Patient-Centered Medical Home

Transform Your Practice
The NYeC Regional Extension Center (NYeC) Regional Extension Center (REC)

- The NYeC Regional Extension Center is the physician’s trusted advisor in the timely delivery of quality healthcare through technology.
- The NYeC REC works with a network of agents throughout the state to assist with this mission.

**NYeC PCMH Team**

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What is a Patient-Centered Medical Home (PCMH)?
- Benefits of PCMH to your practice
- Alignment with Meaningful Use and Accountable Care Organizations
- Research Findings
- Recognition Programs
- National and New York State Activities
- Questions – contact NYeC

Guest - Dr. Sal Volpe - a provider who has transformed his practice to a PCMH since 2009.
- Dr. Volpe was the first solo practice in NY to achieve 2009 Level 3 NCQA PCMH recognition and the first in the United States to earn Level 3 2011 NCQA recognition.
What is Patient-Centered Medical Home?

• PCMH is a care model that strengthens the clinician-patient relationship by
  o Utilizing a team approach implemented with collaborative responsibility for patient care
  o Continuous and quality improvements that are embedded in the practice culture
  o Patients understanding their healthcare needs and participating in managing their care

• A medical home is characterized by
  o Continuous and open communication between patients and providers
  o Use of enabled health information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance
  o High levels of accessibility

http://www.ncqa.org/LinkClick.aspx?fileticket=ycS4coFOGnw%3d&tabid=631
Benefits of the PCMH Model

For your Practice
Principles of a Medical Home

- Personal physician
- Physician directed team based care
- Whole person orientation
- Patient self management
- Population Health management

- Care management
- Care coordination or integration
- Enhanced access to care
- Electronic systems
- Quality and safety
- Measuring and improving Performance
Practice Transformation Features/Benefits

**Features** of a high performing PCMH practice:
- Dedicated care managers
- Expanded access
- Data-driven analytic tools
- Staff learn collaboratively
- Sharing of best practices
- Incentives

**Benefits** may include:
- Improved patient experience
- Reduced clinician burnout
- Reduced hospitalization rates
- Reduced ER visits
- Increased savings per patient
- Higher quality of care
- Reduced cost of care

- Numerous payers in the state offer incentive payments to providers who meet the NCQA criteria
PCMH Alignment with Meaningful Use and Accountable Care Organizations
PCMH 2011 and Meaningful Use

- PCMH is closely aligned with **Stage 1 Meaningful Use** measures including:
  - Electronic prescribing - eRx
  - Drug formulary, drug-drug, drug allergy checks
  - Maintaining an up-to-date problem list of current and active diagnoses and medications
  - Recording demographics on preferred language, gender, race, ethnicity, and date of birth
  - Recording and charting changes in vital signs
  - Recording smoking status
  - Reporting ambulatory quality measures
  - Implementing clinical decision support rules
PCMH as a Foundation for Accountable Care Organizations

ACOs are groups of doctors, hospitals, and other health care providers who come together to provide coordinated, high-quality care to their patients.

An ACO has the legal structure to receive and distribute incentive payments to participating providers.

The goals of both ACOs and the PCMH are focused on the triple aim:

- Better coordinated care
- Better health outcomes
- Lower costs
Alignment of Meaningful Use - PCMHs - ACOs

Meaningful Use as a Building Block

Use information to transform

Improve access to information

Data utilized to improve delivery and outcomes
- Patient self management
- Patient engaged, community resources

Data utilized to improve delivery and outcomes
- Patient centered care coordination
- Team based care, case management

Improved population health
Enhanced access and continuity

Utilize technology to gather information

Basic EHR functionality, structured data
Structured data utilized
Privacy & security protections

Care coordination
Patient informed
Privacy & security protections

Evidenced based medicine
Registries for disease management
Privacy & security protections

Stage 2 MU
PCMHs
ACOs
Stage 3 MU

32
Research Findings
Evidence of Improvements Research

✓ The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout for Providers
  ✓ Saman, Health Affairs, May 2010

✓ Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits and Demonstrated Plan ROI
  ✓ Harbrecht, September 2012

✓ PCMH Improves Low-Income Patient Access, Reduces Inequities
  ✓ Berenson, Commonwealth Fund, May 2012

✓ PCMH Improves Quality and Patient Satisfaction, Lowers Costs
  ✓ PCPCC, September 2013
Medical Home Principles

