

This is the second module of Coach Medical Home—a six-module curriculum designed for practice facilitators who are coaching primary care practices around patient-centered medical home (PCMH) transformation. Based on the Safety Net Medical Home Initiative Framework for Practice Transformation, these modules provide knowledge and tools coaches can use to support practices as they improve quality of care, become medical homes, and achieve PCMH recognition.

Each module has two components: a PDF handbook like this one and a companion PowerPoint® presentation also available on the Coach Medical Home website. The PowerPoint® slides can be saved, modified, and used in your presentations with practice leaders and others. The detailed notes in the handbook will help you learn more and link you to other useful resources. You may also find it helpful to use these notes to guide your talking points during presentations.

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Learning objectives for this module

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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.

Coach Medical Home: Module 2

The second module of the Coach Medical Home curriculum, "Recognition and Payment," provides coaches with an overview of the policy landscape as it relates to Patient-Centered Medical Home (PCMH) transformation, specifically payment reform and PCMH recognition.

Practices beginning the PCMH transformation journey often have questions and concerns about cost and payment.

- What will it cost my practice to become a PCMH?
- Will I be eligible for enhanced payment?
- Practices, particularly practice leadership, need to understand the business case for PCMH transformation: What resources they will need to invest in transformation efforts (expenses) and what they should expect from those investments (direct and indirect financial benefits).

While coaches are not expected to be payment or policy experts, understanding the environment in which a practice operates will help you better understand its challenges, barriers, and resource needs. Most importantly, it can help you identify sources of support to help the practice transform. As a coach, you should be prepared to articulate the business case for PCMH transformation to senior leaders (e.g., CEO, CFO), clinical teams, and community partners and other stakeholders who may be able to contribute resources to support transformation efforts. You should also be prepared to describe the benefits of PCMH recognition and how external recognition is linked to payment.

Overview of contents

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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

Coach Medical Home: Module 2

This module includes five sections. Sections 1-4 present payment and recognition topics you will need to understand and be able to explain to practices. Section 5 provides tips and introduces tools and resources you and the practices you work with can use to apply this information.

Throughout this module, you will find coaching tips and links to useful tools to help you accomplish the action step(s) listed on that page. Look for the following icons on certain pages:



The light bulb icon points out key tips and insights that will help you in your role as a coach.



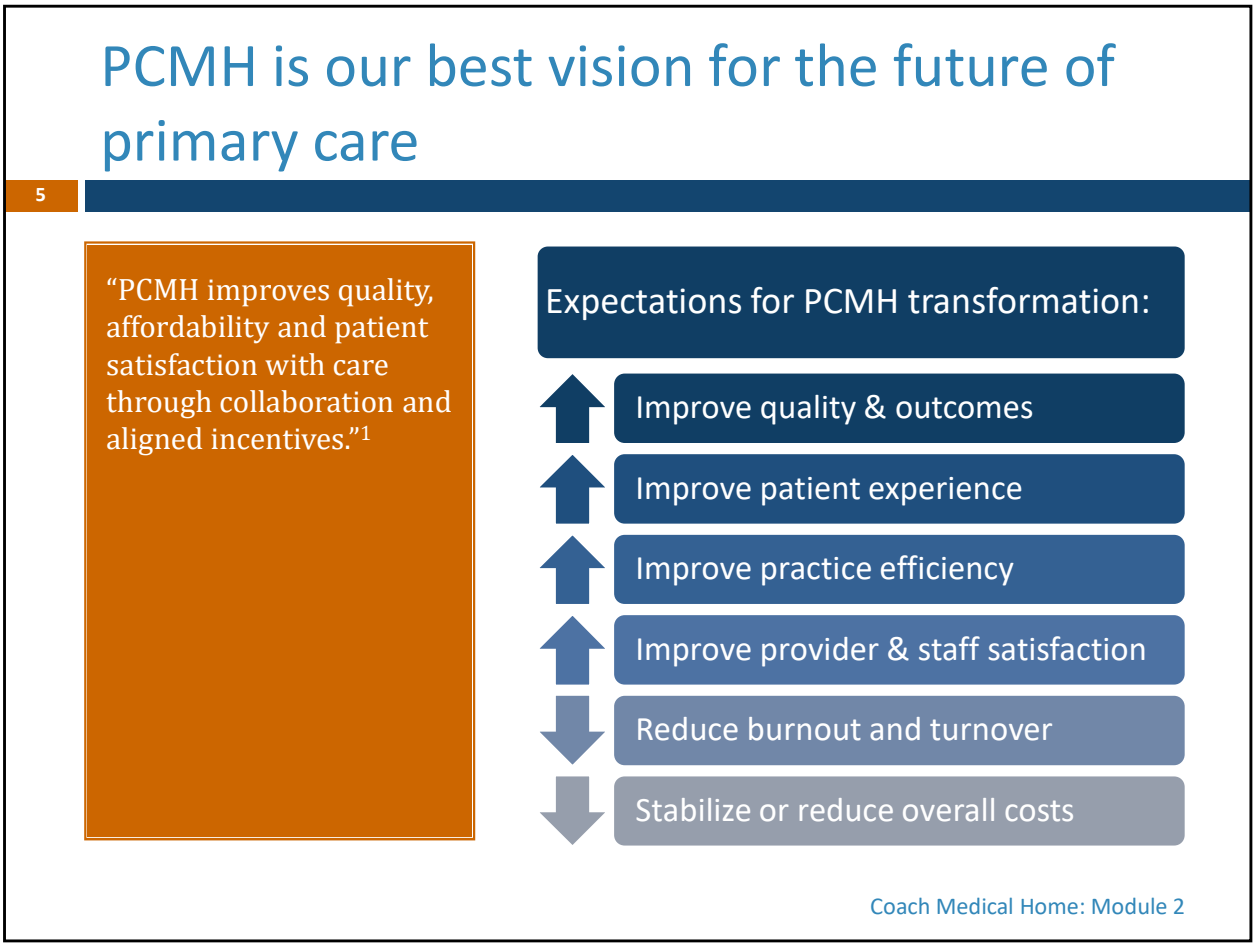
The toolbox icon points out tools you can access via the link provided.

