



Patient-Centered Medical Homes: Overview, Experience to Date, Success Factors

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Patient-Centered Medical Home Defined

Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for adults, youth and children.

Principal Characteristics of PCMH:

- Personal Physician
- Physician Directed Practice
- Whole Person Care Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Care Access
- Full Value Payment
- Optimization through HIT integration (eRx, patient registry)

The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient's family.

*United currently uses the NCQA PPC-PCMH recognition program or convener defined equivalent as a basis for defining "medical home" capabilities but will review other alternative assessment and recognition programs as they become endorsed by the medical professional societies.

UnitedHealthcare PCMH Programs

Thirteen PCMH programs; five started in 2008/2009, others started in 2011 and 2012.

- Eight multi-payer:
NY, CT, MD, RI, OH, CO, TX, MO
- Two single-payer in **AZ** and **TX**
- Chronic care medical home pilot in **MO** – partnering with BOEING, MONSANTO, GE, and UNITED
- CMS Comprehensive Primary Care Initiative (CPCi) 5 year Demonstration Project in **CO**, **NJ**, and **OH**

A significant and growing level of impact:

- Membership: **250K+** members impacted
- Physician Practices: **250+**
- Primary Care Providers: **2000+**
- Participating employer groups: **650+**

Principal Characteristics of PCMH:

- More time for patients
- Better care continuity
- Improved care transitions
- Improved clinical indicators
- Lower per capita costs
- Increased patient participation in health care decisions and adherence to care plans
- Increase in practice profitability and satisfaction
- Simplified and less fragmented coordinated health care experience



PCMH: Reimbursement Model

This is the primary reimbursement model adapted to each program.



PCMH reimbursement model builds on the current Fee for Service (FFS) schedule with a PMPM Care Management Fee and in some cases a bonus / gain share option based on performance.

- **FFS:** Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided (**no plan redesign or FFS payment schedule changes**)
- **CARE MANAGEMENT FEE:** Prospective fixed-rate, **PMPM payments** for anticipated quality, efficiency and satisfaction improvements under the PCMH Model [note: contract addendum required]
- **BONUS:** For some programs, practices are eligible for a periodic **performance bonus or rate adjustment** that aligns with clearly defined clinical quality, medical cost and operational measures
- **GAIN SHARE:** For some programs, practices have a lower Care Management Fee in consideration for sharing in the risk/benefit of realized **cost reduction outcomes**

PCMH: Guiding Principles

- **Clearly defined, engaged physician and practice administrative leadership**
- **Motivated practice transformation engagement**
- **Proactive engagement of patients in the practice**
- **On-site, dedicated care manager role**
- **Improved access for patients/members**
- **Performance management processes centered around access, population management, care coordination, care transitions**
 - E.g. registries, data reports, care protocols, etc.
- **Incentives to reward quality and cost outcomes**

The Evolving Context: Accountable Care Platform

We are transforming how we pay for healthcare and how healthcare is delivered



We are paying for value through outcome-based payment models that reward care providers for improvements in quality and cost-efficiency

