

2011 Military Health System Conference

Incentivizing the Medical Home

The Quadruple Aim: Working Together, Achieving Success

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Navy Medicine

Report Documentation Page

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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



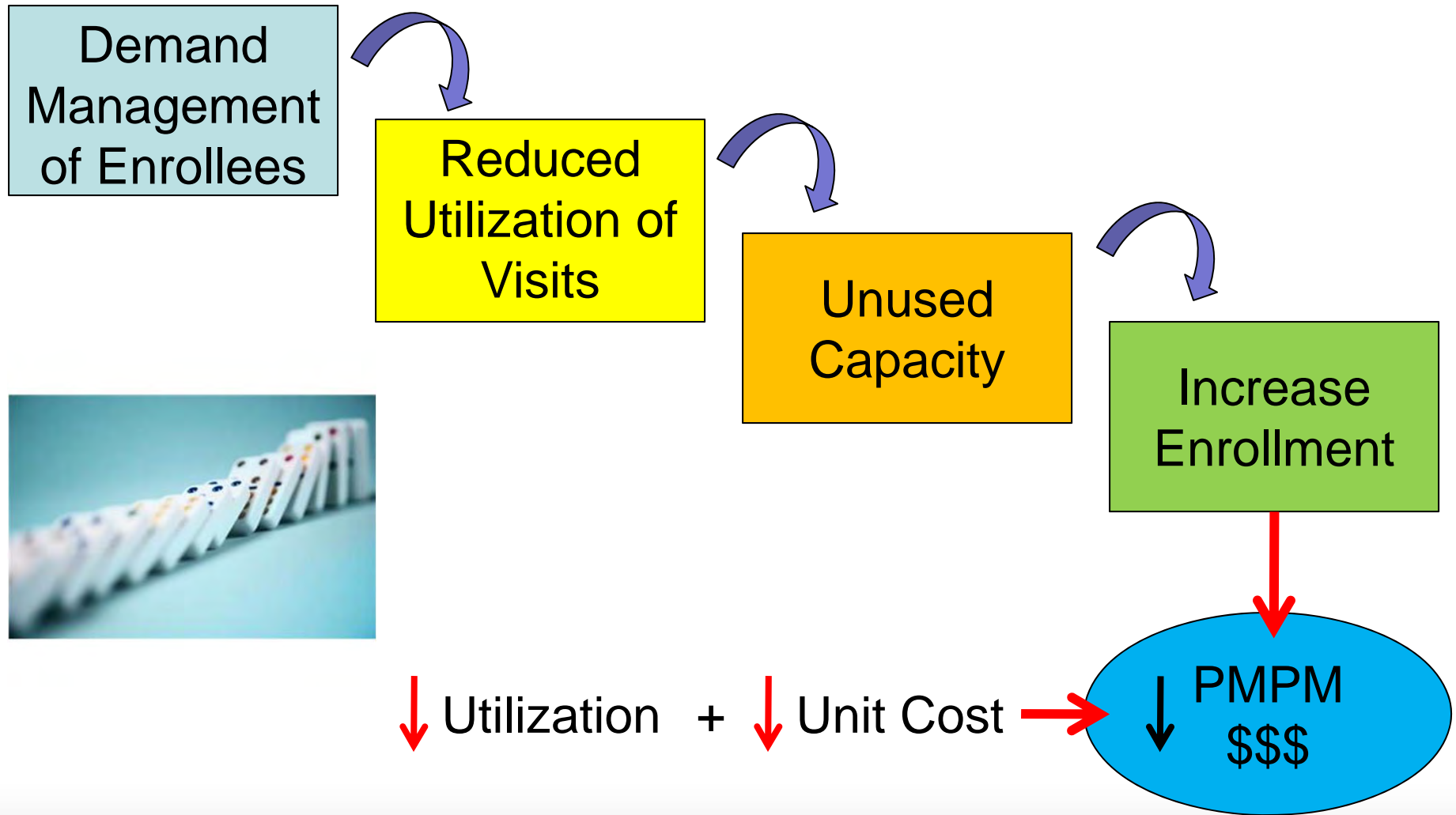
- Improved
 - Access to Care
 - Team continuity
 - PCM continuity
 - Patient satisfaction



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



Potential Impact on Enrollment



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



		Capitation	\$ 8,088,030.00
		Care Mgmt Fee	\$ 2,027,700.00
		Subtotal	\$10,115,730.00
Metric	Baseline*	Goal	Reward
Mammography	80%	↑ 82%	\$122,122.00
Colorectal	71.6%	↑ 75%	\$27,971.12
Cervical	83%	↑ 89%	\$409,718.20
A1C screen	89%	↑ 95%	\$92,937.40
LDL < 100	44.4%	↑ 54.4%	\$69,395.00
A1C > 9.0	21%	↓ 18%	\$78,206.20
		Additional P4P	\$800,349.92

Pay For Performance Cont.



