REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-12

Subject: Medicaid Patient-Centered Medical Home Models

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Referred to: Reference Committee G
(Jerry D. McLaughlin, II, MD, Chair)

At the 2011 Annual Meeting, the House of Delegates adopted Policy D-160.938 (AMA Policy Database), which asks that the American Medical Association (AMA) "study Medicaid patient-centered medical home models including pregnancy medical home models and report back." The Board of Trustees assigned the requested study to the Council on Medical Service.

This report outlines relevant AMA policy; highlights the Community Care of North Carolina patient-centered medical home (PCMH); provides examples of other state Medicaid PCMH models, including a pregnancy medical home model; and presents recommendations. The Council believes that this report accomplishes the study called for in Policy D-160.938 and accordingly recommends that the directive be rescinded.

BACKGROUND

State budget deficits and increasing numbers of Medicaid enrollees have heightened stakeholder concerns about ways to increase value for physician services provided under Medicaid. Community Care of North Carolina (CCNC) is a working example of how states might implement a physician-led Medicaid PCMH model to improve access, quality and outcomes while reducing costs. Independent analysis shows that CCNC generated cost savings of nearly $1 billion in the past three years.

Although there is no standard definition of a medical home, the AMA adopted a set of broad principles to guide the development and implementation of medical homes (Policy H-160.919) in 2008. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association originally developed these principles to emphasize the patient-physician relationship, physician leadership of a care team and physician responsibility for care coordination, supported by other qualified providers. The policy promotes a voluntary recognition process for medical homes and supports integrated care across all elements of the health care system. It advocates for quality and safety, patient-centered outcomes, evidence-based decision making, physician engagement in achieving medical outcomes and utilization of information technology. The policy also advocates access to care through systems such as open scheduling, expanded hours and new options for communicating with patients. It supports physician payments that reflect the value of care management work outside of the face-to-face visit, includes bonuses for measurable and continuous quality improvements and provides a structure for shared savings. Furthermore, Policy H-160.919 can be used as a guide for developing a Medicaid PCMH model.

COMMUNITY CARE OF NORTH CAROLINA

CCNC broadens access to care through networks of physicians, hospitals, local health and social service departments. Within each network, Medicaid beneficiaries are linked with physicians who agree to provide around-the-clock availability for an enhanced fee. Each network uses payments from the state to provide clinical and non-clinical staff to coordinate the care of each Medicaid beneficiary. Networks also facilitate physician-directed disease and care management programs to manage high-cost, high-risk patients. To accomplish these tasks and improve quality within the program, physicians and providers access a state-run "clearinghouse" of all data relevant to patient care.

The CCNC model is consistent with many components of Policy H-160.919. Regarding the personal physician, each CCNC beneficiary has an ongoing relationship with a physician trained to provide first contact and comprehensive care around-the-clock, seven days a week. Physicians educate their patients to call them before seeking emergency department care. In addition, physicians are paid fees to enhance care coordination and address complex patient case mixes. The state Medicaid office pays physicians 95 percent of Medicare rates and an additional care management payment to improve disease management and quality ($3 per-member per-month [PMPM] and $5 PMPM for special high-risk and high-cost patients). The state also pays bonuses for achieving measurable quality improvements.

CCNC acknowledges the importance of integrated delivery with 14 non-profit and physician-led networks comprised of physicians, hospitals and local health and social service departments. Each network is responsible for disease management education, transitional support, and data collection on process and outcome measures. To assist in care management efforts, the state also pays the network a management fee ($3 PMPM or $5 PMPM for elderly or disabled enrollees) to hire enhanced care management staff (e.g. case managers, psychiatrists and pharmacists). CCNC also stresses physician leadership in coordinating patient-centered outcomes-based care. Case managers help physicians identify high-risk or high-need patients, assist with disease management education and follow-up and collect performance measurement data. Also consistent with Policy H-160.919, each medical home in the network shares a medical director who designs and helps implement quality improvement initiatives in CCNC practices.

Furthermore, consistent with the information technology principle of Policy H-160.919, CCNC uses the state's Informatics Center, a clearinghouse of all information relevant to patient care, to complement the medical home. The Informatics Center allows physicians to access real-time information on beneficiary hospitalizations, emergency department visits and provider referrals. In August 2010, CCNC released a provider portal designed to improve patient care and care coordination for the state's Medicaid beneficiaries. Through the portal, physicians, hospitals and other agencies may access care team contact information and claims histories for all visit and pharmacy orders for their Medicaid beneficiaries.

North Carolina contracted with actuarial firm Milliman, Incorporated, to assess whether CCNC is achieving cost savings. The Milliman study showed that from 2007 to 2010 the savings attributable to the program was $984 million. To determine the costs, Milliman calculated the observed costs for CCNC members and non-members, adjusted them to reflect an equivalent health status and then attributed the remaining cost differences to the managed care efforts (Milliman, Inc., December, 2011).

