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UnitedHealthcare Patient-Centered Medical Home (PCMH)

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**NBCH eValue8™ Award for Innovation:
Making a Difference in Health Care**



Overview: Key Aspects of the UHC PCMH Model

Primary Care Practice Transformation: A practice team commits to:

- Expanding patient access and engagement
- Improving chronic condition population management
- Strong emphasis on Prevention and Wellness Education
- Providing team-based care that focuses on care transitions and coordination
- Monitoring performance on key quality/utilization measures and effectiveness
- Utilizing available technologies including patient registries and e-prescribing

Primary Care Practice Support: Assistance by either a pilot convening organization, the state Quality Improvement Organization (QIO) or participating payers that:

- Assist in the practice transformation and acquiring NCQA PPC-PCMH certification
- Provide enabling technologies
- Provide timely/actionable patient clinical data
- Provide care coordination support

Enhanced Reimbursement: Restructuring of the reimbursement model so that the primary care practice processes are aligned with the benefits of a transformed, comprehensive primary care management model

- **Activated Consumer: A consumer that is engaged by the PCMH pilot stakeholders – medical home practices, employers and payers**



Current UnitedHealth Pilot Activity

Rhode Island (RI-CSI)

- Multi-payer, 5 practices; started October 2008
- All practices have achieved NCQA PPC-PCMH recognition
- Currently engaged in weekly care management data sharing and follow-up
- Consistent multi-payer care opportunity reporting under development

Arizona (UnitedHealth Group only)

- 7 practices; started April 2009
- Evaluate8 2009 innovation award received
- All practices have submitted for NCQA PPC-PCMH recognition; two practices at a Level 3
- Transition Care data sharing for IP (augmented with CTM-3 survey tool for readmission risk)
- This market is evaluated using an advanced performance measurement / bonus model

Colorado (CCGC)

- Multi-payer, 15 practices and 45 physicians; started May 2009
- Collaborative deploying performance measurement and bonus model
- UHC has provided baseline for performance measurement
- Engagement with local hospital association to close the 'notification' gap

Ohio

- Multi-payer, 14 practices and over 50 physicians; started 2009 Q4
- Convening authority with strong employer support established

NY Mid-Hudson (THINC)

- Multi-payer, 11 practices; started 2009 Q4
- Performance report under development, built off of local RHIO effort



Program Savings Model

- UnitedHealthcare’s savings model assumes increased access, improved care coordination and a patient-centric approach to ensure the right care, from the right provider, at the right time
- The increased primary care reimbursement is generated from an anticipated reduction in avoidable and/or duplicative services and clinical practice in accordance with the EBM guidelines
- Six primary benefit levers for utilization and medical/pharmacy cost spend are expected to be impacted by the transformed, comprehensive primary care practice

	IP Admits	OP ER Visits	Sub-Optimal Physician Utilization	Pharmacy Spend	Radiology Spend	CCM Per Patient Spend
Target Reduction	10%	15%	25%	3%	2.5%	2%
Gross Savings Contribution	51%	16%	5%	12%	5%	12%



Pilot Reimbursement Model

This is the primary reimbursement model adapted to each pilot market.

FEE FOR SERVICE

+

PMPM FEE

+

PERFORMANCE
BONUS

=

TOTAL REIMBURSEMENT

Total Reimbursement builds on the current Fee for Service (FFS) with a PMPM Fee and a bonus option based on practice performance.

- Physicians remain on current contracted fee schedules and continue to be reimbursed based on actual services provided
- Quarterly, prospective PMPM supplement based upon quality, efficiency and satisfaction improvements anticipated under the PCMH Model – contract addendum required
- PCMH is grounded in providing more comprehensive, coordinated care and reducing the delivery of services in suboptimal settings; it is not about delivering less care to the patient (not capitation)
- Pilot practices will be eligible for a quarterly performance bonus that aligns with clearly defined clinical quality, medical cost and operational measures that will be developed collaboratively with the pilot practices



Performance Measure Evolution Through Pilot

Distinct measures – evaluated at different stages during the pilot – builds the foundation for Performance-Based Contracting.



