Paying for the Advanced Medical Home

A Value-Based Proposition

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Goals

- One of the primary goals for the healthcare industry is to improve the efficiency of delivering medical care.

- If we are to do so, there is no doubt that improving the patient-physician relationship is required.

Relationship = Trust

- This relationship must be founded on trust.
- Trust that the physician is willing and capable of delivering the care a patient needs and that the patient is capable and willing to participate in that care.

Coordination of Care

- Efficient care is not necessarily costly care. It does require the *coordination* of preventative, acute, and chronic interventions by a responsible physician willing to be *persistent* in the effort.

Healthcare Delivery Systems Today

- May be *triage-based* supporting episodic disconnected care performed by multiple sub-specialists with poor communication.
- Loss of *professional dedication* with a shift to employee attitudes.

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Healthcare Delivery Systems Today

- *Fragmentation* of care by utilization of hospitalists, NP, PA, and shift care as seen in many larger physician groups.
- Trend to reduce reimbursement for primary care services in favor of procedural payment.
- Critical *cognitive thinking* is not required, rewarded, or encouraged.

Patient-Centered Medical Home

- A dedicated movement *in support* of primary care.
- An opportunity to resurrect the primary care physician's position.
- Attract new graduates from medical schools.

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Patient-Centered Medical Home

- This model redefines the primary care physician's role in *coordinating* efficient medical care.
- This model promotes trust through its design supporting the patient-physician relationship and ensures improved efficiency.

5 Elements of the PCMH

1. Personal physician
2. Physician-directed medical practice
3. Whole person orientation
4. Coordinated care across all providers
5. Quality and safety

PCMH Elements

1. Personal Physician

- Each patient has an ongoing relationship with a personal physician.

- Physician is trained to provide
  - First contact
  - Continuous and comprehensive care

PCMH Elements

2. Physician-directed medical practice

- Team approach
  - Personal physician leads a team of individuals at the practice level
- Collective responsibility
  - Ongoing care of patients

PCMH Elements

3. Whole person orientation includes care for all stages of life
   - Acute care
   - Chronic Care
   - Preventative services
   - End of life care
   - Tailored to the person's individual needs

PCMH Elements

4. Coordinated and Integrated Care Delivery:
   - Across all providers
   - Across all settings
     - Subspecialty care
     - Hospitals
     - Home Health Care
     - Nursing Homes
     - Patient's community (family)

Cont'd.

PCMH Elements

4. Coordinated and Integrated Care

- Facilitated by
  - Registries
  - Information Technology
  - Health Information Exchange

PCMH Elements

5. Quality, Safety, and Risk Management

- Hallmarks of the Patient-Centered Medical Home

Value of Healthcare

- Increasing the value of healthcare has been a major industry focus.
- People will pay for what they perceive as having value.
- Perceived value is what determines payment.
- Alternatively, it is difficult to get one to pay if little value is perceived.

Value-Based Choice

- Patients will choose the healthcare product with the best value.
- Many healthcare companies are struggling to define value.
- The PCMH model is designed to increase value.

What is value?

- Value can be defined as efficiency divided by cost.

- Research shows the PCMH increases efficiency and patient satisfaction and lowers costs.

PCMH Value

- Primary Care involvement has been proven to decrease:
  - Hospital admits
  - ER utilization
  - Unnecessary tests and procedures
  - Morbidity and mortality
  - Illness and injury
  - Per patient cost

Call for Position Change

- The American College of Physicians Policy Paper of 2006 called for 4 position changes to support PCMH.

- A comprehensive public policy initiative that would fundamentally change the way primary care is delivered.

Position 1

- Patients linked to personal physicians in practices that qualify for the Advanced Medical Home

Position 2

- Fundamental change should be made to support practices that qualify for the Advanced Medical Home
  - Third-party financing
  - Reimbursement
  - Coding
  - Coverage

Position 3

- Fundamental change should be made to train physicians to deliver care consistent with the Advanced Medical Home
  - Medical School/Residency
  - Post graduation on the job

Position 4

- Further research into how the Advanced Medical Home could be accomplished

- Start a national pilot project
- United HealthCare
- Blue Cross/Blue Shield

A Small Provider Service Network's Journey

- In 2000, Metcare of Florida, Inc. "(Metcare") contracted with a large Healthplan in Florida to assume "risk" for approximately 24,000 customers covered under their Medicare Advantage Plan.

