Care Coordination Vs. Assumption of Risk

The Holy Grail of Health Reform is controlling costs while still providing access and quality. In my mind the key in finding this Holy Grail is care coordination, forms of which can include Patient-Centered Medical Homes{PCMH's} and Accountable Care Organizations(ACO's). As a former member of the Federal Commission for the Federal Health Care CO-OP's program, I helped to write recommendations regarding "integrated care", which was a legal requirement to become such a CO-OP. Our Commission recognized both PCMH's and ACO's as reasonable forms of "integrated care.

Today and tomorrow, you will hear various explanations and predictions regarding these forms of care coordination. As a member of an earlier Legislative Commissions regarding health reform, I supported PCMH's; that year, a law was created recommending every Iowan become a member of a PCMH and establishing the state Medical Home Advisory Board. Medicaid also has supported the concept of PCMH with their Health Home provision.

As a practicing family physician, geriatrician, and hospice medical director, whose clinic is a NCQA Level 3 certified PCMH and who has Medicaid Health Home patients, I have been tasked with discussing the Iowa lay of the land for private sector PCMH's.

Private sector primary care can be easily divided between employed physicians of the major hospital systems and the rest, which would include physicians in multi-specialty clinics, small groups, solo's, and small hospital affiliated physicians. I shall reserve my remarks for second group of primary care physicians.

There is, at times, a palpable tension between PCMH and ACO, which I would like to explore at the end.

For me, PCMH at it essence, is a team approach for patient care with the patient, the primary care physician, and various members of the physician's clinic all vying to maintain and improve health, physically and emotionally, in a sustainable manner. There are supra-structural and infrastructural requirements which I do not have time to discuss; but I would add that Paul Grundy, godfather of the national PCMH effort, limited the physician role to two key functions: create healing relationships and deal with tough diagnostic and therapeutic dilemmas. The patient and the PCMH must both be held somewhat accountable for effort and quality.

When PCMH's are done well, the studies from New Hampshire, Pennsylvania, Utah, and upstate New York are over-whelming that quality is improved and savings are obtained. PCMH can and does reduce emergency room visits, hospital admissions, hospital re-admissions, fewer imaging studies, and fewer cross specialty consults; from my experience, PCMH can improve diabetic control, improve mental health care, more connectivity with patients, and greater use of

early detection tests and immunizations; finally, my health coaches are now Certified Application Counselors(CAC's) and starting on Thursday will be helping my patients sign up for health insurance on the Exchange. Two salient points come from evaluating these efforts from other states: one, PCMH, that is care coordination, costs money; it is a work product. Two, the savings outweighed the costs of care coordination. Iowa was positioned 3 years ago for a multi-payer PCMH pilot and was denied when Wellmark veto it, because of its desires to concentrate on an ACO approach. In contrast, the regional CO-OP(Iowa-Nebraska Cooportunity Health) has chosen to pilot a PCMH project using small physician groups.
To facilitate this pilot, 6 and soon to be 7 rural clinics have joined the Heartland Rural Provider Alliance(HRPA); several other clinic who are either independent or affiliated with a local hospital are also consider joining. The future for PCMH centers around two additional features that I do not have yet; case managers on site for my most complicated patients and point of service dashboard that allows me to view the patient's claims data from the payer at the time of seeing the patient.

ACO's are obviously the rage for health cost reform efforts. Wellmark, Medicare, Medicaid, and others in Iowa and throughout the country are engaged or planning for ACO contracting. Through care

coordination, the initial goal for ACO's is to receive a portion of Shared Savings with the ultimate goal is for assumption of risk. ACO's in Iowa for these various efforts now include the large hospital systems, multi-specialty groups, and pure primary care groups. For example, HRPA is part of a multi-state virtual Medicare Shared Saving ACO, with its leadership out of Massachusetts; this Massachusetts effort does offer that point of service dashboard to its primary care providers.

The tension between PCMH and ACO lies one, in the division of work to accomplish care coordination and as always, the division of monies; and two, the assumption of risk.

5 major questions can be entertained:
#1 How will the cost of PCMH care coordination be acknowledged and maintained in a Shared Savings Model?
#2 When risk assumption becomes the baseline contracting principle, will the same dangers that affected HMO's return?
#3 Can primary care groups assume risk? Will they want to?
#4 If the vast majority of savings(after the costs of care coordination are accounted for) can be acquired by primary care physicians using PCMH, why does primary care wants to divide the shared savings with hospitals and specialists?

#5 Most importantly, when shared savings is fully saved, how is total cost of care computed?

For state legislators, the following questions:

#1 Will the large hospital systems be fair to rural county health care?

#2 Will there be room for independent physician groups in Medicaid regional ACO model?

My recommendations:

1. Allow free market to play out.
2. Guard health care in rural areas.
3. Make sure small physician groups that meet criteria be allowed to participate in future Medicaid.
4. Emphasize care coordination and realistically, negotiate risk throughout all parties-providers, payers, and patients.

Carlyle, David

From: Janelle Nielsen [janellenielsen1954@gmail.com]
Sent: Tuesday, November 19, 2013 8:15 AM
To: Carlyle, David
Subject: Re: PCMH in Iowa?

NCQA's website is so hard to count on.
I could be off by 1 or so on each number.

Practitioners 328
Practice sites 51

Clustered Gunderson NE area 7 clinics Mercy CR 15 DM 8 Pella area 5 Ia City 3

Larger cities DM Ia City Sioux City Council Bluffs Mason City Cedar Rapids Waterloo Dubuque Ames

Hope this helps Janelle

On Mon, Nov 18, 2013 at 9:10 PM, Carlyle, David <dcarlyle@mcfarlandclinic.com> wrote:

Janelle,

Leaving at 9am tomorrow; will check e-mail prior.

Thank,

Dave

From: Janelle Nielsen [mailto:janellenielsen1954@gmail.com]
Sent: Monday, November 18, 2013 8:13 PM
To: Carlyle, David
Subject: Re: PCMH in Iowa?

Just got home. Is tomorrow morning soon enough jsn

On Nov 18, 2013 11:55 AM, "Carlyle, David" <dcarlyle@mcfarlandclinic.com> wrote:

Janelle,

Giving talk at Legislature. Need # of PCMH in Iowa, please?

Dave Carlyle MD