The Patient-Centered Medical Home: A Medicaid Perspective

Mark E. Douglas JD, MSN, RN
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Goals for Today’s Discussion
- Revisit the pre-PPACA healthcare system
- PPACA implications for the medical home
- Describe the Medicaid population
- Discuss a Medicaid PCMH perspective
- Preview the ACO (re)evolution

Policy Questions
- What is the role of advanced practice nursing in the national medical home discussion?
- How does the movement to medical home impact our individual and collective practice as nurse practitioners?
- How does the movement to PCMH affect our thinking about accountable care organizations?
- What are the best strategies for managing complex, chronically ill individuals?
Pre-PPACA Healthcare

- Increased Healthcare Costs/loss of coverage
  - 2009 average annual family premium $13,027; by 2020- $23,342*
  - Recession led to more uninsured- loss of employer-based coverage
- Overall Quality Still Lagging
  - U.S. healthcare system fails in dimensions of high performance healthcare system: access, overall quality, efficiency, equity and productive life*
- Increased Variation in Care
  - Substantial geographic differences (Dartmouth study)
  - No relationship between quality and cost
- Lack of Individualized Care for Patients with Chronic Healthcare Needs
  - Little to no care coordination
  - Overuse of and failure to track specialty care
  - Lack of patient accountability and education on self-management strategies
- Stable Primary Care Work Force
  - Diminished pipeline that will struggle to meet the needs of increasingly aging and complex population

Source: Commonwealth Fund

Pre-PPACA Healthcare

- Emergence of value-based purchasing driven by CMS
  - Provided initial quality demonstrations
  - Hospital compare, Never Events, Hospital-acquired Conditions
  - Renewed focus on patient safety, hitting quality measures, HEDIS
  - PCMH Joint Principles Announced by AAFP, AOA, AAP, ACP in 2007
  - PCMH demonstrations began popping up
  - Election of President Barack Obama

Important Payer Trends

- Movement away from traditional fee-for-service payment
- Decreased reimbursement rates
- Increase demand for pay-for-performance- tied to quality
- Movement to integrated delivery systems- bundled payments

PPACA- Impact on Primary Care

- Medicare 10% increase in primary care reimbursement rates, 2011–2016 ($3.5 billion)
- Medicaid reimbursement for primary care increased to at least Medicare levels, 2013–2014 ($8.3 billion)
- 32 million more people insured, with preventive and primary care coverage, leading to less uncompensated care
- Medicare and Medicaid patient-centered medical home pilots
- Grants/contracts to support medical homes through:
  - Community Health Teams increasing access to coordinated care
  - Community-based collaborative care networks for low-income populations
  - Primary Care Extension Center program providing technical assistance to primary care providers
- Scholarships, loan repayment, and training demonstration programs to invest in primary care physicians, advanced practice nursing and community providers
- $11 billion for Federally Qualified Health Centers, 2011–2015, to serve 15 million to 20 million more patients by 2015

Source: Commonwealth Fund Analysis, 2010
So, Are we in better shape now?

Let’s Talk Medicaid…

Understanding the Medicaid Population

- Medicaid is a joint federal-state program that covers more than 60 million Americans*
  - In Indiana over 940,000 Hoosiers on Medicaid**—about 1 in 6
    - 60% children and pregnant women, 37% adults—including the aged, blind disabled
  - Over 40% have serious mental illness*
  - 5% with a developmental disability*
  - Of the 1% most expensive beneficiaries, 83% have three chronic conditions, 60% with five chronic conditions*
  - Often poorly educated, poor social support—at-risk for homelessness, food security and reliable transportation
  - Indiana OMPP budget for 2011—$1.46 billion Indiana share (of $13.7 billion total budget)
  - 60% of spending on 5% of beneficiaries (70/30)*

Wagner Chronic Care Model

Developed by Dr. Ed Wagner—Director of the MacColl Institute for Healthcare Innovation

Source: *Center for Health Care Strategy Report; **Kaiser Family Foundation
The Patient-Centered Medical Home is not a place but an approach to providing continuous, comprehensive, coordinated care, with a partnership between patients and their personal healthcare team, as part of an integrated health neighborhood.

Why do we need a PCMH strategy?
- Changing marketplace spurred by health reform
- Opportunity to deliver value to our members, providers and communities we serve
- Promote quality, access and evidence-based care
- Learn from pilots- adopt best practices and determine what works best for our members
- Bolsters ACO strategy
- Integration and connection point with providers for our products and programs
- Improve the member experience of healthcare

Are providers PCMH-ready?
- Less than 50% with interoperable EMR
- Time and resource intensive- cannot afford the PCMH transformation costs
- Team-based care- ill-equipped or limited staff to promote a team approach
- Still many practices operating with 1980’s technology and mindset

The Current PCMH Landscape
- NCQA is the “favored player”- new criteria announced January 31st
  - Six Standards, 27 elements, 143 factors- three levels
  - New criteria aligned with meaningful use
  - Over 7600 clinicians in 1500 recognized practices
- Others are joining the fray- URAC, Joint Commission- could lead to provider confusion and medical home fatigue
- Growing number of large multi-payer pilots
- Freight train moving down the tracks- but hopefully we’re not on a runaway train!
- Value-based purchasing is here to stay!
What are the tensions in developing a PCMH?

- Follow national standards (NCQA) vs. building our own; unique pilot vs. model office
- PCMH model remains a moving target both in practice and theory
- Few multi-payer models in the market; cost to transform practice
- Competing resources and demands within practices

What can a payer provide to a practice?

