



Delivering on the Promise of the PCMH: Reducing Avoidable Emergency Department Use and Hospitalizations

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A New Era in American Healthcare: Realizing the Potential of Reform

- Health reform has the potential to help usher in a new era in American health care
- Potential -- Ambitious agenda for better access, improved quality, and greater efficiency in the U.S. health system
- Old Paradigm:
 - Fee-for-service rewards volume of services, high occupancy, hospital admissions, specialized services; undervalues primary care
 - Siloed provision of services; hospitals and physicians independent
 - Financial solvency requires limiting provision of uninsured services and patients
- New Paradigm:
 - Emphasis on primary care; patient-centered medical homes
 - Value-based purchasing and bundled payment reward quality, reduced hospitalization and readmissions, and evidence-based care
 - Accountability for patient outcomes requires coordination of care across settings and providers; hospitals and physicians interdependent
 - Reaching out and serving low-income and uninsured communities is the new market growth area



Affordable Care Act: Delivery System Change

Triple Aim of Better Population Health, Better Care Experiences and Slower Cost Growth



Four Health Reform “Game Changers”

- **Affordability provisions**
 - **Income-related assistance with premiums and medical bills; essential benefits; Medicaid expansion**
- **New federal insurance market rules**
 - **Restrictions on underwriting, minimum medical loss ratio requirements, review of premium rate increases, and important consumer protections**
- **New health insurance exchanges**
 - **Lower administrative costs and more choice of affordable health plans for eligible individuals and small businesses**
- **Provider payment and delivery system reforms**
 - **Investment in primary care capacity**
 - **Patient centered medical homes**
 - **Bundled acute and post-acute care payment**
 - **Accountable Care Organizations**
 - **CMS Innovation Center and Independent Payment Advisory Board**



Opportunities in the Affordable Care Act for Federally Qualified Health Centers

- **Eleven billion dollars provided over five years to expand the federally qualified health center (FQHC) program beyond amounts previously appropriated**
- **New teaching health center grant program to support new or expanded primary care residency programs at FQHCs**
- **Loan forgiveness for pediatric subspecialists and mental or behavioral health service providers working with children and adolescents in a federally designated health professional shortage area, medically underserved area, or areas with a medically underserved population.**
- **Training/workforce development, including demonstration grants for family nurse practitioner training programs supporting providers in FQHCs.**
- **Grants to FQHCs to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers.**
- **Essential health benefits requirement for insurance plans offered in the new health insurance exchanges will ensure that networks of preferred providers include FQHCs, and that payments by qualified health plans to FQHCs are at least as high as the payments under Medicaid.**
- **New prospective payment system for Medicare-covered services furnished by FQHCs, including preventive services, with \$400 million in expected additional revenues for health centers.**



Additional Provisions that Strengthen Primary Care

- Medicare 10% primary care bonus, 2011-2016**
- Medicaid primary care reimbursement increased to Medicare levels, 2013-134**
- Incentives for patients to obtain preventive care**
- State option to enhance reimbursement to primary care practices for Medicaid patients with chronic conditions**
- Innovation Center: medical home pilots a priority**
- Grants/contracts to build capacity of medical homes:**
 - Community-based collaborative care networks for low-income patients**
 - Community Health Teams increasing access to coordinated care**
 - Primary Care Extension Center program**



Center for Medicare & Medicaid Innovation

- **Beginning this year, new center in CMS to test innovative payment and service delivery models to reduce spending while preserving or enhancing quality of care**
- **Expanded authority to innovate and spread**
- **Selection based on evidence of population health focus**
 - **Emphasis on care coordination, patient-centeredness**
- **Could increase spending initially**
 - **Over time must improve quality without higher costs, reduce spending without reducing quality, or both**
- **Secretary can expand duration and scope**
- **Two projects focus on medical homes:**
 - **Enhanced payment to FQHC medical homes**
 - **Medicare joining Medicaid, multi-payer initiatives**

