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Who Provides Primary Care Medical Homes for NC Medicaid Recipients?

Impact of Hospital-Owned, Independent, and Safety Net Practices

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KEY POINTS FROM THIS BRIEF:

- Small practices (those with fewer than 500 Medicaid patients) represent a majority of all practices that provide primary care for NC Medicaid recipients, and tend to see sicker or more complex patients
- Two-thirds of Medicaid recipients receive their primary and preventive care in independent or safety net practices
- Historically, independent and safety net practices perform very well on measures of high-value care

Background

While market consolidation has increased the number of primary care practices owned by large medical groups and hospital systems nationally, many people continue to receive their primary care in independent community practices. Nationally, 18% of primary care physicians practice solo, and 60% practice at sites with 10 or fewer physicians.[1] Although it is sometimes assumed that larger practices can provide more efficient care, emerging evidence suggests that small and independent physician-owned practices actually perform better with regard to lower rates of avoidable hospitalizations[2], lower total costs of care[3], and measures of patient satisfaction[4].

Small and independent practices face a number of unique barriers to participation in accountable care contracts or other value-based healthcare payment strategies, however. These include inadequate financial reserves to take on financial risk for fully capitated contracts, and limited means to invest in population health management tools such as health information technology and analytics, care management, and quality improvement strategies.

As North Carolina moves forward with healthcare delivery reform including implementation of risk-sharing models and value-based contracting, it is important to understand the current footprint of primary

care for Medicaid recipients statewide. Over 1800 primary care practices currently participate in North Carolina's medical home program for Medicaid recipients, serving 1.5 million Medicaid recipients. In this analysis, we describe where NC Medicaid beneficiaries access primary and preventive healthcare. We characterize primary care practices that participate in the NC Medicaid medical home program by practice size and ownership, and describe historical performance on key indicators of high-value care.

Small Practices Have a Large Medicaid Footprint and Serve Sicker Patients

While we do not have a direct measure of practice size, we can infer practice size by looking at the number of Medicaid recipients enrolled in a practice. In the figures below, practices that participate in the NC Medicaid medical home program are categorized according to the number of enrolled Medicaid patients. As shown in Figure 1, only 43% of practices have more than 500 Medicaid patients, while 32% of practices see fewer than 200 Medicaid patients.

We also found that practices seeing fewer Medicaid patients tend to serve a disproportionate number of sicker patients. As shown in Figure 2, the smallest practices, those serving less than 50 Medicaid patients, have an illness burden or case mix index more than twice as complex as practices serving at least 500 patients.

In summary, most primary care practices serving Medicaid recipients are relatively small in size, and these smaller practices tend to serve sicker patients.