Findings and Action

- The open-access model was in place. Primary care physicians were not involved in directing patient care.
- The gatekeeper model was reinstituted in an effort to restore the PCP position in the management process and restore the patient-physician relationship.

Findings and Action

- Primary Care Physicians were reimbursed on a FFS schedule.
- Physicians contracted under capitation rates based on a fixed percent of premium.

Findings and Action

- The medical-loss ratio was greater than 100%.
- A concurrent referral review process was developed to evaluate subspecialist utilization and hospital admission utilization to assess cost.

Findings and Action

- Referral review process confirmed the PCP function primarily as triage centers with little incentive to provide continuous comprehensive care.
- Individual practice patterns and capability of the 28 primary care providers were assessed to set the foundation for an intimate relationship with the PCP to address efficiency.

Challenges

- Educated the physician to the expectation of providing continuous comprehensive medical care.
- Developed a Pay for Performance program to support a partnership and to reward physicians for their cooperation with Metcare's management plan.

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Challenges

- Dedicate significant dollars to fund the P4P program in addition to base capitation.

Pay for Performance

The hypothesis of P4P was that "process" improvements would impact performance thus increasing efficiency and quality.

The P4P was designed to measure individual provider process improvement and provide feedback post evaluation as to the deficiencies.

Pay for Performance

The reward was primarily a cash incentive, although ranking was presented in hopes of creating competition within the network.

- The P4P included full disclosure of the criteria and appeals rights. The physician and Medical Director meet face-to-face to review the results of the audit.

Core Criteria Supporting Comprehensive Care Concept

- Chief complaint *addressed*
- Active problems *addressed*
- Plan of care consistent with Dx and clinical assessment
- Appropriate subsequent office visit.
- Hospital discharges seen within 72-hours.

Pay for Performance Issues

- Criteria could be criticized as subjective and biased.
- Quality was difficult to define. The focus was changed to risk management; a concept much better accepted when correlated to poor outcomes.

Lessons Learned

- Processes needed to improve risk management and achieve high P4P scores often required more physician cooperation perceived as more work.
- After three P4P cycles, we noticed a performance plateau and decided to formulate an intervention.

2-Process Program

- We implemented a more specific 2-process program that would support continuous comprehensive care:
  - make risk management sense
  - measurable by the core criteria of the P4P program
  - and be accepted by the physician

2-Process Program
Process 1: Acute Care System

- The ACS is a registry of patients who needed continual care to ensure resolution of illness.

- The ACS is best managed by a licensed nurse, a radical suggestion for present practices who rely on medical assistants and front desk employees to triage patient calls.

Process 1: Applications

- Acutely ill patients who have a risk of declining while being treated.
- Chronically ill patients who are failing treatment and have difficulty recovering/coping.
- Patients who have a change in medical stability or are moving toward frailty.

Process 1: Applications

- For on-call encounters to keep track of progress post treatment.
- Discharged patients:
  - Hospital: 48-hours
  - SNF: 72-hours
  - ER follow-ups and OOSA patients

Process 2: Comprehensive Recovery Plan

- CRP used for all post hospitalization patients to be evaluated in the office within 72 hours of discharge
- Office visit includes:
  - Complete account of hospital stay
  - Specific diagnosis
  - Pharmacy adherence
  - Design of recovery plan
  - Subsequent visits
  - ACS intervention

Physician Survey Results

- Seven months after the 2-Process Program was started:
  - 70% physicians acknowledge that the ACS was an asset to the practice.
  - 81% noted a nurse was best for the position.
  - 44% wanted more assistance in perfecting the process.

Physician Survey Results

- 85% responded yes to performing a CRP on each hospitalized patient during the post hospital visit.
- 44% acknowledged value of the CRP.
- 33% wanted further assistance in perfecting the process.

Performance Scores

- The implementation of the two-process initiative (ACS & CRP) resulted in improved performance scores as measured by PIQ 4.