EARLY		MIDDLE				LATE						
Pilot Yr1, Q1	Pilot Yr1, Q2	Pilot Yr1, Q3	Pilot Yr1, Q4	Pilot Yr2, Q1	Pilot Yr2, Q2	Pilot Yr2, Q3	Pilot Yr2, Q4	Pilot Yr3, Q1	Pilot Yr3, Q2	Pilot Yr3, Q3	Pilot Yr4, Q4	
Electronic Registry Implementation	Electronic Registry Implementation	Electronic Registry Implementation				Electronic Registry Implementation						
		Access & Availability	Care Transitions			Care Transitions						
	Access & Availability	Care Transitions	Population Management	Patient Engagement		Prescribing of Tier1						
	Patient Survey Implementation			Prescribing of Tier1		Patient Satisfaction						
Access & Availability	Care Transitions	Patient Engagement	Q&E Specialty Use (Cardio & Ortho)			Inpatient Bed Days (Med/Surg) per 1000						
		Population Management	Outpatient ER visits per 1000			Outpatient ER visits per 1000						
	Q&E Specialty Use	Q&E Specialty Use	Inpatient Bed Days (Med/Surg) per 1000			Clinical Quality Composite measure						
Patient Survey Implementation	ePrescribing Utilization	ePrescribing Utilization	Clinical Quality Composite measures			Clinical Quality Composite measure						
	Patient Engagement	Patient Satisfaction										
STRUCTURE			PROCESS				OUTCOMES					



Summary - Program Highlights

- **UHC Attribution model** has been accepted as the norm for three multi-payer markets and promoted for other PCMH pilot markets
- **Performance Bonus model** is based on a progressive capability model that evolves from providing a bonus for structural, then for process and finally outcomes-based measures and goals
- Comprehensive **Landscape Report** provides high-level practice assessment data for proactive, performance improvement strategy setting
- **Timely data sharing** provided to practices of IP/ER events from pre-claim processing data with an imbedded CTM-3 (Dr. Eric Coleman) survey to assess patient's IP readmission risk; identified need to improve hospital-PCP communication
- **Coordinated referral** process with OptumHealth and practices to ensure more PCP involvement in referrals for case and disease management for patients with high-risk chronic conditions as well as patients that have behavioral health needs
 - For RI, testing the use of embedded case managers funded by payers
 - For AZ, UHC is testing the value of a **dedicated Care Advocate** that 1) facilitates data sharing between UHC and the practices and 2) promotes care management "best practices" and process improvement
 - For AZ, UHC introduced the **Primary Care Assessment Tools (PCAT)** administered by Michigan State University



Future of the Medical Home

- Increasing role of performance based contracting
 - Creates an equitable (size neutral) basis for determining reimbursement
 - Reduces the emphasis on transaction in favor of quality and cost outcomes
- Role and influence of CMS on the medical home model
 - Accountable care organizations – shared accountability and payment reward
 - Advanced primary care model
 - Proposed funding for CMS to join existing multi-payer pilots
 - Could create other Medicaid medical home pilots
- Evolution of the NCQA PPC-PCMH requirements
 - Current Statistics
 - Currently over 2200 physicians in 975 practices
 - 15% are Level 1, 4% Level 2, and 81% Level 3
 - Some pilots question the need for more restrictive criteria for a distributed range
 - There is an open question as to the essential elements for a medical home
 - There is a need to ensure consistency with CMS PCMH criteria and other programs that support a medical home definition such “Bridges to Excellence”



Future of the Medical Home

- Integration of chronic condition management programs
 - The medical home operation and performance model offers a consolidation opportunity for employer requested disease management programs
 - The medical home model addresses the full range of care from preventive, wellness, acute, and chronic conditions
- Medical homes and the patient centric medical neighborhood
 - Inclusion of facilities to encourage primary care physicians and follow-up
 - Closer association with premium-designated facility and specialty providers
- Integration of member incentives into employer plans
 - Patient engagement and activation is core to the success of medical homes
 - Study data and lessons learned will be applied to plan design
- Employer role for advocating primary care and medical homes
 - Employers will receive market reports (medical homes compared to controls)
 - Campaigns / incentives to support utilization of primary care and medical homes



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Questions?





