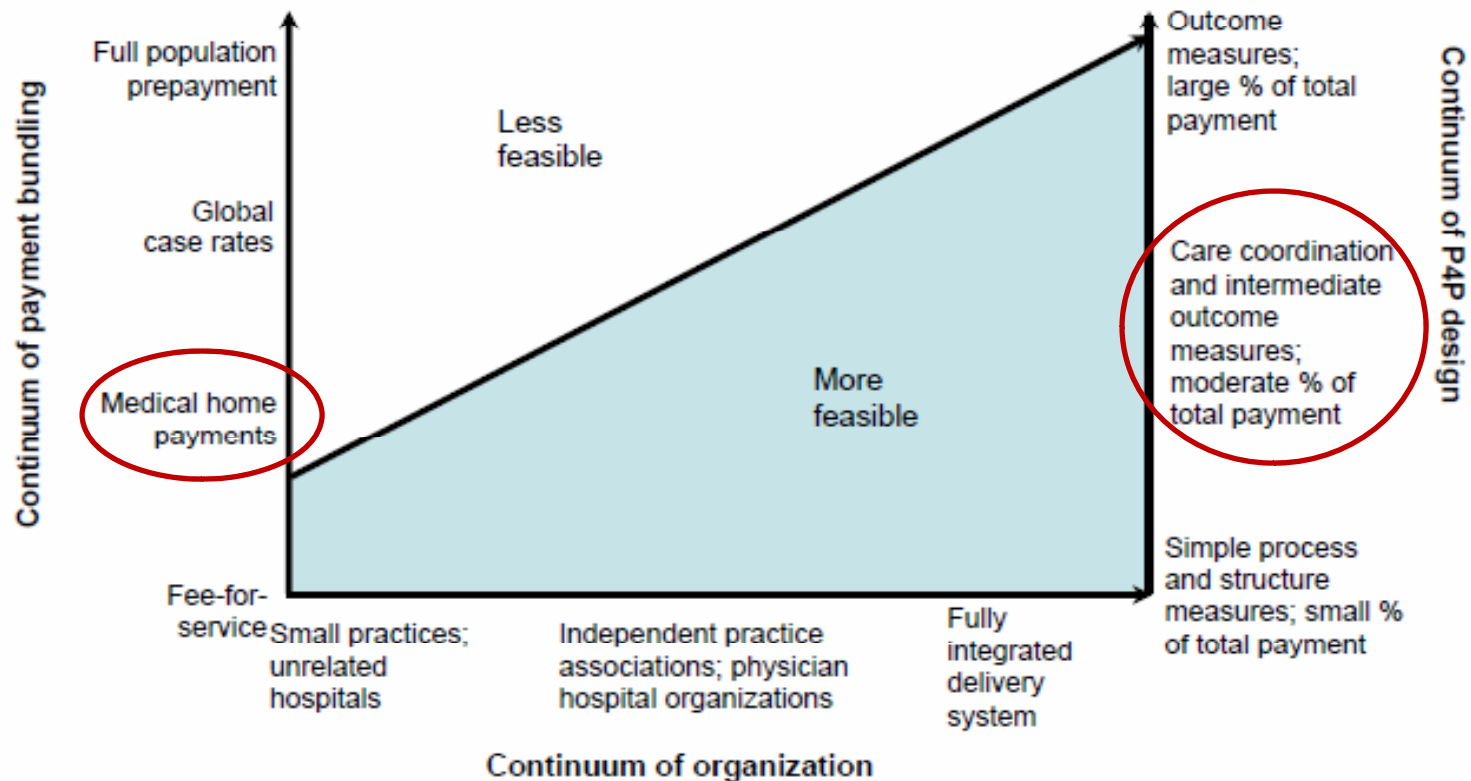
- *Physicians face real challenges in implementing PCMH:*
 - *New functions, new staff, new costs*
 - *Investment needs—EMRs and practice redesign*
 - *Infrastructure needed:*
 - *HIT support, registries, population health supports, regional data exchange*
 - *care management, care coordination*
 - *patient education, engagement*
 - *quality measurement and reporting*
 - *financial and grants management*
- *Infrastructure is beyond the reach of most small practices:*
 - *Provided by group practices and hospitals*
 - *Provided as “shared services” by IPAs and physician collaboratives*
- *Hospitals can:*
 - *Pursue PCMH in your own clinics and practices*
 - *Provide leadership, support and infrastructure to help their PCPs transform their practices into PCMHs*

The Medical Home Is Not a Final Destination, But a Step Along the Way



PCMH: A Foundation for Accountable Care

ORGANIZATION AND PAYMENT METHODS



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, "Organizing the U.S. Health Care Delivery System for High Performance" (New York: The Commonwealth Fund, August 2008)