Medical Home Models: Concepts & Use

Presented to the Medical Home Task Force
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Understanding Medical Home: What it is/Is Not

- Medical Home Model is NOT an insurance product.
- It is a tool on the provider side of health care used to improve patient care through a patient centered, family centered, coordinated approach.
- Can be used to establish payment criteria.
The evidence is strong regarding the importance of a Medical Home approach to the delivery of health care services to patients. The provider and the patient are considered integral and integrated parts of the system. Primary care is the anchor to the system, with a strong coordinated care function.

Some literature says it exists merely in the form of relationships between provider and patient at its core function. However, the definitions go as far as specifying stringent criteria in a case management, patient centered approach using national standards.
Key elements of medical home seem to run through all models:

- Accessibility for first contact primary care
- Long term person-focused care
- Comprehensive Care such that all health needs within the realm of primary care is provided
- Coordinated care is mandated for patients who need services outside the realm of the primary care physician and/or the team
- Some incentives for providers for coordinating care

Evidence shows that the stronger the primary care orientation is in the system, the lower the all-cause mortality is in the long run. Furthermore, there is compelling evidence to show that investing in more primary care will lower overall costs for health services.
Southeastern Consultants Report on Florida Medicaid Analysis Shows:

- Approx. $900M in total medical and drug costs annually was attributed to adult patients with uncoordinated care patterns
- Two indicators as examples:
  - Average annual drug costs of $9,176 vs. $1,640
  - Average medical costs of $13,320 vs $3,479
SEC Recommendations

- Target & expand intervention programs to improve coordinated care
  - Physician & pharmacy medical home programs w/targeted enhanced care management
  - Disease & care management interventions
  - Patient education
  - ER diversion to redirect patients to primary care
  - Providers MUST BE ACTIVE PARTICIPANTS w/patients to achieve coordinated care
Variations on a Theme

- Medical Home models have a variety of implementation strategies, yet for reimbursement no standard payment strategy has been recognized. Payers experiment with different mechanisms, but many are beginning to use the guidelines established by NCQA.
NCQA Guidelines

- Improved access & communication
- Use of data systems to enhance safety and reliability
- Care management
- Patient self management support
- Electronic prescribing
- Referral tracking
- Test tracking
- Performance reporting/improvement
- Advanced electronic communications
Models & Standards

- PCMH Principles (AAFP, AAP, ACCP, AOA)
  - Each patient has a personal physician (development of a primary care network is paramount to success)
  - Physician directed medical practice
  - Whole person orientation
  - Care is coordinated/integrated across all elements of the health care system
Quality and safety are hallmarks of the medical home:

- Evidenced-based medicine/clinical decision-support tools guide decision making
- Physicians accept accountability for CQI
- Patients participate in decision making
- IT is used extensively
- Practices advocate for their patients

Enhanced access to care is available
Payment recognizes the value of a PCMH system and should include incentives
FQHCs

- FQHCs have operated within a variation of the PCMH model for over 30 years in Florida
  - A strong primary care network is in place via FQHCs, serving close to 1M people this year. Coordinated care is a federal mandate for CHCs.
  - Working with hospitals and insurance companies to increase ER diversions to ensure patients get primary care
  - Disease management is a critical aspect of CHC integration of care within the medical home
Select Medical Home Models
SoonerCare Program

- Oklahoma Health Care Authority
  - 1993 1115 Waiver to reform Medicaid Program to implement a statewide managed care model to control costs and improve care
  - Modified over next 15 years - implemented a fully capitated program in urban areas and a partially capitated PCCM program in rural areas; expanded throughout state in 2004.
  - As of July, 2009 there are just over 675,000 patients (69% children, 31% adults).
  - THE PCCM approach is the basis for the medical home transition which relies on FFS reimbursement for office-based services, supplemented by care coordination payments that vary with services offered, patient characteristics, and performance measures.
SoonerCare Program

**Actions**

- Terminated contracts will all MCOs and brought work in-house to reduce costs (took out profit margins, lowered admin costs).
- Innovative partial capitation to encourage participation from physicians who did not want to see Medicaid patients
  - Physicians paid about 10% if enrollees total predicted costs upfront and then they were responsible for providing a specific package of office based PC services. Other costs paid on FFS basis. This would be similar in some ways to our state’s PMPM case management fee for limited coordination
- Established primary care networks and used primary care providers as coordinators of care
- 2004 – OHCA established a Nurse Care Management program. Nurses (in-house) are performing many of the care management and coordination functions the MCOs did, but have extended this into rural areas as well as urban
SoonerCare Program

