FINANCING THE PEDIATRIC MEDICAL HOME

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Maryland AAP Meeting
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Faculty disclosures

- No conflicts of interest
Additional disclosures

• I am a very general pediatrician
• My presentation reflects my personal perspective
  • not that of the American Academy of Pediatrics, Children’s National Medical Center or any of its subsidiaries
Learning Objectives

• At the conclusion of the presentation, learners will be able to:
  • Describe the emergence of Medical Home as a care delivery and payment model
  • Describe local Medical Home payer pilots
  • Detail basic steps pediatric practices can implement to improve quality and Medical Home reimbursement
Medical Home:
Key Component of US Health Care Reform

- Puts patient at the center of the health care system
- Provides primary care that is:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-centered
  - Coordinated
  - Compassionate
  - Culturally effective

*American Academy of Pediatrics*
“Medical Home” : Origin in Pediatrics

- AAP: “Every Child Deserves a Medical Home” (1978)
  - Calvin Sia, MD (AAP)
  - AAP COPP (1967)
- CSHCNs ⇒ All children
- Medical Home expands to all Primary Care
  - Endorsed by AAP-AAFP-ACP
“Patient-centered”

- Puts patients at the center of the health care system, and provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.” (American Academy of Pediatrics)

- Patient Centered Medical Home
  - Origins in Pediatrics
  - Endorsed by ACP, AAFP, AAP
  - Elevated by Health Care Reform
  - Emerging as payment model to achieve triple aim
Align with Health Care Reform & IHI “Triple Aim”

“Improving the US health care system requires simultaneous pursuit of three aims:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care”

CMS: “The 3 Part Aim”

- Better Care
- Better Health
- Lower Costs

- 2 ways to lower costs
  - Cut payments (simple)
  - Improve quality (hard)

- CMS Innovation Grants: $1B total for sustainable, scalable, replicable Medicare, Medicaid, CHIP models
Early evidence: Medical Homes beginning to “bend the cost curve”

“Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization.”

“There is now even stronger evidence that investments in primary care can bend the cost curve, with several major evaluations showing that patient centered medical home initiatives have produced a net savings in total health care expenditures for the patients served by these initiatives.”
Evidence? Payers are not waiting…

- WSJ: January 2012
- Wellpoint & Aetna announce new primary care payment models
  - Increase PCP fee schedule by 10-15%
  - Added payment (pmpm, care plans) for coordinating care, managing chronic disease
  - Additional reward if total cost reductions (20-30% of savings)
"This is not just an exercise or a pilot," said Sam Ho, chief clinical officer at UnitedHealthcare. "It represents a significant change in the architecture of our compensation models for doctors and hospitals."

- WSJ: February 2012
- UnitedHealth states it plans to ramp up "value-based" contracts from 1 – 2 % (currently) to 50 - 70% of the carrier's commercially insured members by 2015.
- UnitedHealth expects the new efforts to save at least twice as much money as they cost.
Emerging Medical Home payment models

- Enhanced FFS
- Care Coordination
- Quality P4P
Enhanced reimbursement to primary care “medical home”

- Enhanced FFS
  - Increased base rate or fee schedule
- Medical Home transformation & care coordination PMPM
  - Proposed Medicare pmpm: $8-20 pmpm
  - Limited benchmarking for pediatric pmpm
  - Practice-based care coordination: evolving skill set
    - Appointment scheduling, outreach/recall, disease/condition management, home care orders, coordination with schools & community resources
    - Chronic complex children- coordinate with hospital resources, specialists, education & community resources
- Quality Incentives/P4P or “shared savings”
  - Shared savings measured, calculated and shared how?
    - Limited pediatric metrics
    - Methodology not clear
    - Impacts and savings difficult to predict
Majority of states now have Medical Home payment models or pilots underway

- Pay PCMH practices additionally for medical home services
- Many linked to NCQA Medical Home Practice Recognition
- Potential shared savings for total expense reduction
- PCP influence on hospital, ED, specialty, pharmacy utilization
Maryland Health Care Commission: PCMH Pilot (2011-2013)

