The Quadruple Aim: Working Together, Achieving Success
CAPT Maureen Padden MD MPH FAAFP
25 January 2011
# Incentivizing the Medical Home

Presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland

1. **REPORT DATE**
   
   25 JAN 2011

2. **REPORT TYPE**

3. **DATES COVERED**
   
   00-00-2011 to 00-00-2011

4. **TITLE AND SUBTITLE**
   
   Incentivizing the Medical Home

5a. **CONTRACT NUMBER**

5b. **GRANT NUMBER**

5c. **PROGRAM ELEMENT NUMBER**

5d. **PROJECT NUMBER**

5e. **TASK NUMBER**

5f. **WORK UNIT NUMBER**

6. **AUTHOR(S)**

Navy Medicine, Bureau of Medicine & Surgery, 2300 E Street NW, Washington, DC, 20372-5300

7. **PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)**

8. **PERFORMING ORGANIZATION REPORT NUMBER**

9. **SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)**

10. **SPONSOR/MONITOR’S ACRONYM(S)**

11. **SPONSOR/MONITOR’S REPORT NUMBER(S)**

12. **DISTRIBUTION/AVAILABILITY STATEMENT**

   Approved for public release; distribution unlimited

13. **SUPPLEMENTARY NOTES**

   presented at the 2011 Military Health System Conference, January 24-27, National Harbor, Maryland

14. **ABSTRACT**

15. **SUBJECT TERMS**

16. **SECURITY CLASSIFICATION OF:**
   
   a. REPORT unclassified
   
   b. ABSTRACT unclassified
   
   c. THIS PAGE unclassified

17. **LIMITATION OF ABSTRACT**

   Same as Report (SAR)

18. **NUMBER OF PAGES**

   16

19a. **NAME OF RESPONSIBLE PERSON**

---

*Standard Form 298 (Rev. 8-98)*

Prescribed by ANSI Std Z39-18
Outline

- Discuss the Navy PCMH Initiative
- Anticipated effects of well executed PCMH
- Civilian experience with PCMH
- MHS Performance Pilots
- Review of the Pensacola Plan
Navy PMCH Initiative

- **Description**
  - Small micro-practices of 3-5 providers
  - Standardized staffing model
  - Strategic reinvestment of current resources
  - Use of 4th level MEPRS to delineate teams

- **Goal: Demand Management of enrollees**
  - Reduce unnecessary visits
  - Leverage asynchronous messaging / team based practice
  - Reduce ER utilization for primary care
Anticipated Effects of PMCH in MHS

- Improved
  - Access to Care
  - Team continuity
  - PCM continuity
  - Patient satisfaction

- Reduced Costs of Care
  - Unnecessary:
    - ER use
    - Network care
    - Ancillary tests
    - Hospitalizations
    - Specialty visits
Potential Impact on Enrollment

- Demand Management of Enrollees
- Reduced Utilization of Visits
- Unused Capacity
- Increase Enrollment

↓ Utilization + ↓ Unit Cost → ↓ PMPM $$$
Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence From Prospective Evaluation Studies in the United States

*Updated November 16, 2010*
Kevin Grumbach, MD, Paul Grundy, MD, MPH

- Group Health, Geisenger, VA, Blue Cross Blue Shield, Medicaid (NC, CO) and others…
  - Decreased PMPM
  - Decreased ER utilization
  - Decreased admissions
  - Improved quality metrics
  - Improved customer satisfaction (patients/staff)
The MHS Performance Pilot

- Could replace aspects of PPS if successful
- Components:
  - PCMH Primary Care: Capitation
  - Non PCMH Primary Care: Fee for service
  - Specialty Care: Fee for service
  - Inpatient: Fee for service
  - APV: Fee for service
  - P4P
  - Includes care management fee
Pensacola PMCH Pilot

- 33,795 enrollees in medical homes
- Historical RVU production valued at $9,105,298 in non capitated environment

But what if we de-incentivized burn and churn and incentivized production of health?
Performance Pilot

- **Capitated Funding:**
  - $267.39 per enrollee
  - 33,795 enrollees
  - $8,088,030.00

