

# **Policy Options to Support the Medical Home**

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# Societal Expectations

- **Pressure for Value**
  - ◆ **Desire for Patient Centered Care**
- **Accountability**
- **Transparency**
- **Payment Incentives**

# What is patient-centered care?

## ■ Commonwealth Fund

- ◆ Superb access
- ◆ Patient engagement
- ◆ Clinical information systems
- ◆ Care coordination
- ◆ Integrated and comprehensive care
- ◆ Smooth transfer of information
- ◆ Ongoing public information
- ◆ Publicly available information to choose a practice and physician

## Indicators of A Medical Home U.S. Adults 18-64

Indicator	Total	
	Millions	Percent
Regular doctor or source of care	142.2	80
Not difficult to contact provider over telephone	125.7	85
Not difficult to get care or medical advice after-hours	96.7	65
Doctor's office visits are always or often well organized and running on time	97.1	66
All four indicators of Medical Home	47.2	27

27



- First need to define the PC-MH:

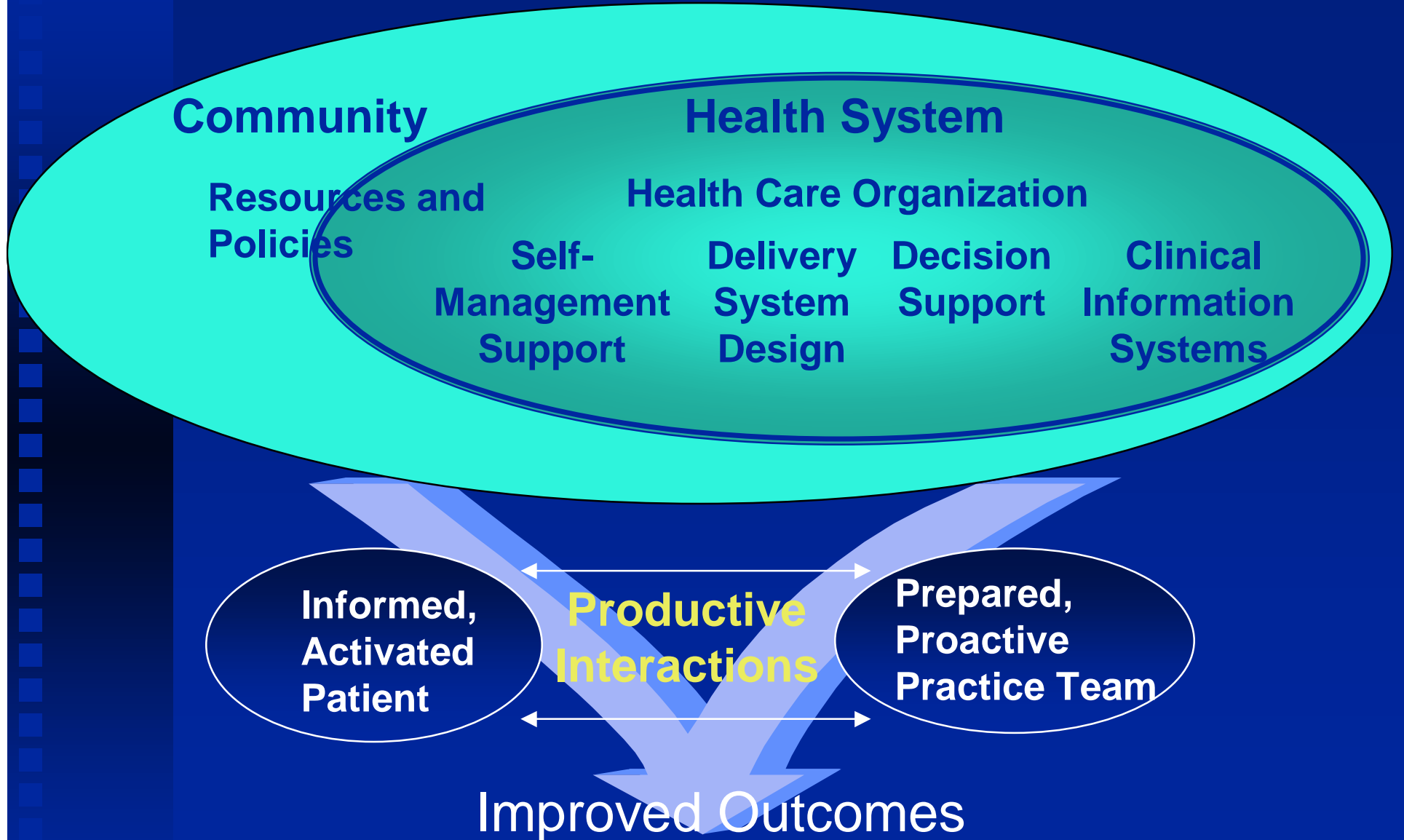
(Joint Principles of the ACP, AAFP, AAP, AOA)

“Physician directed medical practice that provides patient centered care that is accessible, continuous, comprehensive, coordinated and delivered in the context of family and community.”