How to Become a PCMH
Joint Principles for the Medical Home

- The **joint principles** of the “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs” were released in March 2007 by four organizations:
  - American Academy of Family Physicians (AAFP)
  - American Academy of Pediatrics (AAP)
  - American College of Physicians (ACP)
  - American Osteopathic Association (AOA)

- The seven foundational components embodied in these joint principles of PCMH are the following concepts:
  - the personal physician
  - a physician-directed, team-based approach to medical practice
  - a whole-person orientation
  - coordinated and integrated care
  - quality and safety
  - enhanced access
  - appropriate payment framework
There are four Medical Home Recognition and Accreditation Programs

1. National Committee for Quality Assurance (NCQA)
2. URAC (formerly the Utilization Review Accreditation Commission)
3. Joint Commission
4. Accreditation Association for Ambulatory Health Care AAAHC
NCQA and its PCMH Certification

• NYeC is working primarily with NCQA for PCMH accreditation and recognition.
• The National Committee for Quality Assurance (NCQA) is an organization driving improvement throughout the healthcare system and helping to elevate the issue of healthcare quality to the top of the national agenda.
• NCQA reviews the submissions of practices undergoing Patient Centered Medical Home (PCMH) transformation based on their standards.
There are two NCQA medical home certifications - PCMH and PCSP

- NCQA’s Patient-Centered Medical Home standards - for primary care providers - first released in 2008
  - 2011 updated version published in 2011 ("PCMH 2011").
  - 2014 standards were released in late March 2014

- The NCQA 2011 PCMH standards align closely with using health information technology to improve quality and with meaningful use Stage 1 requirements. The 2014 Standards align with MU Stage 2.

NCQA’s Patient-Centered Specialty Practice (PCSP) program is for specialists and was released in 2013
**Site Specific Recognition and Provider Eligibility**

- NCQA recognition is granted to the **practice sites**, as well as the eligible providers practicing at those sites
  - Recognized providers are listed by name on the NCQA website

<table>
<thead>
<tr>
<th>For both Patient Centered Medical Home (PCMH) AND Patient Centered Specialty Practice (PCSP) eligible providers include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers (MDs and DOs)</td>
</tr>
<tr>
<td>Nurse Practitioners (NPs)</td>
</tr>
<tr>
<td>Physician Assistants (PAs)</td>
</tr>
</tbody>
</table>

- For the Patient-Centered Specialty Practice (PCSP) besides physicians (MDs and DOs), NPs, and PAs, the following are also eligible:
  - Certified Nurse Midwives
  - Behavioral Health Specialists including
    - State Certified or Licensed Psychologists and Clinical Social Workers
    - marriage and family counselors registered or licensed by the state to practice independently
NCQA PCMH Recognition

There are **three levels** of NCQA PCMH Recognition. The period of recognition is three years at which point it must be renewed.

- Recognition is based on a points system
- Each level reflects the degree to which a practice meets the requirements of the elements and factors that compose the standards
- To satisfy each element’s requirements, NCQA requires specific documentation

<table>
<thead>
<tr>
<th>Level</th>
<th>Points/100</th>
<th>Level of Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>35 - 59</td>
<td>Can be achieved without an EHR</td>
</tr>
<tr>
<td>Level 2</td>
<td>60 - 84</td>
<td>Requires some EHR functionality</td>
</tr>
<tr>
<td>Level 3</td>
<td>85 - 100</td>
<td>Requires a fully functioning EHR</td>
</tr>
<tr>
<td></td>
<td>0 - 34</td>
<td>Not recognized</td>
</tr>
</tbody>
</table>
The NCQA certification program embraces the standards of the Patient Centered Medical Home.

There are six Standards in the PCMH 2012 Program

- 27 elements and further divided into 149 factors with 6 must pass elements
  - There are six must-pass elements that the practice must pass to obtain recognition.
- The six standards align with the core components of primary care.
  1. Enhance access and continuity
  2. Identify and manage patient populations
  3. Plan and manage care
  4. Provide self-care and community support
  5. Track and coordinate care
  6. Measure and improve performance
# PCMH 2011 Standards, Elements, Must Pass Elements, and Scoring