SECTION 1

Investing in PCMH

Coach Medical Home: Module 2

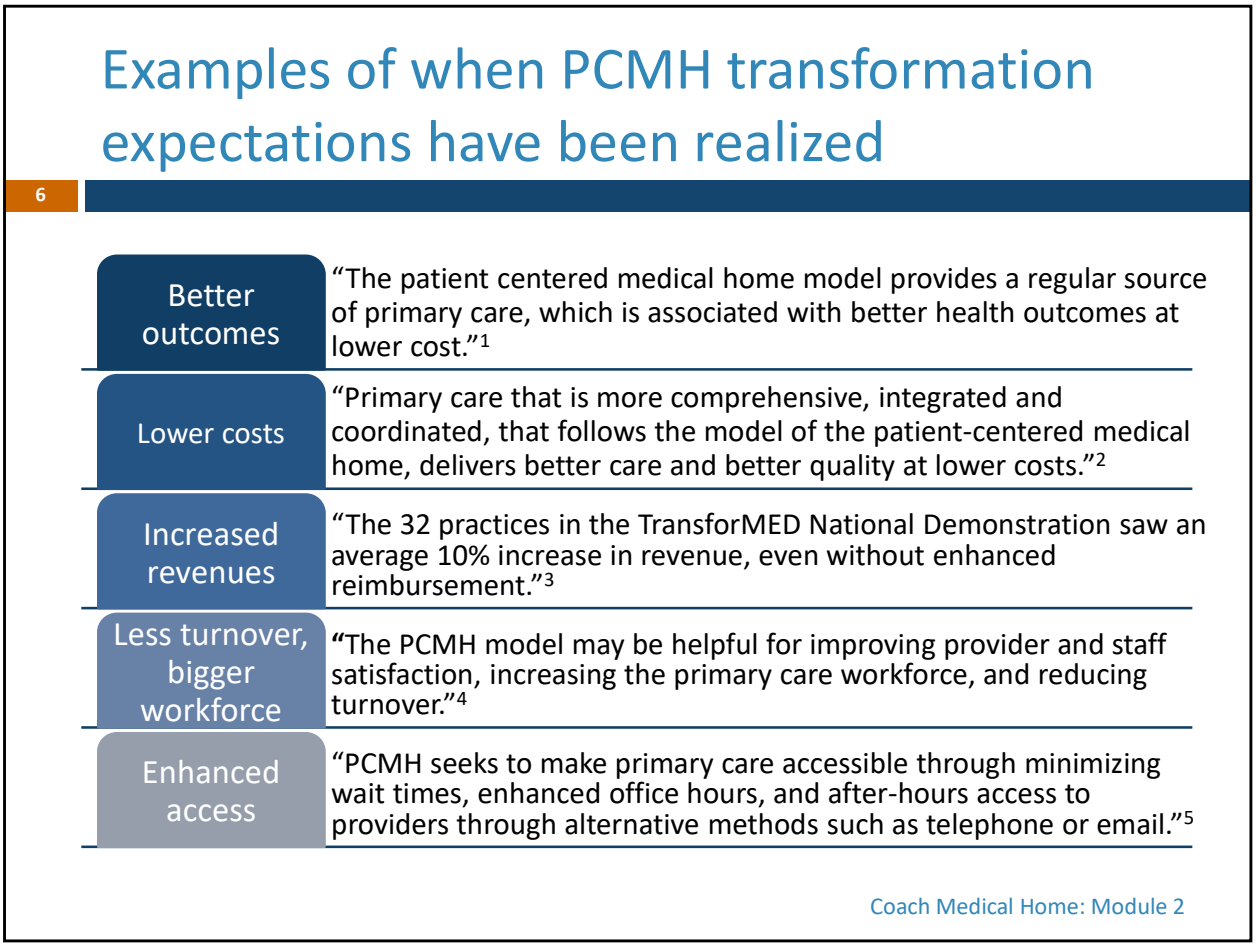
PCMH is quickly becoming an expectation of payers and policymakers, and thus a requirement for practices who want to be eligible for new payment opportunities. Payers and policymakers are increasingly holding primary care providers and their practices accountable for managing and improving population health. As a coach, you may be asked to talk with senior leaders, board members, or clinical staff about why investing in PCMH matters. You can use the slides in this section and the tools at the end to help make the case.



The PCMH model of care has gained attention and support from a wide array of stakeholders: provider groups, patient groups, payers, policymakers, and employers. Why is the PCMH model important, and why has it been able to motivate so many different types of stakeholders?

First, it's the best vision we have for the future of primary care, and second, it improves value for all stakeholders. PCMH has been shown to improve quality and patient health outcomes, patient experience, practice efficiency, and provider and staff satisfaction—thereby reducing burnout and turnover. It has also been shown to stabilize or reduce overall healthcare costs, primarily through decreases in hospital admissions and emergency department (ED) visits.

1. Patient Centered Primary Care Collaborative. Patient-Centered Medical Home. 2008.



How does PCMH provide value to stakeholders? Care delivered to patients in a medical home has been shown to improve patient outcomes and population health. Of particular interest to payers and policymakers is the promise of the PCMH model to stabilize or reduce overall healthcare costs. PCMH, when well implemented, can also increase practice revenue, reduce turnover, and enhance access—three outcomes that benefit practices and their staff. The following pages provide additional information on expectations for PCMH transformation.

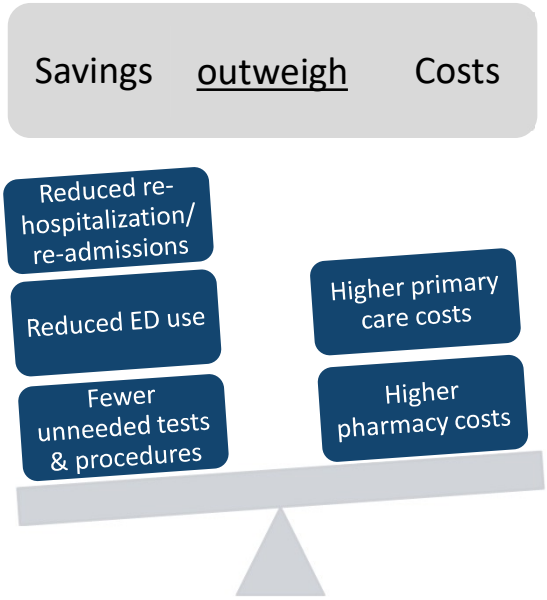
1. American Academy of Family Physicians. The Patient-Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change. Accessed December 2015.
2. Patient-Centered Primary Care Coalition. PCPCC releases evidence brief: Medical home model delivers better care, bends the cost curve. December, 2010. Accessed June, 2012.
3. CEO Report. Studying the Financial Impact of Practice Transformation. TransforMED. Accessed June, 2012.
4. Lewis SE, Nocon RS, Tang H, et al. Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics. Arch Intern Med. 2012;172(1):23-31.
5. HRSA. Patient-Centered Medical Home Resource Center. Accessed June, 2012.

Savings for payers & communities

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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).



