

# The Patient Centered Medical Home: A Theme and Variations

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June 19, 2009

# What is a “medical home”?

- The term “medical home” crops up regularly in state health reform initiatives and, right now, in the discussions of national health reform
- The definition of a “medical home”, however, is not uniform and its characteristics can vary considerably
- All emphasize primary care and coordination of care
- Most anticipate adoption of some kind of medical home model will improve quality of care and reduce health care costs, often with aid of health information technology
- Most also envision enhanced patient/family involvement in care decisions and management

# The “Early Adopter” Enhanced PCCM Model

- In traditional PCCM model primary care provider is paid modest monthly fee (usually \$2-\$3 per enrollee per month) for agreeing to act as a regular source of care for the patient AND coordinate (in some state Medicaid programs, specifically authorize) needed speciality care.
- Next generation, “enhanced” medical home PCCM models ask more of the providers (like 24/7 availability) and pay them more
- Examples: North Carolina, Alabama, Illinois

# Community Care of North Carolina

- Serves children and families in Medicaid
- Goals: improve access and quality; strengthen care coordination provider-provider and provider-community resources; reduce disparities
- Structure: primary practices supported by community “networks” of other disciplines
- Practices get \$2.50 PMPM; networks get similar PMPM

# Alabama Patient 1<sup>st</sup> Program

- Serves children and families in Medicaid
- Goals: 24/7 access, reduced ER utilization, improved care quality, more IT use
- Practice paid variable PMPM fee, depending upon success in meeting various goals. Current maximum is under \$3 per month
- Practices also share in savings “pool”; share based on performance in meeting targets such as greater use of generics and reduction in ER visits

# Illinois Health Connect

- Serves all Medicaid beneficiaries
- Goals: better access, more preventive care, improved care coordination
- Special Medicaid provider agreement with specific obligations, including minimum # of office hours per week
- PMPM varies w/ age and eligibility category
- Bonus for exceeding fiftieth percentile score on certain prevention and care management measures

# The Next Generation: Multi-payer Demonstrations

- Joint projects involving private insurance plans and state Medicaid (or HMOs contracting with Medicaid) programs
- Generally product of long collaborative process among payers before launch
- Goals: strong care coordination, more IT use, significant emphasis on “team” approach to care coordination and patient care
- Example: SE Pennsylvania project

# SE Pennsylvania Medical Home Demo

- Initiative led by Governor's Health Reform Office
- Involves 20 practices sites in Philadelphia area and multiple insurers, including Medicaid HMOs
- Goals: greatly enhanced care for persons with chronic conditions – initially asthma (pediatric) and diabetes
- Focuses on practice transformation using team approach and extensive IT
- Insurers and state providing significant new funding for IT systems, practice redesign and training, and rewards for improved quality

# The Latest Versions: 2009

- State interest and involvement in Medicaid medical home initiatives continues
- Some, such as Minnesota, are well along in their planning processes
- Others, such as New York, have new legislation authorizing medical home initiatives
- Still others, such as Oklahoma Medicaid, moved in 2009 from planning to actual statewide implementation of a medical home structure

# Minnesota Health Care Home

- Part of 2008 comprehensive health reform law
- Regulations defining standards to qualify as health care home published late April
- Eligible providers: personal clinician or clinic that provides primary care services (clinic eligible only if all personal clinicians meet requirements)
- Focuses on patients who have or are at risk of developing complex or chronic conditions and who agree to enroll in health care home

# Minnesota (cont'd)

- Certification requirements:
  - team approach, on site care coordinator
  - patient registry, clinician access to record 24/7
  - promote patient and family centered care; after initial year must document incorporation in practice
  - measure performance; establish QI team that includes patient representatives; after initial year report QI performance data to state

# Oklahoma

- Implemented January 2009 for all Medicaid beneficiaries except duals and those in home and community based care
- Can be led by MD, PA, or APN
- Pays PMPM case mgt. fee (adjusted for patient age and practice's NCQA PC-PCMH recognition level), plus QI bonus
- Seeking federal approval to pilot community network support structure (similar to N. Carolina)

# New York – statewide project

- 2009 law directs Health Commissioner, by 12/09, to develop standards and certify clinicians and clinics as health care homes
- Not focused specifically on chronically ill
- Practices to be paid enhanced amount –TBD – plus quality bonus
- Homes will be required to provide data to state to evaluate impact on access, health outcomes, and cost

# New York – multi-payer project

- 2009 law authorizes state Medicaid, CHIP and state employee programs to participate in multi-payer project being planned for upstate NY Adirondack region
- Project leadership: Hudson Headwaters system, a network of FQHCs and other providers
- Standards for practice participation must be consistent with NCQA PC-PCMH requirements

# Implementing PCMH lessons learned - for the practice

## Challenges faced by practices:

- time and funding for clinician and staff training
- installation/modification of health IT system
- modifying administrative procedures to improve efficiency, accessibility, and care coordination
- engaging in QI measurement/improvement
- finding/maintaining functional links w/ other medical providers and community resources
- maintaining morale during time of change

# PCMH Implementation Challenges -State

Challenges for state include:

- a planning process that stakeholders perceive as credible
- establishing standards and process for practice participation
- determining and securing \$ for practice reimbursement and for state staff to administer and evaluate new system/pilot
- educating patients

# Summing up...

- Concept has widespread support but actual focus, practice participation requirements, and reimbursement structures widely varied
- Common threads: emphasis on primary and preventive care, improved access, care coordination, patient engagement, enhanced payment
- Differences include population focus, practice qualifications, QI expectations, kind of financial incentives, and support structures provided to practices and patients/families

# Implementing a PCMH system

- Putting a PCMH system in place is not easy – for the payer (including a state, if it is the payer) and for the practice
- Experience so far yields valuable lessons for those who would follow
- Change takes time, leadership, broad stakeholder support, and patience...but rewards are happier clinicians, more satisfied and engaged patients and families, and, generally, lower health care costs

For more information...

For latest updates on state PCMH initiatives, consumer-oriented resources, and a consumer advocacy “toolkit”, please go to our website -

[www.nationalpartnership.org](http://www.nationalpartnership.org)