Figure 1: Most Practices Serving Medicaid Patients are Relatively Small

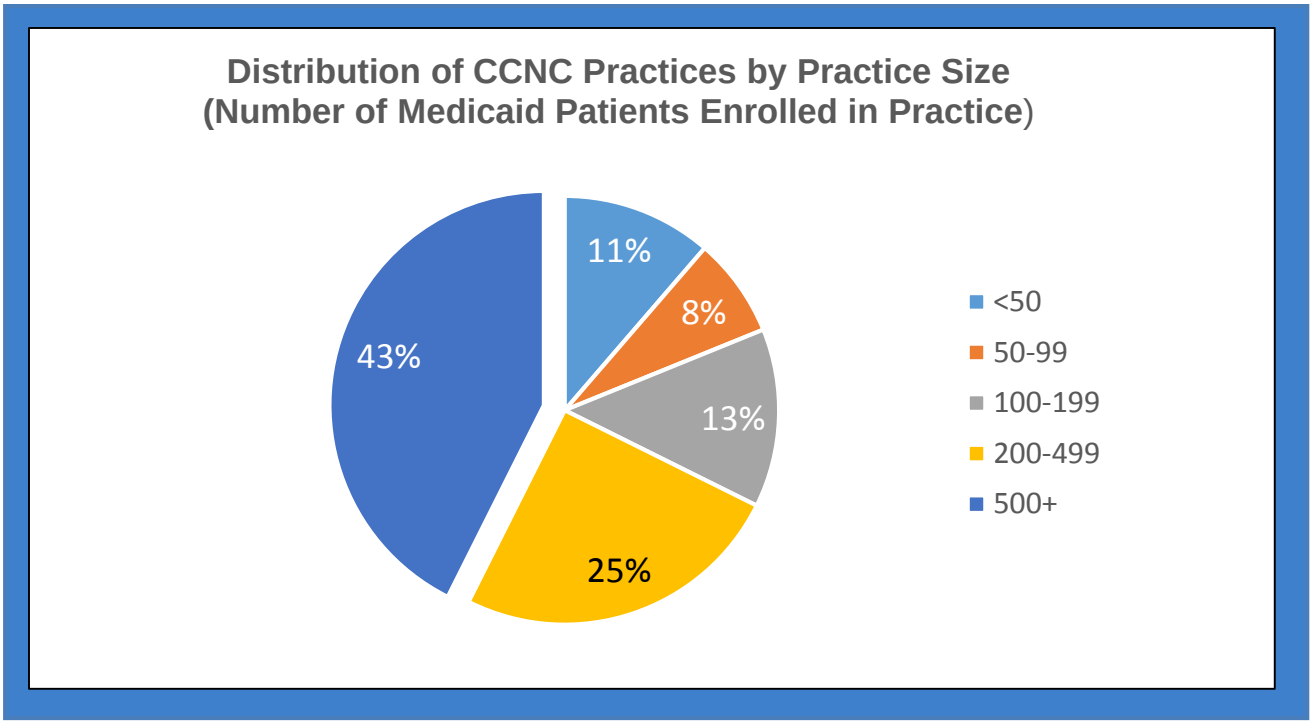
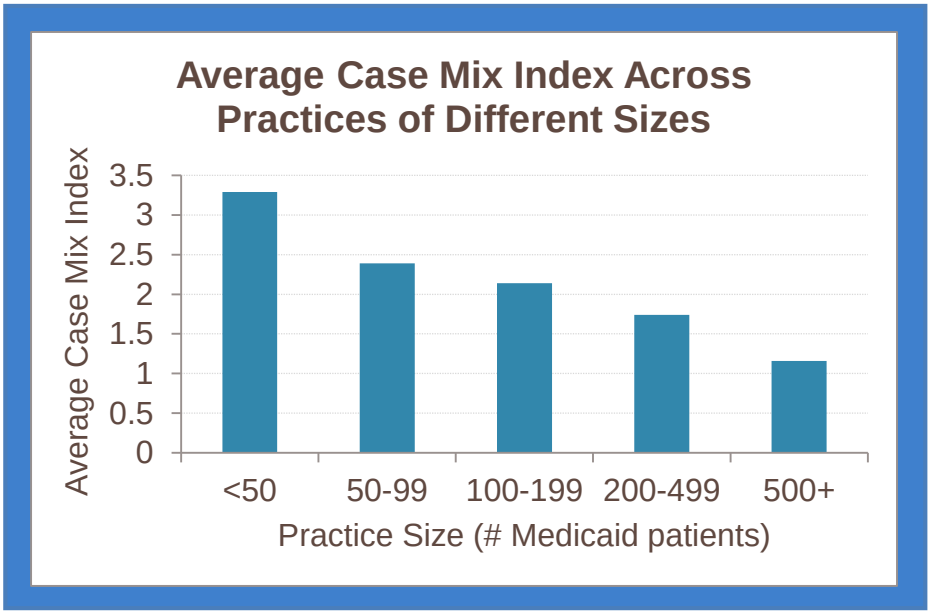


Figure 2: Smaller Practices Serve Sicker Patients



Independent and Safety Net Practices Serve Most Medicaid Recipients, and are More Geographically Diverse than Hospital Owned Practices

We also evaluated the geographic footprint of primary care in North Carolina, by practice ownership. In the maps below, primary care practice sites are represented by circles, with the size of the circle reflecting the number of Medicaid patients enrolled with that practice. Colors depict the type of practice by ownership status.

