Coach Medical Home

Strategies & tools to support patient-centered medical home transformation



MODULE 2: Recognition and Payment

GroupHealth

MacColl Center for Health Care Innovation

THE COMMONWEALTH FUND

QUALIS HEALTH

Learning objectives for this module

After completing this module, you will be able to:

- Communicate goals and expectations for PCMH transformation.
- Articulate the business case for transformation to senior leaders and stakeholders.
- Help practices understand the costs and benefits of PCMH transformation.
- Communicate the benefits of PCMH recognition.

Overview of contents

1. Investing in PCMH
2. PCMH payment 101
3. The business case for practice transformation
4. NCQA PCMH™ Recognition: Ties to payment
5. Coaching tip summary

Section 1

Investing in PCMH

PCMH is our best vision for the future of primary care

"PCMH improves quality, affordability and patient satisfaction with care through collaboration and aligned incentives."[1]

Expectations for PCMH transformation:

- ↑ Improve quality & outcomes
- ↑ Improve patient experience
- ↑ Improve practice efficiency
- ↑ Improve provider & staff satisfaction
- ↓ Reduce burnout and turnover
- ↓ Stabilize or reduce overall costs

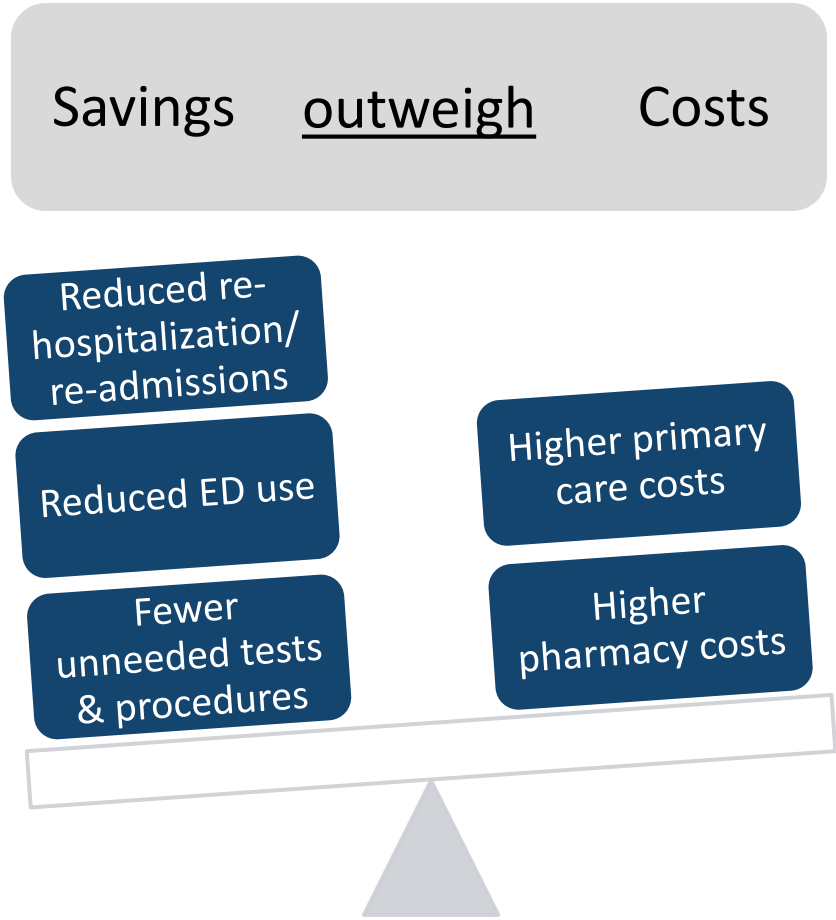
Examples of when PCMH transformation expectations have been realized

Better outcomes	"The patient centered medical home model provides a regular source of primary care, which is associated with better health outcomes at lower cost."[1]
Lower costs	"Primary care that is more comprehensive, integrated and coordinated, that follows the model of the patient-centered medical home, delivers better care and better quality at lower costs."[2]
Increased revenues	"The 32 practices in the TransforMED National Demonstration saw an average 10% increase in revenue, even without enhanced reimbursement."[3]
Less turnover, bigger workforce	"The PCMH model may be helpful for improving provider and staff satisfaction, increasing the primary care workforce, and reducing turnover."[4]
Enhanced access	"PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email."[5]

Savings for payers & communities

Some health care costs increase (e.g., primary care costs, pharmacy costs), but these **costs are outweighed by the savings achieved.**[1,2]

Most demonstrations have achieved **cost savings or cost neutrality** even after making additional investments in primary care (e.g., enhanced payment).



How are the savings achieved?

Typical practice setting	PCMH care	Benefit / Cost savings
No assigned responsibility for patients	Continuity provider is responsible for defined set of patients	Patients stay healthier and avoid complications
Care is a reaction to today's problem	Care is planned and proactive	Fewer duplicative tests & less overall waste
Providers work alone, putting in harder & longer days	Teams work together with a more balanced workload	
False belief that medical training translates to high-quality care	Evidence-based guidelines drive quality, continuous improvement	Better care coordination and reduced care gaps

Examples of cost savings for payers & communities

Group Health Cooperative[1] *Integrated delivery system* Seattle, WA	Payer: Group Health Cooperative (*non-profit co-op*)	**29%** fewer ED visits **16%** fewer hospital admissions **$10** PMPM cost reduction
HealthPartners Medical Group[1] *Integrated delivery system* Minnesota	Payers: Health Partners Cooperative (*non-profit co-op*) & CIGNA (*for-profit commercial*)	**39%** fewer ED visits **24%** fewer hospital admissions **129%** increase in optimal diabetes care **48%** increase in optimal disease care
ProvenHealth, Geisinger Health System[2] *Integrated delivery system* Pennsylvania	Payer: Geisinger	**9%** reduction in total medical costs **40%** fewer hospital 30-day readmissions **20%** fewer overall hospital readmissions

Summary: PCMH…it's here to stay

"HRSA encourages and supports health centers as they strive to continuously improve quality and tailor their care to the needs of the patients and communities that they serve. The PCMH Initiative will allow health centers to demonstrate their leadership as providers of high-quality care."[1]

PCMH is increasingly becoming a requirement for all—not a goal for some. Private payers, HRSA, and CMS are all encouraging practices to adopt PCMH.