- Payer participation legislated by state
  - Aetna, CareFirst BCBS, CIGNA, United Healthcare, Coventry & Maryland Medicaid
- 50 practices, 300 providers, 200,000 patients (mostly adult care)
  - NCQA PCMH recognition & support
  - Practice transformation payments
    - Level 3: $3.51 - $5.01 - $6.01 pmpm (<10,000 pts - >20,000 pts) (commercial)
    - Level 3: $5.84 pmpm (all Medicaid)
  - Shared savings calculated separately for each practice
- State legislated model if successful pilot?

http://www.nashp.org/med-home-map
CareFirst Mid-Atlantic PCMH contract (3.5 million subscribers)

- New PCMH contract for Primary Care Providers
  - “Triple Aim” Payment:
    - Increase PCP fee schedule: 12%
    - Incentivize Care Coordination
      - $200 per Care Plan with CareFirst RN Case Manager for high-utilization/cost patients
    - Gain Sharing: reduce annual costs for attributed patients = higher fee schedule following year
      - 2011 < 2010 = higher 2012 PCP fee schedule
  - Data transparency via CareFirst Portal
    - All patient claims & costs
    - PCPs identify “cost-effective” providers
    - Offering “bypasses” hospitals & specialists-targts & rewards PCPs
- Insurance product: Healthy Blue
  - Reduced premiums & deductibles for selecting & working with “Medical Home” physician
Aetna now paying “Coordination of Care” PMPM to NCQA PCMH

- Beginning August 3, 2012, pay added pmpm to NCQA PCMH recognized practices for attributed patients in most Aetna plans
  - Level 3 = $3.00
  - Levels 1-2 = $2.00
- Cover costs for transforming to PCMH practice
CareFirst: Year 1: $23M payout

- 300 groups- 250 earned rewards
- 60% below projected costs
- 20% increase in 2012 fees
- PCMH program had net savings of 1.5% (= $40M)

CareFirst to pay doctors $23M under primary care program

Baltimore Business Journal by Sarah Grant, Reporter

From the Baltimore Business Journal
http://www.bjournals.com/baltimore/2012/06/07/carefirst-to-pay-23m-to-doctors-under.html

CareFirst to pay doctors $23M under primary care program

Baltimore Business Journal by Sarah Grant, Reporter

Thursday, June 7, 2012, 2:36pm EDT

Sarah Grant
Reporter: Baltimore Business Journal
Email: Twitter

CareFirst BlueCross BlueShield will pay out around $23 million to doctors whose patients' health care costs came in lower than what was expected.

The additional payments, which doctors will receive increased reimbursements for certain primary care services from July 1 through June 30, 2013, are part of CareFirst's Patient-Centered Medical Home, or PCMH program. The program gives doctors financial incentives and other awards for improving their patients' overall health.

CareFirst announced June 7 that in its first year, the program had a net savings of 1.5 percent. That's a slight bump in the health care cost curve and CareFirst CEO Chuck Burwell said he expects the numbers to grow to a 3 percent to 5 percent savings at the program develops over the next few years.

The program hinges on high-rater rewards for doctors whose patients' health care costs were lower than what would otherwise be expected. For joining, doctors get a 1.2 percent increase on their fee payments from CareFirst. They can earn an additional award if their patients' health care costs are below what would otherwise be expected.

In its first year, doctors who achieved that goal earned an average 20 percent increase in their fees. For a group of 10 primary care physicians with 3,000 CareFirst members, that award would equal a total of about $120,000, or $12,000 per physician.

"If you got a 20 percent average award, you won't soon forget it," Burwell said. "And you won't want to lose it."

Participating doctors work in groups of between five and 15 primary care physicians and nurse practitioners. The program currently includes 300 groups, 250 of which were eligible to earn rewards this year. To be eligible, groups had to be registered by July 2011. Of the qualifying doctor

http://www.bjournals.com/baltimore/2012/06/07/carefirst-to-pay-23m-to-doctors-under.html

9/5/2012
PCMH Quality Profile Scorecard Measures

Appropriate Use of Services: 20 points
- Admissions (potentially preventable) (8 points)
- Potentially preventable ED use (4 points)
- Ambulatory, diagnostic, imaging and antibiotics (8 points) (Viral URI, Pharyngitis)

Effectiveness of Care: 20 points
- Chronic Care (10 Points)
  - Asthma, diabetes, CAD, MI, Depression
- Population Health (10 points)
  - Screening: colon CA, chlamydia, cervical CA, breast CA, childhood immunizations