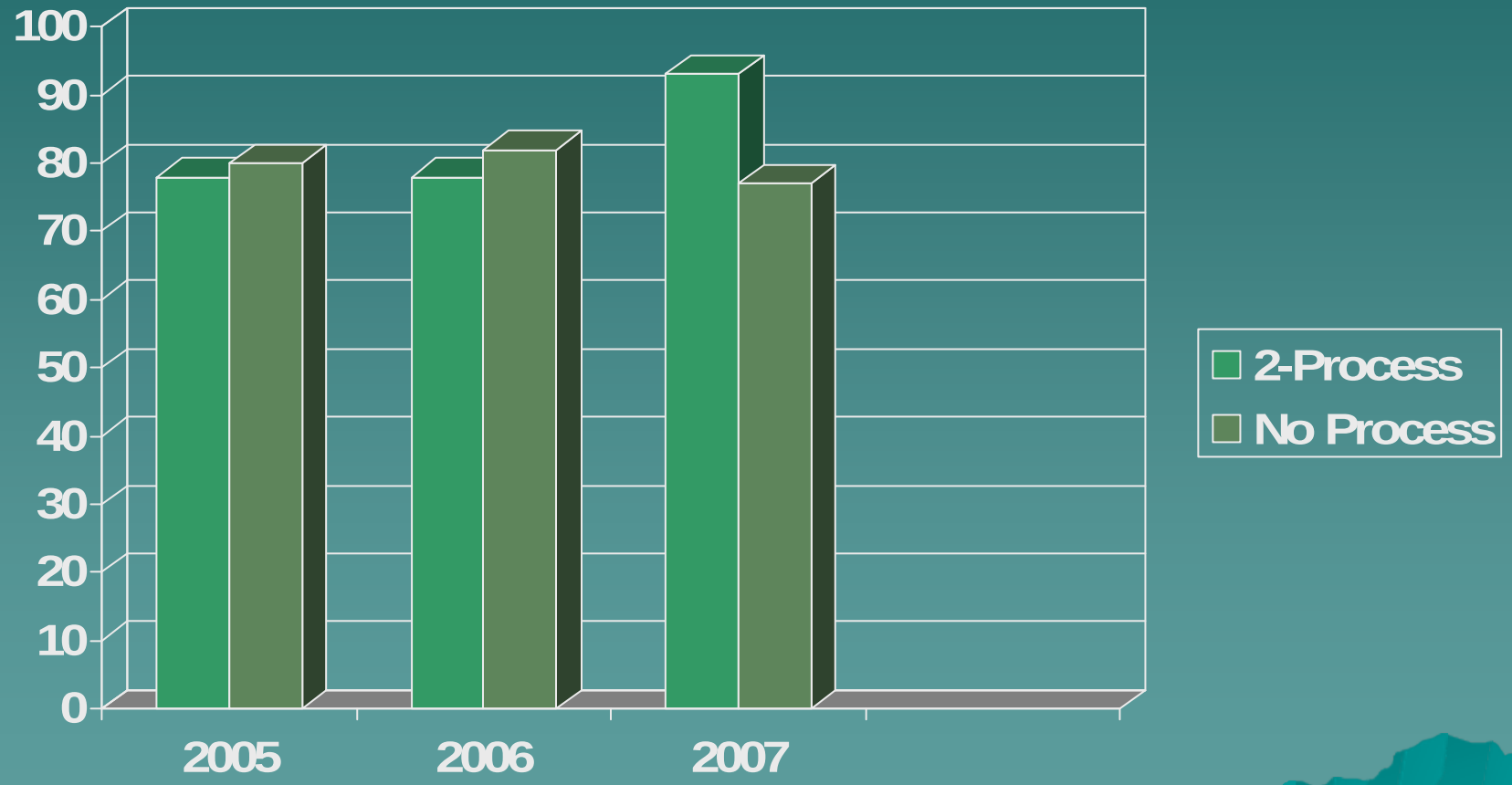
Performance Scores

- In retrospect, it provided a teaching tool, guiding the PCP to practice in a manner consistent with the PCMH, increasing their awareness of its effectiveness in improving:
  - pharmacy adherence
  - response to treatment/resolution of illness