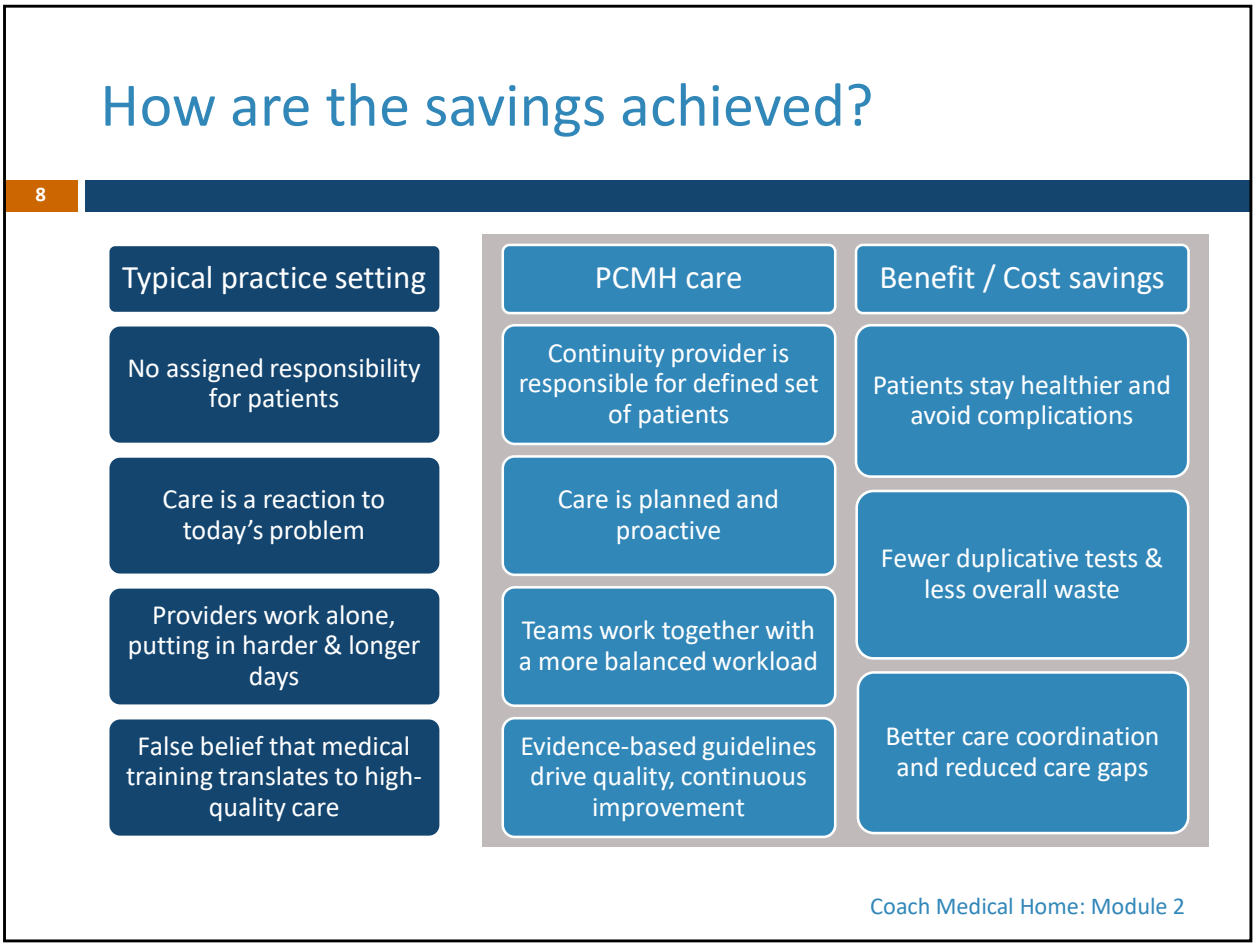
Coach Medical Home: Module 2

How does the PCMH model of care achieve savings? Savings occur in two primary areas: reduced hospitalization and re-hospitalization (reduced utilization, reduced length of stay, reduced re-admission rates) and reduced use of the Emergency Department (ED). How?

PCMH practices provide enhanced access to a care team. Patients get the care they need when and how they need it. PCMH practices are accountable for coordinating patient care. Because patients in PCMH practices have better access and more coordinated care, they are less likely to have care gaps, less likely to be lost to follow up, and less likely to receive duplicative services.

Some healthcare costs increase with PCMH. Studies have shown that overall primary care costs and pharmacy costs are higher among patients in PCMH practices. However, because hospital and ED care are so much more expensive than primary care, savings from reduced hospitalization and ED use are enough to offset these costs. **Thus, most programs find that investing in PCMH is cost-saving or cost neutral, even after accounting for investments in primary care or PCMH implementation support.**

1. Bodenheimer T. Lessons from the trenches—a high-functioning primary care clinic. N Eng J Med 2011; 365:5–8.
2. Gabbay RA, Bailit MH, Mauger DT, Wagner EH, Siminerio L. Multipayer patient-centered medical home implementation guided by the chronic care model. Jt Comm J Qual Patient Saf 2011; 37:265–273.



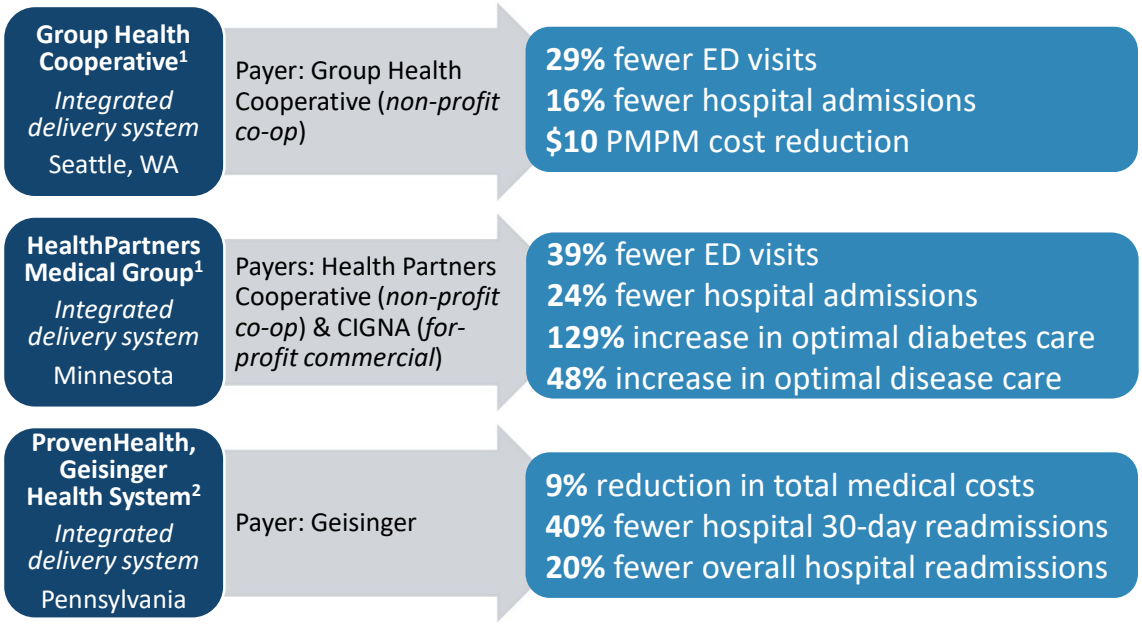
Practice leadership may note that many of the benefits of PCMH transformation accrue to payers. It's true that payers benefit from the savings achieved by reduced utilization and waste. **But there are direct and indirect financial benefits for practices, as well.**

Remind practices of the many benefits PCMH provides: 1) increased efficiency (e.g., reduced no-shows, increased productivity), which should result in increased revenue, 2) improved satisfaction and reduced turnover, which should lower recruitment expenses, and 3) incentives or enhanced payment, including shared savings. Also, remind practice leadership that the major benefit of PCMH transformation is improved care.

