Medical Homes & Health Homes: The Search for Coordinated Care

June 7, 2013

David Ivers
Mitchell Blackstock Ivers & Sneddon
1010 W. Third St.
Little Rock, AR 72201
501 519-2072
divers@mitchellblackstock.com

Medical Homes and Health Homes: What's the difference?

- Medical Homes are led by PCPs – "patient centered Medical Home" or PCMH
- Health Homes are led by community or "neighborhood" providers (Developmental Disabilities, Behavioral Health, Long-Term Care)

Medical Homes – Key Attributes

- 24/7 access
- Evidence-informed care
- Providers with responsibility for a practice's entire population
- Coordinated and integrated care across multidisciplinary provider teams
- Focus on prevention and management of chronic disease
- Referrals to "high-value" providers
- Wellness and preventative care

Health Homes – Key Attributes – cont.

- Develop and adjust integrated care plan
- Coordinate among providers
- Encourage adoption of a healthy lifestyle and support individuals in self-management plans
- Coordinate care during transitions
- Serve as an advocate and educator to individuals and their families
- Serve as or be a part of a comprehensive resource center
- Utilize health information technology to fulfill duties

Gainsharing for Medical Homes

"Upside only cost-sharing"

Two methods:

- Receive shared savings based on your own performance
- Receive shared savings based on being a high performer relative to other PCMHs in the state

For both methods:

- Risk adjusted
- Must meet quality metrics for gain sharing (and for $1 PMPM fee, according to RFQ)
- Must meet min. 5,000 patient panel size – per payer

Gain Sharing – Virtual pooling

- To meet the 5,000-patient threshold for gainsharing, you have 3 options:
  - Qualify through you own practice, if large enough
  - Join together with other practices you choose
  - State will place you in a “virtual pool”

Payment for Medical Homes

- Ave. $4 PMPM for care coordination and general practice investment (amt. may vary greatly dep. on risk adjustment)
- $1 PMPM for practice transformation – if use pre-qualified vendor

Hypothetical: A PCP with 2,000 Medicaid patients could receive up to $120,000 a year in PMPM payments

– but practice must pay for transformation

Payment for Health Homes

- Amount TBD
- Likely to be PMPM + Gainsharing similar to PCMHs but min. 5,000 patient threshold could be a problem