## What is a medical home?

- Partnership with patients
- Linkages to community resources
- Continuous improvement process at the practice level
- Learning collaborative to support practice change
- Improved office systems to
  - Track and monitor progress
  - Evaluate outcomes

# The PCMH is based on the Chronic Care Model



THE NEW ENGLAND JOURNAL OF MEDICINE

HEALTH POLICY REPORT

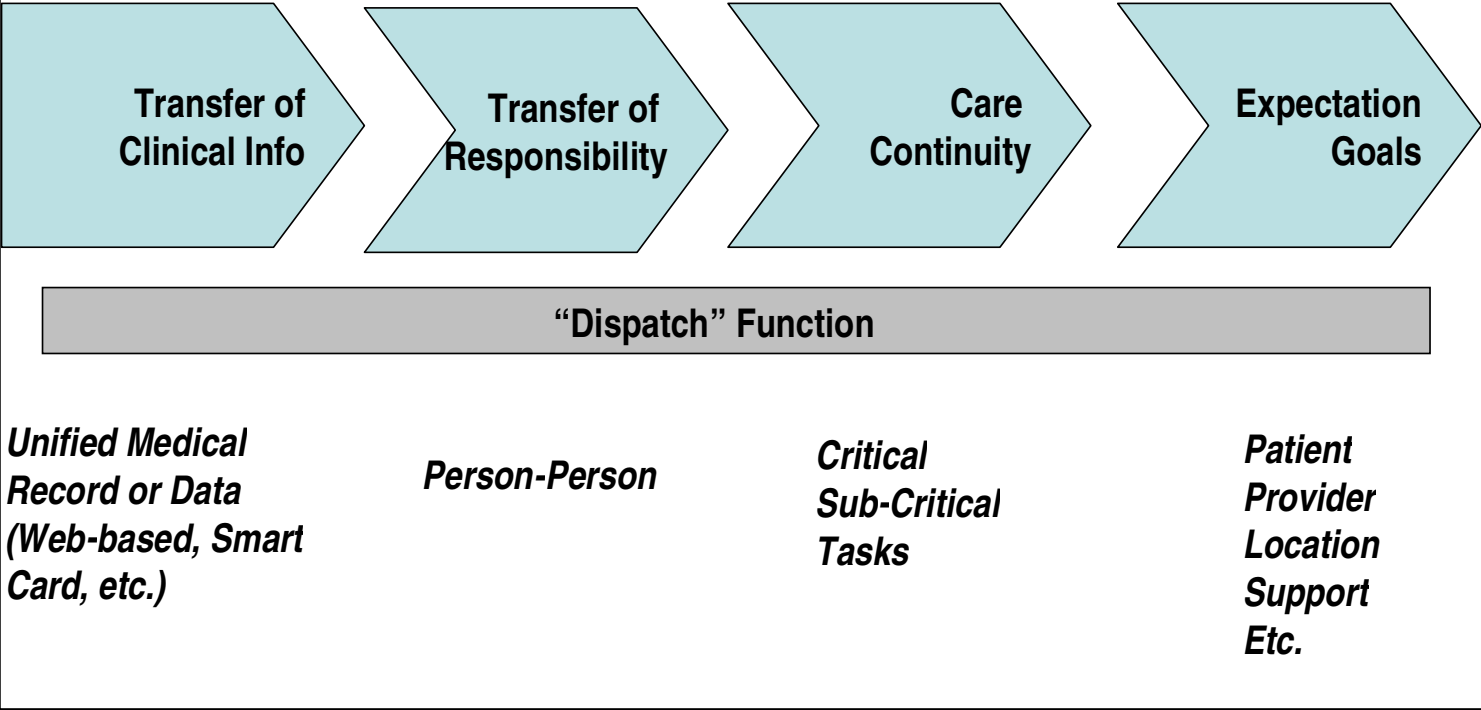
**Coordinating Care — A Perilous Journey  
through the Health Care System**

Thomas Bodenheimer, M.D.