## PCMH 2011 Content and Scoring

### **Must Pass Elements**

<table>
<thead>
<tr>
<th>PCMH 1: Enhance Access and Continuity</th>
<th>Pts</th>
<th>PCMH 4: Provide Self-Care and Community Resources</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
<td>A. Support Self-Care Process**</td>
<td>6</td>
</tr>
<tr>
<td>B. Access After Hours</td>
<td>4</td>
<td>B. Provide Referrals to Community Resources</td>
<td>3</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Continuity (with provider)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Medical Home Responsibilities</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Culturally/Linguistically Appropriate Services</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Practice Organization</td>
<td>20</td>
<td></td>
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### PCMH 2: Identify and Manage Patient Populations

| A. Patient Information                                                   | 3   | PCMH 5: Track and Coordinate Care               | Pts |
| B. Clinical Data                                                         | 4   | A. Track Tests and Follow-Up                    | 6   |
| C. Comprehensive Health Assessment                                       | 4   | B. Track Referrals and Follow-Up**              | 6   |
| D. Use Data for Population Management**                                  | 5   | C. Coordinate with Facilities/Care Transitions  | 6   |
|                                                                           | 16  |                                                 | 18  |

### PCMH 3: Plan and Manage Care

| A. Implement Evidence-Based Guidelines                                    | 4   | PCMH 6: Measure and Improve Performance        | Pts |
| B. Identify High-Risk Patients                                           | 3   | A. Measure Performance                         | 4   |
| C. Care Management**                                                     | 4   | B. Measure Patient/Family Experience           | 4   |
| D. Medication Management                                                 | 3   |                                                 |     |
| E. Use Electronic Prescribing                                            | 3   | C. Implement Continuous Quality Improvement**  | 4   |
|                                                                           | 17  |                                                 | 20  |

| Optional Patient Experiences Survey                                      | 100 |                                                 |     |
NCQA PCMH 2011 and 2014 Application Dates

**PCMH 2011**
- June 30, 2014: Last day to purchase PCMH 2011 ISS Tool
- March 31, 2015: Last day to submit PCMH ISS Tool for recognition
- March 2015: PCMH 2011 retired

**PCMH 2014**
- March 2014: PCMH 2014 Product Released
- June 2014: First Application
PCMH Activity in New York State
PCMH Distribution by Region

Non-NYC PCMH Providers by Region, Practice Type
Sept 2012 (N = 2,544)

4,631 NY providers recognized as PCMH providers by the NCQA September 2013

> 48,000 clinicians achieved NCQA PCMH recognition across the country December 2013

“The Patient-Centered Medical Home Some Open Issues” G. Burke United Hospital Fund
Recognition Initiatives
PCMH Payer Initiatives

37 States* Have Public and Private Patient-Centered Medical Home (PCMH) Initiatives That Use NCQA Recognition

*Includes the District of Columbia

November 2013
Numerous payers in New York State and in the country offer **incentive payments** to providers who meet the NCQA criteria:

- Aetna
- Cigna
- Anthem/WellPoint
- Kaiser
- BCBS of 10 States
- Independent Health (NJ)
- Empire (NY)
- Excellus (NY)
- Amerigroup Corporation

**Health Plans and NYS Initiatives Associated with NCQA PCMH**

A sampling of health plans and payers offering incentives:

- Emblem Health (NY)
- Capital District (CDPHP) (NY)
- Medical Advantage Group (MI)
- Priority Health (MI)
- L.A. Health Care Plan (CA)
- Independence BCBS (PA)
- Highmark (PA)
- Rocky Mountain Health Plan (CO)

Some PCMH initiatives in New York State include:

- NY State Medicaid
- Primary Care Information Project (PCIP)
- New York State Health Foundation
- NYS Hospital Medical Home Demo
New York Medicaid has provided financial incentives for recognized practices to facilitate the expansion of medical homes in NYS as a model of care that seeks to strengthen the physician-patient relationship and improve health care services and outcomes. Incentive for recognition using 2011 NCQA standards.

Payments for NCQA Level 2 and Level 3

| Level 3 PCMH providers, who achieved their recognition under the NCQA 2008 standards, will have their incentive payments reduced to $5PMPM and $14.05 and $17.85 per visit for FFS. Medicaid managed care reductions will be effective as of July 1, 2013. FFS reductions will be retroactive to July 1, 2013, contingent upon completion of eMedNY system edits. When a provider achieves PCMH recognition using the NCQA 2011 standards, their PCMH incentive payments will be reinstated at a higher level (see table below). |

<table>
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<tr>
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<tbody>
<tr>
<td>Institutional</td>
<td>$0 / $11.25</td>
<td>$14.05 / $16.75</td>
</tr>
<tr>
<td>Professional</td>
<td>$0 / $14.25</td>
<td>$17.85 / $21.25</td>
</tr>
</tbody>
</table>