When you hear: What's in it for me? What's in it for my patients? Use information on the following slides to craft a response to reassure practices that PCMH will make their patients' health and healthcare experience better, and it will make their practice a more satisfying work environment.

Examples of cost savings for payers & communities

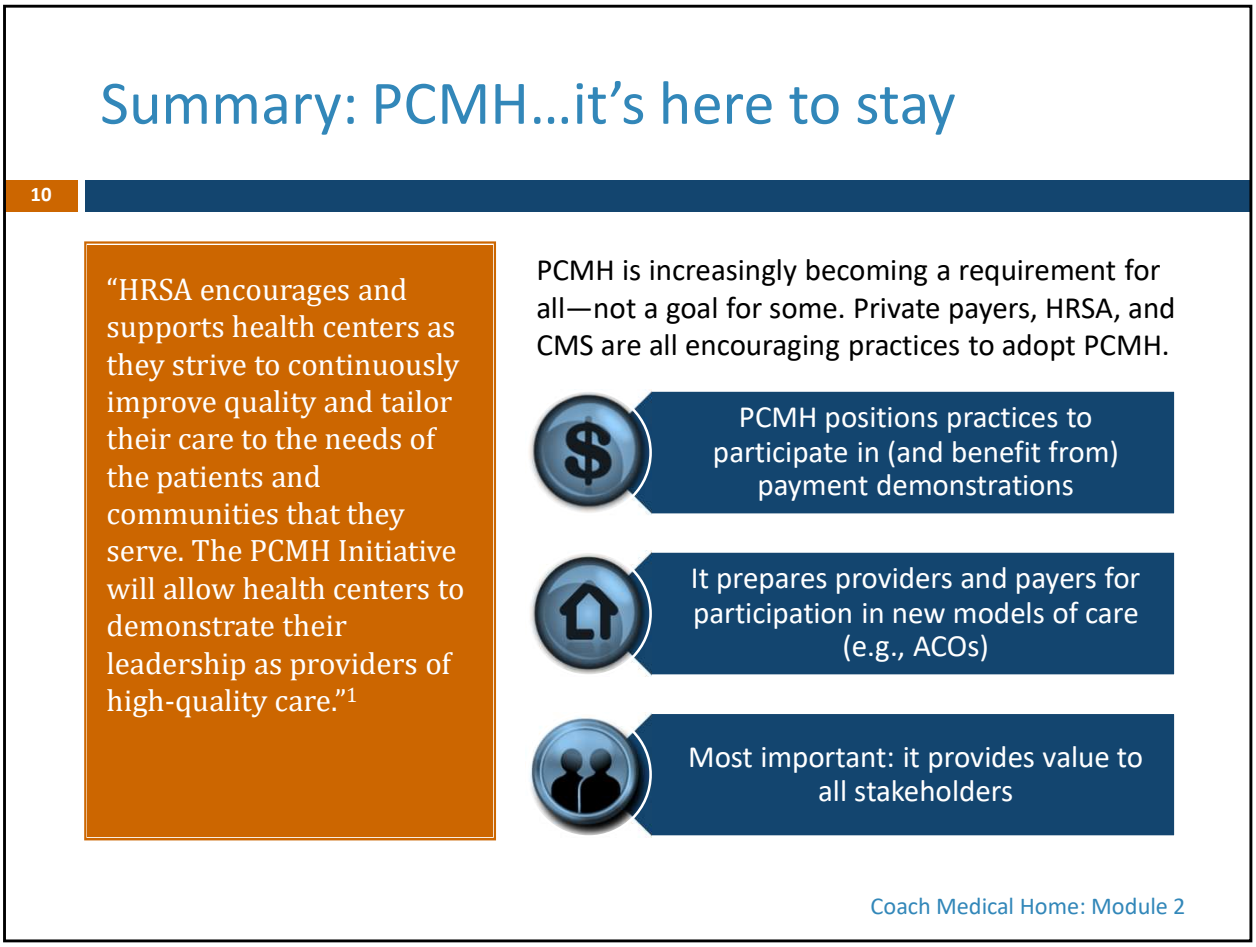
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Coach Medical Home: Module 2

Most of the cost-savings data to date have come from PCMH demonstrations/pilots in integrated systems. If you hear doubt from practices or community stakeholders about whether this experience will hold true in other settings, **acknowledge that evaluation data are limited, but still promising.**

1. Grumbach K, Grundy P. 2010. Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. Washington, D.C.: Patient-Centered Primary Care Collaborative.
2. Arvantes, James. Geisinger Health System Reports That PCMH Model Improves Quality, Lowers Costs. 2011.



As practices undertake the work of PCMH transformation, and particularly as their leaders begin to devote resources to the work, it's important that they understand the long-term benefit of investing in their practices and staff. PCMH transformation provides both immediate and longer-term benefits to practices, patients, and communities. PCMH prepares primary care practices for participation in Accountable Care Organizations (ACOs) and other care delivery models that reward or require coordinated care and pay providers and facilities based on value, not volume.

Never miss an opportunity to reinforce that PCMH enhances the value of health care for all stakeholders:

- Patients receive better care and have better outcomes
- Health care professionals are more satisfied with their work
- Practices operate more efficiently
- Communities receive better value for their health care dollar
- Payers usually achieve overall savings

For safety net practices and other non-profit practice types (e.g., faith-based clinics), PCMH transformation should also directly support the organization's mission, vision, and values.