## **Medicare CHF Readmissions (2005)**

- **27% in 30 days**
  - **39% in 60 days**
  - **~50% in 90 days**
- 
- **610,000 Discharges in 2005**
  - **DRG 127 (CHF) = \$29.6 Billion (2006)**

# Transitions Model



# **Cultural Issues of Transitions**

- **Joint Responsibility/Accountability**
- **Direct Communications**
- **Timely Communication**
- **Patient/Family Engagement**
- **Medical Home**

HOSPITALS & PHYSICIANS

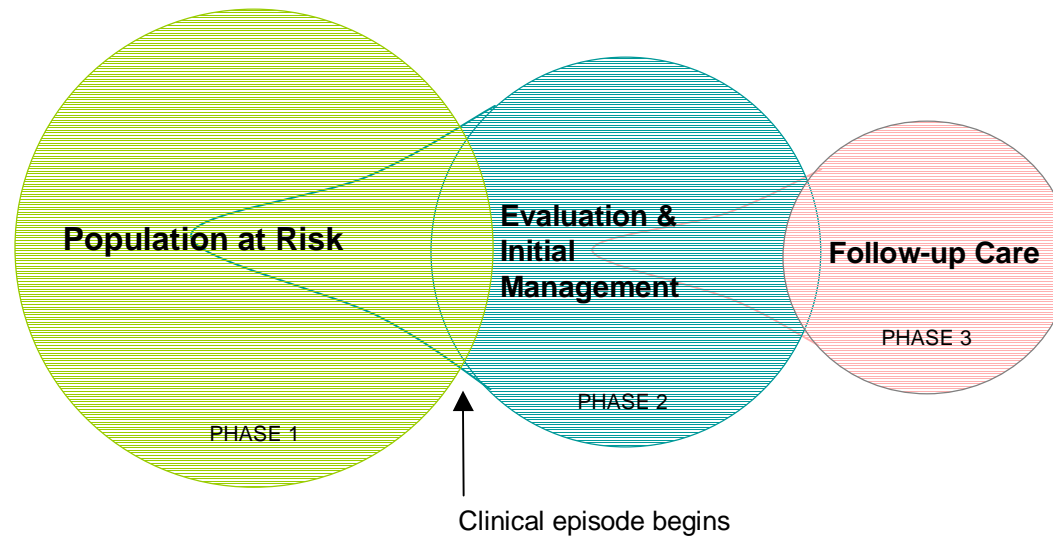
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# Creating Accountable Care Organizations: The Extended Hospital Medical Staff

A new approach to organizing care and ensuring accountability.

by **Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb**

# Generic Episode of Care



## End of Episode

- Risk-adjusted health outcomes (i.e. mortality & functional status)
- Risk-adjusted total cost of care