* NCQA Level 1 payments discontinued effective January 1, 2013. NCQA Level 2 payments (for 2008 standards) discontinued effective July 1, 2013.
### Some of the NYeC REC programs include

<table>
<thead>
<tr>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EHR adoption and implementation support for over 6,000 Primary Care Providers and Specialists</strong></td>
</tr>
<tr>
<td><strong>Meaningful Use recognition for over 3,700 providers in the state</strong></td>
</tr>
<tr>
<td><strong>Technical assistance and EHR adoption support and connectivity for over 3,200 behavioral health providers</strong></td>
</tr>
<tr>
<td><strong>Privacy and Security guidance for practices to secure their protected health information (PHI) and satisfy the MU and HIPAA requirements</strong></td>
</tr>
<tr>
<td><strong>Diabetes Recognition Program for participating providers</strong></td>
</tr>
</tbody>
</table>
The New York eHealth Collaborative Regional Extension Center

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Dr. Sal Volpe

PCMH NCQA Level 3 Practice
since 2009
Sal Volpe – NCQA PCMH Level 3 Practice Since 2009

Salvatore Volpe, MD FAAP FACP CHCQM has 25 years of primary care medical practice experience in New York City.

He is one of the few physicians in the country to have achieved board certification in Pediatrics, Internal Medicine, Geriatrics and Quality Assurance

• In 2009 Dr. Volpe’s medical practice became the first solo practice in the state of NY to achieve Level 3 NCQA Patient Centered Medical Home Recognition.

• In 2011 Dr. Volpe was the first solo practice in the country to achieve Level 3 NCQA recognition.
Polling Questions
Polling Questions

• What is your practice’s status relative to the PCMH transformation process?
• What is your greatest concern about implementing PCMH in your practice?
• What Health IT initiatives can we NYeC help you learn more about? Meaningful Use Stage 2
Some Resources

and

Your Questions
Some Resources and Links

- "Transitioning Your Practice to the Patient-Centered Medical Home" educational video explains the 2011 NCQA standards and process for obtaining an accreditation
- Benefits of Implementing the Primary Care Patient-Centered Medical Home: A review of Cost and Quality Results, 2012 at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=CPQoPjxO47Q%3D&tabid=114
- May 17, 2013 “The Patient-Centered Medical Home Some Open Issues“ G. Burke United Hospital Fund HEALTHFIRST 2013 SPRING SYMPOSIUM Patient Centered Medical Homes - Building Healthy Communities
- Healthit.gov

- Organizations
  - ncqa.org
  - pcmh.ahrq.gov
  - pcpcc.net
  - aafp.org
  - medhomeinfo.org
  - aap.org
  - acponline.org
Upcoming NYeC REC Webinar

• Privacy and Security of your Electronic Health Records

• Stay tuned!

: Look for the announcement!
Questions
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Other NYS Payer Programs that have been Active in the State

• Capital District Physicians Health Plan (CDPHP), Aetna, and United Healthcare had pilots where they paid an enhanced fee for physicians that offer primary care in NCQA recognized PCMHs.

<table>
<thead>
<tr>
<th>Payment Model Component</th>
<th>PMPM Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care management payments</td>
<td>Up to $2.50 PMPM</td>
</tr>
<tr>
<td>Pay-for-performance payments</td>
<td>Up to $2.50 PMPM</td>
</tr>
</tbody>
</table>

• Emblem Health PCMH Program that had been in effect

<table>
<thead>
<tr>
<th>Payment Model Component</th>
<th>PMPM Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice transformation cost payments (year 1 only)</td>
<td>$1.67 PMPM</td>
</tr>
<tr>
<td>Performance bonus (beginning in year 2)</td>
<td>Up to $2.38 PMPM (value based on performance)</td>
</tr>
<tr>
<td>Risk-adjustment</td>
<td>Up to $1.67 PMPM (only for practices with above average patient panel risk profiles; amount varies by practice)</td>
</tr>
</tbody>
</table>
Federal Support for PCMH

- Direct Contracts with NCQA Involvement
  - HRSA PCMH Initiative
  - CMS Advanced Primary Care Practice Demo
  - Military Health System

- Other Federal Initiatives
  - HRSA FQHC Advanced Primary Care Practice Demo
  - Comprehensive Primary Care Initiative
  - Beacon and SIM Grants
  - EHR Incentive Programs

- Congress, CMS debating additional support
  - Proposals would tie Medicare care management payment to recognition

- Source – NCQA