Timetable

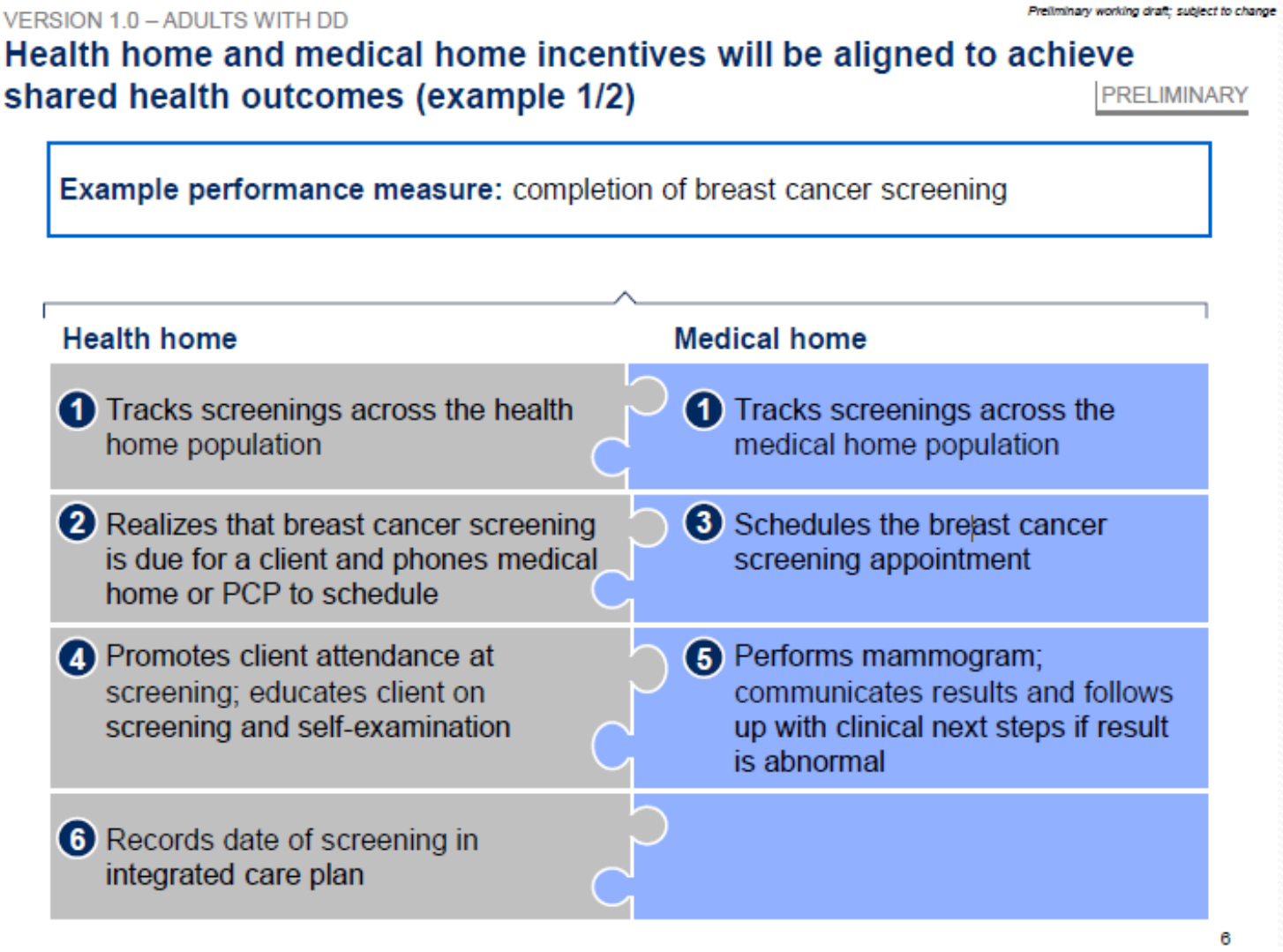
Approach		Timing	Wave (Description)
Population-based models	PCMH	2Q 2012 – 3Q 2012	1 69* CPC enrolled practices, 228 providers, 100k+ Arkansans
		3Q 2013 – 3Q 2014	2 Target voluntary enrollment of ~30% practices
		3Q 2014 – 3Q 2015	3 Target enrollment of remaining primary care practices
	Health Homes	1H 2013 – 1H 2014	1 All LTSS and adult DD providers (children follow 6-12 months)
		2H 2013 – 2H 2014	2 Voluntary enrollment for eligible BH providers
		2H 2014 – 2H 2014	3 Enrollment of remaining eligible BH providers

- *69 physician practices already participating in the "Comprehensive Primary Care Initiative" – a four-year multi-payer medical home initiative

Does it make sense to have both?

- DHS views combined PCMH-Health Home model as opportunity to incentivize both PCPs and community providers to coordinate care for high-needs individuals in long-term services and supports (LTSS)
- *"The Health Home complements the Medical Home: the Medical Home will continue to retain responsibility for diagnosis treatment, and referral, while the Health Home will help to ensure the populations …receive proper follow-up, treatment adherence, and communication between providers, individuals receiving services, and their families." –DHS*

Does it make sense to have both?



Does it make sense to have both?