1. Human Resources and Service Administration (HRSA). HRSA Patient-Centered Medical/Health Home Initiative. 2011.

SECTION 2

PCMH payment 101

Coach Medical Home: Module 2

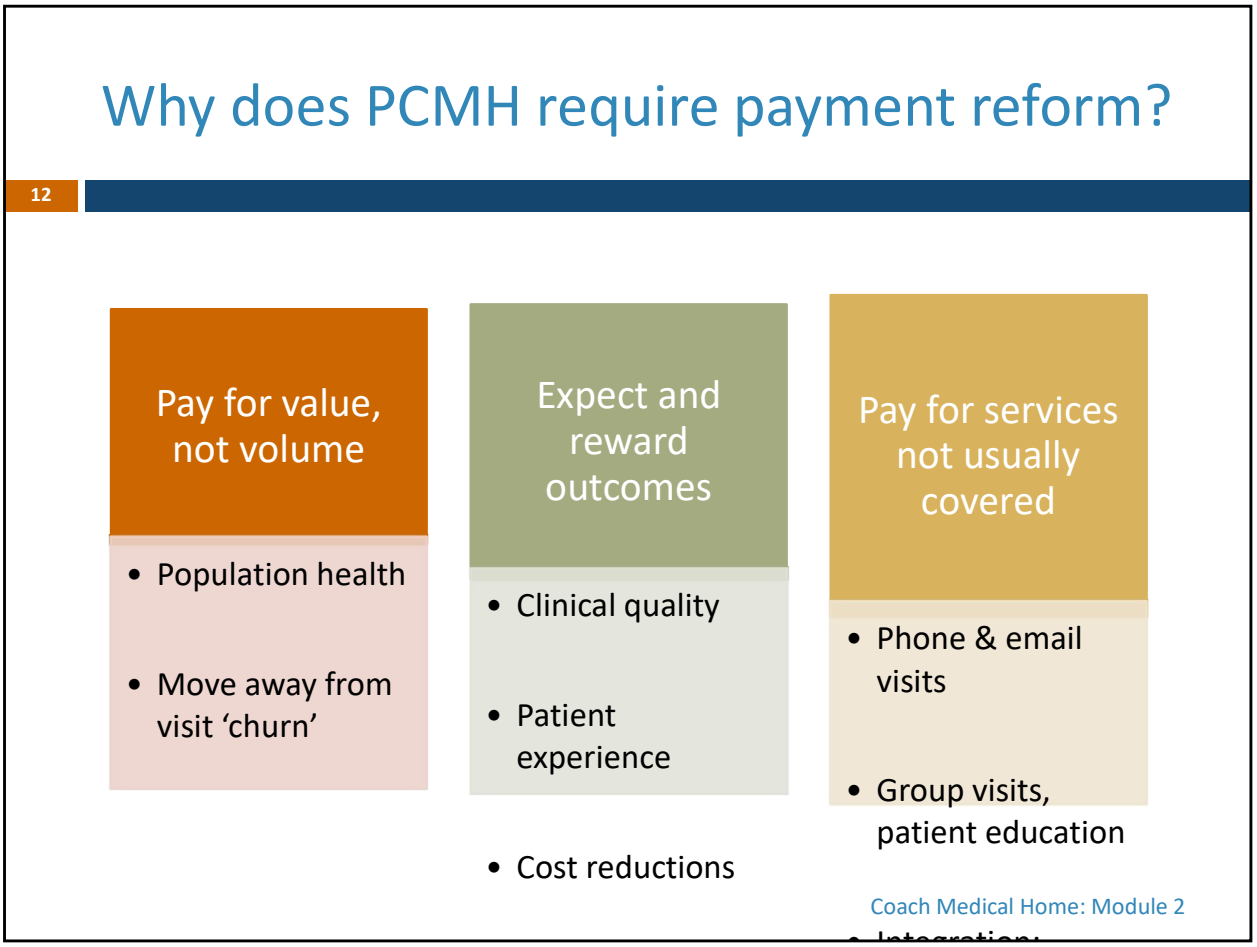
The PCMH model of care, articulated by the Joint Principles in 2007, included a specific reference to PCMH payment. "PCMH payment" includes two concepts**:**

1. **Payment reform:** *how* we pay for healthcare services.
2. **Enhanced payment:** *how much* we pay for healthcare services.

In your role as a coach, you can use the information and examples in this section to help practices understand the likely costs and benefits associated with transformation—what it will cost their practice to transform and what they will earn back from that investment. Review the PCMH Return on Investment (ROI) Calculator for more information and consider using the calculator to help leadership identify and understand *their* specific costs and opportunities.



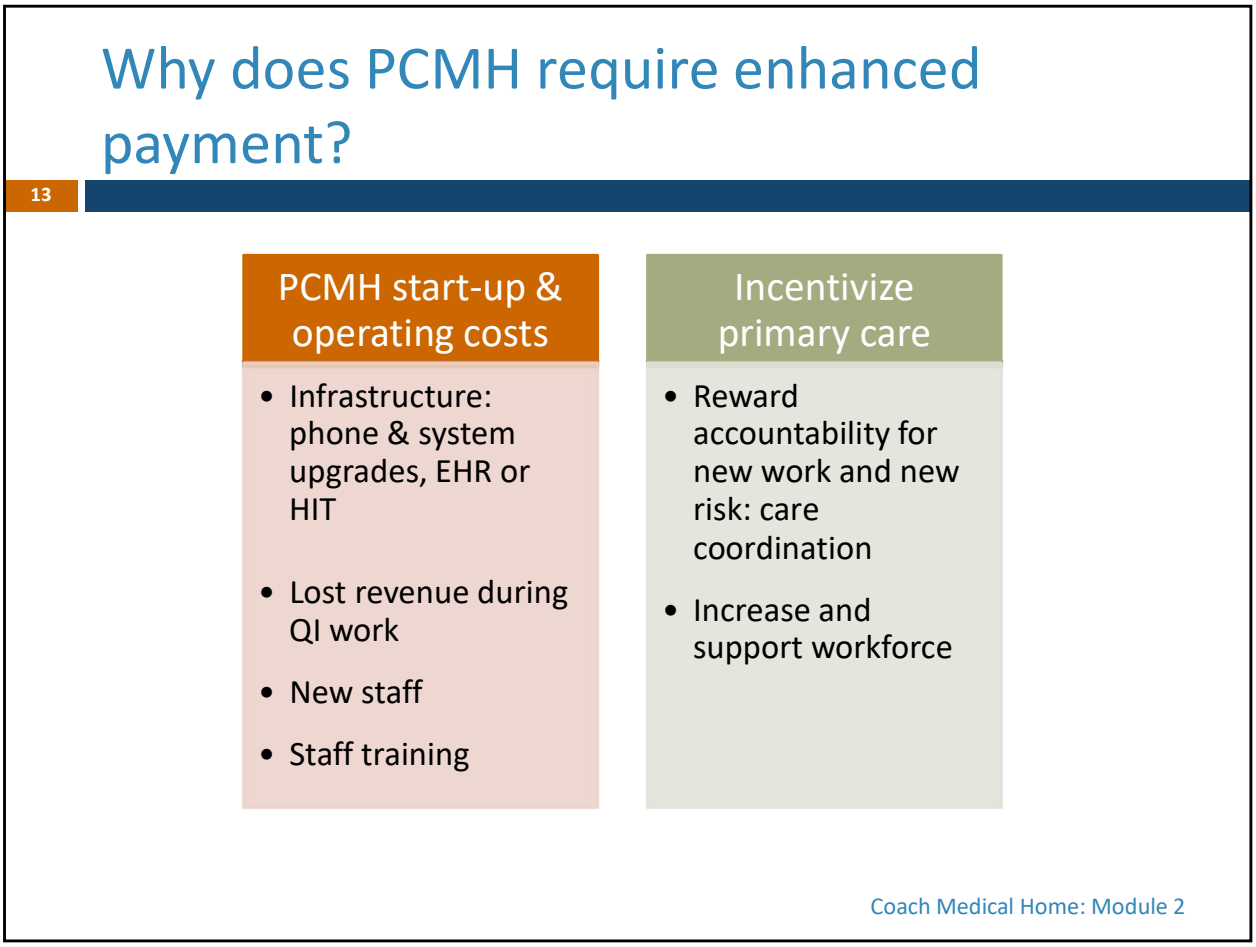
PCMH ROI Calculator



PCMH care is designed to provide value: improved health outcomes, improved patient experience, reduced healthcare costs, etc. But our current healthcare system rewards volume: number of visits, number of procedures, etc.