Patient Access: 20 points
- e-Scheduling, e-Visits, extended office hours (eves & weekends)

Structural Capabilities: 10 points
- E-Rx, e-mail, EMR, EMR Meaningful Use (MU), external certification

Degree of Engagement: 30 points (NOT measured in 2011)

2011 TOTAL POTENTIAL POINTS: 70 (converted to 100 point scale)
1 NoVa practice: 24% fee increase

- >3000 member panel size
- >4% 2011 total savings vs projected expense calculation (medical + pharmacy)
- Quality score: 39.3

Practice Comment:
“With added incentive, moved from “low” to “average” payer for our practice…but they are a big payer for us.”

Success factors?
- Extended hours
  - Early am, evenings, weekends
- EMR, eRx, email
- Screening: Immunizations
- Asthma disease mgmt
- Minimal coaching
  - “Watch referrals”
- Limited engagement with CF care coordination/plans
  - Did internal survey for chronic/expensive patients & reviewed with CF coordinator
Isn’t my practice already a Medical Home?

- Most pediatric practices provide many aspects of “medical home”- but likely not all…

- Still have practice redesign and/or documentation to do to be recognized as an NCQA Patient Centered Medical Home (PCMH)
Medical Home Building Blocks

1. Care Partnership Support
   Empowers children, youth and families to manage their health and healthcare

2. Clinical Care Information
   Assures delivery of effective, efficient clinical care & patient self-management support

3. Care Delivery Management
   Promotes clinical care that is consistent with patient and family preference and scientific evidence

4. Resources & Linkages
   Mobilizes community resources to meet patient and family needs

5. Practice Performance Measurement
   Addresses the organization and promotion of safe and high quality care

6. Payment & Finance
   Matches quality care and NQA recognition with payment/solid return on investment

Section 1: Care Partnership Support

Building Your Medical Home & Getting Paid Appropriately

Achieving medical home recognition using the NCQA PCMH patient recognition program requires your practice to have implemented payment systems that reward the development and implementation of medical homes.

NHA offers innovative solutions that can help your practice take the next steps in the journey to getting paid for the quality of care you provide.

Pediatric Council:
Appropriate reimbursement for medical homes continues to be an issue for practitioners. Public and private payers may be fully aware of the impact of a medical home on medical services, especially in access to appropriate, quality care and reimbursement. In order to address these concerns, several American Academy of Pediatrics (AAP) Chapters have developed Pediatric Councils. Pediatric Councils serve as forums for collaboration to address concerns with payer coverage and policies, and administrative procedures, which impact access, quality of care, and reimbursement.

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Accreditation & Recognition: NCQA “recognizes” Medical Homes

- Hospitals
  - JCAHO
  - Leapfrog Group
  - ANCC-Magnet Status
- Physicians:
  - Board Certification:
    - American Board of Pediatrics
  - NCQA
    - PCMH Recognition

The Joint Commission
Helping Health Care Organizations Help Patients

Leapfrog Group

American Board of Pediatrics
Recognized Practice 2011
NCQA PCMH “Model for Care”

- NCQA PCMH Model for Care
  - Personal physician (or NP)
  - Coordinated care
  - Care team
  - Enhanced care, access & communication

- Facilitated by HIT: registries, information technology, health information exchange and patient web portals.

- Assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
NCQA PCMH 2011

6 standards, 28 elements (6 “must pass”)