PCMH positions practices to participate in (and benefit from) payment demonstrations



It prepares providers and payers for participation in new models of care (e.g., ACOs)



Most important: it provides value to all stakeholders

Section 2

PCMH payment 101

Why does PCMH require payment reform?

Pay for value, not volume

- Population health
- Move away from visit 'churn'

Expect and reward outcomes

- Clinical quality
- Patient experience
- Cost reductions

Pay for services not usually covered

- Phone & email visits
- Group visits, patient education

Why does PCMH require enhanced payment?

PCMH start-up & operating costs

- Infrastructure: phone & system upgrades, EHR or HIT
- Lost revenue during QI work
- New staff
- Staff training

Incentivize primary care

- Reward accountability for new work and new risk: care coordination
- Increase and support workforce

Payment pilots, demonstrations, and models abound



Dozens of payment demonstrations across the U.S. are:

- Testing innovative ways of paying for PCMH care
- Testing ways to reward improvement
- Multi-payer & single payer; some include Medicare/Medicaid managed care



Many different payment models support PCMH:

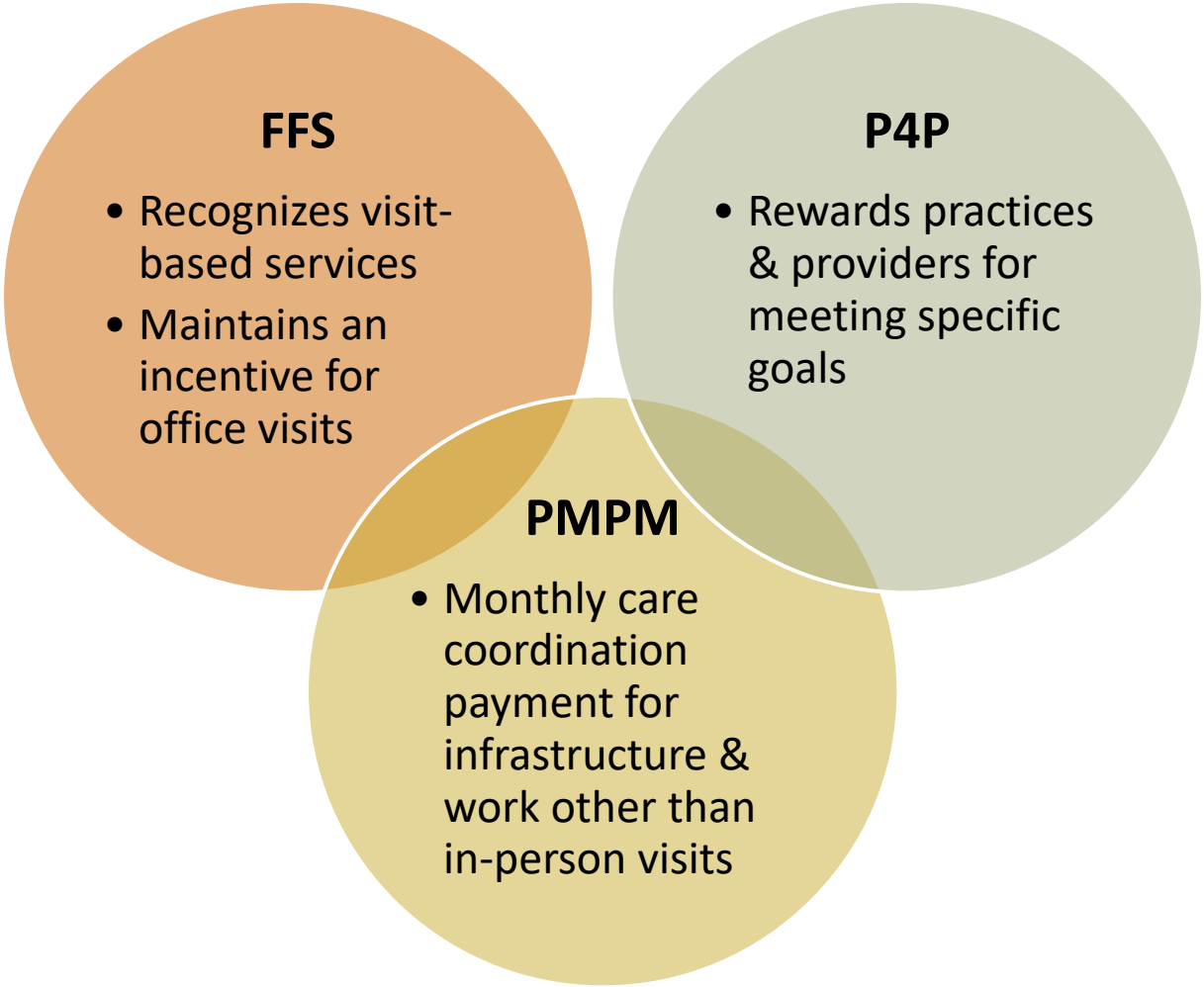
- All have pros & cons—or risks & benefits
- Traditional models add to fee-for-service
- "Reform-minded" models replace FFS with performance-based or comprehensive payment

Enhanced payment models: A snapshot

Grants-based	• Paid for by grants
FFS with adjustments	• FFS with new codes • FFS with higher payment levels
FFS plus	• FFS with lump-sum payments • FFS with PMPM payment
Shared savings	• FFS with PMPY payment • FFS with PMPY payment & shared savings • FFS with PMPM & P4P • FFS with P4P, lump-sum payments, & shared savings
Comprehensive	• Comprehensive payment with P4P

