



Health Care Access for All

Community Clinics and Health Centers: Developing an Enhanced Primary Care Medical Home

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Background

The medical home is a model of care that is taking root in both public and private payer programs in an effort to improve quality, control costs and increase both patient and provider satisfaction. Since 2006, more than 30 states have been leading efforts to advance medical homes in their Medicaid and Children's Health Insurance Program and several states are leading multi-payer medical home collaboratives to spread this model in the private sector. In addition, in late 2009, the federal Centers for Medicare and Medicaid Services (CMS) announced its intention to implement and evaluate a Medicare Patient-Centered Medical Home demonstration working with federally qualified health centers (FQHCs) as the medical home.

CPCA believes that California's next 1115 Medicaid waiver provides an opportunity to develop, demonstrate and implement the primary care medical home (PCMH), or enhanced PCMH programs. California should propose to use the five years of a new waiver to demonstrate, develop and refine the elements of a community clinic and health center-based patient-centered medical home (CCHC-PCMH) in the Medi-Cal program.¹ CPCA believes that California can and should pilot PCMH models to serve the various Medi-Cal populations covered under the waiver, including seniors and persons with disabilities (SPDs), in different care settings and communities, urban and rural, and in counties with active Medi-Cal managed care programs and in non-managed care counties.

Community Clinics as Primary Care Medical Homes

CCHCs are uniquely experienced to serve as the PCMH for SPDs because of their track record as providers who have always developed the medical and social services necessary to meet the specific needs of the special populations they serve--whether it be low-income women and children, migrant farmworkers, patients with HIV/AIDS, homeless persons, or seniors and disabled persons needing home and community-based services and supports. CCHCs have historically offered cost-effective, patient-centered services that address the health, mental health and social service needs of low-income and vulnerable populations. CCHCs by mission and organizational structure are leaders in designing programs and services that address health disparities, as well as the social and environmental factors that contribute to poor health outcomes, such as homelessness, unemployment, drug and alcohol addiction, poor nutrition, illiteracy, and poverty. CCHCs offer a medical home

¹ Community clinics and health centers are those nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CCHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. Clinics meeting federal requirements and definitions for purposes of Medicaid reimbursement may also be referred to as federally qualified health centers (FQHCs) or FQHC look-alikes.

for the hardest to reach patients by addressing the obstacles that keep them away from care. The CMS announcement of the Medicare medical home demonstration is recognition of the successes demonstrated by CCHCs.

California's CCHCs are well positioned to engage in the development and the implementation of the PCMH concept in California, building on the track record of the CCHC as a community-based, patient-centered delivery system that emphasizes the diverse needs of patients--health, medical and social support.

Defining a Medical Home

A patient-centered primary care medical home, sometimes also referred to as an “enhanced medical home” is a model for care provided in community-based primary care settings. The PCMH provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management – across the lifespan. It seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship. Care in a medical home is rewarding for clinical teams to provide and satisfying for patients and families to receive.

Many believe that this comprehensive vision for primary care services through a PCMH is a model of care that holds significant promise for better health care quality, improved involvement of patients in their own care and reduced avoidable costs over time. While there are multiple approaches and models of care, the most commonly defined elements of the PCMH are:

- Assignment of enrollees to a provider of primary care services or PCMH that assumes lead responsibility for the medical and health care needs of the assigned members;
- Identification, assessment, and stratification of the needs of the target population(s) by the PCMH;
- Tailored care interventions to meet the health and medical care needs of subsets of the target population, including those experiencing disparities in care associated with race, ethnicity, language, and literacy;
- Effective care coordination and referral management to link beneficiaries to the specialty providers and community-based services that can assist in addressing complex medical, psychosocial, and social support needs, with an emphasis on focused care coordination and monitoring of high-risk enrollees who might otherwise experience expensive hospitalizations and/or emergency room utilization;
- Use of innovative Health Information Technology (HIT) solutions to share data with providers on the PCMH panel of patients, support practice performance improvement, and expand the use of evidence-based care guidelines;
- Measurement of the PCMH performance to promote accountability and quality improvement; and,
- Financing structured to support the PCMH ability to perform the above functions.

Recognizing Medical Homes Using Measurable Standards

A central feature of the PCMH is the adoption of measurable standards and recognition processes that identify the PCMH as having the systems and the capacity to effectively manage and coordinate health and medical care services across a defined population of enrollees. The most effective models for PCMH standards are emerging and developing in the context of the numerous demonstration programs implemented around the country. No single set of measurable standards has yet been identified as ideal.

One of the preeminent models, the Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) standards and guidelines developed by the National Committee for Quality Assurance (NCQA), is to date one of the most widely used set of standards for demonstration of the PCMH concept. NCQA standards could form the basis of a California demonstration, with appropriate modifications for the Medi-Cal population

to be served, CCHCs and other safety net providers. The NCQA recognition model contemplates three levels of standards with increasing complexity and technology enhancements that improve the ability of the PCMH to track and monitor the care of patients enrolled at the primary care practice. NCQA is currently working on revisions to the medical home standards (expected by January 2011) to specifically address non-physician led practice settings, including safety-net care providers such as CCHCs.

