The Patient-Centered Medical Home Model of Care

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Louise Bryde
Principal

Stroudwater

Presentation Outline

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- Imperatives for Change
- Overview: What Is a Patient-Centered Medical Home?
- The Medical Neighborhood
- Impact of PCMH Practice Transformation
- PCMH Certification/Recognition Programs
  - NCQA Recognition
- Payment Mechanisms and Impact of MACRA
- Becoming a PCMH

Imperatives for Change – Why Implement a Medical Home Model of Care?

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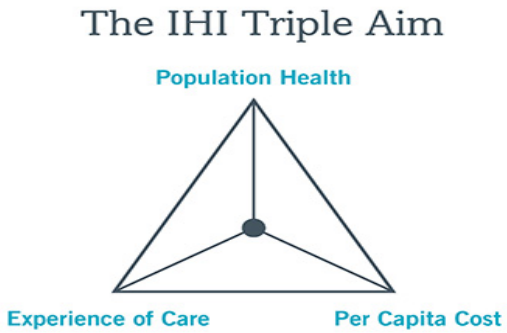
- Achieving the Triple Aim



  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care
- Increasing Focus on Primary Care
  - Serves as entry point into health care delivery system for most Americans
    - 55% of all medical office visits are for primary care*

* Source: "The Patient-Centered Medical Home's Impact on Cost and Quality - Annual Review of the Evidence 2014-2015"

Imperatives for Change (continued)

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- Rising Health Care Costs and Poor Clinical Outcomes
  - Traditionally episodic, fragmented, and uncoordinated care
  - Only 4-7% of healthcare dollars spent on primary care*
  - Total US spending for healthcare was $3.2 trillion in 2015, up 5.8% over 2014**
- Increasing Focus on Value vs. Volume of Care Delivery
  - Estimated 30% of total US healthcare spend can be attributed to overuse, underuse, and misuse of healthcare resources*

- Source: "The Patient-Centered Medical Home's Impact on Cost and Quality - Annual Review of the Evidence 2014-2015"
- ** Source: CMS.gov/research-statistics/ National Health Expenditure Data 2015; accessed May 10, 2017.

Overview: What Is a Patient-Centered Medical Home?

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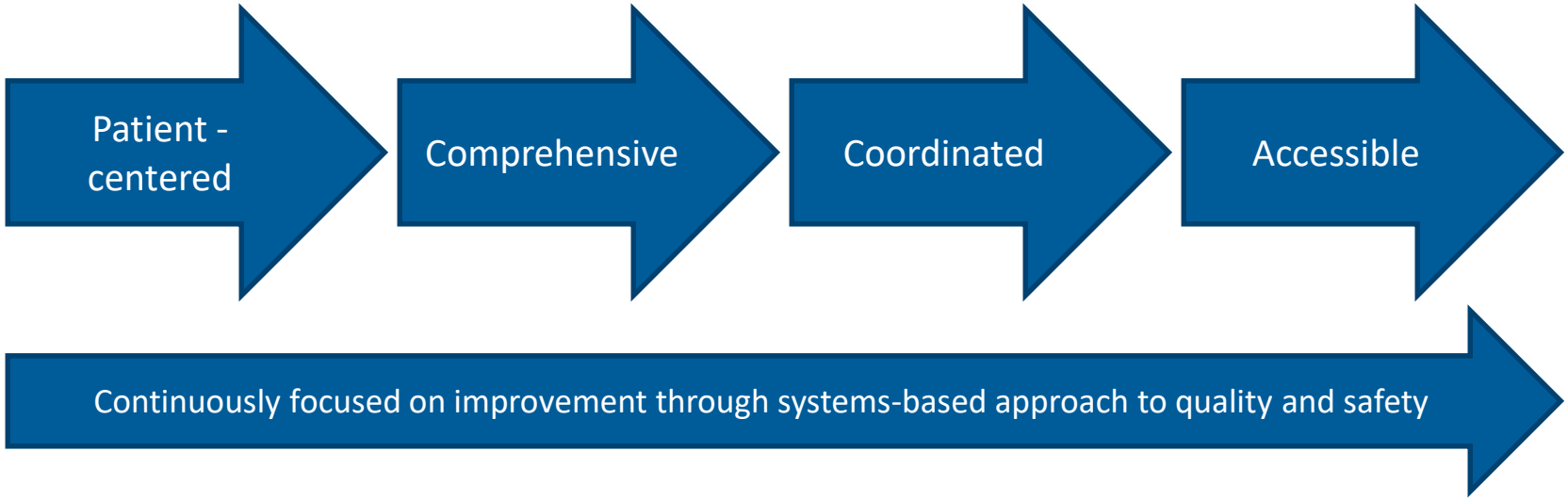
- Defined as "A team-based model of care led by a personal physician who provides continuous, coordinated care throughout a patient's lifetime, to maximize health outcomes." (American College of Physicians)
- The PCMH provides or arranges for all of the patient's healthcare needs, including:
  - Preventive care
  - Treatment of acute and chronic illnesses
  - Assistance with end-of-life care
- Key Building blocks: teamwork, leadership, communication, willingness to change