FFS = Fee-For-Service; **PMPM** = Per-Member-Per-Month
PMPY = Per-Member-Per-Year; **P4P** = Pay-for-Performance

The most common PCMH payment model combines three payment mechanisms



Two other payment mechanisms

Shared savings

- Typically added to another model or mechanism
- Allows providers & practices to share in savings generated by the program

Comprehensive payment

- A lump sum paid per patient for total primary care costs
- Also known as global payment or capitated payment

An example of FFS Plus

Blue Cross Blue Shield Michigan (BCBSM)[2]

- 2,477 practices
- 8,147 physicians
- 1-90 physicians/practice
- Internal & family medicine, pediatrics, geriatrics, specialists (oncology, cardiology, ob-gyn, etc.), mixed PCP/specialist practices
- 1,800,000 covered lives

BCBSM's PCMH practices have[1]:

- **22% fewer** hospital admissions for people with chronic conditions
- **9.9% lower** rate of ED visits
- **7.5% lower** rate of high-tech radiology use

An example of FFS with PMPM & shared savings

PRESCRIPTION FOR PENNSYLVANIA
Right State | Right Plan | Right Now

Pennsylvania Chronic Care Initiative[1]

- **Diversity in plans**
- 170 practices (including FQHCs). 780 physicians
- 1-10 physicians/practice
- Internal & family medicine, pediatrics
- Commercial payers, Medicare Advantage, Medicaid Managed Care
- 1,093,246 covered lives

- **Southeast PA**
  - Payers very engaged
  - CRNP practices included
  - 8 pediatric practices
- **Southwest & South Central PA**
  - Large region with multiple systems
  - Some compensated & uncompensated practices
  - 2 pediatric practices

Up to $4 PMPM

- **Northeast PA**
  - Geisinger, Intermountain, Horizon, & other health systems
  - Smaller practice sites
  - Care management initiated early in the creation of a system of care

Up to $3 PMPM + shared savings

An example of PMPM, P4P, & shared savings:

Maryland Multi-Payer PCMH Pilot

- 53 practices
- 329 providers (including NPs & PAs)
- Internal & family medicine, pediatrics, geriatrics
- 200,000 covered lives

*Year 1: Level 1 or higher
Year 2: Level 2 or higher

	Practice size (# of patients)	Level of NCQA PCMH™ Recognition		
		1+	2+	3+
Commercial population	< 10,000	$4.68	$5.34	$6.01
	10,000 – 20,000	$3.90	$4.45	$5.01
	> 20,000	$3.51	$4.01	$4.51
Medicaid population	< 10,000	$5.45	$6.22	$7.00
	10,000 – 20,000	$4.54	$5.19	$5.84
	> 20,000	$4.08	$4.67	$5.25
Medicare population	< 10,000	$11.54*		
	10,000 – 20,000	$9.62*		

An example of comprehensive payment

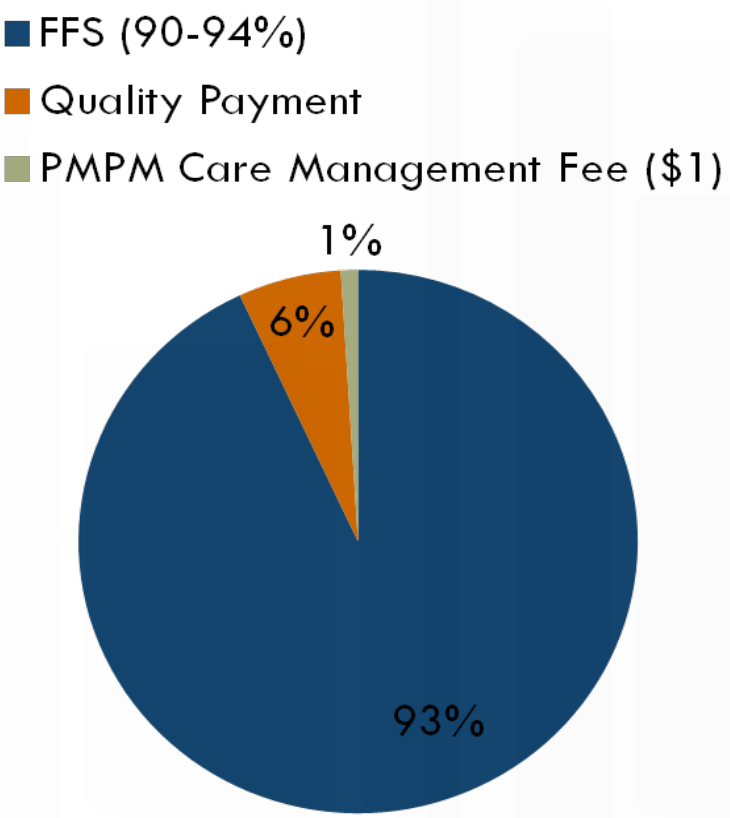
Capital District Physician's Health Plan (CDPHP)[1]

- 3 practices
- 18 physicians
- 3-10 physicians per practice
- Internal & family medicine
- 13,000 covered lives