Current UnitedHealth Pilot Activity

Pilot	Type / Convening Authority	Practices / Physicians	Members / Payment Model	NCQA PPC-PMCH Level	Study Type	Start / Length
RI	Multi-payer: The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) is one of four “Regional Quality Initiative” sites funded by the Center for Health Care Strategies in 2006.	5 Practices 36 Physicians	<ul style="list-style-type: none"> ●6,000 – 7,000 includes Medicaid and Medicare ●Care Mgmt PMPM only 	Flat rate PMPM for all NCQA levels	<ul style="list-style-type: none"> ●External (Harvard School of Public Health) ●Internal UHC measurements 	10/1/2008 (two years) – extension and expansion under discussion
AZ	Single-payer: UnitedHealthcare (partnering with IBM) – Phoenix and Tucson areas	7 Practices 25 Physicians	<ul style="list-style-type: none"> ●About 14,000 - includes Medicaid and Medicare ●Care Mgmt PMPM plus performance bonus 	Level 1 required by year two of pilot with incentive for attaining Level 3	<ul style="list-style-type: none"> ●UHC Measurement with Mathematica advisory ● Third party PCAT (MI State Univ.) 	4/1/2009 (three years)
CO	Multi-payer: Colorado Clinical Guidelines Collaborative (CCGC); non-profit coalition based in Colorado aligned with Improving Performance in Practice (IPIP) programs on CO	15 Practices 45 Physicians	<ul style="list-style-type: none"> ●7,000 – 10,000 Commercial plus one practice that includes Ovations ●Care Mgmt PMPM plus performance bonus 	Level 2 required by year two of pilot with incentive for attaining Level III	<ul style="list-style-type: none"> ●Agreed-to clinical self-reporting measures ●External (Harvard School of Public Health) 	5/1/2009 (two years – being extended to 3 years)
OH	Multi-payer: The Greater Cincinnati Health Care - Aligning Forces for Quality/ RWJF project – a sister study pilot of CO	14 Practices 60 plus	<ul style="list-style-type: none"> ●10,000 including Medicare ●Care Mgmt PMPM plus performance bonus 	Level I required within 6 months with incentives for Levels 2/3	<ul style="list-style-type: none"> ●Agreed-to clinical self-reporting measures ●External (Harvard School of Public Health) 	10/01/09 (two years)
NY	Multi-Stakeholder: Taconic Health Information Network and Communities (THINC) funded by P4P grant from NYS Dept of Health – Hudson Valley	11 Practices 200-220 Physicians	<ul style="list-style-type: none"> ●30,000 members of the Empire Plan for State Employees ●Performance (outcomes) & NCQA components achieved 	RHIO Program - Incentives for achieving Level II	<ul style="list-style-type: none"> ●Weill Cornell Medical College ●Internal UHC measurements 	Late 09 or early 2010 (five years)



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Appendices

Appendix A: National Activity

Appendix B: PCMH Definition

Appendix C: Delivery Model

Appendix D: Reports

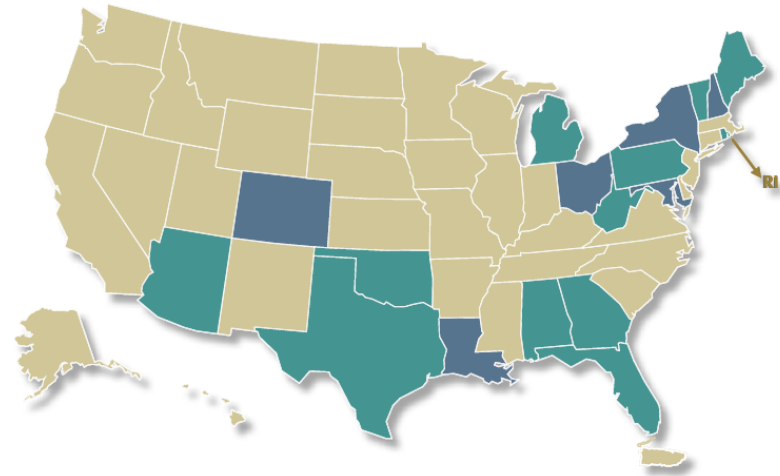
Appendix E: Care Management



A) National Medical Home Activity

Overview of Activity

- 27 multi-stakeholder pilots in 18 States
- 8 state Medicare pilots planned for 2009
- 44 states and the District of Columbia have passed over 330 laws and/or have PCMH activity