VERSION 1.0 – ADULTS WITH DD

Preliminary working draft; subject to change

Health home and medical home incentives will be aligned to achieve shared health outcomes (example 2/2)

PRELIMINARY

Example performance measure: blood pressure control (hypertension)

Health home	Medical home
1 Promotes client attendance at annual wellness visit	2 Measures blood pressure (BP) and diagnoses client with hypertension; prescribes medication therapy and diet changes; schedules follow up visit
3 Educates client on hypertension and dietary changes Documents BP, medication and instructions in integrated care plan; communicates changes to all relevant providers Promotes adherence to medication and dietary changes	4 Measures BP in follow up session and seeks qualitative input from health home; recommends changes as necessary

7

Too much of a good thing?

- CMS raising duplicate payment issue
- To complicate matters – DHS has issued RFQ for care coordination vendors who would be required to do what Health Homes are supposed to do
- Too much care coordination can be as bad as too little

When in doubt issue an RFQ

- DHS has released 2 RFQs to support PCMHs
  - Care coordination
  - Practice transformation

Seeking 2-3 private companies to become “pre-qualified” vendors.

Expect physician practices to use PMPM payments to hire the vendors.

Care Coordination Vendors

- Must "hire, train, and deploy care coordinators who will deliver service on-site at least once per week"
- Must serve practices in every county
- Must offer services regardless of payer pool
- Must offer "standard service package" at $3 PMPM or less per provider
- May offer "enhanced service packages" that exceed $3 PMPM
- May offer "standalone or piecemeal services" at less than $3 PMPM

Care Coordination Vendors – cont.

- Must use standard fee schedule
- Must use standard menu of services
- May negotiate "shared upside contracts"
  - Vendors forego a portion of fixed fees in exchange for a predefined percentage of any PCP shared savings.

Vendor's fixed fee cannot exceed total PMPM fees, which vary by practice's population mix.

Practice Transformation Vendors

- Practices must contract with practice transformation vendor to receive the $1 PMPM fee, which is paid to the vendor (along with any additional amount negotiated)
- "Practice transformation is the set of approaches, capabilities, and tools needed to transform how a practice works, including the process of re-envisioning itself as a medical home and making the innovations and investments to realize the goals of the medical home."

Practice Transformation Vendors—cont.

- Conduct assessments to understand the progress that practices have made towards PCMH goals
- Train practice leaders how to build and administer a financially sustainable and solvent PCMH practice
- Coach practice leaders in population health approach
- Train practices to develop strategies to improve care of high-risk subpopulations
- Train practices on how to make structural changes in practice workflows to meet PCMS goals
- Train practices in health IT
- Improve collaboration, communications, and transitions of care within the practice and with other providers
- Engage practices in learning collaboratives, medical neighborhoods, etc.
- Help practices increase patient responsibility

Practice Transformation Vendors – cont.

- Other requirements similar to those for care coordination vendors, but must hire "practice transformation coach" who will conduct at least one in-person visit/mo.

Practice Transformation Vendors – cont.

- Must offer "standard service package" at $1 PMPM or less per provider
- May offer "enhanced service packages" that exceed $1 PMPM
- May offer "standalone or piecemeal services" at less than $1 PMPM
- May negotiate "shared upside contracts"

Observations and Implications

- Heavy investment of DHS time and money in the PCMH, very little so far in the Health Homes
- With private option, Medicaid will revert to primarily a program for poor disabled and elderly – the prime targets of Health Home model
- State will either have to resolve conflict between its PCMH and HH models, or merge them
- Laudable goal to have one integrated treatment plan, but we are a long way from making that happen with patients who are DD, Aging, Physical Disabilities, and Behavioral Health
- Health IT is big problem – physicians responsible for coordinating with these community providers who are much farther behind on HIT
- Without improved HIT, much of this will not be possible

Observations and Implications – cont.

- Appears likely that physicians will have few if any PMPM fees left over if they use the pre-qualified vendors
- Practices will have to decide if they can do it on their own or not, and if so, will they save any money?
- State envisions 3 year cycle for the RFQ vendors, and then presumably practices will have learned the needed skills
- Possible that state will eventually do away with PCMH/HH fees or collapse them into "episode" payments