

## The Patient-Centered Medical Home for the Medicaid Population

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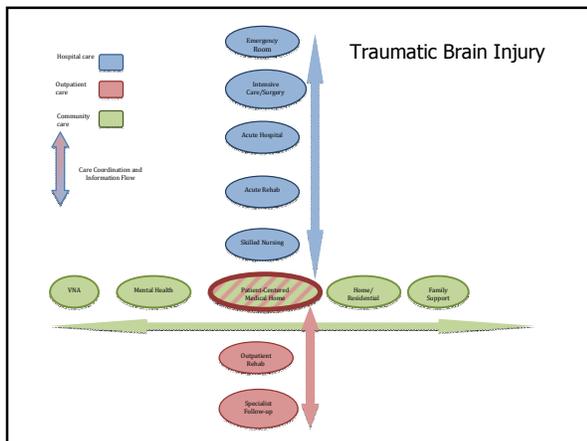
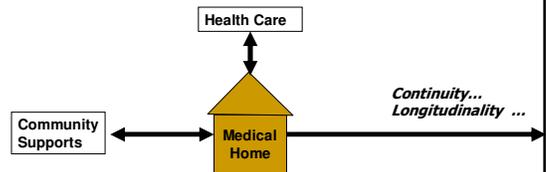
## Patient-Centered Medical Home

- What's a patient-centered medical home?
- Why is having a PCMH important to Medicaid members and to the Medicaid population?
- What is needed to ensure a PCMH for Medicaid members?



## The Patient-Centered Medical Home ...positioned at the crossroads of care

- Vertically – among health care systems/specialists/other providers
- Horizontally – among community agencies/mental health
- Continuously – across providers, settings, episodes of care, services
- Longitudinally - over time



## What's different about a PCMH?

### Traditional PC model

- Reactive
- Provider-centric
- Encounter-based care
- Provider delivered care
- Limited access
- Process > outcomes
- Results = patient-focused

### PCMH

- Proactive, anticipatory
- Patient-centered
- Coordinated, integrated care
- Team-based care
- Right care, right time
- Outcomes > process
- Results = population-focused



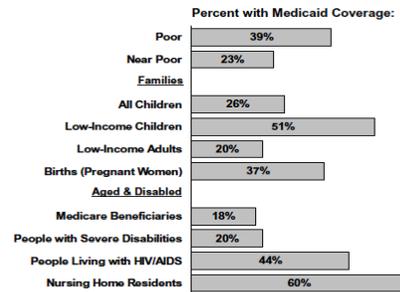
## Necessary Medical Home functionalities

- Empanelment – known relationship with patients and families
- Access – evening, weekends, holidays, same day, electronic
- Proactive, health promotion
- Co-management with specialists – explicit, clear
- Coordination of care and services
  - Vertically and horizontally
- Management of transitions in care
- Integrated, high quality information systems
- Family engagement in care and improvement



## Value of PCMH for Medicaid population

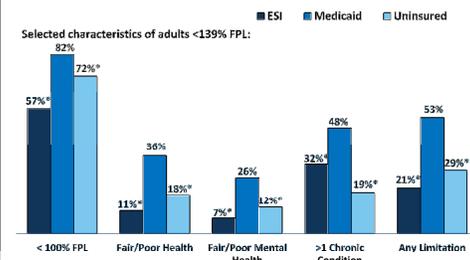
### Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was \$19,207 for a family of four in 2004. SOURCE: KCMU, KFF, and Urban Institute estimates, Birth data: NSA, MCH Update.

## Value of PCMH for Medicaid population

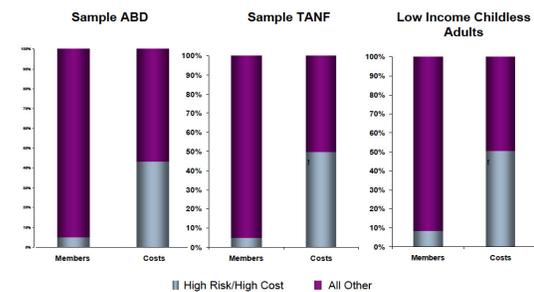
Figure 2  
Adults with Medicaid are both poorer and sicker than low-income adults with private health insurance.



\*Difference from Medicaid is significant at .01 level.  
SOURCE: Coughlin T et al., What Difference Does Medicaid Make: Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults, Kaiser Commission on Medicaid and the Uninsured, May 2013, Appendix Table 1, data from 2003-2009 MEPS.

## Value of PCMH for Medicaid population

### All Populations: Small Group → Poor Outcomes and Higher Costs



## Value of PCMH for Medicaid population

- **A small group of members drive a large portion of cost**
  - ~5% of members → ~50% of cost of care
- **Typical profiles**
  - Chronic diseases, multiple co-morbidities, co-morbid SMI/SA
- **Members not utilizing care efficiently**
  - Social Supports are often lacking - stable home, transportation
  - Multiple providers, settings, and levels of care
  - Healthcare is uncoordinated - health home not existent or not engaged
  - Unnecessary ER use, ACS hospitalizations/readmissions
  - Poly-pharmacy
  - Difficulty engaging in conventional DM
- **Reducing uncoordinated care reduces costs, improves quality**

## Value of a PCMH for Medicaid population

- Ability to track and coordinate care
- Ensure needed services
- Reduce duplication of services
- Ensure completion of referral processes
- Reconcile medication usage
- Ensure connection with needed resources
- Reduce unplanned utilization of ER and hospital
- Reduce hospital readmissions



### Value of a PCMH for Medicaid population

- Access
  - Expanded hours
  - Patient portals
  - Care coordinators and health coaches
- Chronic condition management
  - Registries
  - Evidence based protocols
- Population health
  - EHRs and registries
  - Performance measures



### MEDICAL HOME FERVOR



### Ensuring PCMH for Medicaid population

- Robust definition with functionalities to produce desired outcomes
- Ability to identify high quality PCMHs
  - Fully functional
  - Partially functional
  - Foundational
- Availability of technical help or coaching
- Adequate and appropriate compensation



### Ensuring PCMH for Medicaid population

- Definition and identification
  - Standard PCMH recognition processes exist
    - NCQA – PCMH recognition
    - CMHI – Medical Home Index
      - Adopted as national measure by CHIPRA project
    - Joint Commission, others
  - Some states have created their own process
    - Minnesota, Colorado, Oregon
- Required of all primary care settings in network
  - Allow for tiered recognition
  - Allow for movement



### Ensuring PCMH for Medicaid population

- Identified sources of coaching or assistance
  - Larger systems have internal capacity
  - Community health centers have experience and skills
  - Independent, small practices often lack support
- Payment reforms that reflect value of PCMH
  - Traditional encounter-based payments
  - PMPM administrative fee based on PCMH level or tier
  - Performance incentives based on population processes and outcomes in place



## PCMH – continuing discussion

- Today
  - PCMH – the Keene experience
    - Improved patient care & population health at reduced cost
- October 3
  - Integrating behavioral health and the PCMH
- November 7
  - Integrating service systems for populations with the most complex needs
    - A Health Home model in Nashua



## Confusing labels...

- Medical Home  $\neq$  Health Home
  - Well, not usually – but sometimes it can



## Health Home – according to ACA

- Delivers a defined set of six services
- To Medicaid beneficiaries with specific chronic health or mental health conditions; or dually eligible individuals
- By a designated provider, team of health professionals, or health team
- Could be provided by a primary care medical home, but may involve a larger team or a non-traditional health care setting