- Improve Member Show Rate and Engagement
- Reporting/Data Exchange/Profiles
- Innovative Reimbursement Models
- Team-Based Care Management and Coordination
- Member Risk Stratification and Identification
- Relationship Management
- Education Support and Reinforcement
- Care Transition Support
- Member Surveillance
- Partner in Performance and Outcome Improvement

Aetna MBU PCMH Strategy Overview

- Strategy #1: Provide members and providers with actionable health information
- Strategy #2: Engage and Empower Members
- Strategy #3: Promote PCMH as the preferred primary care practice model
  - a) Support practice transformation
  - b) Support Integrated Care Management in at least three environments (plan, practice and community)
  - c) Align incentives with preferred practices

Overview of MBU PCMH Standards

- Personal Clinician: Each member will have a continuous relationship with a personal clinician who is able to provide individualized preventive, acute and chronic care.
- Organizational Capacity/Access: The practice demonstrates the ability and commitment to provide every member access to the care team with processes that facilitate open communication and exchange of information regarding all aspects of the member’s care.
- Coordination of Care/Services: The practice is orientated towards a collaborative team approach to coordinate each member’s care across multiple care settings and environments.
- Performance Measures/Quality Improvement: The practice has processes in place to measure and evaluate care and achieve outcomes that reflect a commitment to continuous quality improvement and evidence-based practice.
Defining characteristics of a medical/healthcare home

- **Basic (level 1)**
  - Access to a personal clinician
  - Coordination of care
  - Lab and referral tracking
  - Behavioral health referral capability
  - Evidence-based treatment
  - Family and Caregiver Integration
  - Open access environment

- **Intermediate (level 2)**
  - Team Approach to Care
  - Disease Registry
  - Individualized Plan of Care
  - Electronic Health Record Capability
  - Support for self-management
  - Quality improvement plan
  - Provider feedback on performance

- **Advanced (level 3)**
  - Comprehensive electronic health record
  - Interactive web site
  - Advanced clinical decision support
  - Use of performance dashboards
  - Advanced care management with team-specific roles- pre, during and post-visit process
  - Behavioral health provider part of the care team

Does PCMH = positive outcomes?

- **Key pilot outcomes**
  - Patient-Centered Primary Care Collaborative Outcomes Report- November, 2010:
    - Geisinger- reduced total costs by 4% in first pilot year and reduced hospital admissions by 18%
    - Group Health- 16% reduction in hospital admissions, 29% reduction in ED visits, $14 PMPM reduction
    - Intermountain Healthcare- net reduction in costs by $640 per patient, per year, $1,650 among highest risk
    - Medicaid Plan
    - Community Care of North Carolina- cumulative savings over six years (2003-2008) of $974.5 million, 40% reduction in hospitalizations for asthma
Impact of Medical Homes on Quality Care

<table>
<thead>
<tr>
<th>Has medical home</th>
<th>No medical home</th>
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<tbody>
<tr>
<td>Very/somewhat difficult to get off-hours care outside the ER: 61</td>
<td>16</td>
</tr>
<tr>
<td>Medical records not available or duplicated: 72</td>
<td>29</td>
</tr>
<tr>
<td>Experienced medical, medication, or lab error: 55</td>
<td>34</td>
</tr>
<tr>
<td>Doctor gives written plan for managing care at home: 47</td>
<td>21</td>
</tr>
<tr>
<td>Receive reminder for preventive/follow-up care: 63</td>
<td>47</td>
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Source: Commonwealth Fund International Study, 2007

Readmissions - Pay Attention!

- 30-day readmission rate for Medicaid population is 16%, rising to 53% within one year*
- 50% did not receive a visit with PCP during 30 days post discharge*
- Diagnoses with highest probability of readmission for any diagnosis within 30 days:
  - CHF 21%
  - Asthma/COPD 15.8%
  - Diabetes 15%
- Steps to a successful readmission program
  - Begin discharge planning in the hospital
  - Medication reconciliation and education
  - Communicate the discharge plan to the member’s PCP
  - Involve the family, caregivers, and/or support network and other providers in discharge planning
  - Schedule follow-up appointment with the member’s PCP before leaving the hospital

Source: *Center for Health Care Strategy Study, Hospital Readmissions, December, 2010

What is an Accountable Care Organization?

As defined by CMS:
“an organization of health care providers that agrees to be accountable for the quality cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program...”

Also from Elliott Fisher:
“ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth... these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and...ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”

Key Elements of an Accountable Care Organization

- The medical home is a critical building block for the ACO model
- Must align with agreed upon: incentives, quality metrics and targets, population, clinical data and governance model
- Many primary care providers will be in an exclusive arrangement with an ACO
- Comprehensive care management for the ACO population
- Must have strong clinical leadership- this includes NPs!
Closing Thoughts

- **Research**: find something you know and are passionate about and communicate to the public—can be a blog, radio show, article or through social media.
- **Connect**: with other clinicians, not just NPs—expand your network and sphere of influence—but get together with a group of NPs regularly for lunch/dinner—share, vent, teach.
- **Support**: reach out to an organization in your community or a colleague in need—we cannot do this alone and others need our expertise—find a mentor!
- **Stay Active**: physically and mentally—keep your body and mind fit—take vacations!
- **Be Innovative**: you all have good ideas—pursue them!
- **Engage Your Patients**: are you listening or are you hearing them? Get them more activated, motivated and self-managing with each visit!
- **Continue to do good work!!!**

THANK YOU!

Mark E. Douglas
markdouglasnp@yahoo.com
317.514.4815