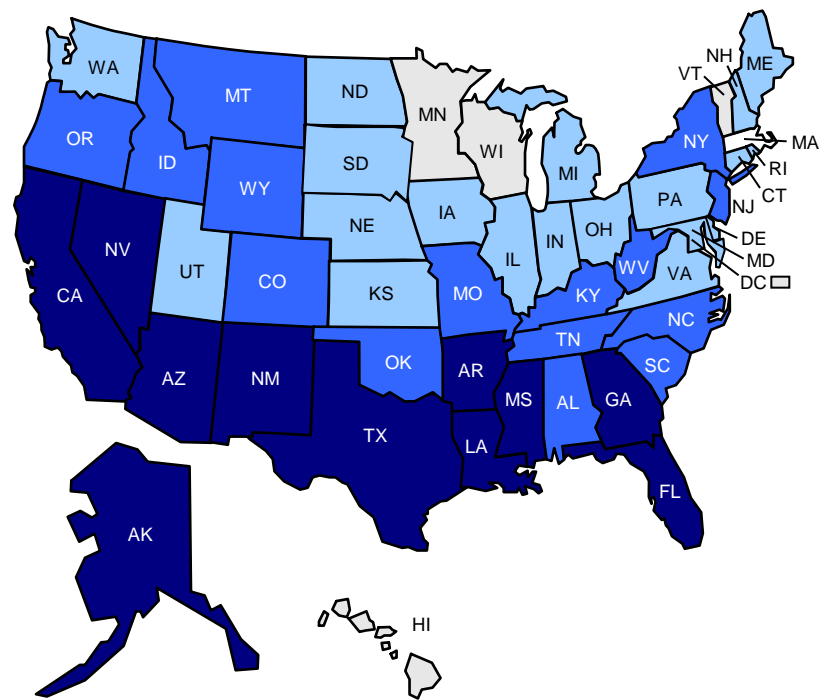


Impact of the Affordable Care Act on Patients and Providers

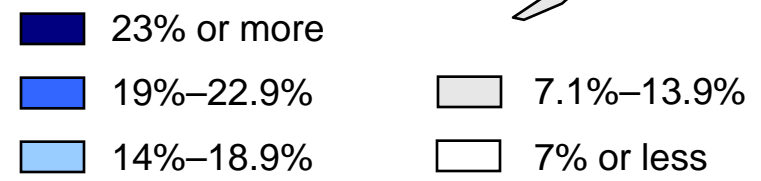
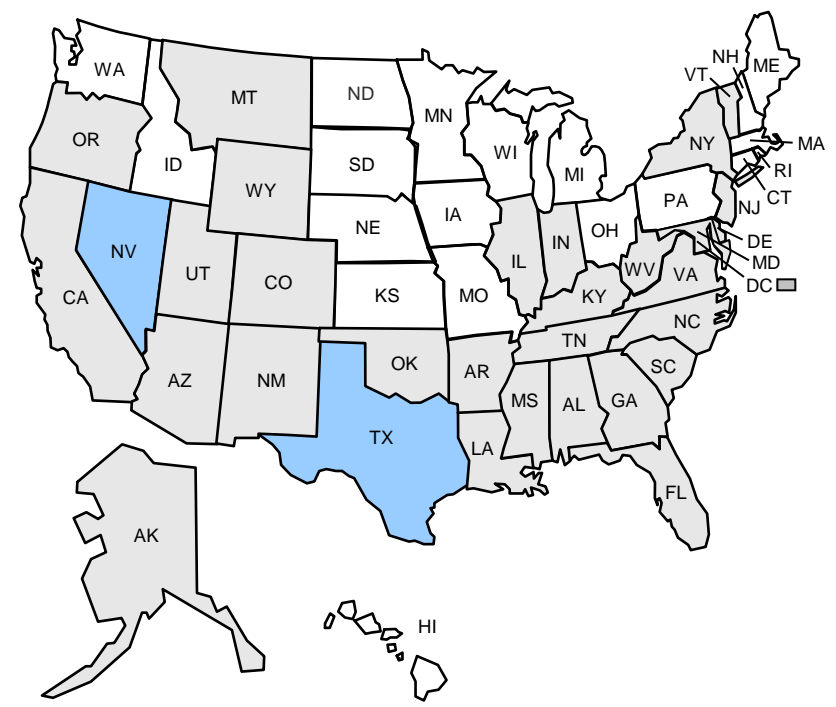


Estimated Impact of ACA on Uninsured Rate Among Adults Ages 19–64, 2008–09 and 2019

2008–09



2019 (estimated)



Data: U.S. Census Bureau, 2009–10 Current Population Survey ASEC Supplement; estimates for 2019 by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund. Source: Commonwealth Fund State Scorecard on Child Health System Performance, forthcoming 2011.