Figure 3: Primary Care Practices owned by Large Health Systems and Small Hospitals Have Limited Reach in Medicaid

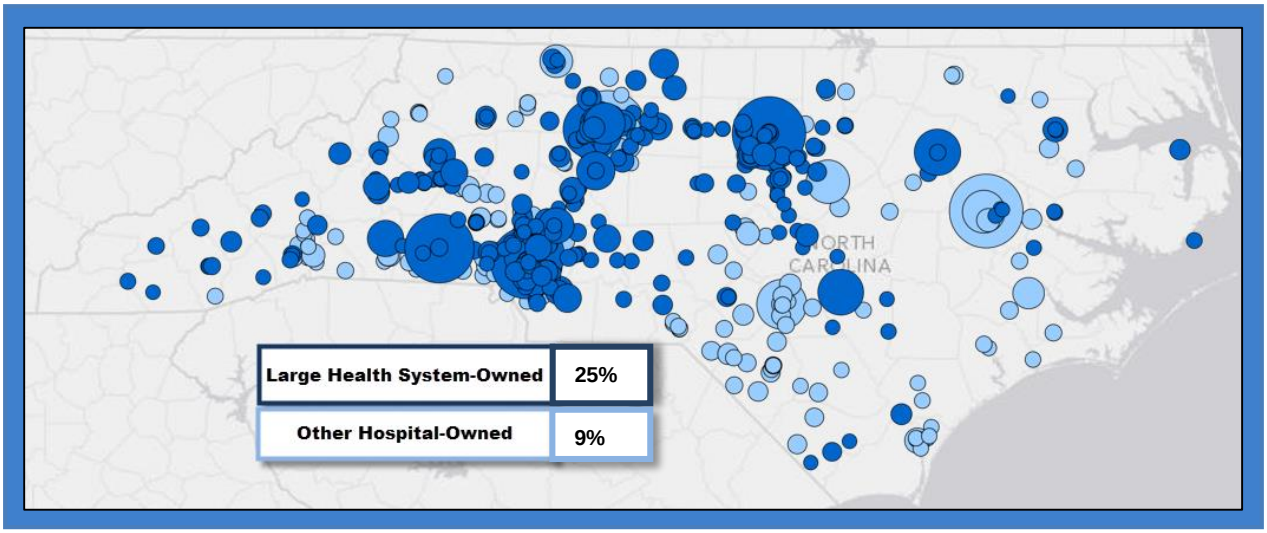
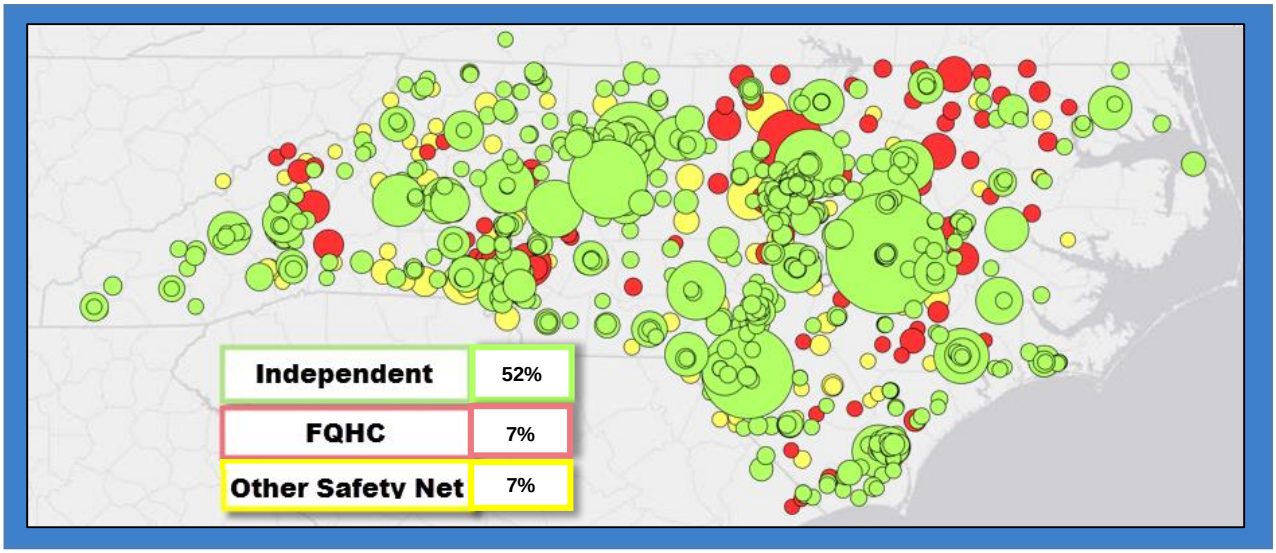