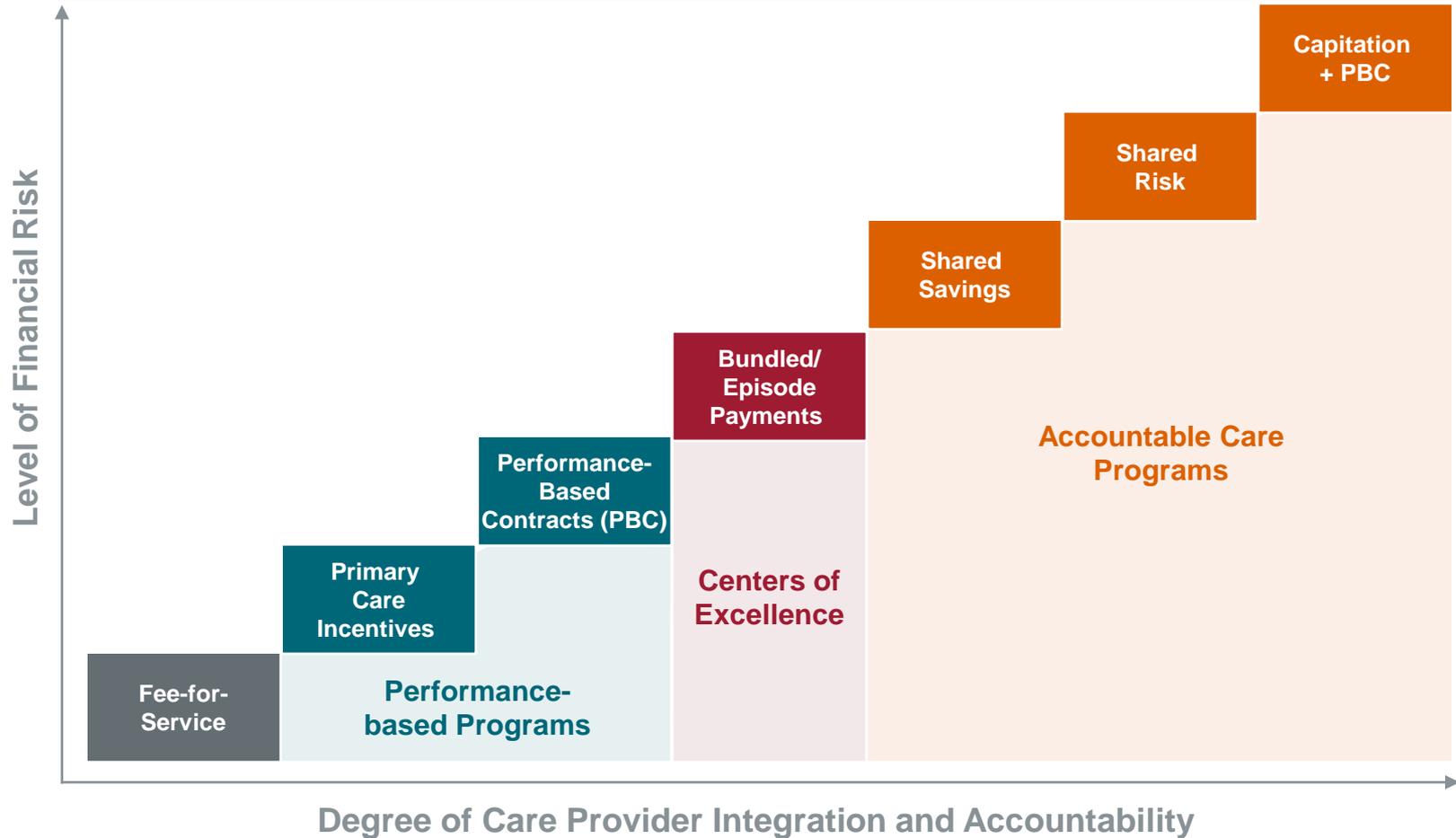
We are transforming the delivery system to be more accountable for cost, quality and experience outcomes, helping make health care more affordable

We are aligning incentives across employers, consumers and care providers to achieve the Triple Aim of better health, better care and lower costs

Accountable Care Platform | Accountability Continuum



OUR MODULAR SET OF VALUE-BASED PAYMENT MODELS ARE DEPLOYED ACROSS THE CONTINUUM. WE ARE ABLE TO ALIGN OUR VALUE-BASED PAYMENT MODELS WITH A CARE PROVIDER'S RISK READINESS.



Accountable Care Platform | Deployment Snapshot



OVER \$21 BILLION OF NETWORK SPEND IS TIED TO OUR ACCOUNTABLE CARE PLATFORM¹

Performance-based Programs

Achieving specific METRICS

Primary care incentives, Performance-based contracts

- 30,000+ physicians
- 800+ medical groups
- 550+ hospitals

Centers of Excellence

Managing a specific CONDITION

Bundle/episode payments

- 160+ Centers of Excellence

Accountable Care Programs

Managing ENTIRE POPULATION HEALTH

Shared savings, Shared risk, Capitation (including ACO, PCMH)

- 58,000+ physicians
- 500+ medical groups
- 65+ hospitals

Increasing level of integration, financial risk and accountability

THIS MATTERS

We have value-based engagement with more than 600 hospitals, 1,150 medical groups and 80,000 physicians participating in our Accountable Care Platform.¹

PCMH: Initial Findings on Medical Cost Trend

PATIENT-CENTERED MEDICAL HOMES (PCMH)

PCMH experience includes 13 programs in 10 states with more than 250 medical groups, 2,000 physicians and 250k members participating.