Impact of Selected Provisions on Safety Net Patients and Clinics

- **Additional \$8.3 billion paid to primary care physicians accepting Medicaid reimbursement (2013-2014). Impact will vary by state. E&M services will increase:**
 - **Pennsylvania:** 61 percent **Idaho:** No change
 - **Colorado:** 15 percent **Massachusetts:** 28 percent
 - **Oregon:** 28 percent
- **No copayment for preventive services for nearly 40 million Medicaid enrollees in 2013 and up to another 16 million new Medicaid beneficiaries in 2019**
- **Starting in 2011, as many as 10 million Medicaid patients with at least one chronic condition could have a “health home” to help manage their condition.**
- **An estimated 8 million newly eligible Medicaid beneficiaries with at least one chronic condition could have a health home by 2014**
- **The ACA and the “Stimulus Package” will support the training of more than 16,000 new primary care providers over the next five years**
- **Doubling of federally qualified health centers (FQHCs)**
- **15 to 25 million more people are expected to have access to care at community health centers (FQHCs)**



Why Safety Net Clinics Should Seize Opportunities in Health Reform to Become Medical Homes

- **Results from medical home pilots consistently show:**
 - **Better clinical quality for patients**
 - **Improvements in patient experience**
 - **Improvements in clinician/staff satisfaction**
 - **Opportunity for enhanced reimbursement as “medical homes” or “health homes”**
 - **Opportunity to share in savings due to reduction in ED use, hospitalizations and practice of evidence-based care**



Why Reductions in ED Use Matter

- **ED visits have been steadily rising, increasing nearly 20% in a decade to 115.3 million annually in 2005**
- **As many as 50% of all ED visits could have been avoided by care in other settings**
- **The average cost of an ED visit is \$580 more than the cost of an office health care visit**
- **Reducing ED overuse represents an estimated \$38 billion opportunity**



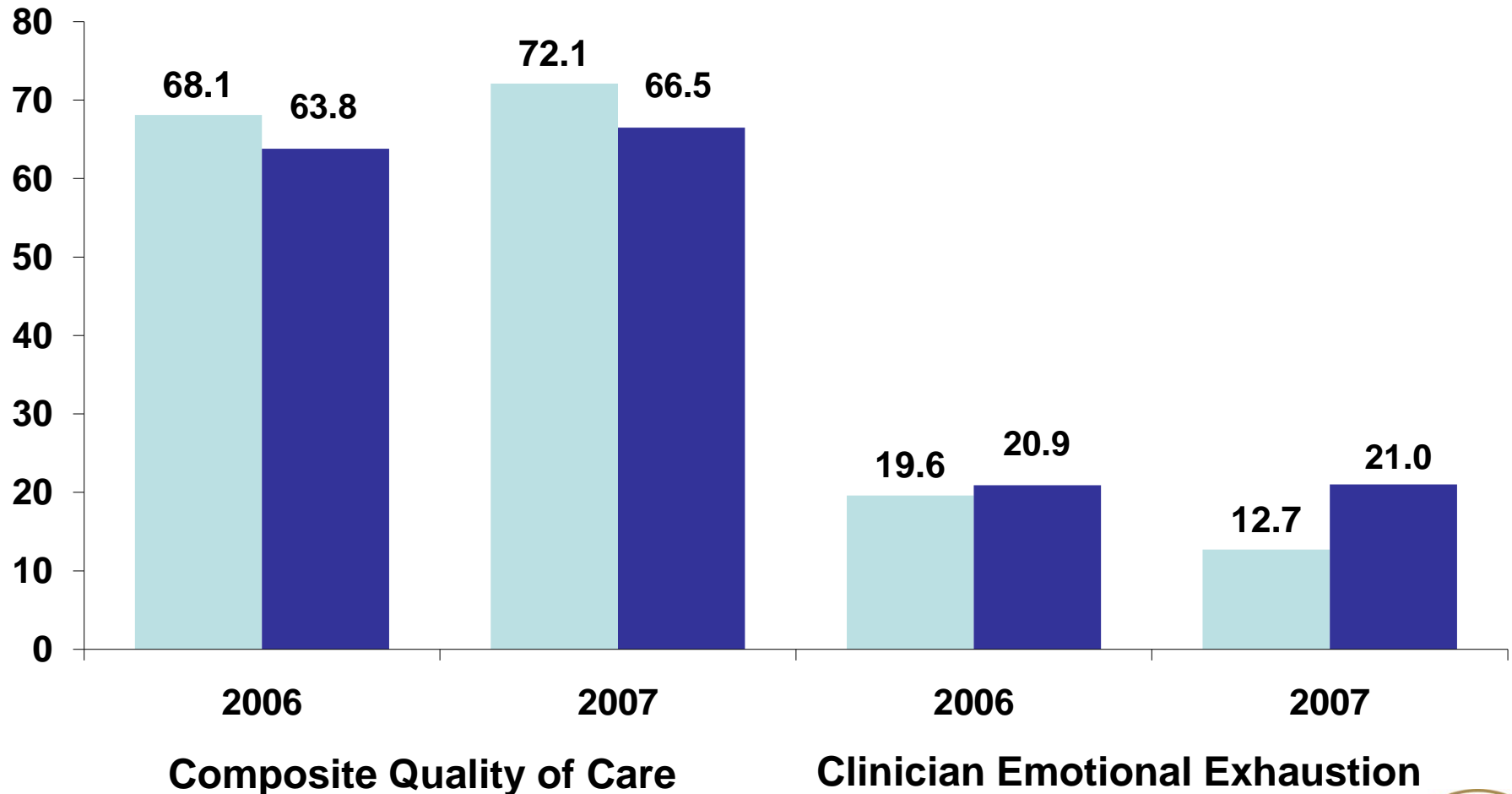
Evidence that Patient-Centered Medical Homes Can Improve Quality, Increase Efficiency and Promote Equity in Health Care