1. Enhance Access & Continuity
   - Access During Office Hours

2. Identify & Manage Patient Populations
   - Use Data for Population Management

3. Plan & Manage Care
   - Care Management

4. Provide Self-Care Support & Community Resources
   - Support Self-Care Processes

5. Track & Coordinate Care
   - Referral Tracking & Follow-up

6. Measure & Improve Performance
   - Implement Continuous Quality Improvement

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### Points

<table>
<thead>
<tr>
<th>Points</th>
<th>Standard and Element</th>
<th>No. Factors</th>
<th>Must Pass</th>
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<tbody>
<tr>
<td>20</td>
<td>1 Enhance Access and Continuity</td>
<td>54</td>
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<tr>
<td>4</td>
<td>A Access During Office Hours</td>
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<td>X</td>
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<tr>
<td>4</td>
<td>B After-hours Access</td>
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<tr>
<td>2</td>
<td>D Electronic Access</td>
<td>8</td>
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<td>2</td>
<td>D Continuity</td>
<td>3</td>
<td></td>
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<td>2</td>
<td>E Medical Home Responsibilities</td>
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<td>F Culturally and Linguistically Appropriate Services (CLAS)</td>
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<td>4</td>
<td>G The Practice Team</td>
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<td>16</td>
<td>2 Identify and Manage Patient Populations</td>
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<td>3</td>
<td>A Patient Information</td>
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<td>4</td>
<td>B Clinical Data</td>
<td>9</td>
<td></td>
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<tr>
<td>4</td>
<td>C Comprehensive Health Assessment</td>
<td>9</td>
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<tr>
<td>6</td>
<td>D Use Data for Population Management</td>
<td>4</td>
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<td>17</td>
<td>3 Plan and Manage Care</td>
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<td>4</td>
<td>A Implement Evidence-Based Guidelines</td>
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<td>2</td>
<td>B Identify High-Risk Patients</td>
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<td>4</td>
<td>C Care Management</td>
<td>7</td>
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<tr>
<td>3</td>
<td>D Medication Management</td>
<td>6</td>
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<tr>
<td>3</td>
<td>E Use Electronic Prescribing</td>
<td>8</td>
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<tr>
<td>9</td>
<td>4 Provide Self-Care Support and Community Resources</td>
<td>10</td>
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<tr>
<td>6</td>
<td>A Support Self-Care Process</td>
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<td>X</td>
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<tr>
<td>3</td>
<td>B Provide Referrals to Community Resources</td>
<td>4</td>
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<tr>
<td>18</td>
<td>5 Track and Coordinate Care</td>
<td>25</td>
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<tr>
<td>6</td>
<td>A Test Tracking and Follow-Up</td>
<td>10</td>
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<tr>
<td>6</td>
<td>B Referral Tracking and Follow-up</td>
<td>10</td>
<td>X</td>
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<tr>
<td>8</td>
<td>C Coordinate w/ Facilities/Care Transitions</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>8 Measure and Improve Performance</td>
<td>22</td>
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<tr>
<td>4</td>
<td>A Measure Performance</td>
<td>4</td>
<td></td>
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<tr>
<td>4</td>
<td>B Measure Patient/Family Experience</td>
<td>4</td>
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<tr>
<td>4</td>
<td>C Implement Continuous Quality Improvement</td>
<td>4</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>D Demonstrate Continuous Quality Improvement</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>E Report Performance</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>F Report Data Internally</td>
<td>4</td>
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<tr>
<td>0</td>
<td>G Use Certified EHR Technology</td>
<td>2</td>
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</table>

106 Points

28 Elements

152 Factors

6 MP Elements 29 points
NCQA PCMH Application

- Detailed electronic application
- Extensive documentation of processes
  - Policies & procedures, data, screenshots, quality improvement
  - At least 90 continuous days
- Fees:
  - $80 Survey Tool
  - $800 - $4000 (1 – 8+ providers/practice site)
    - +$10/# >50
    - 20% discount if sponsored by health plan, employers or other programs
    - Discounts for Multi-Site Group Survey (common system)
NCQA PCMH Recognition