Figure 4: Independent Practices, Safety Net Clinics Play Huge Role, Especially in Rural NC



Independent, Safety Net Practices Perform Well on Measures of Value-based Healthcare

Value-based healthcare reform aims to improve patient outcomes and patient experience while controlling costs. When providers are held accountable to high-value care for patient populations, performance on total cost of care and hospital utilization rates can be strong indicators of care efficiency and better outcomes. The graphs below compare performance on these indicators for the Medicaid population from SFY 2009 (baseline period) through March 2013, by ownership status of the patient's primary care medical home. These graphs are risk adjusted to allow for "apples to apples" comparison across practice types, controlling for any differences in clinical complexity. Risk-adjusted Indices below 1.0 indicate better-than-expected performance.

As shown in Figure 5, total Medicaid spending was lowest for patients enrolled in federally qualified health centers (FQHCs). Patients enrolled in practices owned by large hospital systems generated higher overall costs than patients enrolled with other practice types. In addition, Figures 6 and 7 show that inpatient admission rates and emergency department visit rates were lowest among patients enrolled in independent practices.

Figure 5: Total Risk-Adjusted Spending PMPM Lowest Among FQHC Practices

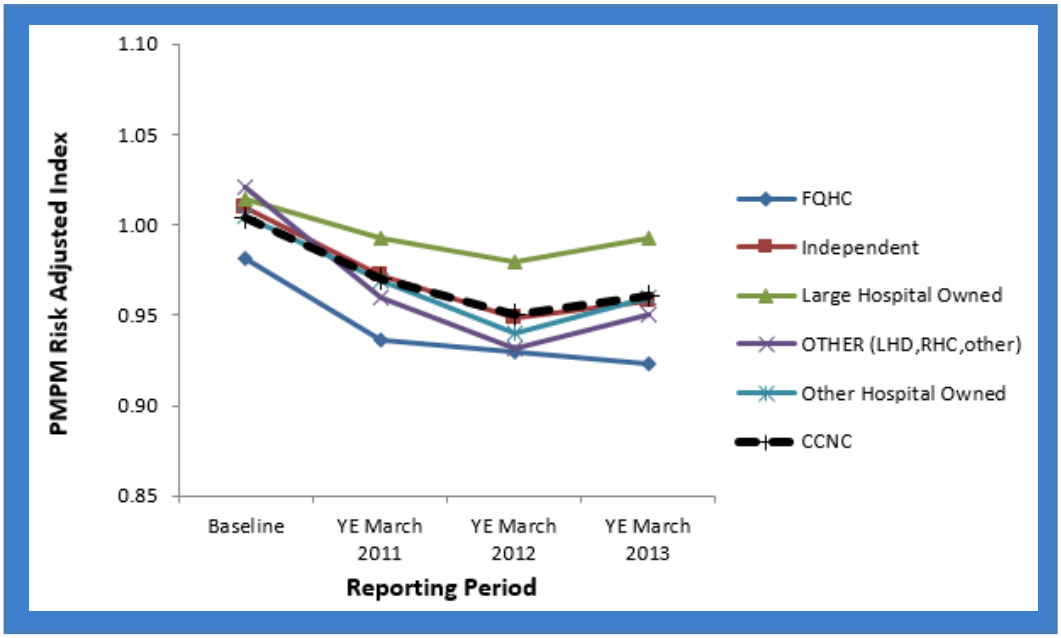


Figure 6: Risk-Adjusted Inpatient Utilization Lowest Among Independent Practices

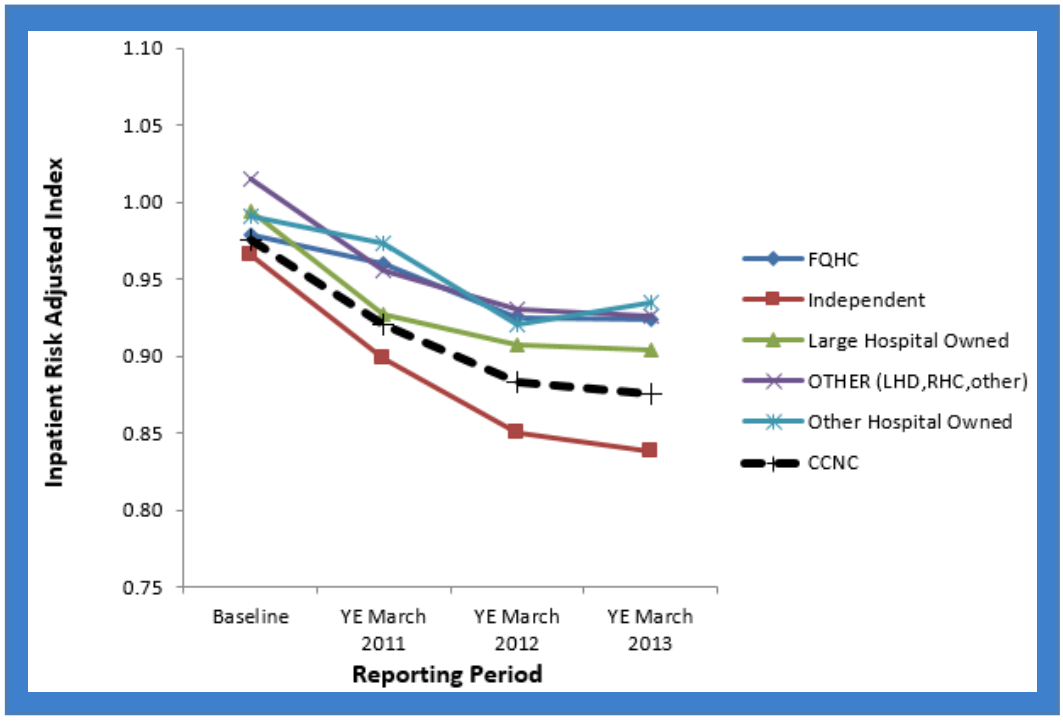
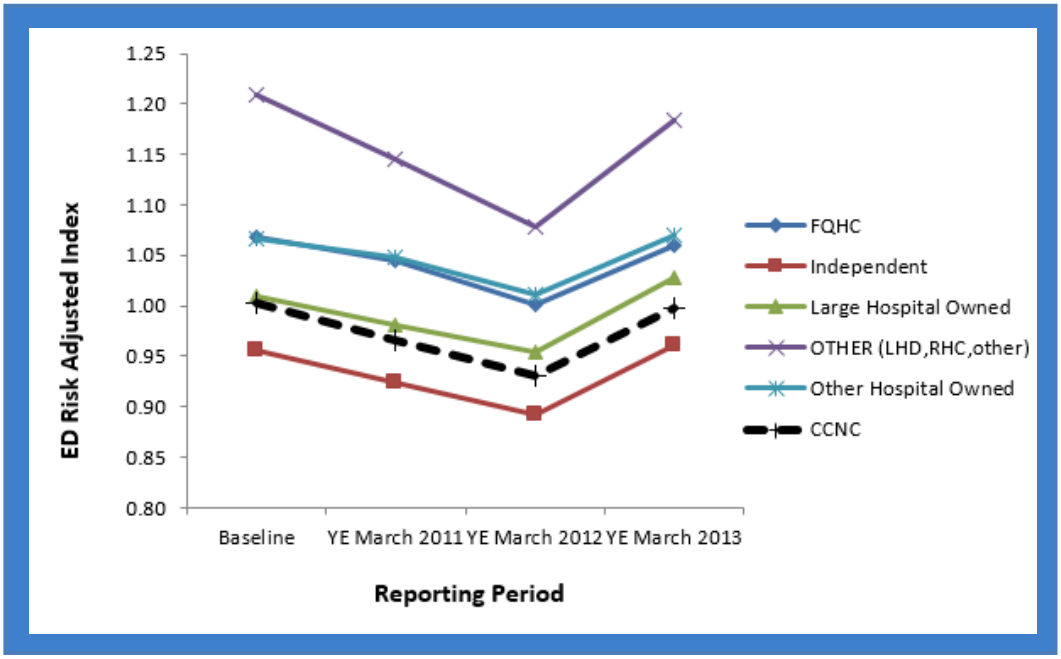