- Health Management Program established for high cost, high need patients
- Development/implementation of Medical Home Model moving away from partial capitation towards FFS
- Expanded Coverage (“Insure Oklahoma”) by helping small employers coverage
SoonerCare Key Elements

- Stand-alone Medicaid agency
- OHCA extensive work with MCOs providers, and advocates
- Established strong performance measurement capabilities to provide reliable data to support key decisions
- Focus on providers as clients to improve participation
  - Medicaid reimbursement is 100% of Medicare rates in 2005
- Concerted outreach, simplified applications to increase enrollment in Medicaid
- OHCA has taken advantage of the medical home model to enhance the reimbursement system and build in more financial incentives for providers to improve their performance (Immunizations, EPSDT, ED Utilization, Cervical Cancer Screenings)
- Effective and Continuous communication with stakeholders
Community Care of North Carolina

- Created to enhance the PCCM program through community based coordinated delivery systems
- Five key principles:
  - Public-private partnership uniting and strengthening local providers
  - Physician leadership and local control
  - Focus on quality of care and population health management
  - Shared state/local responsibility
  - Shared incentives
- Established 14 community care networks
- Local networks/PR Providers received supplemental funding for care management and CQI activities
- Each network – vertically integrated (PC, specialty, hospitals, CHDs, other key stakeholders)
- Key participation elements: primary/preventive care services, 24 hour coverage, coordinating specialty care, participation in care management and CQI activities
Community Care of North Carolina

- Uses $3 PMPM to cover costs of network management activities
- Network’s management fees are competitive with those charged by disease management vendors
- Physicians are paid FFS at 95% of Medicare rates, plus a $2.50 PMPM for medical home/population management activities
- Web-based case management information system to coordinate care of enrollees. Can be used to ID high risk patients for chronic disease management
- Contracts with AHEC for chart reviews
- All CCNC networks work together with state to track and report performance measures.
- Outcomes have been exceptional
- CCNC clinical directors developed a voluntary drug list. used to encourage the use of less expensive meds
Community Care of North Carolina

- Medical Home Operation
  - Patient selects or assigned a personal primary care provider who serves as medical home
  - Physician provides acute and preventive services and facilitates patient access to overall health care system
  - CCNC has a patient education system to engage patient in healthy lifestyles, preventive services, etc.

- HealthNet Collaborative Networks
  - CCNC works with safety-net providers and indigent care programs to create integrated networks of care for uninsured.

- From Commonwealth Fund Case Study on CCNC
Florida’s Challenge

- Clearly the medical home tool can have a positive impact on health care costs and delivery.
- Florida must decide if it wants to use a medical home model for the basis of a new delivery system that will improve care, reduce costs in our state.
- Florida needs to agree on what would be the criteria for qualifying for “medical home status”.
- Look at the elements of existing plans and take what can fit for us.
- Must insure a solid primary care network is in place.
- Must establish fiscal goals as well as quality goals.
- Do we have the primary care workforce for this?
Concerns

- Both models that are highlighted here have populations that are significantly lower than Florida’s Medicaid population.
- Costs for increasing reimbursement to the 95-100% range would have an impact for Florida.
- The number of primary care providers coming out of residencies and med school is shrinking for Florida.
- Unlike Oklahoma, Florida has a multitude of MCOs to deal with, although the agency could address this.
- Florida pays more PMPM than and provides only 57% Medicare and no incentives than OK who pays about $44 PMPM AND pays Medicare plus incentives to providers.
- Florida’s system is not aligned for efficient patient care and cost containment.
What Florida Has

- The network concept is loosely the same as the initial concept of the Rural Health Networks which in some forms still exist.
- PSN and vertically integrated can be networks can be developed.
- FQHCs already have a strong primary care network statewide that utilizes the medical home concept.
- Private physicians can form strong networks locally.
- There is not a great deal of change needed to adopt this powerful tool to improve health care in Florida other than on the payor side and the reimbursement strategy.
Conclusions

- Oklahoma has found a formula to pay higher reimbursements, incentivize PCP to coordinate care, and reduce cost to the state significantly – Florida can do this.
- North Carolina has taken the community based network concept to the state level, with ALL 14 cooperating on standard medical home concepts, reporting, data collection, and delivery system utilization – Florida has numerous pieces of these which can be integrated to meet the needs.
Florida needs to shift its focus in health care from the payor to the health system and its providers as clients.