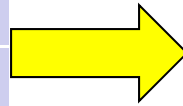
Metric	Baseline	Goal	Reward
PCM Continuity	38.8%	60%	\$328,652.16
3 rd next routine	79.2%	86.4%	\$94,842.94
3 rd next acute	55.6%	64.8%	\$383,984.70
Satisfaction – care	92.3%	92.3%	--
		Additional P4P	\$807,479.80

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

Pilot Basics



Capitation	\$ 8,088,030.00
Care Mgmt Fee	\$ 2,027,700.00
P4P HEDIS	\$800,349.92
P4P Experience	\$807,479.80
Subtotal	11,723,559.72



- Doesn't include
 - Oryx measures
 - ER Utilization
 - Earn or lose based on increase/decrease
 - PMPM Costs
 - Earn or lose based on increase/decrease of inflationary costs
- Other areas of care remain in FFS

Risks

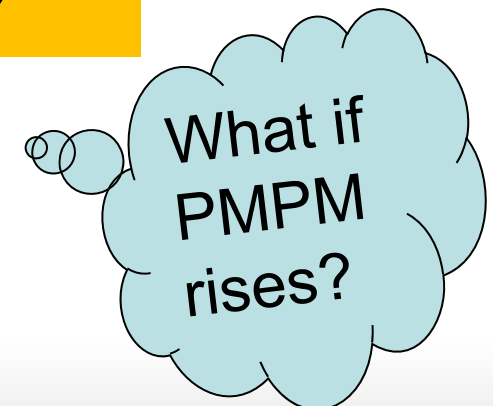
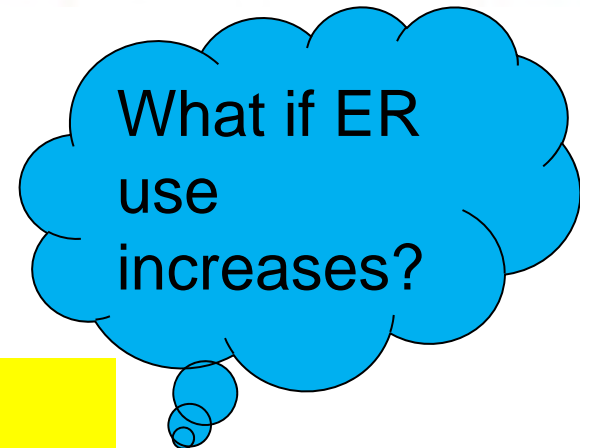


PPS Environment: \$9,105,298.00

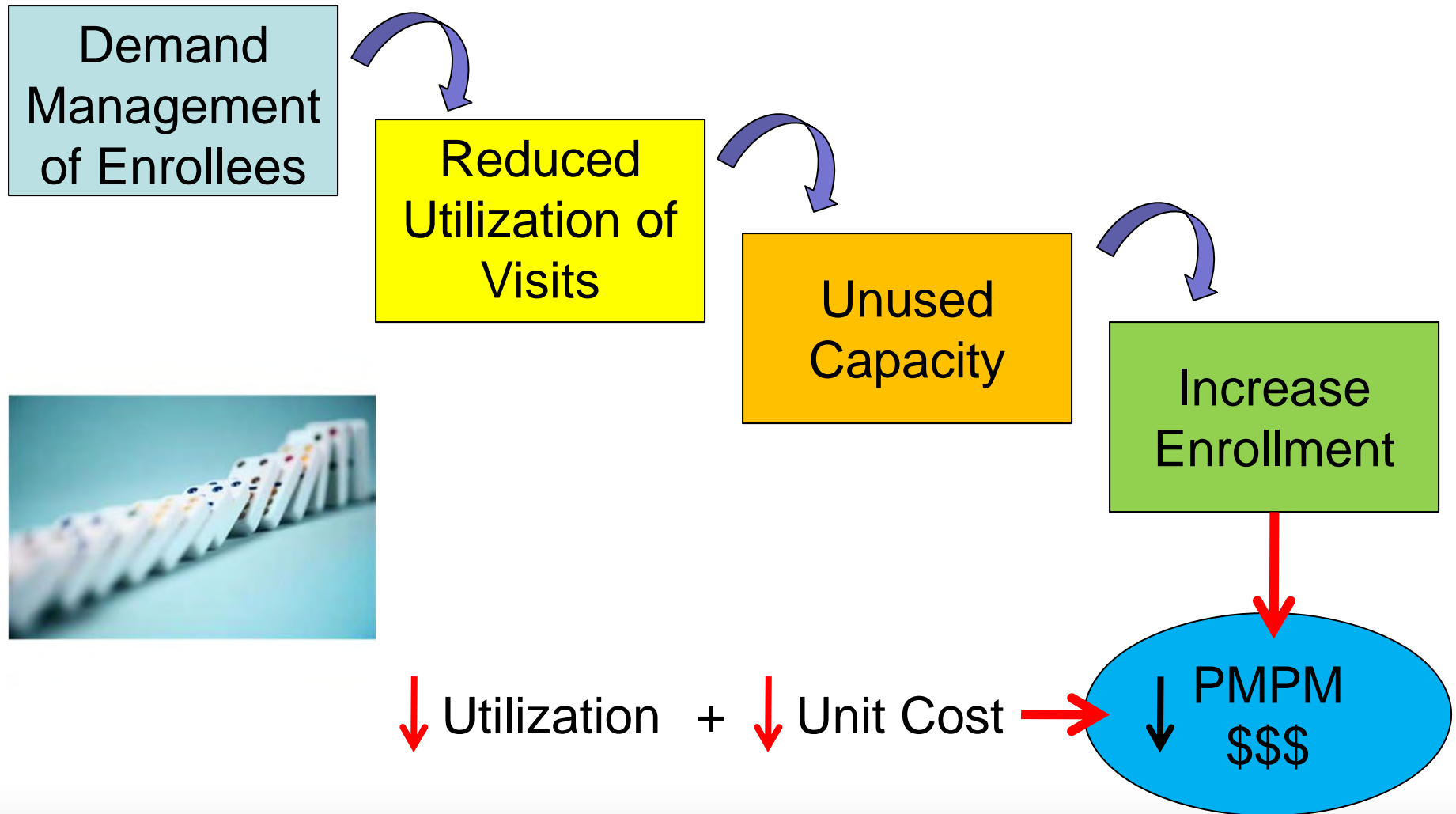
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? NCQA
recognition

What if don't
improve?



Impact on MHS Bottom Line



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?