California can and should also look to new and emerging approaches which have built on and refined the NCQA standards. The model CMS selects for implementation of the FQHC PCMH in Medicare may be a good starting point. CMS may choose to implement the elements of a PCMH developed in 2008 for CMS by Mathematica. The Mathematica approach incorporates a two-tier model that reflects standards to be met by the PCMH, but also adds an illness severity score for patients with chronic and complex health conditions permitting risk-adjusted and tiered reimbursement based on the anticipated care needs of the patients. The Center for Medical Home Improvement's Medical Home Index Criteria focuses on the PCMHs organizational capacity, management of chronic conditions, care coordination, community outreach, quality improvement and data management. To the extent that appropriate medical home standards are incorporated into already existing accreditation and certification programs, such as the Joint Commission and the Accreditation Association for Ambulatory Health Care, these methods of recognition should also be acknowledged.

Regardless of the specific model(s) adopted, CPCA believes that the waiver should include a PCMH demonstration that meets the following standards:

- Multiple levels of PCMHs based on the capacities of the PCMH and the standards to be met to ensure maximum participation by the full range of safety net primary care providers now serving Medi-Cal patients;
- Standards and expectations that emphasize a team-based approach to care, active care coordination and care monitoring, chronic disease management and linkages to specialists and community-based social support services;
- Phase-in of the standards and the opportunity for technical assistance / support in the development and expansion of the PCMH's capacity to manage, track and measure care delivered; and,
- Reimbursement structures and care management fees that acknowledge both the level of standards required and the specific needs of patients at different levels of risk and costs.

Care Management Fees

Once a primary care practice has been designated a medical home, the goal of the new standards programs is to provide to the PCMH a supplemental reimbursement called a *care management fee*. This fee recognizes the added value provided to patients by the PCMH and the additional costs associated with enhanced responsibilities for the primary care providers involved in their care.

- The *care management fee* is generally paid based on a per member per month (PMPM) amount for each patient linked to the PCMH and represents an additional and separate payment in addition to payments for health care services provided and reimbursed. However, in some states, payers have made lump sum payments up front to fund the additional costs for care coordinators and HIT improvements.
- The *care management fee* amount can and should vary for the levels of risk associated with various patient types and would also vary by the standard-based levels achieved by the CCHC. CPCA believes that the care management fee should be adjusted based on the severity of illness and burden to the clinic similar in concept to the Mathematica model developed for CMS.

As in other medical home demonstration projects involving CCHCs around the country, FQHCs and FQHC look-alikes would continue to receive the federally required Medi-Cal FQHC rates, but would also receive additional monthly care coordination fees for the members enrolled at CCHC primary care sites. The payment would be for levels of case management and care coordination beyond the case management services contemplated under the federal rules for FQHC reimbursement and allowable as FQHC costs. For example, in a three-tier model, all CCHC-PCMHs would receive graduated care coordination fees for three levels of PCMH. FQHCs and FQHC look-alikes might receive the enhanced payments at levels two and three, depending on the services delineated at each.

Delivery System Support

The PCMH model needs to be integrated into the overall Medi-Cal delivery system in both managed care and non-managed care counties. In counties where the PCMH demonstration is implemented, any and all managed care organizations or administrative entity engaged in the medical home demonstration should be required to include in the Medi-Cal PCMH delivery system all safety net providers who meet the standards, including qualified CCHCs.

Managed Care Counties: In Medi-Cal managed care counties, the PCMH and the managed care plan or plans engaged in the demonstration should engage in a partnership to develop the PCMH program and to coordinate service delivery with the other providers in the system, including specialists and hospital providers. Medi-Cal managed care plans should do the following:

- Contract with PCMHs and implement care management fees, quality reward payments and shared savings arrangements to enhance primary care reimbursement and to reflect the care coordination and service needs of the specific covered populations;
- Identify and assign enrollees based on enrollee choice of primary care provider and provide PCMH partners with the results of an initial health risk assessment at enrollment and with ongoing utilization data and support, including hospitalization, emergency room use and discharge planning support;
- Collect and disseminate claims and encounter data;
- Develop outcomes data and reporting for internal quality improvement and state compliance;
- Provide grants and technical assistance to PCMHs, to helping meeting and monitor their compliance with PCMH core standards;
- Provide required IT and ongoing enhancements; and,
- Offer stop-loss, risk management or other related financial support depending on the reimbursement and risk model(s) adopted.

Non-managed Care Counties: In non-managed care counties, including rural counties, the PCMH demonstration could also be developed. Any administering entity or entities selected by the state to manage the project in those counties would engage in the partnership to develop the PCMH program and to coordinate service delivery with the other providers in the system.