- Children’s National: Goldberg Center for Community Pediatric Health
  - Seven primary care health centers & mobile health program
  - Fall 2010 – Summer 2011:
    - Significant practice redesign (6 months) and detailed 90-day documentation of practice PCMH performance (2008 standards)
    - Shared leadership, faculty & management team incentive goals
  - Submitted group application: each center recognized by NCQA at highest Level III PCMH (August 2011)
- DC: 1st pediatric practices & 1st practices serving underserved populations
- Nationally: among 1st pediatric practices in academic settings (children’s hospitals)
  - 1st adolescent medicine practice
<table>
<thead>
<tr>
<th>PPC-PCMH (9 standards/30 elements)</th>
<th>PCMH 2011 (6 standards/26 elements)</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Access &amp; Communication</strong></td>
<td><strong>1. Access/Continuity</strong></td>
</tr>
<tr>
<td>- Processes</td>
<td>- Access</td>
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<tr>
<td>- Results</td>
<td>- Medical Home Responsibilities</td>
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<tr>
<td><strong>2. Patient Tracking and Registry Function</strong></td>
<td><strong>2. Identify/Manage Patient Populations</strong></td>
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<td><strong>3. Care Management</strong></td>
<td><strong>3. Plan/Manage Care</strong></td>
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<tr>
<td>- Continuity Between Settings</td>
<td>- Care Management</td>
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<td><strong>4. Self-Management Support</strong></td>
<td>- Medication Management/e-Prescribing</td>
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<td><strong>5. Electronic Prescribing</strong></td>
<td><strong>4. Self-Care Support</strong></td>
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<td><strong>6. Test Tracking</strong></td>
<td><strong>5. Track/Coordinate Care</strong></td>
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<td><strong>7. Referral Tracking</strong></td>
<td>- Test/Referral Tracking</td>
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<td><strong>8. Performance Reporting and Improvement</strong></td>
<td>- Facilities</td>
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<td>- Patient Experience</td>
<td>- Measures of Performance</td>
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<td><strong>9. Advance Electronic Communications</strong></td>
<td>- Patient Experience</td>
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<td></td>
<td>- Quality Improvement</td>
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<td></td>
<td>- Reporting</td>
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</table>
EMR incentives

• “Eligible providers” (>30% Medicaid) can receive up to $65,000 over 5 years for implementing a certified EMR and documenting “meaningful use”
  • Reduced payment for Medicaid >20%
  • Maryland REC: CRISP
• Maryland: payer incentives for EMR implementation
• Position for triple aim (care, health, cost), NCQA PCMH and evolving payment models
Surveying patient experience
Massachusetts: Consumer Reports Ratings of PCP's

How Does Your Doctor Compare?

How does your doctor compare?

We rate adult, family, and pediatric physician groups in the Bay State

High- and low-scoring practices exist in all parts of the state.
Ratings of pediatric practices (MHQP)

- Willingness to recommend
  - Def YES-Prob YES-Not sure-Prob Not-Def Not

- Performance (4 ↔ 1)
  - How well doctors communicate with patients
  - How well doctors know their patients
  - How well doctors give preventative care and advice
  - Getting timely appointments, care and information
  - Getting courteous and respectful help from office staff
Added CAHPS Medical Home Survey Questions: Emphasis on Convenient Access & Care Coordination

- In the last 12 months:
  - How many days did you usually have to wait for an appointment when your child needed care right away?
  - How often were you able to get the care your child needed during evenings, weekends or holidays?
  - Did you get any reminders about your child’s care between visits?
  - How often did your provider seem informed and up-to-date about the care your child got from specialists?
  - Did anyone talk at each visit about all the prescription medicines your child was taking?
  - Did anyone talk with you about specific goals for your child’s health?
  - Did anyone ask you if there are things that make it hard for you to take care of your child’s health?
- Supplemental survey questions for children with special health care needs
## Patient experience surveys:
Measure & incorporate into practice improvements

### Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Count</th>
<th>Mean</th>
<th>Category Percentages</th>
<th>Favorable</th>
<th>Neutral</th>
<th>Unfavorable</th>
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<tbody>
<tr>
<td>Is this your regular provider</td>
<td>768</td>
<td>3.64</td>
<td>31.4% 23.1% 31.0% 38.4%</td>
<td>65.9%</td>
<td>0.0%</td>
<td>34.1%</td>
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<tr>
<td>Ease of calling the Clinic for refills or to get advice from the nurse</td>
<td>5655</td>
<td>4.12</td>
<td>44.8% 29.9% 35.0%</td>
<td>39.0%</td>
<td>29.8%</td>
<td>19.8%</td>
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<tr>
<td>Ability to schedule an appointment on a convenient day and time</td>
<td>5707</td>
<td>4.18</td>
<td>34.4% 29.3% 48.3%</td>
<td>49.3%</td>
<td>29.3%</td>
<td>19.8%</td>
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<tr>
<td>Doctors are available to talk to me when I call or return my calls promptly</td>
<td>5664</td>
<td>4.00</td>
<td>23.8% 27.6% 37.7%</td>
<td>37.7%</td>
<td>27.6%</td>
<td>23.8%</td>
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<tr>
<td>Someone in the Clinic always answers the phone during the day</td>
<td>5653</td>
<td>3.89</td>
<td>30.1% 26.5% 39.6%</td>
<td>39.6%</td>
<td>26.5%</td>
<td>30.1%</td>
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<tr>
<td>Time in waiting room</td>
<td>5736</td>
<td>3.91</td>
<td>30.4% 31.0% 38.4%</td>
<td>38.4%</td>
<td>31.0%</td>
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<tr>
<td>Time in exam room</td>
<td>5685</td>
<td>4.00</td>
<td>25.1% 32.9% 38.6%</td>
<td>40.6%</td>
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<td>26.1%</td>
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<td>Time waiting for shots</td>
<td>5455</td>
<td>4.09</td>
<td>21.9% 30.3% 39.0%</td>
<td>40.0%</td>
<td>30.3%</td>
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<tr>
<td>Neat and clean waiting room</td>
<td>5610</td>
<td>4.56</td>
<td>36.0% 25.6% 66.2%</td>
<td>66.2%</td>
<td>25.6%</td>
<td>8.0%</td>
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<tr>
<td>Neat and clean exam room</td>
<td>5577</td>
<td>4.62</td>
<td>24.9% 49.3% 64.9%</td>
<td>68.9%</td>
<td>24.9%</td>
<td>5.9%</td>
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<tr>
<td>Ease of finding where to go</td>
<td>5549</td>
<td>4.60</td>
<td>25.7% 67.6%</td>
<td>67.6%</td>
<td>25.7%</td>
<td>6.4%</td>
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<tr>
<td>Comfort while waiting</td>
<td>5544</td>
<td>4.45</td>
<td>27.2% 63.7%</td>
<td>60.7%</td>
<td>27.2%</td>
<td>11.8%</td>
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<tr>
<td>Privacy during the visit</td>
<td>5538</td>
<td>4.63</td>
<td>23.3% 70.4%</td>
<td>70.4%</td>
<td>23.3%</td>
<td>6.2%</td>
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<tr>
<td>Friendly and helpful to you</td>
<td>5373</td>
<td>4.56</td>
<td>22.6% 68.5%</td>
<td>68.5%</td>
<td>22.6%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Answers your questions</td>
<td>5314</td>
<td>4.58</td>
<td>23.0% 68.4%</td>
<td>68.3%</td>
<td>23.0%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Friendly and helpful to you</td>
<td>5341</td>
<td>4.61</td>
<td>23.3% 69.3%</td>
<td>69.9%</td>
<td>23.3%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Cares about your child</td>
<td>5282</td>
<td>4.61</td>
<td>22.0% 69.7%</td>
<td>69.7%</td>
<td>22.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Answers your questions</td>
<td>5361</td>
<td>4.60</td>
<td>23.4% 68.5%</td>
<td>68.5%</td>
<td>23.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Listens to you and your child</td>
<td>5398</td>
<td>4.60</td>
<td>21.4% 72.1%</td>
<td>72.1%</td>
<td>21.4%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Takes enough time with you</td>
<td>5375</td>
<td>4.64</td>
<td>22.8% 70.8%</td>
<td>70.8%</td>
<td>22.8%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Explains what you want to know</td>
<td>5327</td>
<td>4.66</td>
<td>21.7% 72.4%</td>
<td>72.3%</td>
<td>21.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Gives you good advice and treatment</td>
<td>5305</td>
<td>4.64</td>
<td>21.6% 71.7%</td>
<td>71.7%</td>
<td>21.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Is respectful and caring</td>
<td>4884</td>
<td>4.71</td>
<td>18.1% 76.9%</td>
<td>76.9%</td>
<td>18.1%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Would you send your family or friends to us for care?</td>
<td>5261</td>
<td>4.79</td>
<td>94.8%</td>
<td>94.8%</td>
<td>0.0%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Is this Center your Medical Home (regular source of care)</td>
<td>5156</td>
<td>4.75</td>
<td>88.7%</td>
<td>93.7%</td>
<td>0.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Overall Averages (Weighted)</td>
<td>5252.7</td>
<td>4.45</td>
<td>23.1% 62.7%</td>
<td>62.7%</td>
<td>23.1%</td>
<td>12.3%</td>
</tr>
</tbody>
</table>
How many here survey patients/families?