Core Components of a Patient - Centered Medical Home

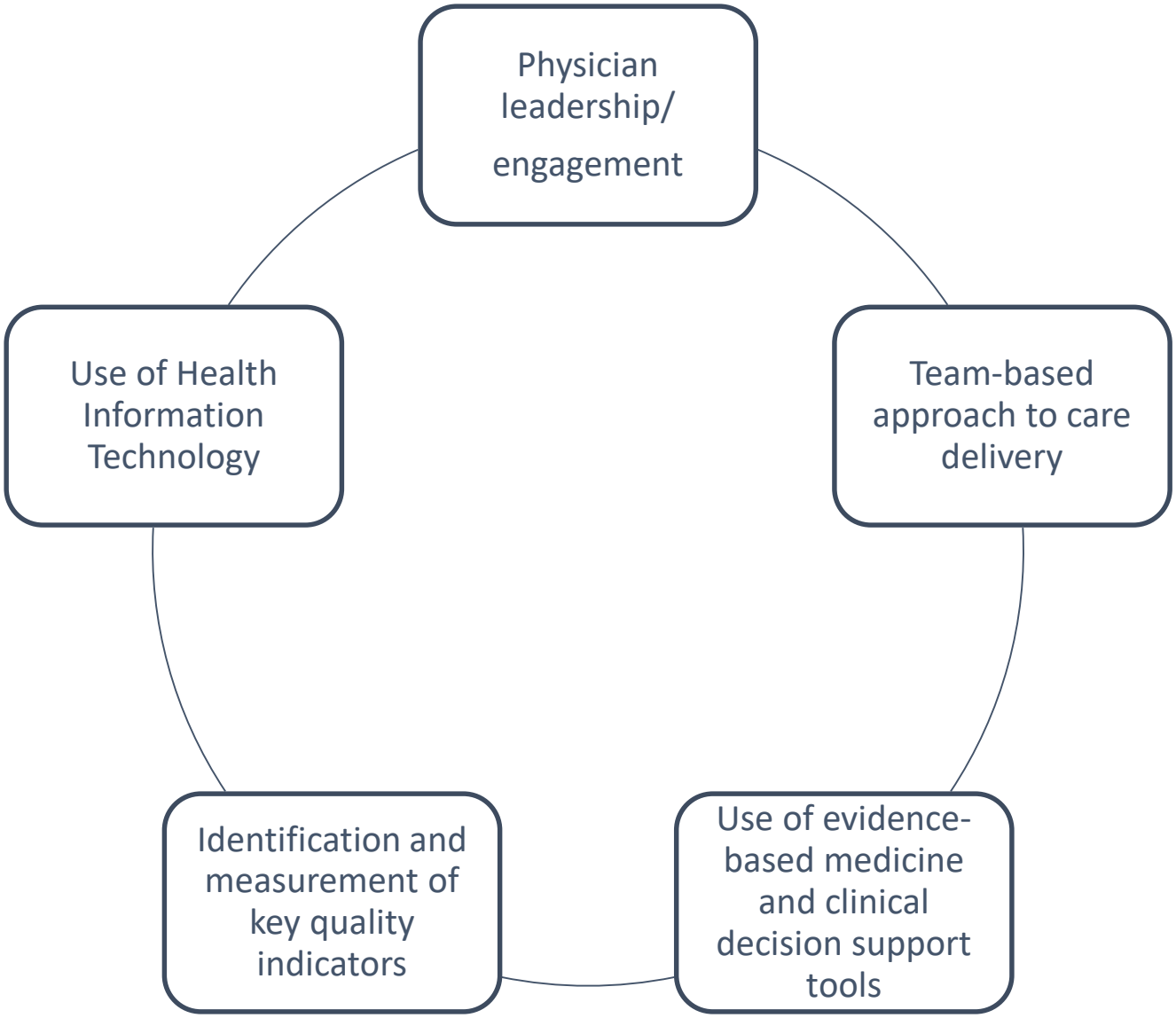
Transformation of care delivery to become a **model of primary care** delivering care that is:



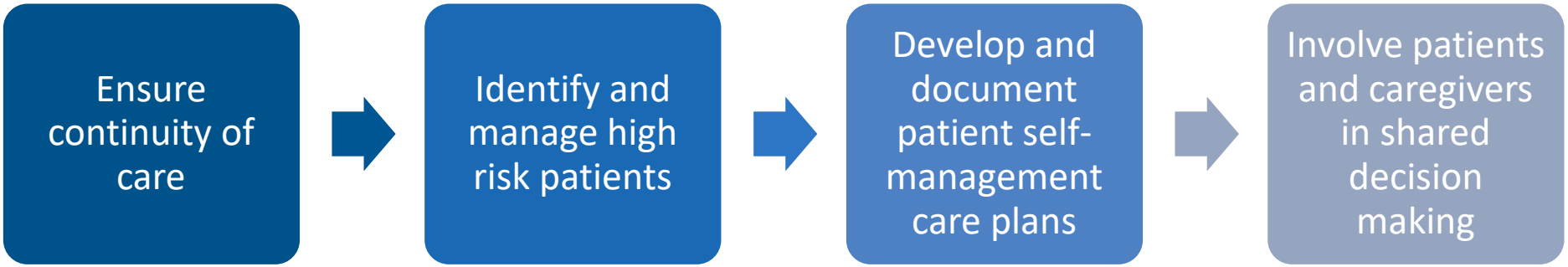
These core components track closely with NCQA's PCMH Recognition Standards.

Source: Agency for Healthcare Research and Quality- An agency within the Department of Health & Human Services committed to improving care safety and quality