- Includes participation in the CMS Comprehensive Primary Care Initiative Program in Ohio, Colorado and New Jersey

On average, our commercial model in the initial launch markets, RI, OH, CO, AZ, demonstrates:

4-4.5%

Medical Cost
Reduction

2:1

Return on
Investment (ROI)



Internal and external evaluation also demonstrates that clinical quality as well as patient and provider experience are consistently improved,

THIS
MATTERS

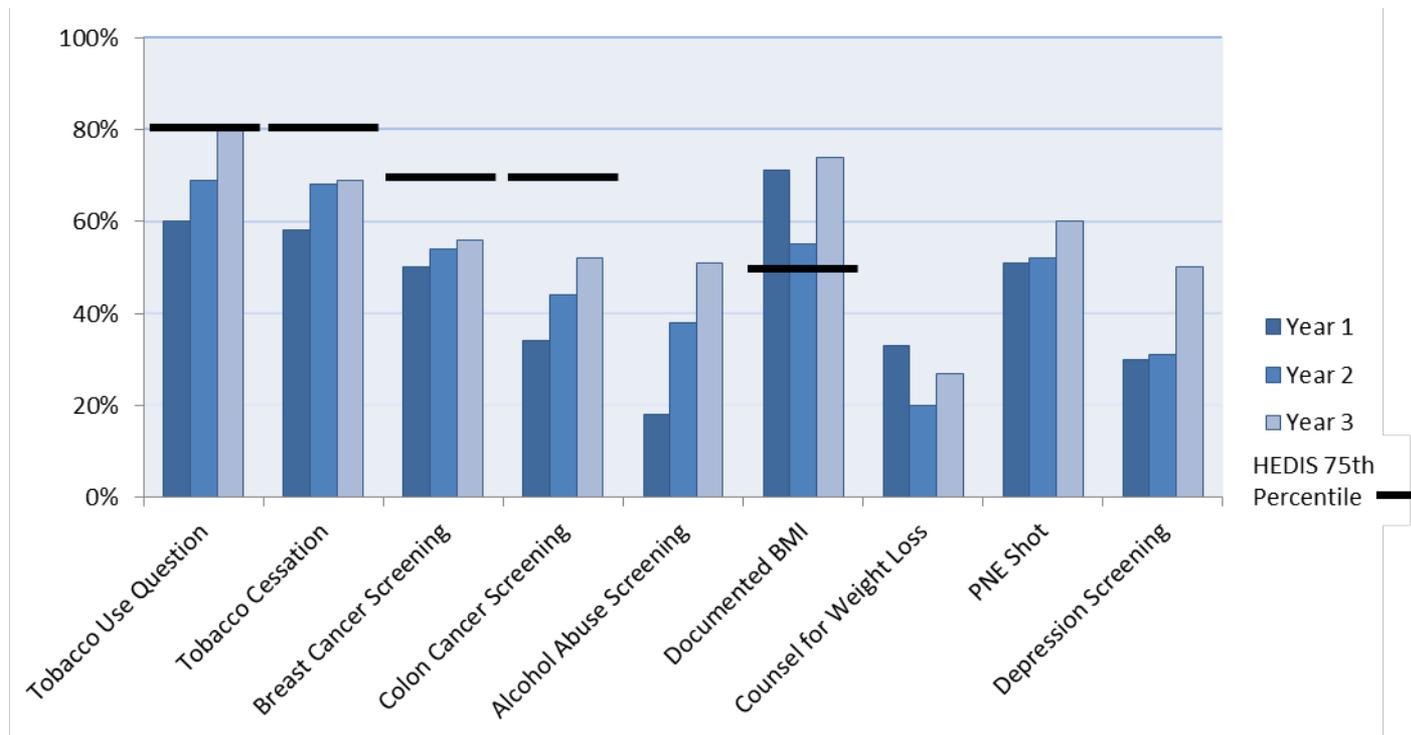
Comprehensive evaluation, validated with external studies, demonstrates our portfolio of PCMH programs are positively impacting all elements of the triple aim

PCMH: Initial Findings on Quality

External evaluations demonstrate preventive care quality measures improved but are still not consistently at target / best practice levels

- Patient Centered Medical Home practices improved on nearly all quality measures
- Not all measures achieved best practice targets suggesting opportunity for further improvement