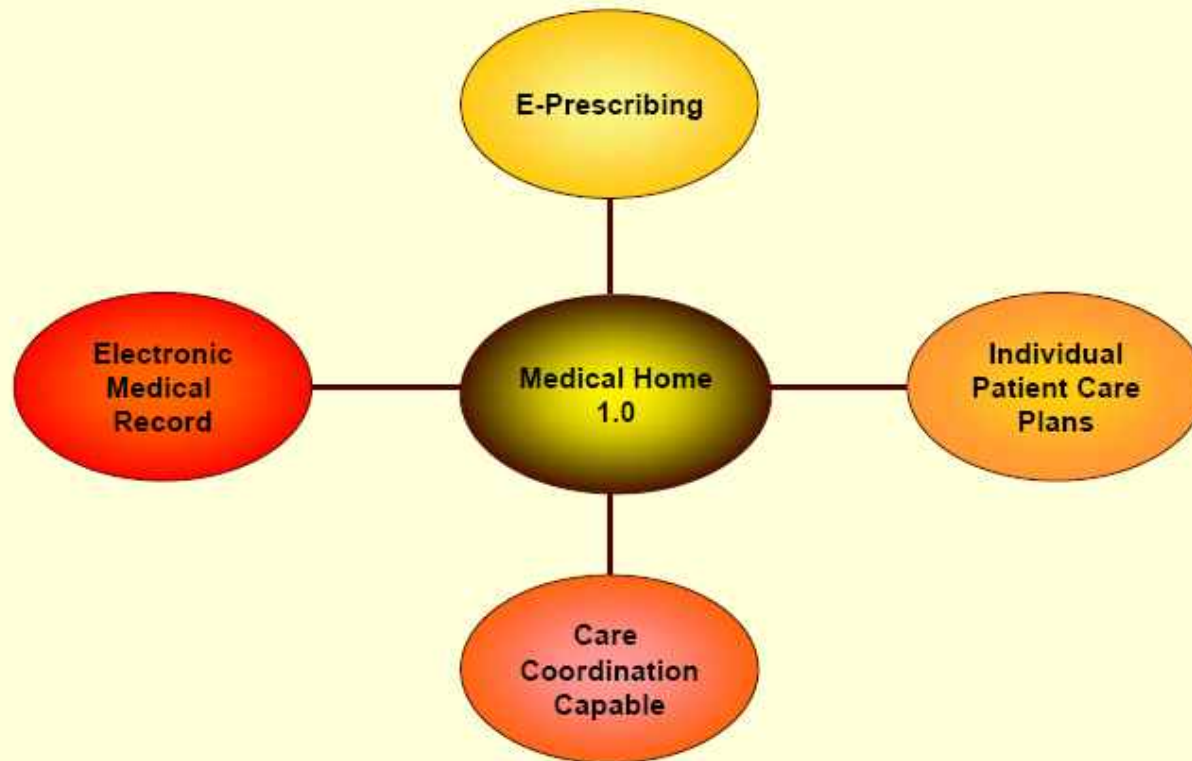
Time

## Appropriate Times Throughout Episode

- Determination of key patient attributes for risk adjustment
- Assessment of patient preferences and the degree of alignment of care processes with these preferences
- Assessment of symptom, functional, and emotional status



# Medical Home 1.0



# Supporting the Medical Home

- **Reimbursement Policy**
  - ◆ Access, Complexity, Coordination, Metrics
- **Infrastructure Support**
  - ◆ ePrescribing, EMR, EHR, Telephony
  - ◆ Case Managers
  - ◆ Telehealth, Home Monitoring

# Bonus Pay Planned To Boost Access to Medical Homes

*Proposal could yield up to \$100K per year.*

BY ALICIA AULT

*Associate Editor, Practice Trends*

One of the nation's largest health care quality coalitions is launching a pro-

de Brantes, CEO of the coalition, said in an interview. By late spring, however, he expects to "have a couple of exciting announcements."

Dr. Michael Barr, ACP vice

## Five PCMH Payment Models

1. FFS with discrete new codes
2. FFS with higher payment levels
3. FFS with additional lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P

## Pilot Joint Principles Developed (cont.)



- Reimbursement should
  - Reflect the value of non-face time
  - Pay for care coordination
  - Support adoption and use of HIT for QI
  - Support enhanced communication such as secure email and telephone consultation
  - Allow for separate fee-for-service visit payment
  - Recognize case mix differences in patient population
  - Allow for physicians to share in savings from reduced hospitalizations
  - Allow for additional payments for achieving measureable quality improvements

# PPC-PCMH Content and Scoring

<b>Standard 1: Access and Communication</b> A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	<b>Standard 5: Electronic Prescribing</b> A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
<b>Standard 2: Patient Tracking and Registry Functions</b> A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	<b>Standard 6: Test Tracking</b> A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
<b>Standard 3: Care Management</b> A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	<b>Standard 7: Referral Tracking</b> A. Tracks referrals using paper-based or electronic system**	Pts 4 4
<b>Standard 4: Patient Self-Management Support</b> A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	<b>Standard 8: Performance Reporting and Improvement</b> A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goal and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	Pts 3 3 3 3 2 1 15
		<b>Standard 9: Advanced Electronic Communications</b> A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4

\*\* Must Pass Elements

## MMHD Care Management Fee

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Per Member per Month Payments			
	HCC Score <1.6	HCC Score >1.6	Blended Rate
Tier 1	\$27.12	\$80.25	\$40.40
Tier 2	\$35.48	\$100.35	\$51.70

- HCC score indicates disease burden
- Estimate that 25% of beneficiaries with HCC <1.6 and Medicare costs at least 60% higher than average
- First 2% of savings not shared
- 80% of savings above 2% (minus fees) shared with practices

## Current P4P Payments

- Physician Participation in P4P -\$200 per practitioner
  - PCPs – (Family Practice, Pediatricians, Internists)
  - Dentists (new program modification)
  - OB/GYN's (new program modification)
- Enrollment Support-\$40/high risk pt contacted by a participating office
- Enrollment Support-\$30/high risk pt where office provides new contact information
- Chronic Care Feedback Form (CCFF)  
\$60 per completed CCFF 2 times a year