Key Attributes of a PCMH



Characteristics of a PCMH



The Medical Neighborhood Model

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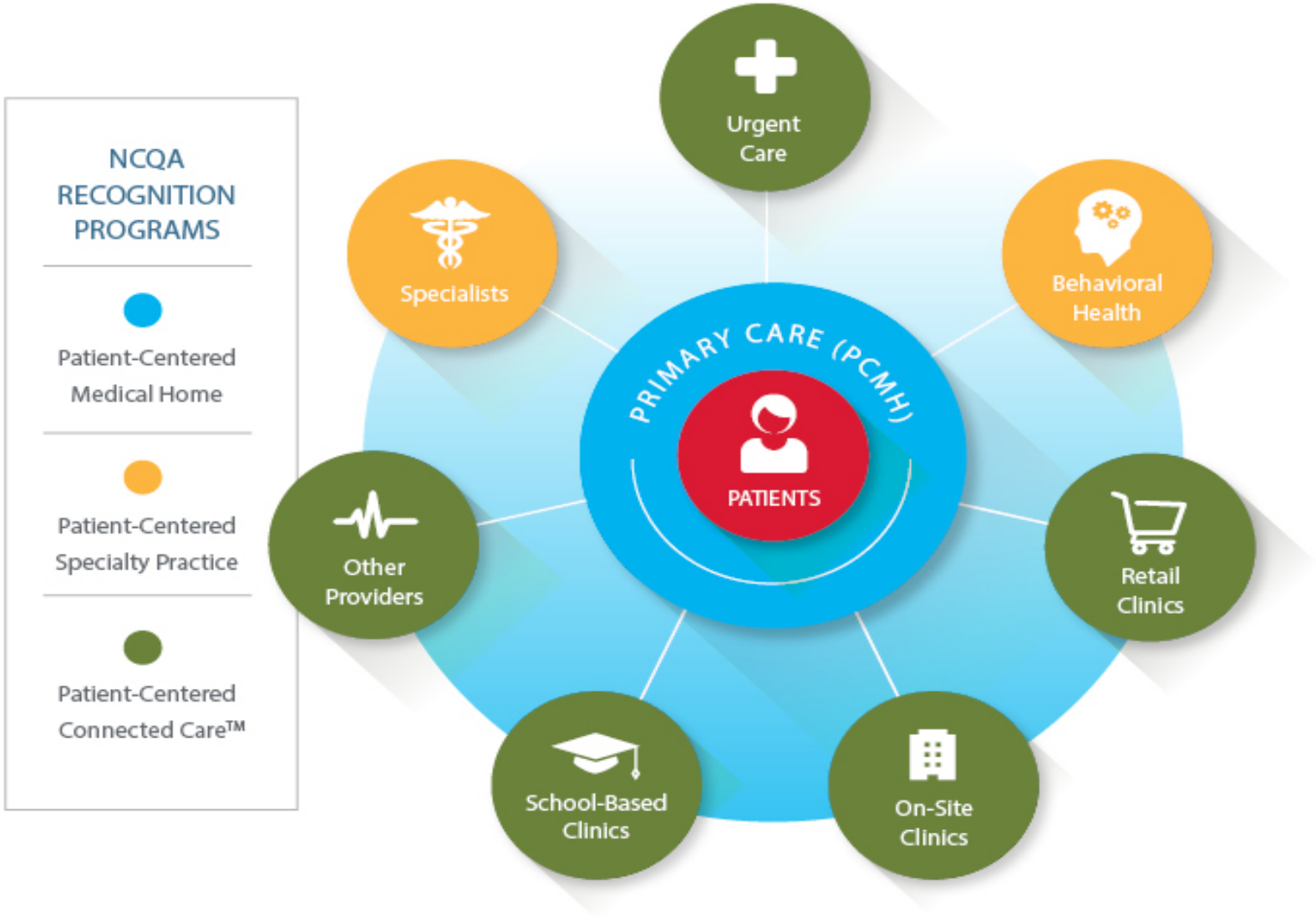

The Medical Neighborhood Model

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- The medical home model of care delivers whole-person care that is coordinated and tracked by one primary care provider. Providers outside of the medical home that connect with that primary care provider are vital partners to make the medical home neighborhood effective for patients.
- NCQA also has programs that recognize other types of practices that make up the medical home neighborhood. Since 2007, NCQA has added:
  - Patient-Centered Specialty Practice (PCSP) Recognition Program for specialty practices
  - Patient-Centered Connected Care™ Recognition Program for other ambulatory care sites, such as onsite employee health clinics, retail clinics, and urgent care centers
- These programs help facilitate team-based care by improving collaboration with primary care and recognizing practices that streamline and improve health care delivery

The Medical Neighborhood Model

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Aligns use of information technology to help providers support the Triple Aim and improve population health

Demonstrates a commitment to quality and quality improvement

Has been proven to reduce healthcare costs, especially for people with complex chronic conditions

Improves patient satisfaction

Supports “team-based care” that frees providers to work to their highest level of training

Source: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/why- pcmh/overview-of-pcmh/the-medical-home-neighborhood