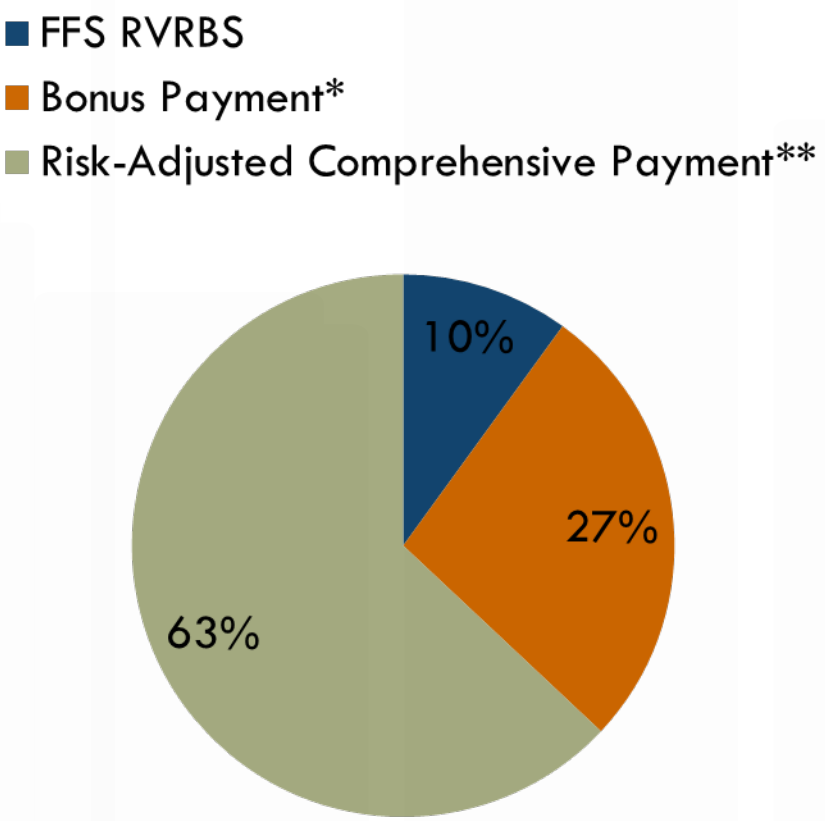
After one year, practices in the CDPHP PCMH pilot experienced:

- **Improvements** in quality measures
- **9% reduction** in cost increases—a savings of $32 PMPM
- **Significant reductions** in advanced imaging and ED visits
- **24% fewer** hospital admissions

Traditional Payment



PCMH Payment Pilot



* Uses IHI Triple Aim for bonus payment.

**Targeted at improving base reimbursement by approximately $35,000.

Required targets for CDPHP bonus payments

Population health

18 HEDIS quality metrics in 5 domains

1. **Population Health:** cervical cancer, breast cancer, colorectal cancer, Chlamydia, glaucoma, adolescent well care visits
2. **Diabetes:** eye exam, HbA1c testing, LDL testing, nephropathy attention
3. **Cardiovascular**: complete lipid profile, persistent medication management-ACE/ARB, persistent medication monitoring diuretics
4. **Respiratory**: antibiotic use for acute bronchitis, asthma medications, treatment for children with pharyngitis, treatment for children with UTI
5. **Imaging studies** for low back pain

Satisfaction

CG-CAHPS: threshold for bonus eligibility

Per capita cost

Population & episode-based:

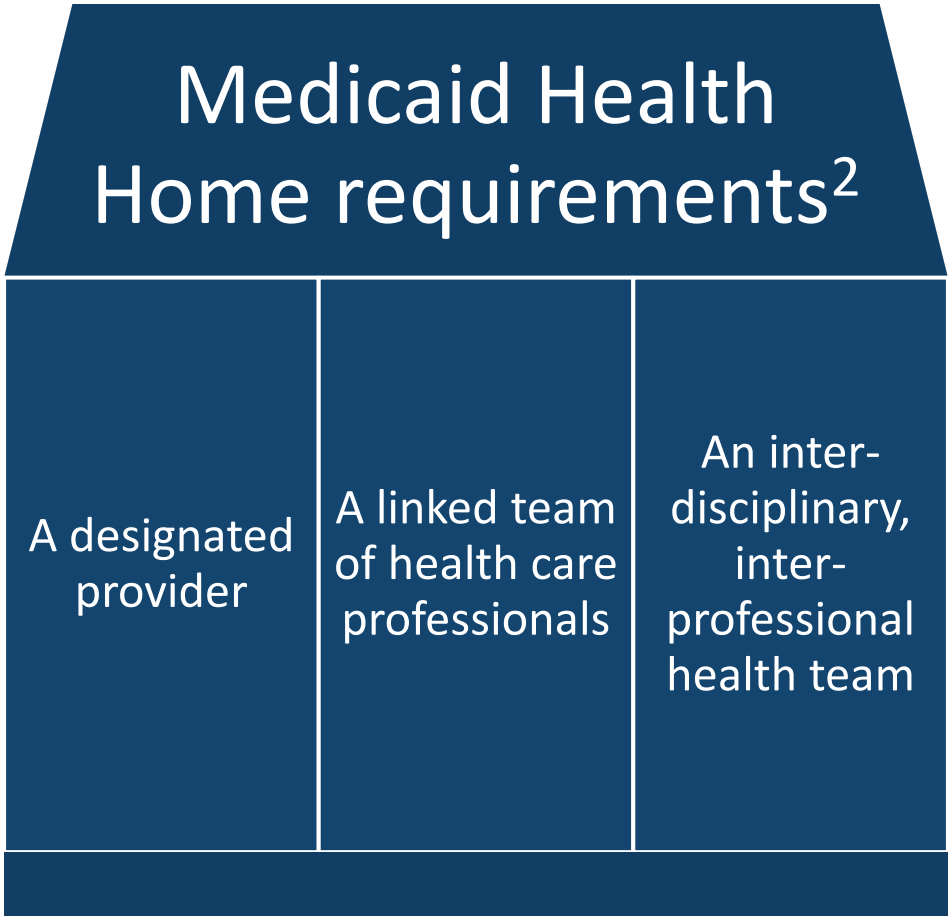
- Specialty care and other outpatient hospital
- Pharmacy
- Radiology

Utilization:

- Select inpatient hospital admissions
- Select ED encounters

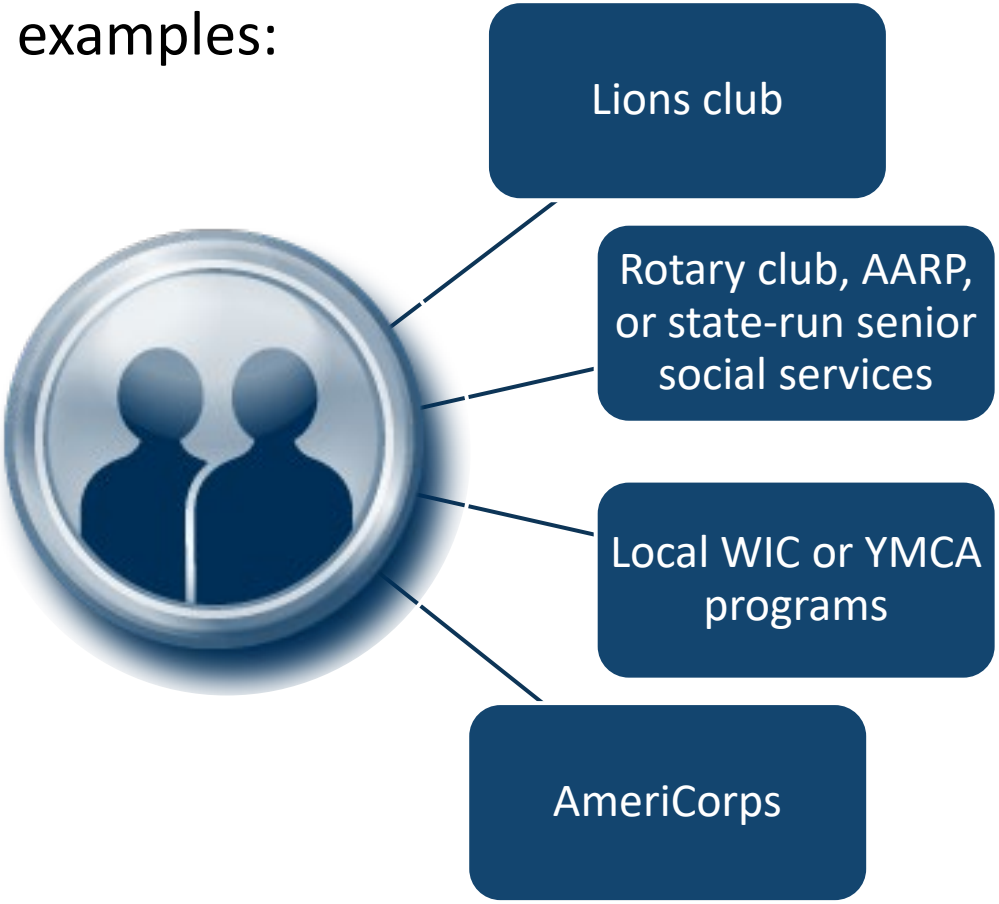
Other opportunities: Medicaid Health Home

The Patient Protection and Affordable Care Act provided states with a new Medicaid option of providing "health home" services for enrollees with chronic conditions.[1] Health home services can be reimbursed as an increase to the existing PMPM rate. States eligible for 90% Federal Match Rate (FMAP) for eight calendar quarters.



Other opportunities: Community partnerships

Innovative examples:



Section 3

Business case for practice transformation

Business case overview: What will it cost?

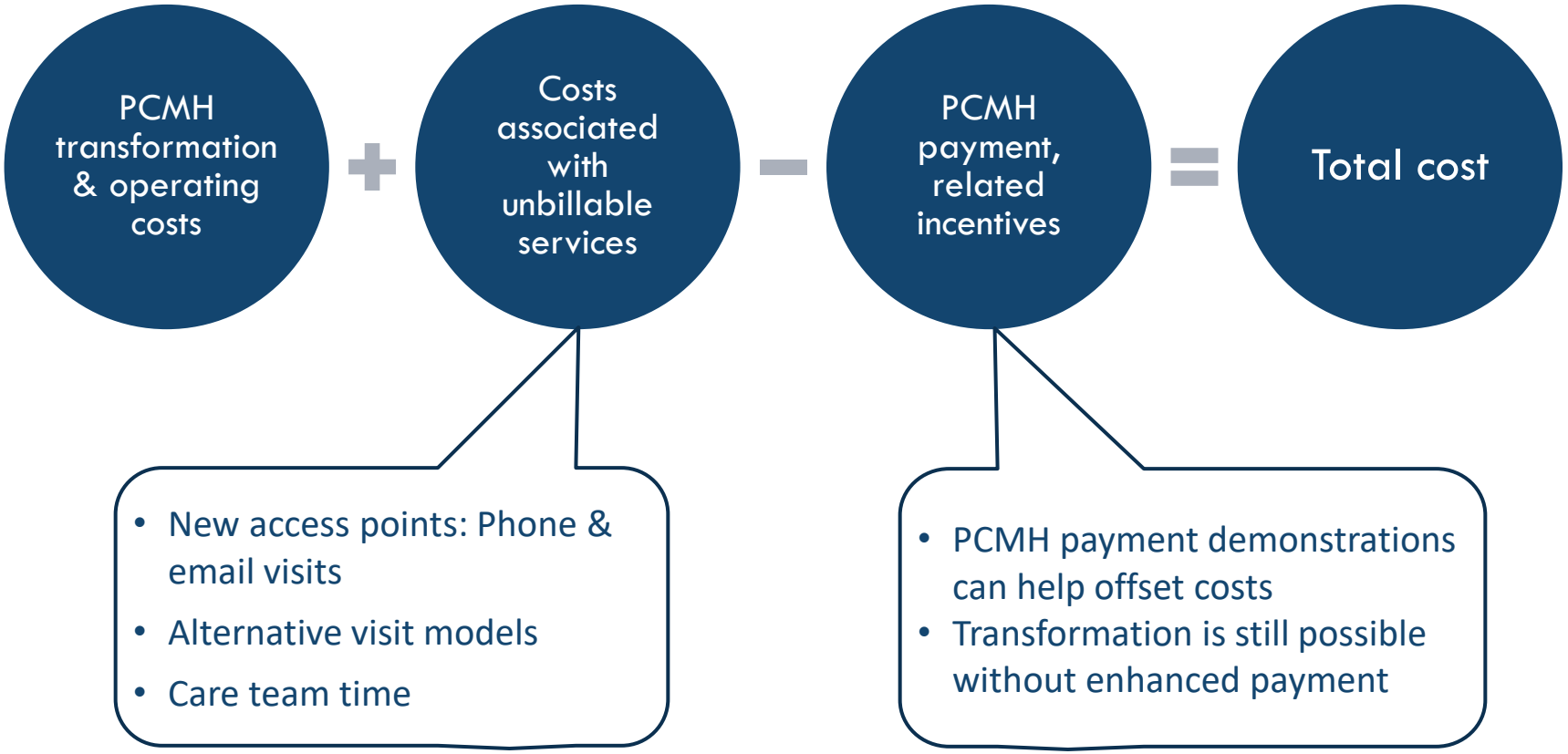
Transformation is an investment in a practice's future.