- Start small
- Download CAHPS
- Survey 20 families
- $5 gift card = $100 “best advice”

- You will be graded on this exam in the near future…
Evolution & alignment of quality measures

- CMS: Medicaid (CHIPRA)
- EHR: Meaningful Use
- NCQA: HEDIS

QUALITY MEASURES
NCQA HEDIS measures
(Healthcare Effectiveness & Data Information Sets)

- Measure health plan & provider performance (admin claims & chart audits)
- Pediatric measures: (for patients assigned to PCP)
  - # of recommended well-child visits
  - Immunizations: childhood & adolescent
  - Asthma: controller meds if asthma dx
  - ADHD + stimulant Rx: evidence of follow-up care
  - Chlamydia screening
  - Obesity: BMI%ile, nutrition & activity counseling
  - URI diagnosis- no antibiotic Rx (PBM)
  - Strep pharyngitis dx + antibiotic Rx ⇒ TC/rapid test?
Evolution from practice measures to population measures

• Clinical practice performance
  • All attributed patients

• Patient satisfaction with care experience
  • Health plan, provider/practice/hospital

• Cost of care (total expense for patients attributed to PCP/practice)

• Triple Aim…
  • New payment models will reward high performers (and pay less to low performers)
What drives expense (total cost)?

- **Not** primary care practice charges (maximize these)
- Hospitalization
- ED visits
- Specialty visits (and procedures)
- Pharmacy
- DME/Home Care
- (manage reasonably & appropriately)
Where’s the savings in kids?
EXPENDITURES FOR SELECTED HEALTH PROGRAMS: 2006

- **Medicare + Part D**: $380.9 billion
- **Medicare**: $342.9 billion
- **Medicaid**: $268.8 billion
- **Medicaid for Children**: $51.072 billion
- **SCHIP**: $7.8 billion

Wise, 2007
Where’s the savings in kids?

• The savings opportunity may be in adult care, but pediatrics is along for the ride!
Medical Home: Origin in Pediatrics

Opportunities for cost savings in adult care

Opportunities for making care more cost-effective in Pediatrics?

- Maximizing preventive care
- Chronic disease management: asthma, ADHD, obesity
- Care coordination for CSHCNs/complex illness
- Pharmacy utilization: brand vs generic
- Specialty referrals, studies & F/U care: frequency & expense
- Mental/behavioral health (co-morbidity, influence on utilization)
- Medical Home access & ED utilization
- “Elective” surgery
- Ambulatory sensitive admissions
- Directing patients by quality or cost

We are going to need to develop skill set & experience to manage population health & cost successfully
I’m too busy to manage complex patients

- **Historic business model**
  - 6 x 99213 URI/OM >>> 1 x 99215 anything
    - B Starfield: “tyranny of the 15 minute visit”
  - Volume rules; refer anything that takes time

- **Emerging business model**
  - Increased primary care payments for access, population & disease management
    - Payment for care coordination & expanded medical home access/services
    - Gain-sharing/rewards for reducing total population expense
Successfully managing new contracts

• Pro-actively reach out to improve:
  • Well child visits & immunizations
  • Chronic disease management: asthma, ADHD, obesity, other prevalent conditions
  • Phone & email access for condition management
  • Chronic complex illness: high utilizers (coordinate with care coordination/case management resources at referral center (CNMC Complex Care Program) and/or insurance plan

• Who are your frequent flyers: admissions, ED visits?

• Can you identify children who:
  • Have not come in for: WCC or F/U visits
  • See a lot of specialists (cost & quality of specialists)
  • Have asthma & need flu shots
  • Have risk factors and need Synagis (RSV immune globulin)?
Where have all the OME’s gone?

- Changing illness pattern: impact of immunizations
- Changing utilization patterns
  - Economic belt-tightening
    - Reduced health care visits for acute & preventive care nationally
    - Improved profits for insurance plans (less medical expense)
    - Employer shift to high-deductible plans
  - Convenience care
    - Retail-based clinics and urgent care centers
Walmart: coming to your health neighborhood soon…

• A **disruptive technology** or **disruptive innovation** is an innovation that helps create a new **market** and **value network**, and eventually goes on to disrupt an existing market and value network (over a few years or decades), displacing an earlier technology.
  • The term is used in business and technology literature to describe innovations that improve a product or service in ways that the market does not expect, typically first by designing for a different set of consumers in the new market and later by lowering prices in the existing market.