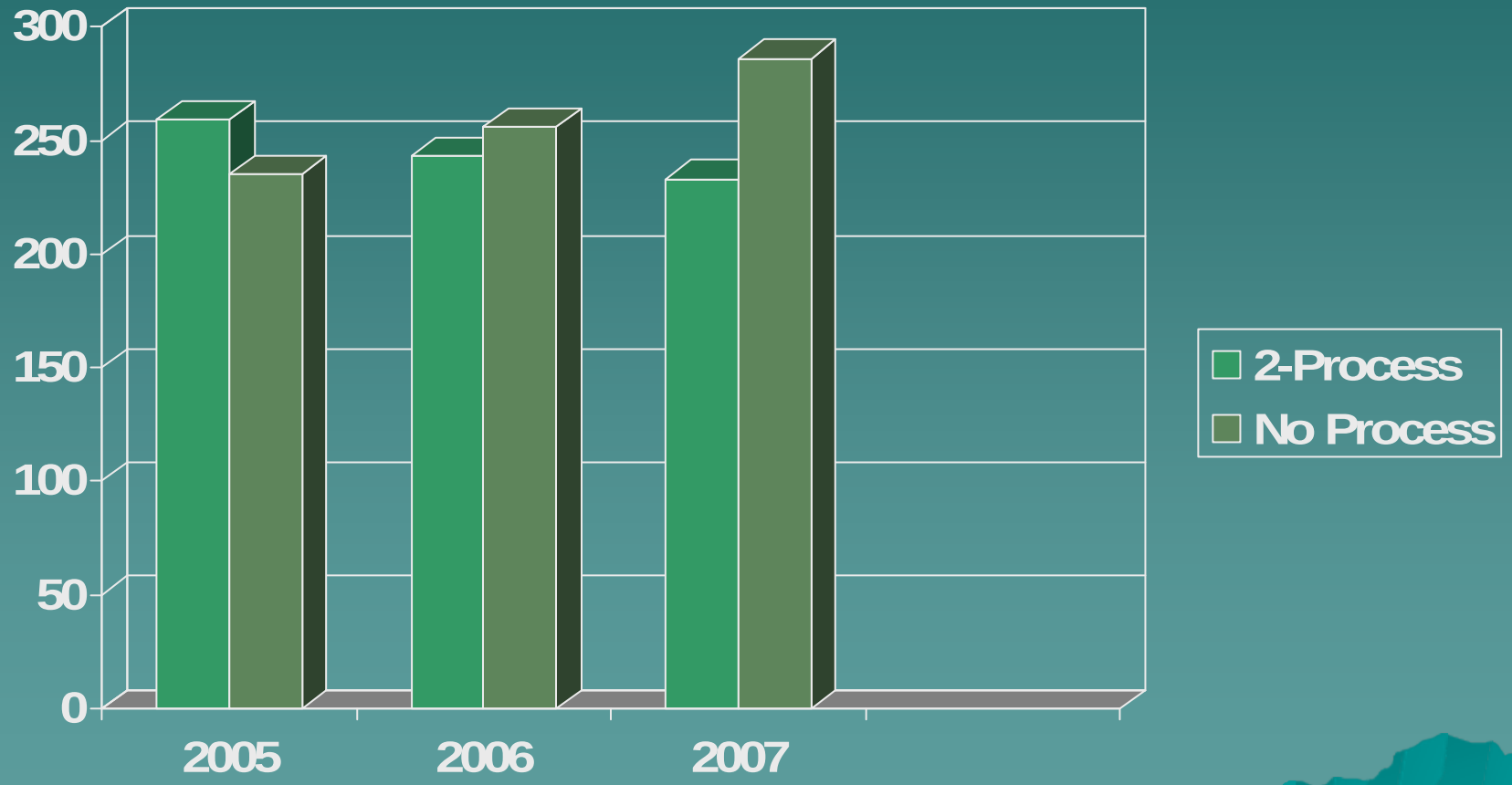
PIQ P4P Results

PCP	PIQ 2-3-4			Part A Expense $			Admits/K			MRA
	’05	’06	‘07	’05	’06	‘07	’05	’06	’07	
A	84	80	95	255	203	163	244	183	193	.96
B	75	78	93	270	238	245	295	270	234	1.39
C	74	75	91	253	288	291	297	324	277	1.23
D	73	81	73	237	293	308	264	279	289	1.02
E	87	84	82	208	219	260	229	229	261	.97
F	79	80	75	260	255	291	289	308	316	.95