Group Health Cooperative: Comparison of Clinical Quality and Staff Burnout at the Patient-Centered Medical Home Site and Comparison

Clinics, 2006 to 2007

■ PCMH Clinics ■ Control Clinics



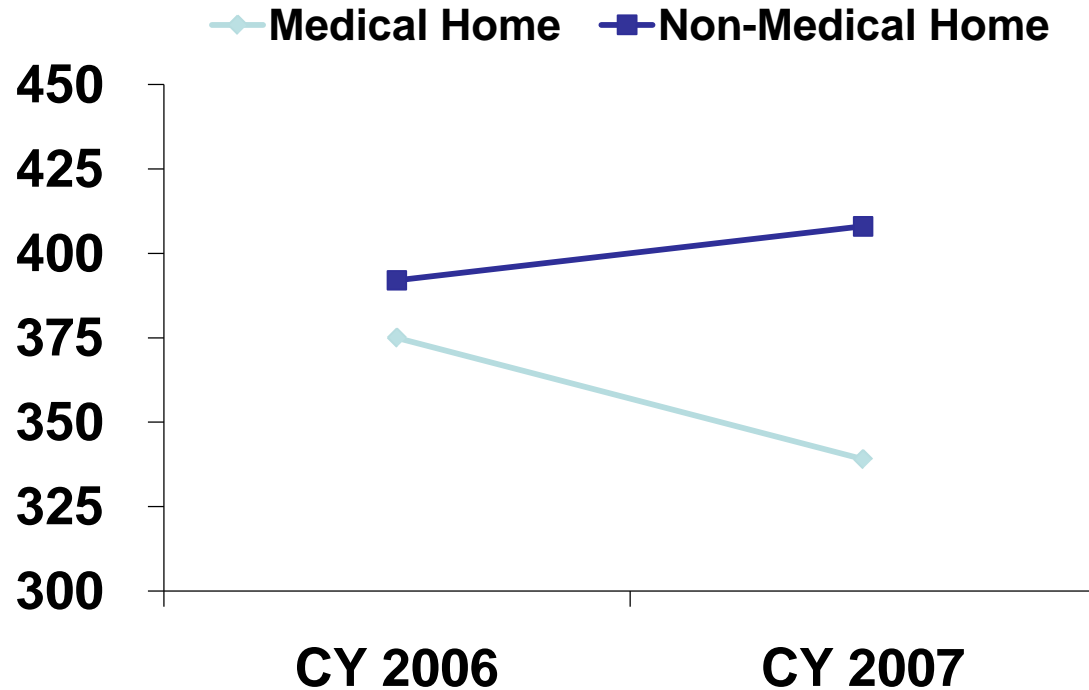
Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at $p < 0.01$; difference in mean emotional exhaustion in 2007 between clinics significant at $p < 0.01$.