# Pennsylvania

- **The PCP must conduct outreach to Enrollees who miss an appointment to determine why the Enrollee missed the appointment and to reschedule the appointment.**
- **The PCP must also outreach to Enrollees identified in the monthly panel lists as new Enrollees, Enrollees who have not had an encounter during the previous twelve (12) months and Enrollees who have an EPSDT Screening due or are not current with EPSDT periodicity and immunization schedules for children, to schedule an appointment.**
- **The PCP must record in an Enrollee's medical record, when he or she misses an appointment or is not current with the EPSDT periodicity and immunization schedules.**

## ACCESS Plus P4P New Clinical Measures

### #12. CAD: Lowering the LDL Level to Less than 100 mg/dl

#### Payment Amount:

- PCPs will receive a \$30 incentive payment for each CAD patient demonstrating an LDL level <100 mg/dl.
- An additional payment of \$10 per CAD patient in the practice per year will be paid to the practice if the practice achieves a performance rate that meets or exceeds NCQA's 50th percentile benchmark for Medicaid plans.

#### Payment Frequency:

- Quarterly evaluation and payment to PCPs – one payment per year
- Annually to the Practice

# 24 Hour Access

## ■ North Carolina

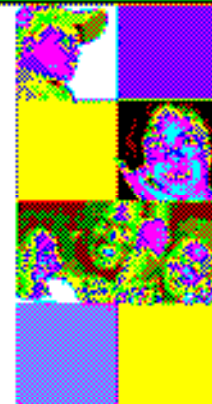
**An office telephone line that is not answered after hours, or is answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care, is not acceptable. It is not acceptable to refer enrollees to the PCP's home telephone if there is no system in place to respond to calls.**

# The PCMH is based on the Chronic Care Model



# What is a Medical Home System?

- The state and local personnel, processes, individuals, procedures, materials that support providers to implement the practice-level medical home standards
- Often there are local and state systemic issues such as lack of specialists and uncertainty of local resources that prohibit providers from providing a medical home approach
- A state and local infrastructure to overcome these barriers and to provide technical assistance to providers is called a medical home system