Preventive Care: Results of HealthTeam Works evaluation of Colorado PCMH Program

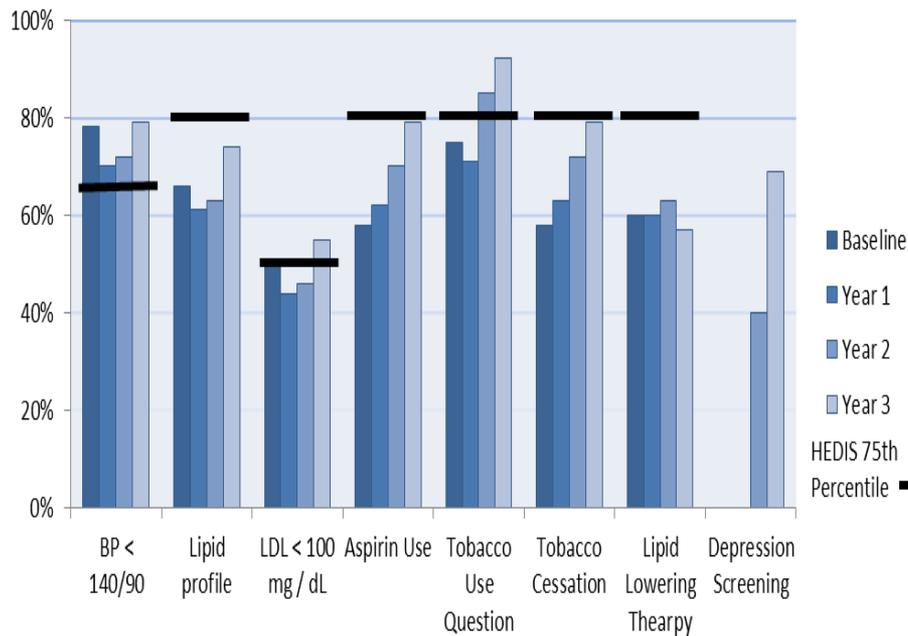


PCMH: Initial Findings on Quality

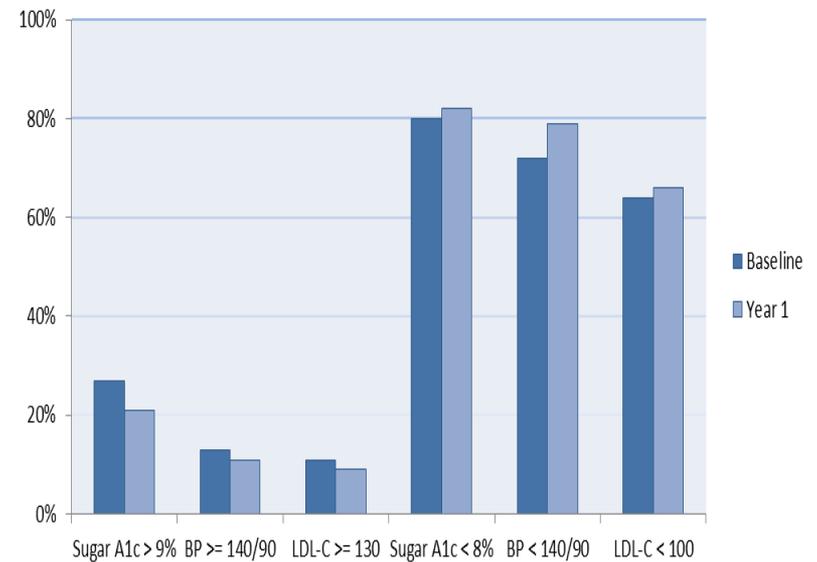
External evaluations demonstrate chronic care quality measures improved and are more consistently at target / best practice levels

- Improvement indicates that practices invested in managing the chronic care population

**Chronic Care Diabetes & Cardiovascular Disease Management:
Results of HealthTeam Works evaluation of Colorado PCMH Program**



**Chronic Care Diabetes Management:
Results of HealthCare Access evaluation of SW OH PCMH Program**



PCMH: Program Observations and Findings

Observations

- Practices need to be ready and willing to change
- Need clearly defined, engaged physician and administrative leadership
- Structure alone does not drive outcomes
- Processes need to be adopted and sustained to realize clinical and operational efficiency improvements
- Multi-stakeholder pilots provide the economies for sustainable change

Early Findings

- Dedicated embedded, care manager and coordination is key to success of overall patient population management
- Two-way data sharing enables better care management actions
- Performance payments can affect change in behavior
- Practice collaboration is key to leveraging best practices
- This is hard stuff which requires heavy lifting.....if there were easy answers, primary care wouldn't be in crisis!

Conclusion

- UnitedHealthcare is committed to working with care providers to transform the delivery system and pay for value
 - Our programs incorporate value-based payment models driving **improved quality**(as defined by evidence-based guidelines) **and cost-efficiency**
 - Care providers participating in our programs are rewarded for **improved outcomes**

- The approach to advancing a PCMH needs to be modular and targeted
 - It is critical to meet the practice where they are at on the continuum
 - Use data analysis and best practices to chart the path to improved performance

- Success requires partnership, real change and heavy lifting
 - Clearly defined, engaged physician and practice administrative leadership
 - Dedicated embedded, care manager and coordination is key
 - Two-way data sharing enables better care management actions
 - Performance payments, with distribution mechanisms, drives change in behavior
 - Collaboration and communication between stakeholders is critical

Questions