Costs will depend on existing staffing model, existing health information technology (HIT), and other factors.

Practice transformation: Costs to *become* a PCMH

- New staff
- Staff training
- PCMH recognition
- Infrastructure upgrade
- Health information technology

Total cost of PCMH



Is it more expensive to operate as a PCMH?

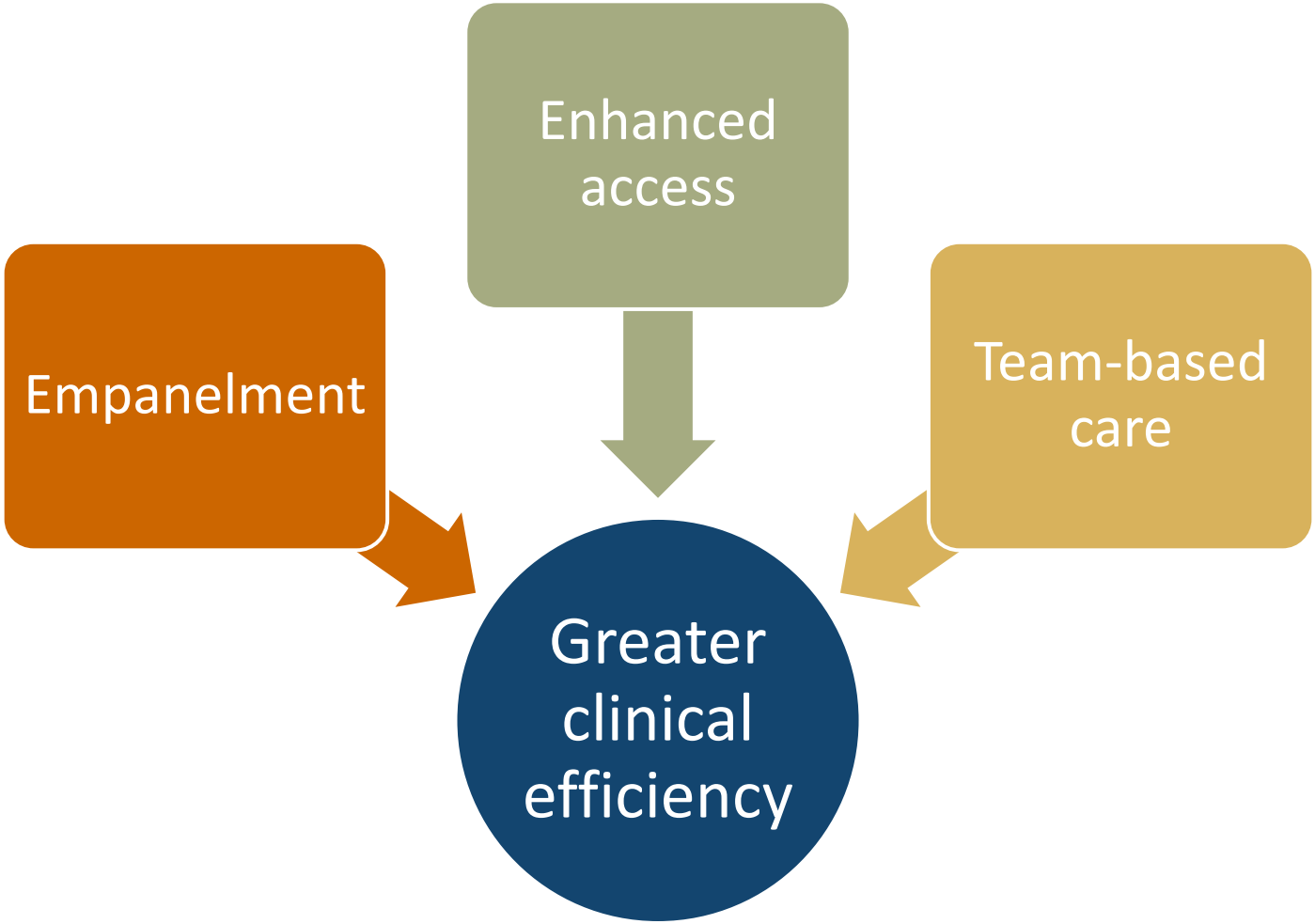
Evidence is limited, but new research has identified incremental costs.[1,2]

For practices operating on small margins, even small costs can be problematic.