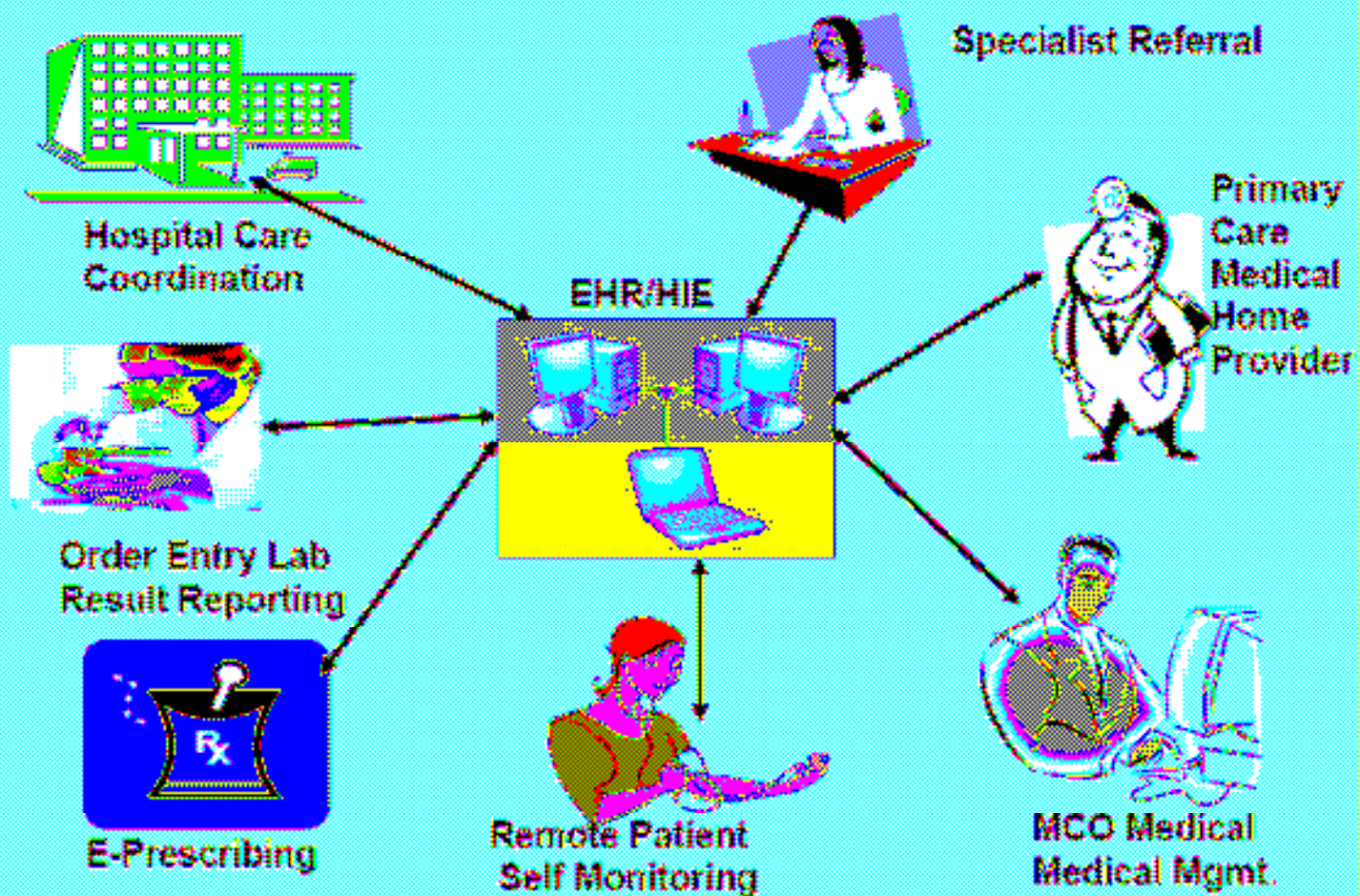


## Community Care Networks:

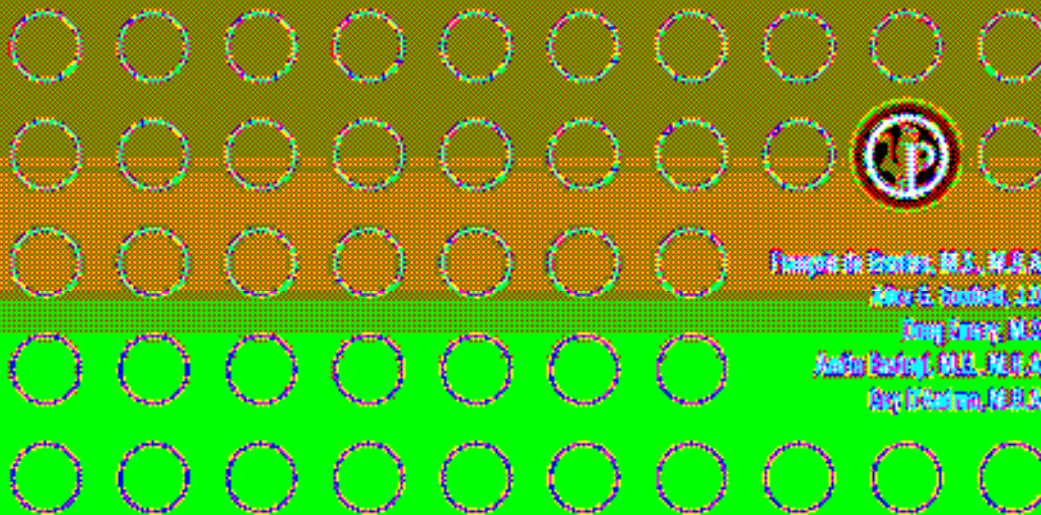
- Non-profit organizations
- Includes all providers including safety net providers
- Medical management committee
- Receive \$3.00 pm/pm from the State
- Hire care managers/medical management staff to work with PCPs
- PCP also get \$2.50 pm/pm to serve as medical home and to participate in Disease Management and Quality Improvement
- NC Medicaid pays 95% of Medicare FFS