• Walmart: $4 co-pays for generic prescriptions
• Walmart VP: “*We want to make Walmart your #1 healthcare destination*”
Convenience vs Medical Home

• Low-priced convenience care
  • Retail-based clinics: 100 sq ft, NP, computer algorithms, remote medical director
  • Money loser vs same store sales

• How can pediatricians compete?
  • Sell formula, diapers…
  • Can you compete with Walmart on price for medical visit & convenience, parking, food prices, sales?
One approach...
Plan for climate change...

“All I’m saying is now is the time to develop the technology to deflect an asteroid.”
When life gives you lemons…
Don’t just make lemonade- sell it!
How can Medical Homes survive & thrive?

A checklist

- Be patient-centered
- Survey your patients regularly, listen & respond; public ratings will become standard practice
- Maximize & personalize customer service at all points in practice; phone access
- Educate your healthcare consumer: value of expertise, quality care, personal relationship (concierge care for all patients)
- Build on-going doctor-patient relationship, trust, business model
- Leverage electronic health records, portals, email & social media to build patient communication & engagement (’like’ us: it’s a new generation)
- Refocus business model from volume to value-based contracts;
  - utilize Medical Home payments to expand resources for outreach, care coordination & condition management
- Extend hours and/or offer convenience (urgent care/walk-in hours- early/late)
  - for convenience care vs let it go?
  - Extend hours for higher value services: WCC, behavioral health, chronic disease mgmt, asthma/ADHD/obesity/new parent groups, seasonal sports exams
- Focus on preventive care & chronic illness management (new morbidities is new business model)
- Improve care experience, population outcomes & reduce total expense (chronic disease management, behavioral health, care coordination for chronic complex children, co-management with specialists)
Old business model vs new?
Health care (payment) reform

• ACA repeal? Election?
  • United States needs to reduce health care expenditures to remain competitive in global economy

• Major payers already moving towards "value-based" contracting
  • UHC, Aetna, and Wellpoint announce new value models to shareholders
  • UnitedHealthcare--70% of provider contracts by 2015

• Fortune 500 promote “high deductible” plans for employees
  • Reduce company expense; give employees “more choice”
  • Patients will select care options by quality and cost
Multiple shades of blue…

- New regional CareFirst contracts
  - Patient-Centered Medical Home (Mid-Atlantic)
    - Enhanced PCP payments for access and care coordination
    - Cost transparency for hospital and specialty care
    - 4% total savings in PCMHs; $23M in year 1 incentives for PCPs

- Tiered co-pays and deductibles (Massachusetts)
  - Would you prefer to pay $50 or $500 for that MRI?

- Global contracts (Children’s Boston-Massachusetts)
  - One system payment: Children’s Hospital, employed specialists and contracted primary care network
  - Incentives for quality not volume

- Coming soon to our neighborhood
Volume vs value payments

- **Volume**: basic business model of U.S. healthcare (hospital, specialty, and primary care)
  - See more, do more, bill more
    - PCP: multiple 99213s vs. 99214/99215

- **Value**: incentivizes quality outcomes and total expense reduction
  - Added payment for Medical Home access and services
  - Promote care coordination, chronic disease management
  - Incentives/shared savings for reducing total expense
    - Hospital, ED, specialty, elective surgery, pharmacy, etc.
Don’t touch that dial ⇒ adjust cautiously
Get bigger?

- Consolidate into larger groups, networks to achieve economies of scale (contracting, staffing extended hours)
- Partner in global contracts/ACO’s?
  - Provider organizations/health systems manage total care/expense of defined cohort of patients
  - CMS Medicare pilots
- Where are pediatrics best served?
  - Provider-led ACO (adult) vs hospital systems
    - Degree of influence, risk/gain sharing
- Evolution in antitrust/group contracting
  - Physicians may organize around quality
  - ACO vs clinically integrated quality network (FTC)
Take home message

- Medical Home is emerging as care delivery & payment model
- NCQA PCMH recognition can be useful tool to guide practice transformation but is labor intensive
- Health care payment evolving from volume to value-based models
- Value is framed by triple aim: better care, better health, lower cost
- Pediatricians need to position for value-based care through measuring & improving patient experience, population outcomes and total expense
It is **not** necessary to **change**.

*Survival is not mandatory.*

W. Edwards Deming
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