- **Care Management Fee (level 2 NCQA):**
  - $5.00 per enrollee
  - 33,795 enrollees
  - $2,027,700.00

- **Pay For Performance:**
  - Mammography
  - Cancer screenings
  - Diabetes HEDIS
  - Oryx measures
  - PCM continuity
  - 3rd next available
  - Satisfaction ratings
  - PMPM Inflation
  - ER utilization
## Pay For Performance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline*</th>
<th>Goal</th>
<th>Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>80%</td>
<td>82%</td>
<td>$122,122.00</td>
</tr>
<tr>
<td>Colorectal</td>
<td>71.6%</td>
<td>75%</td>
<td>$27,971.12</td>
</tr>
<tr>
<td>Cervical</td>
<td>83%</td>
<td>89%</td>
<td>$409,718.20</td>
</tr>
<tr>
<td>A1C screen</td>
<td>89%</td>
<td>95%</td>
<td>$92,937.40</td>
</tr>
<tr>
<td>LDL &lt; 100</td>
<td>44.4%</td>
<td>54.4%</td>
<td>$69,395.00</td>
</tr>
<tr>
<td>A1C &gt; 9.0</td>
<td>21%</td>
<td>18%</td>
<td>$78,206.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline*</th>
<th>Goal</th>
<th>Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional P4P</td>
<td></td>
<td></td>
<td>$800,349.92</td>
</tr>
</tbody>
</table>

**TOTAL**
- **Capitation**: $8,088,030.00
- **Care Mgmt Fee**: $2,027,700.00
- **Subtotal**: $10,115,730.00

*Baseline represents the current percentage achieved, and Goal represents the target percentage for the reward.
### Pay For Performance Performance Cont.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline</th>
<th>Goal</th>
<th>Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCM Continuity</td>
<td>38.8%</td>
<td>60%</td>
<td>$328,652.16</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; next routine</td>
<td>79.2%</td>
<td>86.4%</td>
<td>$94,842.94</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; next acute</td>
<td>55.6%</td>
<td>64.8%</td>
<td>$383,984.70</td>
</tr>
<tr>
<td>Satisfaction – care</td>
<td>92.3%</td>
<td>92.3%</td>
<td>--</td>
</tr>
<tr>
<td>Additional P4P</td>
<td></td>
<td></td>
<td>$807,479.80</td>
</tr>
</tbody>
</table>

*NOTE: rewards are based on increases or decreases from baseline*
Pilot Basics

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>$8,088,030.00</td>
</tr>
<tr>
<td>Care Mgmt Fee</td>
<td>$2,027,700.00</td>
</tr>
<tr>
<td>P4P HEDIS</td>
<td>$800,349.92</td>
</tr>
<tr>
<td>P4P Experience</td>
<td>$807,479.80</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$11,723,559.72</td>
</tr>
</tbody>
</table>

- Doesn’t include
  - Oryx measures
  - ER Utilization
  - PMPM Costs
    • Earn or lose based on increase/decrease of inflationary costs

- Other areas of care remain in FFS
Risks

### PPS Environment: $9,105,298.00

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>$ 8,088,030.00</td>
</tr>
<tr>
<td>Care Mgmt Fee</td>
<td>$ 2,027,700.00</td>
</tr>
<tr>
<td>P4P HEDIS</td>
<td>$800,349.92</td>
</tr>
<tr>
<td>P4P Experience</td>
<td>$807,479.80</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>11,723,559.72</strong></td>
</tr>
</tbody>
</table>

- **What if ER use increases?**
- **? NCQA recognition**
- **What if don’t improve?**
- **What if PMPM rises?**
Impact on MHS Bottom Line

- Demand Management of Enrollees
- Reduced Utilization of Visits
- Unused Capacity
- Increase Enrollment

↓ Utilization + ↓ Unit Cost

↓ PMPM $$$
Bottom Line

- Business as usual = high risk!
- Transformation of practice could result in significant reward

“If you don't like change, you're going to like irrelevance even less.”

General Eric Shinseki (ret)
Former Chief of Staff, U.S. Army

“Every system is perfectly designed to get the results it produces”

W. Edwards Deming
Questions?