Source: R.J. Reid, P.A. Fishman, O. Yu, et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation," *The American Journal of Managed Care* 2009, 15(9):e71-e87.

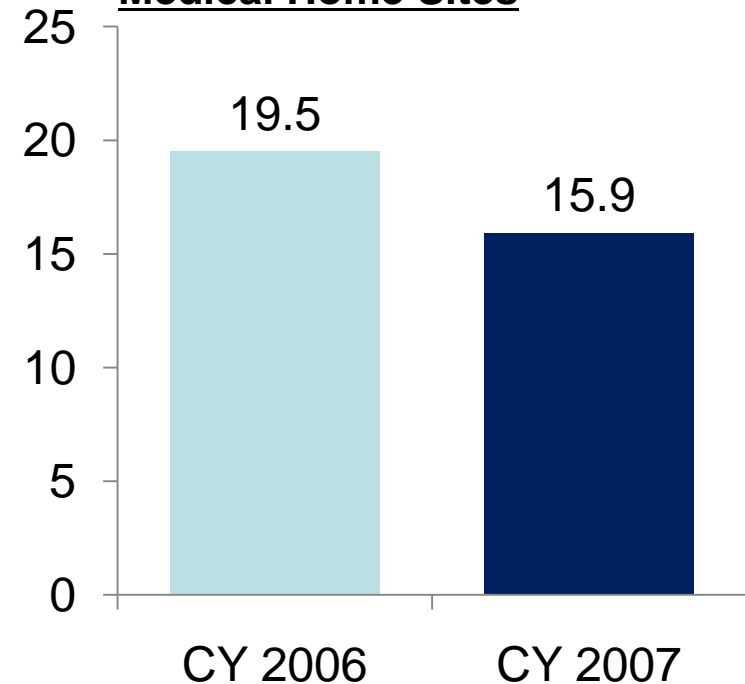


Geisinger Medical Home Sites and Hospital Admissions/ Readmissions

Hospital admissions per 1,000 Medicare patients



Readmission rates for all Medical Home Sites



- 18 percent reduction in hospital admissions
- 36 percent reduction in hospital readmissions for Medicare Advantage enrollees
- Total cost of care for the medical home patients decreased by 7 percent, but not statistically significant



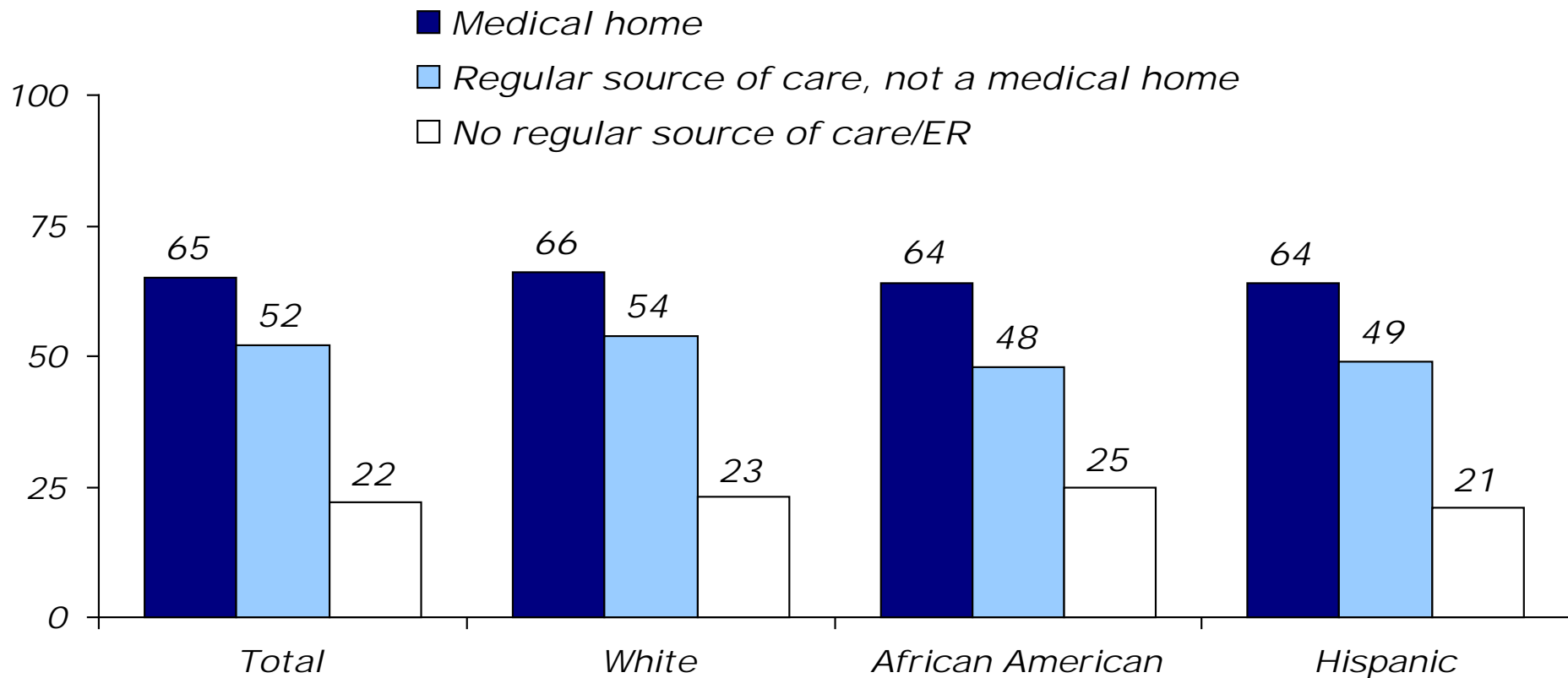
Summary of Cost and Quality Outcomes from PCMH Demonstrations with Low-Income Patients

