APRIL 2011

diagnostic

The Patient-Centered Medical Home Model

The patient-centered medical home (PCMH) model is gaining renewed momentum after the Patient Protection and Affordable Care Act (PPACA) included it as one approach to improve healthcare quality and efficiency. In further recognition of the model's value, third-party payors are already collaborating with providers to use PCMH-like arrangements as a foundation to implement innovative ways to redesign the delivery of healthcare. This Diagnostic *highlights how providers can contract with commercial payors to use potential shared savings to fund the development of a PCMH or support similar pay-for-performance (P4P) arrangements.*

KEY TAKEAWAYS:

- *The PCMH model is poised to be the new and improved primary care model in the era of health reform.*
- *Recent pilots have realized cost savings through reduced emergency room utilization, reduced acute care episodes, and decreases in hospital admissions.*
- *The PCMH model has shown improvements in care coordination, patient/family engagement, and patient satisfaction compared to the traditional gatekeeper model.*
- *Payors and providers will need to revamp their reimbursement methodologies to align incentives across the full care delivery continuum in order to be successful in the long term.*

The PCMH model is not new to healthcare. In fact, the American Academy of Pediatrics (AAP) coined the term in the 1960s to describe a model of care in which primary care services are delivered to families in an accessible, continuous, comprehensive, and integrated fashion. The Institute of Medicine refers to patient-centeredness as healthcare that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients' needs and preferences. The goal of the partnership is to ensure that patients have the education and support they require to make decisions and participate in their own care.[1] In support of those goals, providers and payors seek to increase the coordination of care across the healthcare delivery continuum. The success of PCMH relies on a model in which each patient has a primary physician and a team of professionals who are responsible for coordinating

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[1]Margarita P. Hurtado et al. (eds.), Envisioning the National Health Care Quality Report, Institute of Medicine, National Academies Press, Washington, D.C., 2001.

the services needed to ensure appropriate and timely medical care. The support structure is overseen by a care coordinator (typically a registered nurse) who manages the interdisciplinary skills provided by social workers, physician extenders, dieticians, clinical pharmacists, and of course, the patient's family. Most importantly, the PCMH model focuses on establishing systems to promote adequate and timely follow-up with patients to ensure they receive their prescriptions, obtain necessary tests, and follow through with necessary specialty appointments. In addition, this model effectively promulgates the transition between various levels of care, such as the discharge from acute to subacute settings; the team's responsibility is to prevent its patients from "falling through the cracks."

Key attributes of a successful PCMH include:

- Enhanced access to care.
- Improved communication and patient/family education.
- Coordination and integration across the continuum of care.
- Clearly articulated expectations for the care delivery team and the patient/family.
- An integrated enterprise-wide IT platform.

While similar models, such as the primary care model, have been tried with varying levels of success, several factors provide the impetus for the PCMH model to be more successful. These factors include:

- Continued subspecialization and fragmentation of healthcare providers that makes it more difficult for a patient to ensure that all of his/her health concerns are being addressed.
- Evidence of successful pilots that have either focused on care management of patients with certain disease categories (e.g., diabetes) or of high-cost patients with multiple chronic conditions.
- Healthcare reform and the increasing emphasis on outcomes-dependent reimbursement (e.g., P4P) from payors coupled with a demand for value by healthcare consumers.
- Advances in information technology (IT) such as the greater prevalence of electronic medical records (EMRs) and the ability to share information between providers and payors. Among other things, this provides a mechanism to appropriately risk-adjust premium revenue by prompting the accurate diagnosis and procedural coding needed to support Hierarchical Condition Category (HCC) coding.
- Recognition of the potential value of the model by the PPACA.

Benefits of the PCMH Model

Recent studies have demonstrated a decreased cost of healthcare as a result of reduced emergency room utilization and acute care episodes, a decrease in hospital admissions, and a reduction in specialty referrals. Examples illustrating the magnitude of potential improvements include the following:

- In 1 year, Group Health Cooperative, a consumer-driven, not-for-profit health system, reduced its PCMH patients' emergency room visits by 29 percent, hospital admissions by 11 percent, and office visits by 6 percent.[2]
- North Carolina's primary care case management Medicaid program experienced a combined total cost savings of $231 million by improving outcomes for diabetic and asthma patients. This program provides these chronically ill patients with access to a primary care physician and nurse education support 24 hours per day, 7 days per week. The annual incremental cost to provide these savings was approximately $20 million.[3]
- Dartmouth-Hitchcock Medical Center saved $10 million for the Medicare trust fund through the implementation of a PCMH model. As a participant in this Centers for Medicare & Medicaid Services (CMS)-sponsored trial, Dartmouth-Hitchcock received a $6.8 million bonus payment from CMS.[4]

These opportunities can be more easily developed, funded, and implemented through collaborative arrangements with managed care organizations. For example, health plans may be willing to make initial or incremental investments in anticipation of future savings. These investments can be used to partially fund the implementation of the IT systems and other operational infrastructure requirements to support the pilot. The plans may also be willing to negotiate a shared

[2]Kyle Hardy, "Study: Medical home model increases quality of care, reduces cost," Healthcare Finance News, September 1, 2009, *www.healthcarefinancenews.com/news/study-medical-home-model-increases-quality-care-reduces-cost.*

[3]James Arvantes, "North Carolina Primary Care Program Continues To Save Millions," American Academy of Family Physicians, October 10, 2007, *www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20071011ccnccutscosts.html.*

[4]Joyce Frieden, "Medical home lowers cost of care in trial," Internal Medicine News, June 15, 2009, *www.entrepreneur.com/tradejournals/article/203359412.html.*

savings or capitated arrangement that gives providers the opportunity to share in the medical expense savings produced from the program.