Commonwealth Fund National Survey of 669 FQHCs (2009)[2]

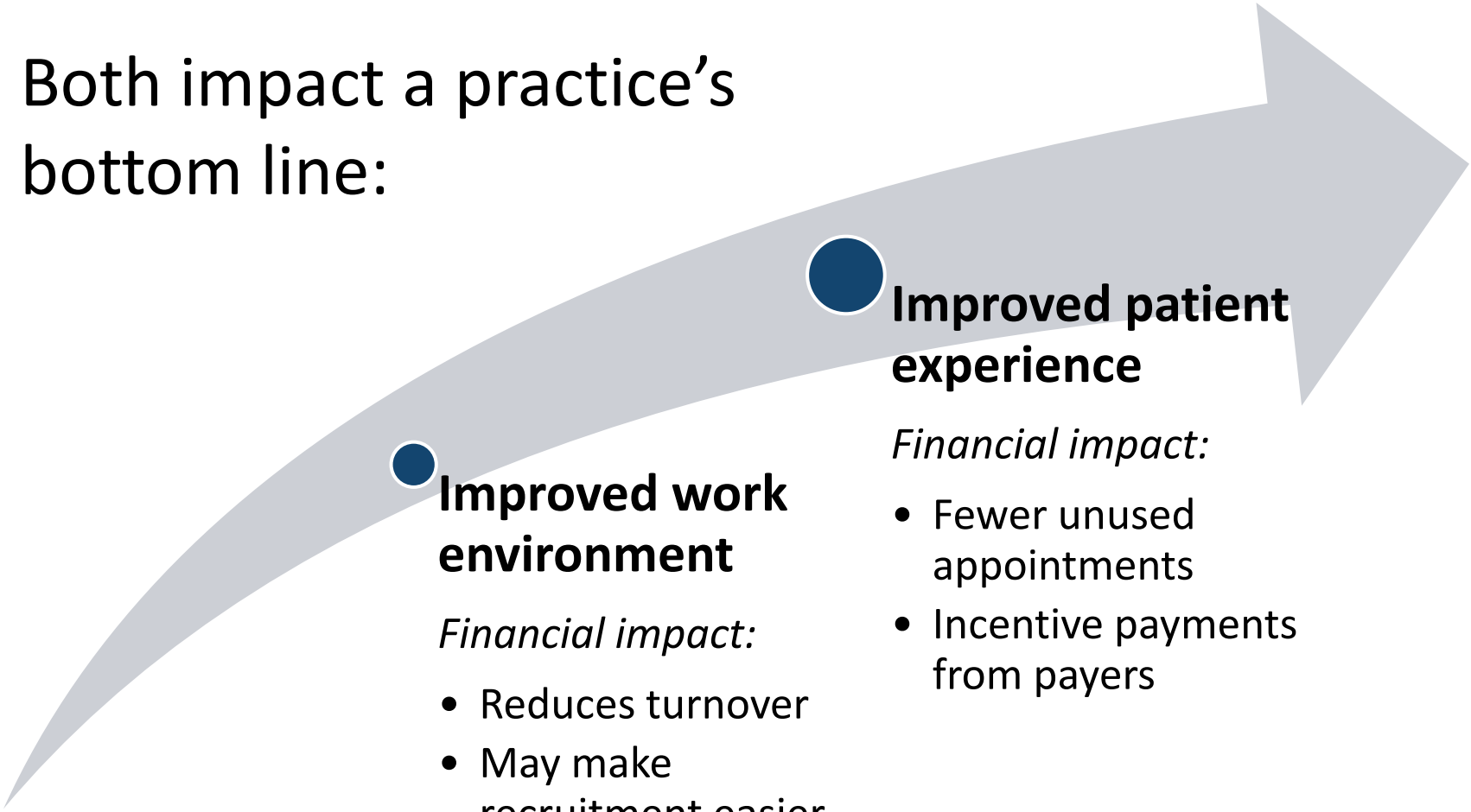
- FQHCs with more PCMH attributes had higher overall operating costs.
- Some subscale scores were associated with higher operating costs (e.g., patient tracking) while others (e.g., access and communication) were associated with lower operating costs.
- A 10-point-higher *overall* PCMH score was associated with a 4.6% higher operating cost per patient per month. For the average clinic (mean visits = 73,100), this amounted to an extra $2.26 per patient, per month—or an increased annual operating budget of $508,207.

PCMH will boost efficiency



Other benefits: Better work environment & patient experience

Both impact a practice's bottom line:



Improved work environment

Financial impact:

- Reduces turnover
- May make recruitment easier

Improved patient experience

Financial impact:

- Fewer unused appointments
- Incentive payments from payers

Summary of the business case



The current predominant primary care payment system (FFS) does not support PCMH care.



Payment reform is critical in the long term, and payment models are being tested across the country.



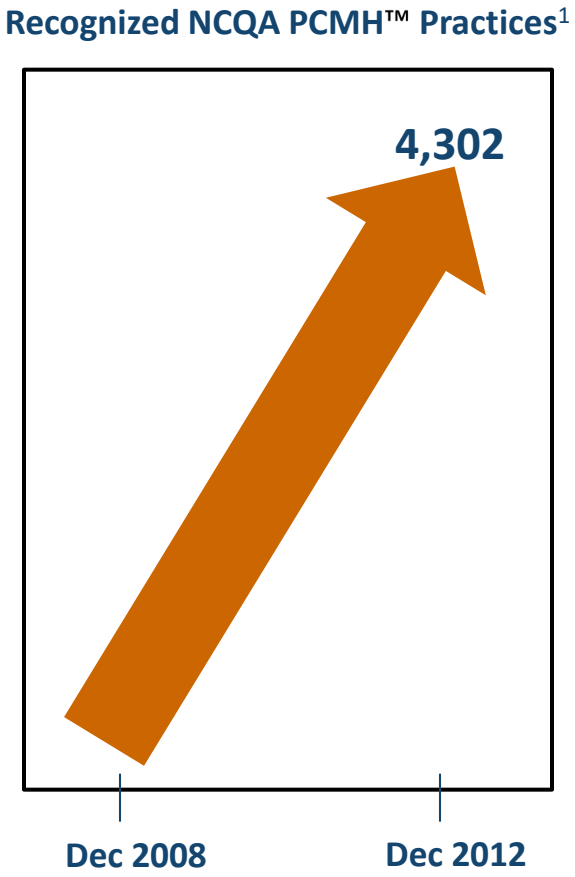
Many practices—of all types—have adopted the PCMH model without payment changes or increases.