- **Colorado Medicaid and SCHIP**
 - Median annual costs \$215 less for children in PCMH practices due to reductions in ER visits and hospitalizations
 - Median annual costs \$1,129 less for children with chronic diseases in a PCMH practice
- **Community Care of North Carolina**
 - 40 percent decrease in hospitalizations for asthma
 - 16 percent decrease in ER use
 - Total savings to the Medicaid and SCHIP programs: \$535 million
- **Genesee Health Plan (MMC product)**
 - 50 percent decrease in ER visits
 - 15 percent fewer inpatient hospitalizations
 - Total hospital days per 1,000 enrollees cited as 26.6 % lower than competitors
- **Clinic Patients in New Orleans**
 - NoLA clinic patients are less likely to forgo care or report inefficiencies than national average of patients
 - NoLA clinic patients report better access to care than national average
 - Clinic patients with “excellent patient experience” report better access to care, better preventive care and more support to manage chronic conditions



When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



How Medical Homes Fit into Accountable Care Systems



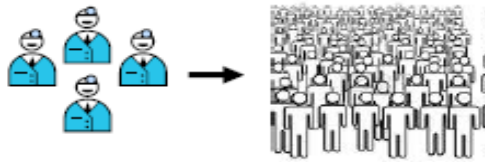
Accountable Care Organizations

“A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.”



ACO Requirements

Sufficient providers for 5,000 patients



Formal legal structure to receive and distribute share savings payments



Leadership & management structure that includes clinical & administrative systems



Three-year participation agreement



Processes for promoting evidence-based medicine, reporting on quality and cost, and coordinating care



Accountable for quality, cost and overall care of assigned Medicare beneficiaries



PCMH and ACO Interface

- ACOs will only succeed in reducing costs if they are built on a strong foundation of patient-centered medical homes
- Medical homes will not achieve their full potential unless they have a infrastructure that can enhance their capacity – help the sites fulfill functional requirements
- Investment in the PCMH model could accelerate the development of high-performing ACOs.
- Examples of how ACOs and PCMHs can work together
 - An ACO can help small and medium-sized independent practices
 - offer after-hours coverage,
 - web-based services
 - HIT support
 - Shared care coordinators
 - Shared onsite coaching for quality improvement



A New Era in Health Care Delivery: How Health Professionals Can Lead

- **Health professionals can lead and help make reform work**
- **Putting patients first is in the interest of all**
- **Active participation in innovative payment pilots**
- **Join efforts to create integrated delivery systems and Accountable Care Organizations**
- **Convert to Patient-Centered Medical Home models of primary care**
 - **Important to understand your patients' total care experience – where they go for services at different times, including emergency departments**
 - **Important to develop systems that ensure coordinated care**
 - **Important to achieve patient-centered care, to be the provider of first choice when competition increases for low-income and at-risk patients**
- **Important to stay together and stay the course**



Realizing Health Reform's Potential: A New Series of Briefs on the Affordable Care Act