Growth of the PCMH – Medical Neighborhood Model

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- As of March 2017, more than 12,000 primary care practices representing more than 60,000 clinicians have been recognized as medical homes by NCQA
  - 1 in 6 physicians now practice in an NCQA - Recognized PCMH
- 43 states have embraced the PCMH model
- 200 specialty practices, representing more than 1,200 clinicians, have achieved NCQA's PCSP Recognition
- Almost 50 sites are recognized under NCQA's Patient-Centered Connected Care Recognition Program

Source: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/why- pcmh/overview-of-pcmh/the-medical-home-neighborhood

Findings from the Patient-Centered Primary Care Collaborative February 2016 Annual Report

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- PCMH studies continue to demonstrate impressive improvements across a broad range of categories including cost, utilization, population health, prevention, access to care, and patient satisfaction, while a gap still exists in reporting impact on clinician satisfaction
- The PCMH continues to play a role in strengthening the larger health care system, including Accountable Care Organizations and the emerging medical neighborhood model
- Significant payment reforms are incorporating the PCMH and its key attributes

The Impact of PCMHs – Findings from the PCPCC February 2016 Annual Report

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- **21** of **23** PCMH studies that reported on cost measures found reductions in one or more measures
  - Lower PMPM costs
  - Lower total cost of care
- **23** of **25** PCMH studies that reported on utilization measures found reductions in one or more measures
  - Reduced ED utilization
  - Reduced inpatient hospitalization rates
  - Reduced specialist visits
- Multiple PCMH Initiatives have demonstrated improvements in chronic disease management and increased preventive health screenings
  - Diabetes and high blood pressure management
  - Breast and cervical cancer screenings

PCMH Payment Methodologies

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- ***Payment Innovation Models***
  - Enhanced Fee-for-Service (FFS)
    - Increased FFS payments to practices that are recognized and/or functioning as PCMHs
  - FFS with PCMH-specific billing codes
    - Practices can bill for new PCMH-related activities (i.e., care coordination)
  - Pay-for-Performance
    - Practices are paid more for meeting process measures (HEDIS), utilization targets (ED use, generic prescribing), and/or improving patient experience
  - Per-Member-Per-Month (PMPM) Payments
    - Practices are paid a capitated monthly fee in addition to typical FFS billing, often adjusted for PCMH recognition level or degree of care coordination expected

PCMH Payment Methodologies

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- ***Payment Innovation Models (continued)***
  - Shared Savings
    - Practices are rewarded with a portion of savings if the total cost of care for their patient panel increases more slowly than a preset target and quality thresholds are met
  - Comprehensive or Population-based Payment
    - Partial or complete risk for total cost of care (risk adjusted), to include new models of “direct primary care”

PCMH and MACRA

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- **What is MACRA?**
  - The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaces the Sustainable Growth Rate (SGR) formula for Centers for Medicare and Medicaid Services (CMS) Medicare payments to clinicians for beneficiaries in the traditional Medicare program
  - Under MACRA, Medicare will pay physicians and other clinicians for how well they meet patients' care needs, not just how many services they provide
- **How does MACRA impact clinician payment?**
  - Beginning in 2019, clinicians will receive payments through either the new Merit-based Incentive Payment System (MIPS) or Alternative Payment Models (APMs)
  - Majority of clinicians will receive payments through MIPS
  - 2019 payment will be based on what clinicians are doing and reporting in 2017

PCMH and MACRA

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- **How does MACRA impact clinician payment? (continued)**
  - Clinicians in MIPS will receive bonuses or penalties to their fee-for-service payments based on measures in four areas
- Becoming an NCQA-Recognized PCMH or PCSP directly increases clinicians' payments through MIPS
  - Clinicians in NCQA-Recognized PCMHs or PCSPs automatically get full credit in the MIPS **Clinical Practice Improvement Activities** (CPIA) category
- Clinicians in NCQA-Recognized PCMH and PCSP practices will likely do well in the other MIPS categories:
  - **Quality Measures:** NCQA's PCMH and PCSP programs increase the use of high-value care, including prevention and chronic care management, and actively promote quality improvement that will be reflected in MIPS quality measures

PCMH and MACRA

- **Advancing Care Information:** Recognition emphasizes coordination of care and the use of HIT to share care information
- **Resource Use Measures:** A growing body of scientific evidence shows that the PCMH model is saving money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes

➢ **APMs** - the proposed MACRA rule also rewards clinicians in APMs with NCQA Recognized PCMHs and PCSPs

- Clinicians in NCQA PCMHs and PCSPs get automatic full CPIA credit
- Having more PCMH and PCSP clinicians in an APM automatically gives all of that APM's clinicians higher MIPS scores

Source: http://www.ncqa.org/public-policy/macra/the-medicare-access-and-chip-reauthorization-act-of-2015-macra-and-ncqa

Becoming a PCMH

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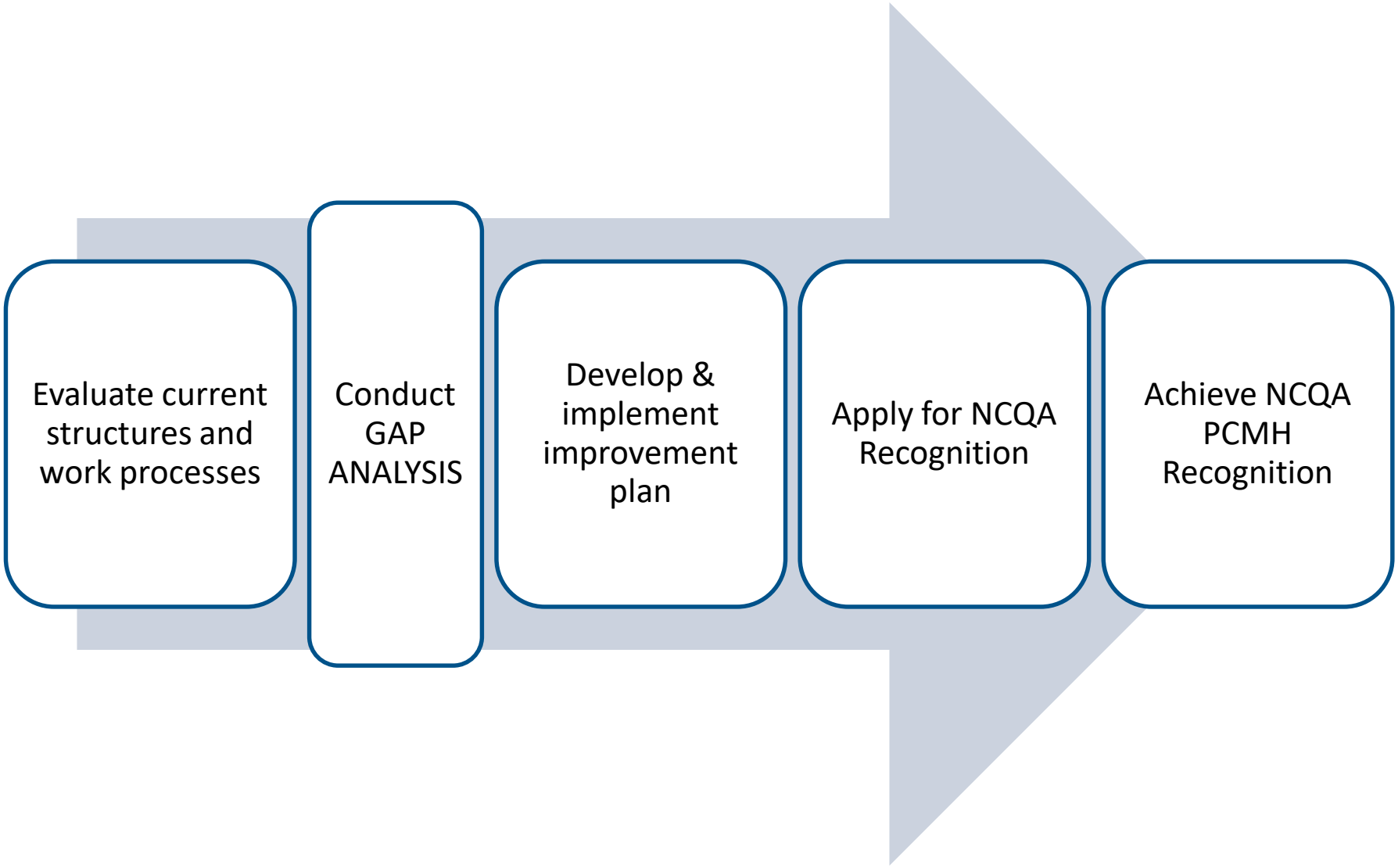