Section 4

NCQA PCMH™ Recognition: Ties to payment

The case for recognition: Ties to payment

- External validation of PCMH transformation
- Requirement for participation in enhanced payment demonstrations (e.g., CMS FQHC APCP Demonstration)
- Payment incentive (see: Maryland Multi-Payer PCMH Pilot)
- Included/advertised by health plans
- Staff motivator
- Supports the process of transformation



Overview: NCQA PCMH™ Recognition levels

Three levels of NCQA PCMH™ Recognition reflect the degree to which a practice meets the requirements.

NCQA PCMH™	Description	Point requirement	Other requirements
Level 1	Can be achieved without deploying electronic health records (EHR)	35–59 points	All 6 "must-pass" elements
Level 2	Requires some electronic functions	60–84 points	
Level 3	Requires a fully functional EHR	85–100 points	

NCQA PCMH™ Recognition standards

Enhance Access & Continuity

- Access During Office Hours*
- Access After Hours
- Electronic Access
- Continuity (with provider)
- Medical Home Responsibilities
- Culturally/Linguistically Appropriate Services
- Practice Organization

Identify/Manage Patient Populations

- Patient Information
- Clinical Data
- Comprehensive Health Assessment
- Use Data for Population Management*

Plan/Manage Care

- Implement Evidence-Based Guidelines
- Identify High-Risk Patients
- Manage Care*
- Manage Medications
- Electronic Prescribing

Provide Self-Care & Community Resources

- Self-Care Process*
- Referrals to Community Resources

Track/Coordinate Care

- Test Tracking and Follow-Up
- Referral Tracking and Follow-Up*
- Coordinate with Facilities/Care Transitions

Measure & Improve Performance

- Measures of Performance
- Patient/Family Feedback
- Implements Continuous Quality* Improvement
- Demonstrates Continuous Quality Improvement
- Report Performance
- Report Data Externally

* Indicates **must-pass element**: Practices must achieve a score of 50% or higher on ALL 6 of must-pass elements

Program design: Who becomes recognized?

- **Outpatient primary care practices** that meet the scoring criteria.
- **"Practice"** is defined as a clinician or clinicians practicing together at a single geographic location, including nurse-led practices in states where state licensing designates NPs as independent practitioners.
- **"Primary Care"** is defined as a practice that provides "whole person care": If a practice can demonstrate that it provides whole person care and meets the other elements of the joint principles for at least 75% of its patients, it can be eligible for NCQA PCMH™ Recognition (even if it is not a traditional primary care practice).

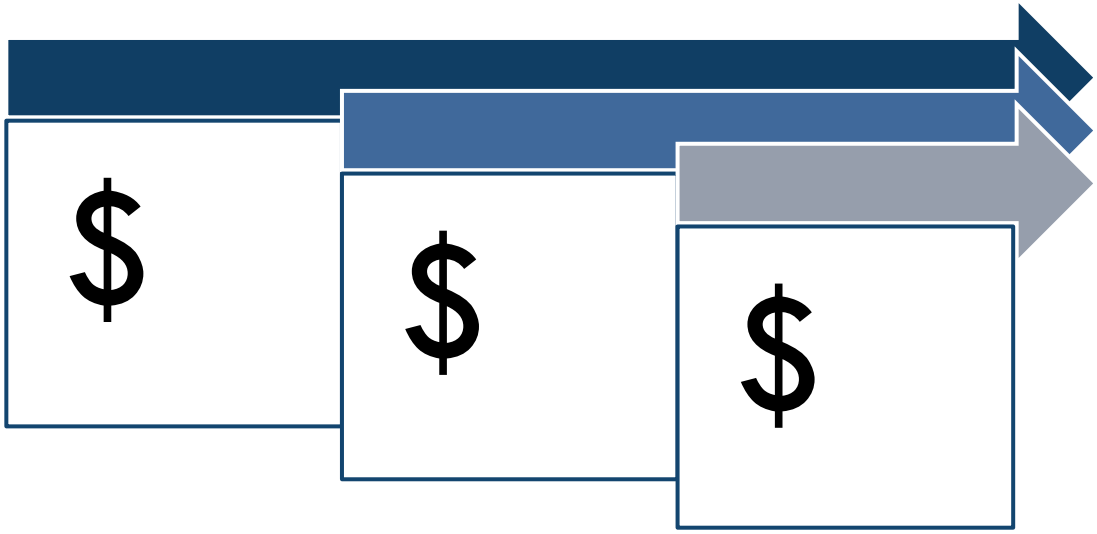
Section 5

Coaching tip summary

Your role as a coach: Understand the PCMH environment

Coaches are not expected to be payment or policy experts, but they need to understand the "bigger picture"—the environment in which practices operate—in order to effectively guide change at the site level.

Coaches and the organizations that employ them (e.g., State Primary Care Association, Professional Association) can advocate for aligning incentives and programs meant to support PCMH transformation.



Coaching tip summary



Educate yourself about PCMH



Understand what's going on in your state



Help sites understand the value of investing in PCMH:

- Insert parts of this PowerPoint in your presentations
- Use the PCMH ROI Calculator to help sites identify their specific transformation costs
- Use the PCMH Business Case Talking Points to prepare for conversations with leadership
- Additional resources available at CoachMedicalHome.org

Tailoring the message to your audience

Role	Emphasize how PCMH transformation…..
CEO, practice owner, board members	Will allow the practice to be competitive in the future; supports the organization's MVV; positions the practice for participation in new models of care delivery; achieves the triple aim; is an expectation of payers and policy makers; etc.
CFO, COO, finance, billing	Can increase revenue; provides access to incentives and reduced/ or low-cost support; can provide more flexible revenue (PMPM vs. FFS); reduces turnover costs; improves operational efficiency; etc.
Medical Director, clinical staff	Improves provider/staff satisfaction; improves patient health outcomes; enhances access; encourages continuity of care; revitalizes and values primary care; etc.
Non-clinical staff	Improves staff satisfaction; encourages all staff to contribute to the clinical care of the patient; encourages all staff to work to the top of their ability and licensure; improves work flows; etc.