This sets up a system where practices benefit financially from providing face-to-face physician office visits (needed or not), and are penalized (by lack of payment) for providing other types of care—such as email or phone visits, Community Health Worker education visits, and proactive outreach or counseling—and for spending time on care coordination.

In order for PCMH to be sustainable in the long run, payers will need to find a way to reward and incentivize primary care services that provide *value*. This means finding a way to pay for services that are essential for care coordination and enhanced access but that aren't typically covered.

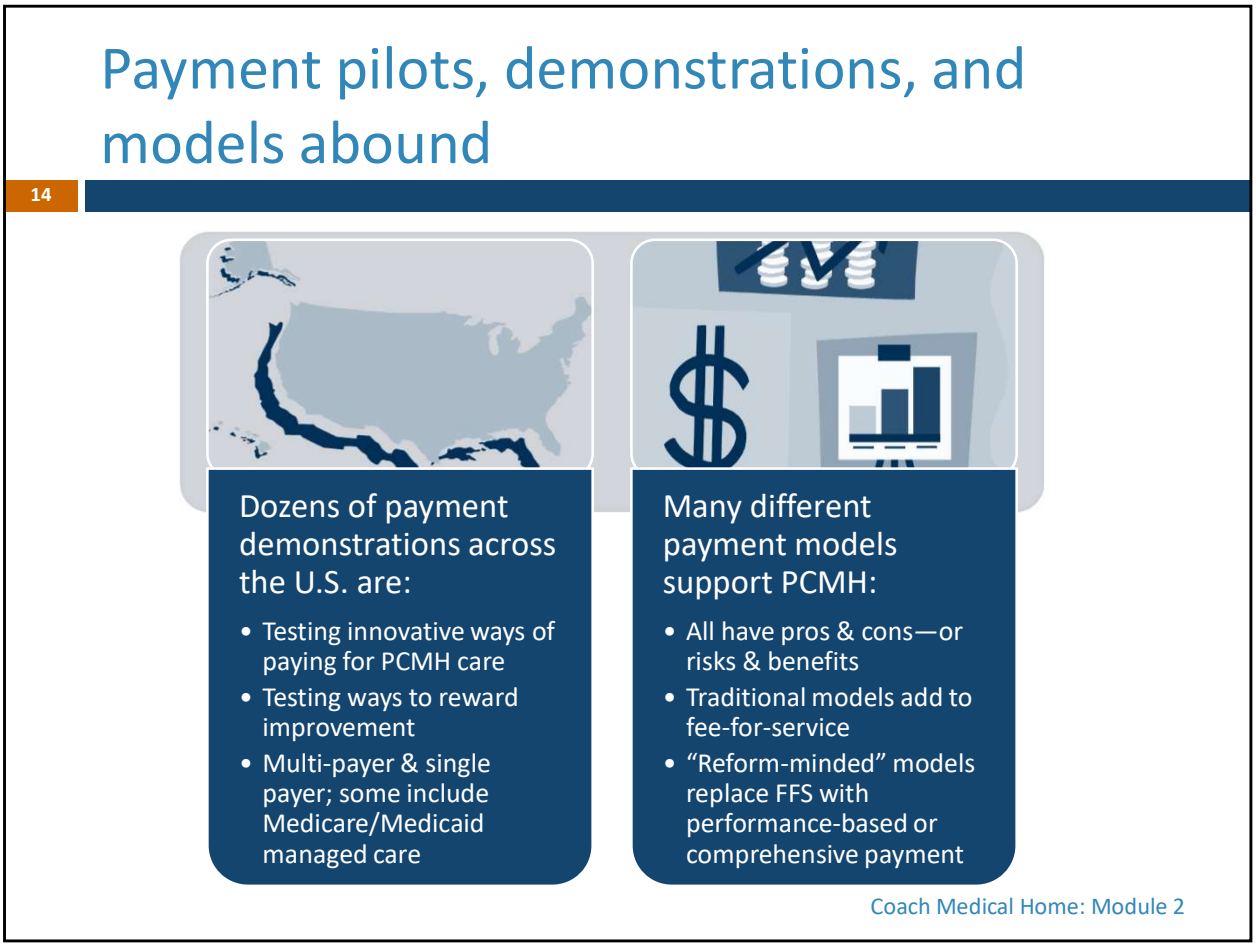


For most practices, PCMH transformation will require a financial investment. Many practices will need to purchase or upgrade health information technology (e.g., EHR or registry) or infrastructure (e.g., phone system). All practices will need to invest in staff training and time "off the line" for team planning and quality improvement work. Many practices have been able to make these investments without enhanced or additional payments or other external resources. But some practices, particularly those that operate on small margins, will not be able to sustain lost revenue, even for short periods of time. Almost all practices will be unable to sustain specific aspects of PCMH care unless they can find a reliable revenue source. For example, practices cannot be expected to provide nurse education services that are not billable.

Another reason to enhance payment for primary care services is to acknowledge and reward the new accountabilities and risks primary care practices will take on as they transition to the PCMH model of care. Lastly, payment is thought to be an essential factor in recruiting and sustaining the next generation of primary care providers.



Acknowledge that payment reform and enhanced payment are both important aspects of the PCMH model of care, but be sure to remind practices that PCMH is also an investment in their own future. All businesses—public and private, for-profit and non-profit—are required to make investments in order to stay competitive and deliver value to their customers. Healthcare is no different. Payment reform is necessary for the sustainability and spread of the PCMH model of care, but the current payment system, with all its flaws, isn't an excuse to maintain the status quo. Remind practices that they benefit from PCMH transformation, too.



Across the country, payers have developed PCMH payment demonstrations and pilots to test new models of paying for primary care services. PCMH payment demonstrations/pilots vary tremendously—from small to large, local to national. On the following pages are examples of the most common PCMH payment models. Some are only minor tweaks on the current, predominant system (fee-for-service, or FFS), while others diverge radically (e.g., comprehensive payment).

The following pages provide basic information on the most common PCMH payment models being tested as of 2011.

Encourage practice leadership to think broadly about what resources they can draw on to support their efforts. Even if a practice may not be eligible for a PCMH payment demonstration/pilot, most practices are eligible for funding or resources that can support their PCMH transformation work. For example, meaningful use funding can help practices select, purchase, or install an EHR. See page 25 for additional ideas on community partnerships.

To see the demonstration projects taking place in your area or for your particular practice type (e.g., FQHC, Ryan White Clinic) refer to: Patient-Centered Primary Care Collaborative and the National Academy for State Health Policy. Both organizations track PCMH demonstrations.