NCQA's PCMH Recognition Program

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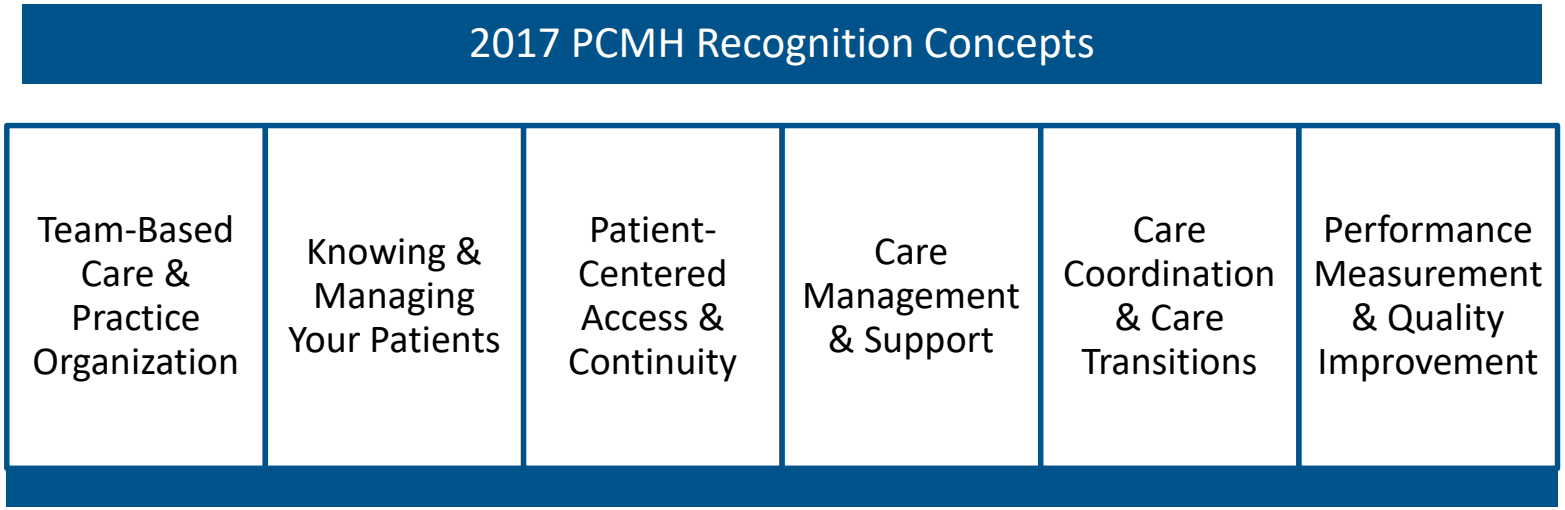
- The National Committee for Quality Assurance (NCQA)'s Patient-Centered Medical Home Recognition Program provides a roadmap for physician practices working to improve care delivery and the experience of care for both patients and clinicians



  - To achieve recognition, a practice must meet all core criteria and earn 25 credits in elective criteria across five of the six PCMH Concepts

NCQA's PCMH Recognition Application Process

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- Revamped Recognition Program and application process effective April 2017
  - Q-PASS- NCQA's new online PCMH application platform
- Practices are assigned to an NCQA Representative/NCQA Evaluator for assistance throughout the application process
- *PCMH Policies & Procedures* and *Standards & Guidelines* provide extensive guidance, evidence requirements, and relevant examples to Practices seeking PCMH Recognition
- Renewal: annual reporting and review process after initial PCMH Recognition

Questions and Discussion

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