# The Connected Medical Home

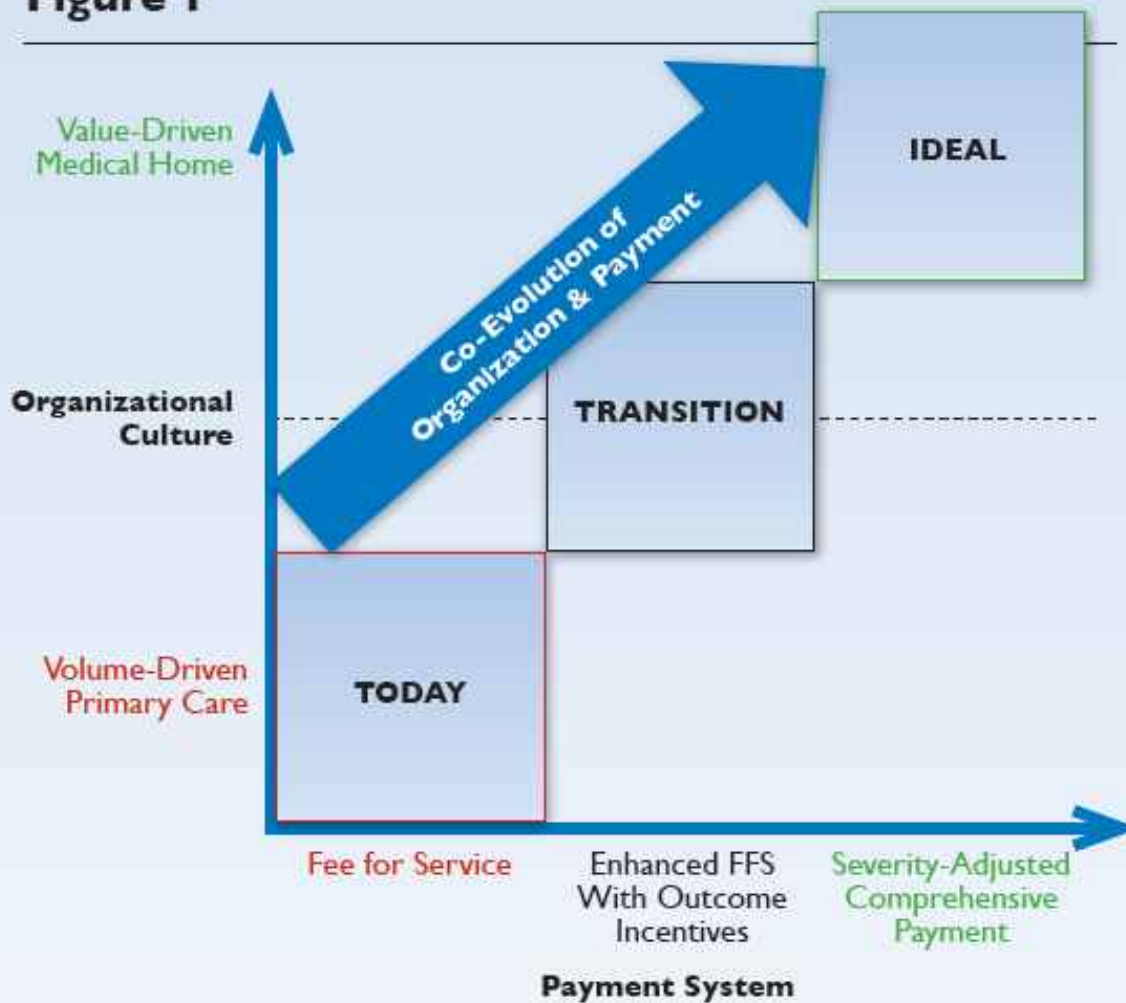


# SUSTAINING THE MEDICAL HOME: HOW PROMETHEUS PAYMENT® CAN REVITALIZE PRIMARY CARE



Francis de Serres, M.D., M.P.A.  
Alan S. Gendell, J.D.  
Doug Emery, M.D.  
Aimee Bartel, M.D., M.P.A.  
Clay K. Adams, M.D., M.P.A.