Enhanced payment models: A snapshot

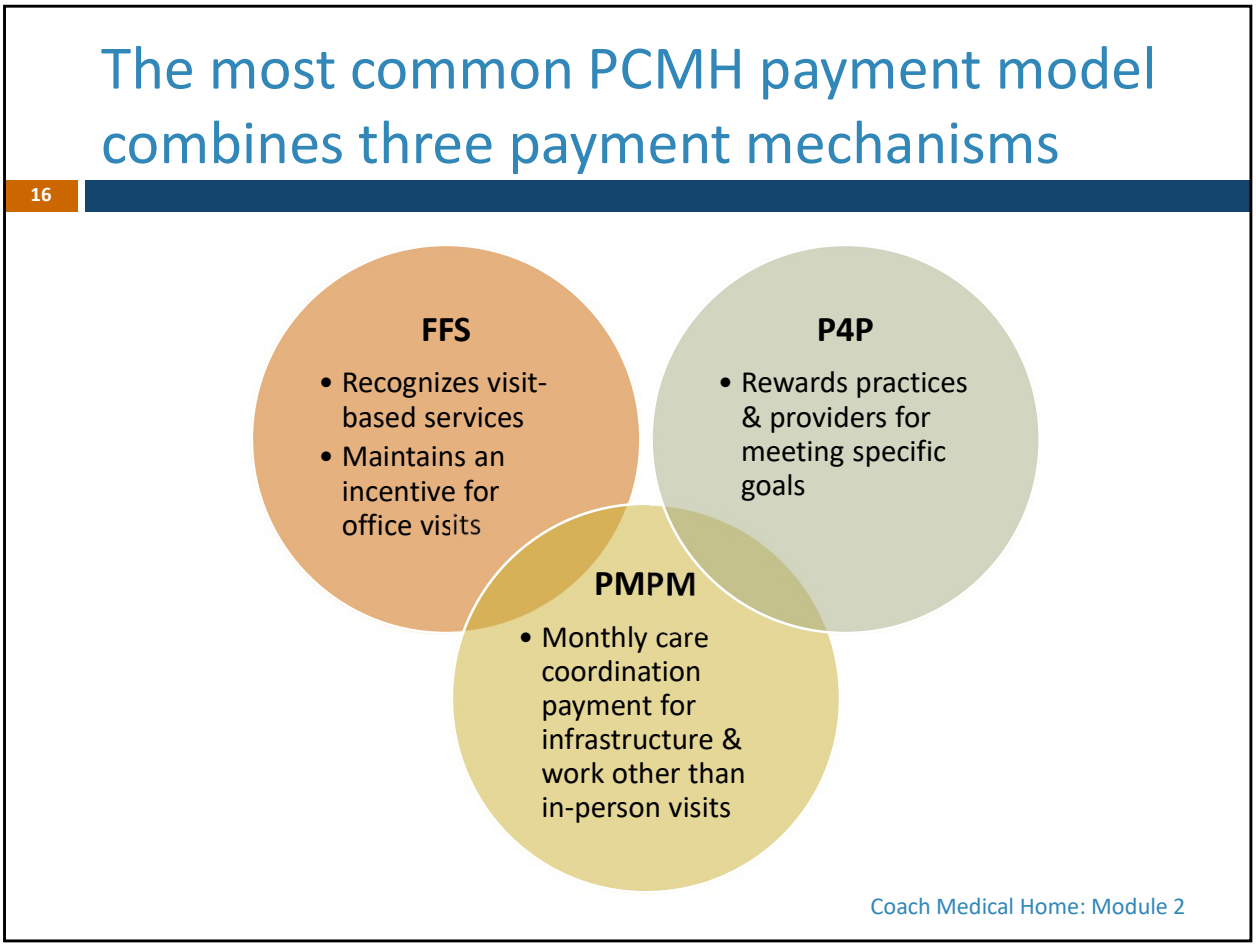
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Grants-based	• Paid for by grants
FFS with adjustments	• FFS with new codes • FFS with higher payment levels
FFS plus	• FFS with lump-sum payments • FFS with PMPM payment
Shared savings	• FFS with PMPY payment • FFS with PMPY payment & shared savings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

Coach Medical Home: Module 2

This table provides a high-level overview of PCMH payment models, with more detail on the following pages.

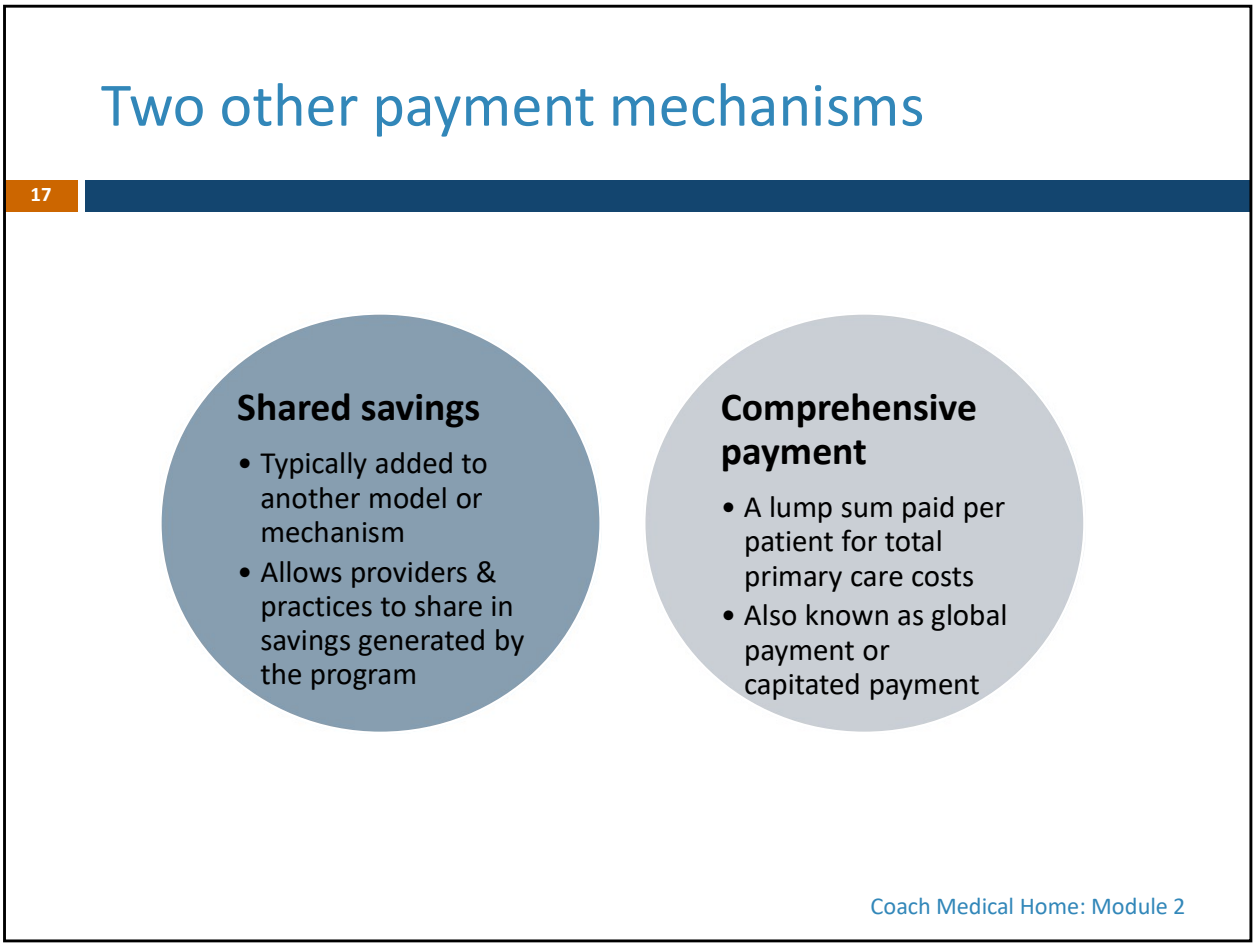


As of 2011, the most common way to re-align payment incentives to support PCMH is to combine traditional FFS for office visits in a three-part model: FFS, PMPM, and P4P.