ADDITIONAL STATE MEDICAID PCMH MODELS

Currently, states are implementing at least 30 Medicaid medical home demonstration projects, and much of the information regarding the success of these programs is emerging. The Council notes two examples, Oklahoma and Colorado that include similarities to CCNC and highlight other innovations.

Oklahoma: SoonerCare Choice

In January 2009, with input from physicians, the Oklahoma Health Care Authority converted SoonerCare Choice, its Medicaid managed care program, to a budget-neutral Medicaid medical home. Prior to 2009, SoonerCare Choice included partial capitation payments that were made regardless of whether beneficiary visits occurred. The program failed because it did not increase the value for SoonerCare Choice providers to see patients.

In its redesign of SoonerCare Choice, Oklahoma developed a payment mechanism that would not only stimulate practice transformation, but also improve beneficiary outcomes. Physician payments are based on four types of fees, including a one-time payment to transition from capitation to fee-for-service (based on 100 percent of Medicare), tiered PMPM fees ranging from $3 to $9 depending on the patient mix, enhanced payments for around-the-clock access and information technology use, and pay-for-performance payments based on the provision of certain services.

Unlike CCNC, Oklahoma coordinates care through a large stand-alone state agency, Oklahoma Health Care Authority (OHCA), which has 450 clinical and medical employees. OHCA hires nurse care managers and social service coordinators, who focus on care management for high-risk and high-cost beneficiaries with intensive in-person services. OHCA also hires practice coaches who typically spend two weeks onsite with physician practice staff to help them identify practice strengths and areas for improvement. Both OHCA and CCNC provide practice coaches or facilitators, one-time transition fees and assistance with or direct provision of electronic health records.

According to OHCA, from 2008-2010, costs under Medicaid decreased $29 per-patient-per-year. In addition, more than 244 new physicians have enrolled in Medicaid and patient inquiries related to same-day/next-day appointment availability decreased from 1,670 inquiries to 13 in a one-year period (Health Affairs, July 2011). A 2010 survey of adult SoonerCare Choice enrollees showed an increase in the number of patients reporting that they received timely treatment.

The Colorado Medical Home

Colorado implemented a PCMH program for low-income children enrolled in the state's Medicaid program and Children's Health Insurance Program (CHIP). To qualify as a medical home, primary care practices must provide around-the-clock access or a way to conveniently schedule appointments and provide care coordination. As with CCNC and SoonerCare Choice, the Colorado payment model includes supplemental PMPM payments. Colorado pays bonuses for achieving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) metrics. By 2010, 96 percent of Colorado pediatricians accepted Medicaid, whereas only 20 percent of pediatricians accepted Medicaid before the initiative.

The Colorado Department of Health Care Policy and Financing determined that the median annual cost of care for PCMH children was $785 compared to $1,000 for children not enrolled in PCMHs.

In Denver, an evaluation specifically examining children with chronic conditions showed that PCMH enrollees had lower median annual costs ($2,275) than those not enrolled in PCMH practices ($3,404). Of the children in a PCMH, 72 percent had well-child visits, compared to 27 percent of children in the non-PCMH group.

MEDICAID PREGNANCY MEDICAL HOMES

Policy D-160.938 specifically asks the AMA to study pregnancy PCMH models. The Council focused its study on the North Carolina pregnancy PCMH and highlights the Centers for Medicare and Medicaid Service (CMS) "Strong Start" initiative.

Medicaid plays a major role in improving maternity care and birth outcomes by financing the cost of nearly 40 percent of all US births. In 2009, the cost of Medicaid neonatal intensive care stays in North Carolina was more than $223 million for 21,000 claims, according to unpublished data from the North Carolina Division of Medical Assistance. To reduce health care costs and improve access and quality, Medicaid pregnancy medical homes target riskier pregnancies among the Medicaid population.

The Medicaid Pregnancy Medical Home (PMH) of North Carolina leverages the medical home concept developed by the CCNC. Each pregnancy PCMH is locally managed through joint agreements between local providers, CCNC and the local health department or case management group. Case managers are paid on a PMPM arrangement with incentives for effectively coordinating care. Success is based on outcome-driven metrics such as lowering the primary C-section rate to 20 percent or less, administering the hormone 17 alpha hydroxyprogesterone caproate (17P) in the treatment of premature labor, and limiting elective induction of labor before the 39th week of gestation (North Carolina Medical Journal, July 2011). Unpublished financial projections from the North Carolina Division of Medical Assistance estimate $15 million in savings for fiscal year 2012 and $9.9 million in savings for fiscal year 2013. Savings generated from the program are used to pay North Carolina obstetrical providers a higher Medicaid rate.

Strong Start

In February 2012, CMS announced "Strong Start," a four-year initiative to test and evaluate prenatal care interventions for women with Medicaid coverage who are at risk for having pre-term births. The program aims to expand access to care, improve care coordination and provide a broader array of health services. In addition to traditional prenatal care, the program offers enhanced prenatal care including psychosocial support, education and health promotion. Physicians and other obstetric care providers, state Medicaid agencies, managed care organizations and other health care entities are eligible to apply.