- Alabama Health Improvement Initiative—Medical Home Pilot (AL)
- UnitedHealth Group PCMH Demonstration Program (AZ)
- The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot (CO)
- Colorado Family Medicine Residency PCMH Project (CO)
- MetCare of Florida/Humana Patient-Centered Medical Home (FL)
- WellStar Health System/Humana Patient-Centered Medical Home (GA)
- Greater New Orleans Primary Care Access and Stabilization Grant (PCASG) (LA)
- Louisiana Health Care Quality Forum Medical Home Initiative (LA)
- Maine Patient-Centered Medical Home Pilot (ME)
- CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program (MD)
- National Naval Medical Center Medical Home Program (MD)
- Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)
- Priority Health PCMH Grant Program (MI)
- CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)
- NH Multi-Stakeholder Medical Home Pilot (NH)
- CDPHP Patient-Centered Medical Home Pilot (NY)
- EmblemHealth Medical Home High Value Network Project (NY)
- Hudson Valley P4P-Medical Home Project (NY)
- Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
- Queen City Physicians/Humana Patient-Centered Medical Home (OH)
- TriHealth Physician Practices/Humana Patient-Centered Medical Home (OH)
- OU School of Community Medicine—Patient-Centered Medical Home Project (OK)
- Pennsylvania Chronic Care Initiative (PA)
- Rhode Island Chronic Care Sustainability Initiative (RI)
- Texas Medical Home Initiative (TX)
- Vermont Blueprint Integrated Pilot Program (VT)
- West Virginia Medical Home Pilot (WV)



B) Patient-Centered Medical Home Defined*

Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care of adults, youth and children. The PCMH is a health care setting that facilitates partnerships between individual patients, their personal physicians and, when appropriate, the patient's family.

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)

* As originally defined by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians, American Osteopathic Association (AOA)

** To include a voluntary recognition process by an appropriate non-governmental entity to demonstrate that practices have the capabilities to provide patient-centered services consistent with the medical home model.



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C) Patient-Centered Medical Home Delivery Model

Expanded Patient-Centric Clinical Services and Capabilities

Enhanced Access

- Timely appointment scheduling
- Evening, weekend and holiday hours
- After-hours support

Care Coordination and Chronic Condition Management

- Weekly identification of patients in transition or at risk
- Specialty referral coordination and tracking
- Disease and case management enrollment

Team Care

- Physician-directed team both in and outside of the practice setting
- Management of care transitions across the health care continuum

Performance Measurement, Assessment and Improvement

- Practice in accordance with clinical evidence
- Performance evaluation based on medical best practices
- Measurement of clinical processes and outcomes

Clinical Information Systems

- Care management
- Decision support
- Electronic prescription filling

Benefits

- More time for patients
- Better care continuity
- Improved care transitions
- Improved quality of reporting
- More efficient care delivery
- Enhanced patient focus
- Improved patient safety
- Improved practice profitability and satisfaction
- Simplified and coordinated health care experience

Enabling Technology and Practice Support

Technology and Tools

- Personal Health Record
- Point of care information
- Electronic prescriptions
- In-depth reporting



Care Coordination Management and Support

- Health plan care and disease management
- Educational materials
- Patient activation tools



Transformation Support

- Assigned facilitator
- Online tools
- "Boots on the ground" resources



PRACTICE QUALIFICATIONS (Based on NCQA PCC-PCMH Standards)





D) Reporting

Name	REPORT OVERVIEW	Description	Frequency
Landscape Report	Baseline and semi-annual practice "Landscape" reports	<ul style="list-style-type: none"> This report provides a baseline, in-depth analysis of many facets of the practice's patient panel to enable understanding and decision-making of pilot opportunities for the Medical Home and pilot team This report provides a view of the practice's attributed patient population and quantitative data on IP admits, ER utilization, RX tier utilization, radiology utilization, evidence-based medicine measures and specialty network utilization 	At least semi-annually
Panel List	Quarterly practice panel lists	<ul style="list-style-type: none"> This report identifies the specific list of members that attributed to the medical home 	Quarterly
Practice Performance Scorecard	Quarterly Practice Performance Bonus reporting	<ul style="list-style-type: none"> The report assesses and scores the performance of the Medical Home practice upon a set of structure, process, and outcomes measures 	Quarterly
Practice Data Set	Recurring practice data sharing (gaps in care, acute event alerts, etc.)	<ul style="list-style-type: none"> This report alerts the practice and care advocate of specific patients that are at high risk, have gaps in care, have recently visited the ER, need follow-up after discharge, opportunities for referral to Disease or Case Management 	At least monthly



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E) Care Management Components