Figure 7: Risk-Adjusted ED Utilization Lowest Among Independent Practices



Data Sources and Methodology

Primary care practice addresses and enrollment were determined from NC Medicaid administrative data as of June 2013. Federally qualified health centers, rural health clinics, and local health departments were identified based on provider type self-identification in Medicaid administrative data. Hospital ownership was determined through billing information (primarily, shared Tax Identification Numbers); along with internet searches of health system websites with listings of owned practices, as of Fall 2013.

Cost and utilization performance indicators were calculated from Medicaid claims data for CCNC-enrolled non-dual NC Medicaid recipients. The reporting period reflects dates of service, and includes claims paid through 90 days of the end of the reporting period. Services that currently fall under behavioral health managed care capitation were excluded from all reporting periods. Capitation payments for imaging and CCNC management fees were also excluded. Inpatient visit rates excluded same-day transfers and women who delivered a baby during the measurement period. 3M Clinical Risk Groups (CRGs) were used for risk adjustment to control for variation in illness burden by practice type and over time. Average cost and utilization were determined within each CRG for the baseline year (State Fiscal Year 2009), to develop resource intensity weights reflecting relative expected costs/utilization by CRG. The "Risk Adjusted Index" is actual costs or utilization divided by the cost or utilization that would be expected given the case mix (or distribution of CRGS) in the population.

Conclusions

Currently, over 1800 primary care practices provide medical homes for North Carolina Medicaid recipients through the state's medical home managed care model known as Community Care of North Carolina. Efforts to transform healthcare must take into account that small and independent practice sites represent a sizable share of these practices, and indeed are the primary point of contact for most of the NC Medicaid population. Recipients rely on access to independent and safety net practices throughout the state, in both urban and rural areas. Historically, these practices have out-performed hospital-owned practices on value-based measures of healthcare efficiency and achieved lower rates of hospitalization and lower total costs of care for the patients they serve. From the perspective of the Medicaid program, it will be imperative for these small practices to continue to succeed under value-based healthcare reform. Creative solutions to assist small, independent and safety net practices in adopting delivery system innovations could include maintaining an infrastructure for sharing resources for care management, quality improvement, and health information technology.

References

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