Reimbursement Methodologies Under the PCMH Model

Recent successes demonstrate that PCMH is a promising model for driving improved quality and patient satisfaction and decreased medical costs across the patient care continuum. In order to realize these benefits, strong physician leadership to champion cultural change, in addition to significant capital investment, is required. Transforming a traditional medical group to be successful in a P4P model such as PCMH requires a complete redesign of how care is delivered, an advanced and optimized IT infrastructure, significantly enhanced patient education, and collaboration between institutional and professional providers and payors. In order for organizations to afford the transition, innovative contractual terms with payors must be established.

To support the necessary investments, contracting models must have incentive payment mechanisms that support collaboration between payors and providers (and potentially patients). While a variety of models are being considered under the guise of accountable care organizations (ACOs), their ultimate structure is evolving. There are models that anticipate the performance-based aspects of healthcare reform and that can be implemented now. One such collaborative reimbursement model includes four key components that are designed to add value for providers, payors, and patients. In anticipation of improved premium revenue and reduced cost of medical services, health plans are able to help providers invest in the needed infrastructure.

Example Payment Structure for the PCMH Model

- *Component #1 – Infrastructure Support*
  The first component addresses the initial and ongoing investment necessary to develop the IT and human infrastructure needed to support the PCMH model. This can be in the form of an initial grant or up-front payment with repayment forgiven contingent upon meeting specific criteria for implementing key processes and infrastructure. Specific investments an organization may need to make include implementing an EMR with disease management or registry functionality, hiring and training dedicated care coordinators, and arranging for social, nutritional, and clinical pharmacy services – all within the primary care physician's office. After the initial investment, the payors may provide ongoing support in the form of per member per month payments. It is also important to note that as the responsibility of providing care management moves to the provider, the health plans may be able to realize comparable cost reductions.
- *Component #2 – Care Management Payment*
  The second component incentivizes physicians by increasing payments for spending more direct patient time coordinating care and by ensuring that physicians

THE COLLABORATIVE CONTRAST

Traditional Gatekeeper Model	PCMH Model
Care is episodic and based on illness and patient complaints.	Care is coordinated and focused on a long-term healing relationship.
Providers operate in silos with limited communication.	A physician-led care team takes responsibility for all patient care needs, arranging for referrals as appropriate. Communication among providers and the patient (and family) is continuous.
The patient is a passive participant with limited say in treatment.	Patients actively participate in decision making, and patient feedback is sought to ensure that expectations are being met.
Practice patterns vary widely according to physician preference.	Evidence-based medicine (EBM) and clinical support tools guide consistent decision making.
Payment is procedure-based, and volume is rewarded.	Payment recognizes the value of care management and communication with the patient outside of face-to-face visits. Measurable and continuous quality improvements are rewarded.

Source: National Committee for Quality Assurance (NCQA).

have adequate time to effectively document patient visits in the EMR. At least initially, this component is in the form of an enhanced fee-for-service payment. As the delivery system matures, this may be replaced by other mechanisms such as bundled payments or, ultimately, capitation payments.

- *Component #3 – Shared Savings*
  The third component is a bonus payment that is calculated based on shared surpluses generated by reducing costs and improving premium revenues. The revenue side of the equation is impacted by improved HCC coding. Currently, this is primarily a means for Medicare Advantage plans to ensure that they appropriately receive risk-adjusted premium revenue for their chronically ill patients; however, there is a potential to implement the methodology for different patient populations. It would also be a critical factor in a mature delivery system that accepts risk for a substantial portion of the healthcare for a given population.
- *Component #4 – P4P Programs*
  The final component is a combination of process-oriented quality measures and indicators of performance toward defined goals for improving the cost and utilization of services. The process measures should be designed to further the delivery of quality and efficient care, while the utilization measures should demonstrate success in providing quality care.

Each of these components can be modified to meet the specific needs and capabilities of various payors. As providers become more savvy in their ability to manage care, higher levels of financial risk can be accepted in exchange for a greater share of the savings. While we discuss these payment methodologies in the context of PCMH, it is important to consider that this model may be implemented as the foundation for a broader-based population management approach (e.g., an ACO risk-based arrangement). It is also important to note that the model will be more successful if implemented in a way that aligns the incentives of all of its provider partners, including primary care physicians, specialists, and hospitals.

About ECG

ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As an industry leader, ECG is particularly known for providing specialized expertise regarding the complexities of the academic healthcare enterprise, strategic and business planning, reimbursement planning, specialty program development, and hospital/physician relationships.

Future *Diagnostics* will examine the various strategies employed to reach a successful transformation. Please contact any of the authors listed below to learn more about the PCMH model or for additional information.

BOSTON

Tel **617.227.0100**

Todd Godfrey, Manager
tgodfrey@ecgmc.com

WASHINGTON, D.C.

Tel **703.522.8450**

Charles Brown, Senior Manager
cbrown@ecgmc.com

Terri Welter, Principal
twelter@ecgmc.com

LEADING HEALTHCARE FORWARD

ecgmc.com 800.729.7635

Boston San Diego Seattle St. Louis Washington, D.C.

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