PIQ P4P Scores

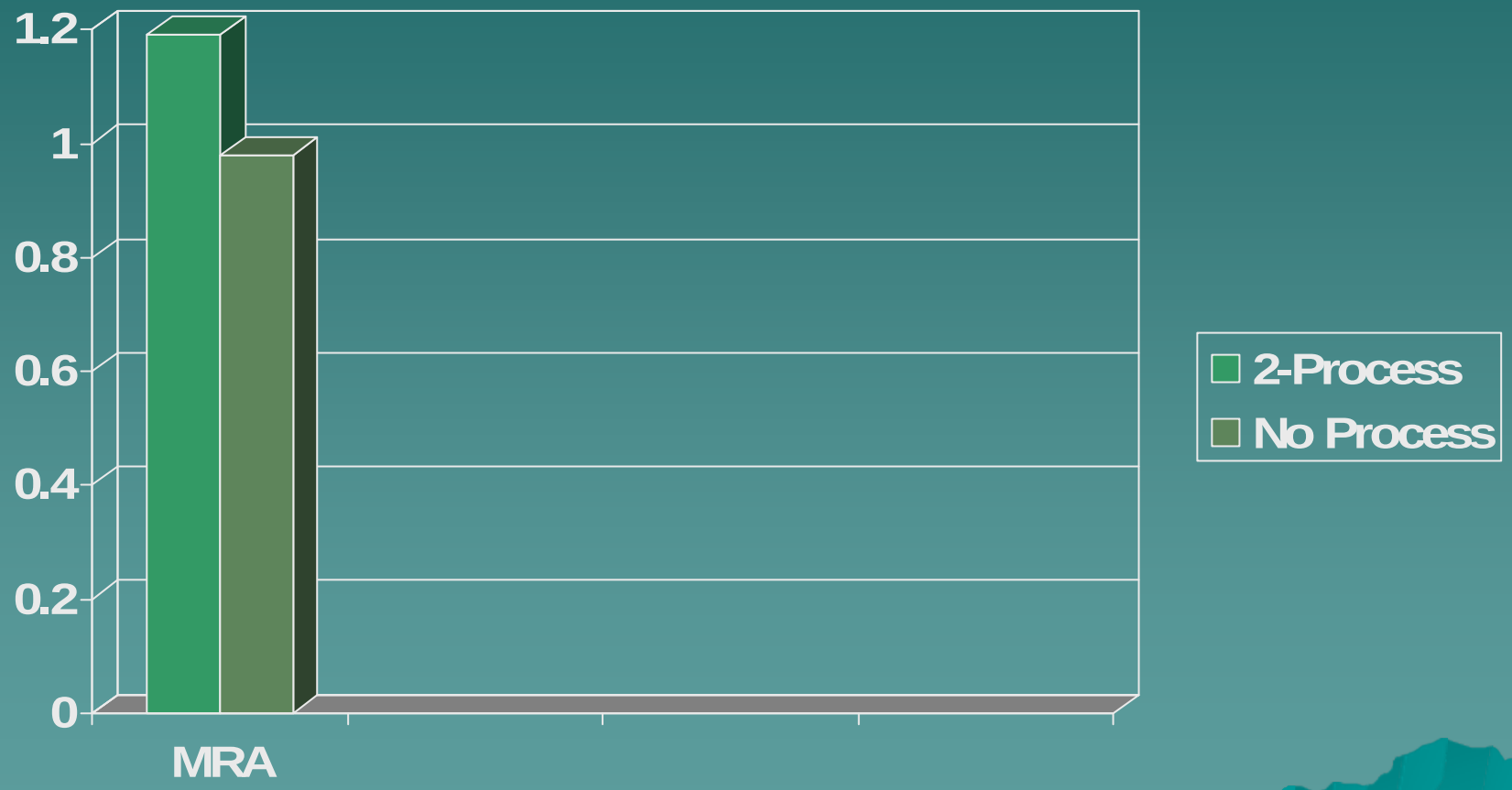


Part A Expense ($)



Admits/K

MRA Scores



Trends

- The data reveals several correlating trends:
  - Those who incorporated the principles had a higher PIQ score and a downward trend of A/K with decreased Part A expense.
  - The converse is also true.

Bonus

- A bonus effect of PIQ criteria compliance was:
  - more accurate Medicare Risk Adjustment scores (more premium)
  - increased percentage of patients seen monthly
  - increased patient and physician satisfaction

Reimbursement

- The average reimbursement in terms of Medicare equivalent for the PCP who qualifies for:
  - top tier = 147%
  - bottom tier = 107%
  - market average = 121%

Patient perspective of PCMH

December 7, 2007

Gentlemen:

Again, it is with great pleasure to praise your organization for doing an outstanding job in monitoring our health situations. We have been with you for over four years without a single complaint, which shows you must be doing something right.

Dr. B, is very thorough, understanding and takes his time explaining problems and medications. Rather rare in this day and age. Besides our physician, the people working for you are the backbone and deserve equal praise. Debbie, calling and looking over us like a mother hen, not just from 8:00 to 5:00, but when needed. Gloria, always smiling, helpful and very efficient. Christie on the ball with the referrals. Carol, your receptionist, is a pleasure to speak with, always informative, and never forgets a call. To all the rest of your wonderful group, we thank you.

Take care of them like a family, they really are what a health organization should be like.

Sincerely,