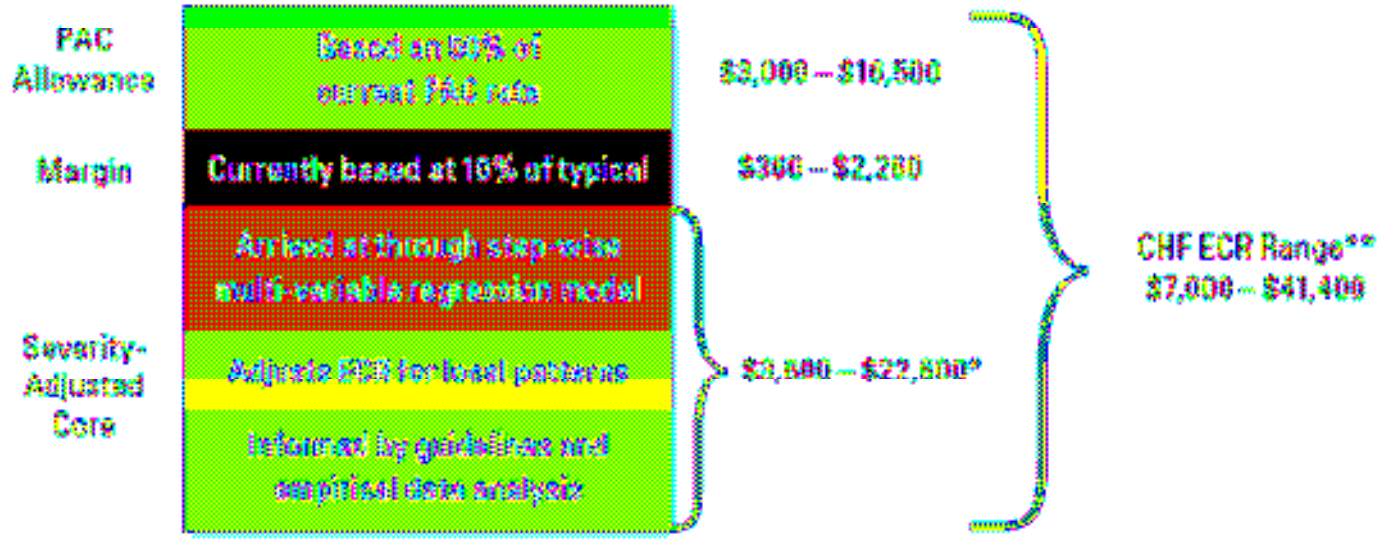
**Figure 1**



# Prometheus Model

- **Reward Functionality of Medical Home**
  - ◆ Episodes of Care – Adjusted for Severity
- **Evidence Informed Case Rate**
- **Potentially Avoidable Complications (PACs)**
  - ◆ 40% of Costs?
- **Address Co-Produced Care**

**Total ECR Price = Type of Services x Frequency x Price per Service**



# Questions for AR

- **Goals?**
- **Incentives?**
- **Value to Whom?**
  - ◆ **Providers, Program, Patients (or Subsets)**
- **Accountability?**
- **Coordination**

# What's Next?

- **Defining Medical Home**
  - ◆ **Inherent Properties**
  - ◆ **Patient Centered Services**
  - ◆ **Self Assessment**
- **Redefining Managed Care Fee**
  - ◆ **Expectations**
  - ◆ **New Support**
- **Set Priorities**

# AR Medicaid

- **Complex Care Plans**
  - ◆ **Foster Children**
  - ◆ **Developmental Disabilities**
  - ◆ **Community Based Long Term Care**

# Medical Home System

## ■ Foster Children

### ◆ Personal Health Record

☞ Health Professionals, Foster Families, Case Managers

### ◆ Care Coordinators

☞ Adherence, Guidance, Facilitation

# Examples

- **Twice Yearly Fee for Complex Care Plan**
  - ◆ **Foster Kids, Special Needs, Mental Health**
- **Bonus Pay for After Hour Clinics**
- **Use of ePrescribing**
- **Monitored Use of ER by Panel**
- **EPSDT Screening**
- **ACH Home For Complex Children**

# eHealth Arkansas

Connecting to the Future

Wednesday, October 24, 2007

Embassy Suites Hotel • Little Rock • Ambassador Ballroom

## AGENDA

**8:00 - 8:30 A.M.**  
**Registration and Continental Breakfast**

**8:30 - 8:45 A.M.**  
**Welcome**

William E. Golden, MD, FRACP, Vice President for  
Clinical Quality Improvement, AFMC

Mick J. Paslidis, MD, PhD, MFHM,  
Chief Executive Officer, AFMC

**8:45 - 9:15 A.M.**  
**Keynote Address**  
Governor Mike Beebe

Ray Jeffes, Director, Division of Medical Services,  
Arkansas Department of Human Services

**10:45 - 11:30 A.M.**  
**Inland Northwest Health Services**  
Thomas Fritz, MA, MPA, Chief Executive Officer

**11:30 A.M. - 12:15 P.M.**  
**MidSouth eHealth Alliance**  
Thomas E. Duarte, Executive Director,  
MidSouth eHealth Alliance

Merese Wesley, CISM, Regional Informatics Security Director,  
Vanderbilt Center for Better Health

**12:15 - 12:30 P.M. Break**

**12:30 - 1:15 P.M.**  
**Lunch - Q & A Panel of Morning Speakers**  
Hasselman, Bechtel, Fritz, Duarte, Wesley

# Current Projects

- **Statewide ePrescribing**
- **Blue Cross PHR**
- **FCC Grant – Telehealth – ATOM**
- **The RQI Steering Committee (ACHIEV)**
- **Medicaid HER**
- **Federal Stimulus Package**



## *Save The Date*

**EHC Annual Conference**  
**August 25<sup>th</sup>-27<sup>th</sup> 2009**

**Hot Springs Convention Center**  
**Hot Springs, AR**

*Watch our website for updates!!!*  
*[www.ehcark.org](http://www.ehcark.org)*

**479-201-8510**