RELEVENT AMA POLICY

In addition to the broad principles articulated in Policy H-160.919, several other AMA policies provide guidance for use by physicians and states. For example, Policy D-165.966 supports giving states new options to improve coverage for patients with low incomes, including working with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop state-based options for improving health insurance coverage for lower income persons. Policy H-160.918 urges assistance for physician practices seeking to qualify for medical home status with financial and other resources, and advocates for adequate incentive payments paid with system-wide savings.

Several policies support physicians, states and state medical associations in implementing payment and delivery reforms tailored to the needs of their state or region. Policies D-390.961[3], H-160.915 and H-200.955 emphasize that the process to transform health care payment and delivery must be physician-led and should encourage an environment of collaboration among physicians. Policy H-465.982 supports resources to assist state associations in dealing with managed competition in rural areas. Policy D-390.961[5] supports local innovation and funding that best fit local needs.

CHALLENGES

Physicians and states interested in implementing Medicaid PCMHs face several challenges, including, but not limited to, difficult budget conditions, uncertain costs, complex recognition standards and workforce shortages. As states continue to address difficult budget conditions, they are also implementing the Patient Protection and Affordable Care Act (ACA, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152), which envisions new roles for Medicaid and for states. Under the ACA, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty, resulting in a large adult expansion in most states. States should consider the adequacy of their provider networks and anticipate whether their managed care organizations have the capacity to handle significantly more Medicaid enrollees.

States also face uncertainty regarding the costs of the program. In its study of CCNC, Milliman noted the difficulty of estimating the impact of managed care efforts, such as those provided by CCNC, given that beneficiaries receive more primary care services and prescription drugs, which have associated costs.

Similarly, physicians face substantial start-up costs such as systems investments, cultural changes and financial uncertainty. The estimated cost for practices to implement the medical home is $100,000, with an additional $150,000 in ongoing expenses (Deloitte Center for Health Solutions, 2008). Beyond monetary costs, Medicaid programs may choose to adopt multiple highly specific and somewhat burdensome PCMH recognition standards (e.g., accreditation by the National Committee for Quality Assurance or The Joint Commission). Some physician practices may need to invest significant time and unknown resources to adhere to such complex standards.

States also should be aware that by 2025, the shortage of physicians is estimated to reach 130,600 and the shortage of registered nurses is expected to reach 260,000. Physicians and state medical associations should be integrally involved in workforce planning efforts. Furthermore, in some states Medicaid is experiencing a shortage of specialty physicians, and medical home efforts should determine how to best structure delivery and payment innovations to broaden specialty access.

DISCUSSION

Despite a number of challenges, the Council is highly optimistic about the value of the medical home concept. Patients enrolled in Medicaid PCMH programs receive several benefits including same-day appointments, after-hours access, coordinated disease management, ongoing health education and shared decision-making about their care. A physician-led care coordination team is one of the greatest strengths of the PCMH model. PCMH physicians benefit from better information flow among physicians and providers, resulting in fewer medical errors and duplicative efforts. Furthermore, Medicaid PCMH physicians provide enhanced care to all of their patients, not just to those enrolled in the PCMH.

North Carolina, Oklahoma and Colorado have successfully experimented with the Medicaid PCMH models. Common PCMH elements include patient access to around-the-clock care, leadership by active and creative physicians, and payment arrangements that fairly and effectively reflect costs associated with care coordination. Several factors contributed to the success of North Carolina's CCNC program including sustainable funding, low start-up costs, strong physician leadership, state-supported health information technology, minimal reliance on external recognition standards and other environmental factors. Given these examples of various medical PCMH models, physicians, state legislatures and patients and their advocates should determine what is meaningful and relevant to their state. A "one-size-fits-all" approach can not be successfully applied to implement PCMH models.

Therefore, the Council encourages physicians, state medical association and states to consider factors including, but not limited to, state budget challenges, upfront costs, requirements developed by various PCMH "recognition" entities, workforce shortages. Consistent with Policies H-465.982, D-390.961[5], H-200.955 and H-160.918[2], the Council supports physicians, states and state medical associations implementing payment and delivery reforms to address such concerns.

The Council recognizes the importance of providing relevant information that will help states implement new ways to improve access and quality while controlling costs in Medicaid. Accordingly, the Council recommends that the AMA work with states to implement Medicaid PCMH models based on the unique needs of the physicians and patients in their states.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of this report be filed:

1. That our American Medical Association (AMA) recognize that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs. (New HOD Policy)

2. That our AMA work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states. (New HOD Policy)

3. That our AMA rescind Policy D-160.938. (Rescind HOD Policy)

Fiscal Note: Less than $500.

References for this report are available from the AMA Division of Socioeconomic Policy Development.