Fee for service (FFS). This is the predominant payment mechanism in the United States. In PCMH payment demonstrations that use FFS, payers typically adjust FFS payments by agreeing to pay more for each service provided or allowing practices to bill for new or historically unbillable services, such as patient education visits or phone visits. This is known as "FFS with Adjustments." Or they add to FFS (known as "FFS Plus") by pairing FFS with PMPM or P4P payments.

Per member per month (PMPM), or per member per year (PMPY). This refers to a payment, often called a "care coordination" or "care management" fee, that is paid on a per-patient basis every month or every year to the patient's primary care practice. This payment is meant to cover services that fall outside of face-to-face office visits, including non-provider services and infrastructure. It is typically paid in addition to FFS or another payment mechanism. The benefit of PMPM, from a practice's perspective, is that is allows predictable and flexible revenue. The practice can use the revenue it generates from PMPM/PMPY payments for a wide variety of personnel, services, or equipment it thinks will improve care and outcomes for its patient population.

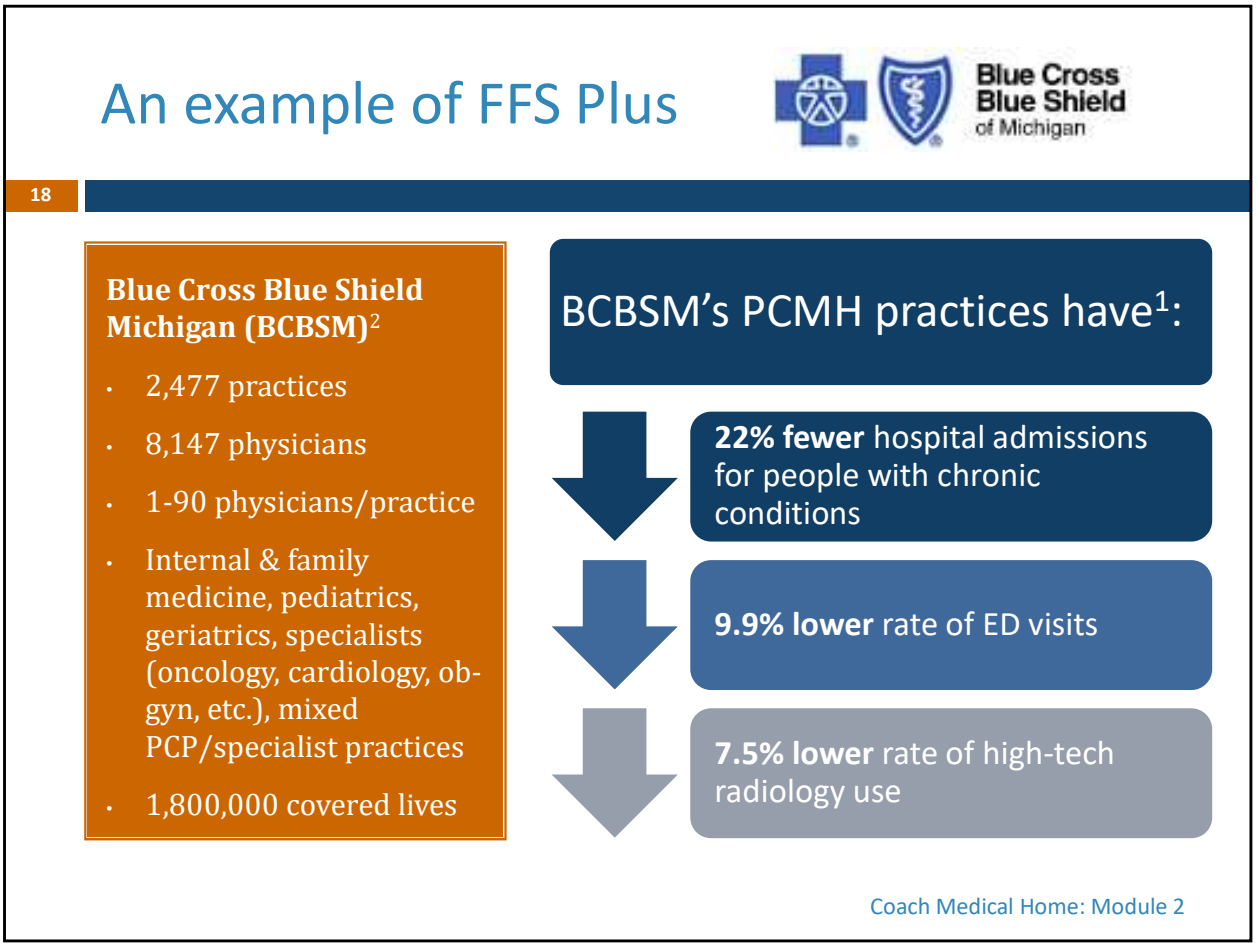
Pay for performance (P4P). This refers to a performance-based payment, typically additive to FFS, PMPM, or both, that rewards attainment of specific quality or efficiency goals. These can be access goals (e.g., night or weekend hours), quality of care goals or patient health outcomes goals (e.g., HEDIS targets), or cost reduction goals.



Some payment models add another payment mechanism, shared savings, as a fourth component or use it in place of P4P. Payment models that include shared savings offer practices the opportunity to share in the savings generated by PCMH across the healthcare system. Most payers recognize overall net savings: The PCMH program must generate enough savings to pay for the investments the payer made in the program (e.g., enhanced FFS or PMPM, technical assistance, etc.).

Also known as capitated payment, comprehensive payment has been extensively tested in Medicaid Managed Care and integrated systems, but is less common in other settings. In PCMH payment demonstrations/pilots, comprehensive payment is usually paired with P4P. In a comprehensive payment model, a practice receives a lump sum (paid monthly or annually) for each eligible patient. Payment is typically risk-adjusted based on age, gender, number of chronic conditions, or other factors. The payment covers all care the patient may need in a given month or year and is not tied to the patient's utilization or specific needs in a given time period. (This differentiates it from FFS and bundled/episodic payments.)

This model provides practices with a predictable and flexible revenue stream. However, it carries much more risk, especially for small practices or practices that serve especially high-risk or complex patients. In a large practice, the number of patients needing more services than expected should balance with those needing fewer services, so the practice should have enough revenue for staff, etc., to provide care for all patients. In a small practice, if too many patients in a single year need more services than expected, the practice can lose revenue.



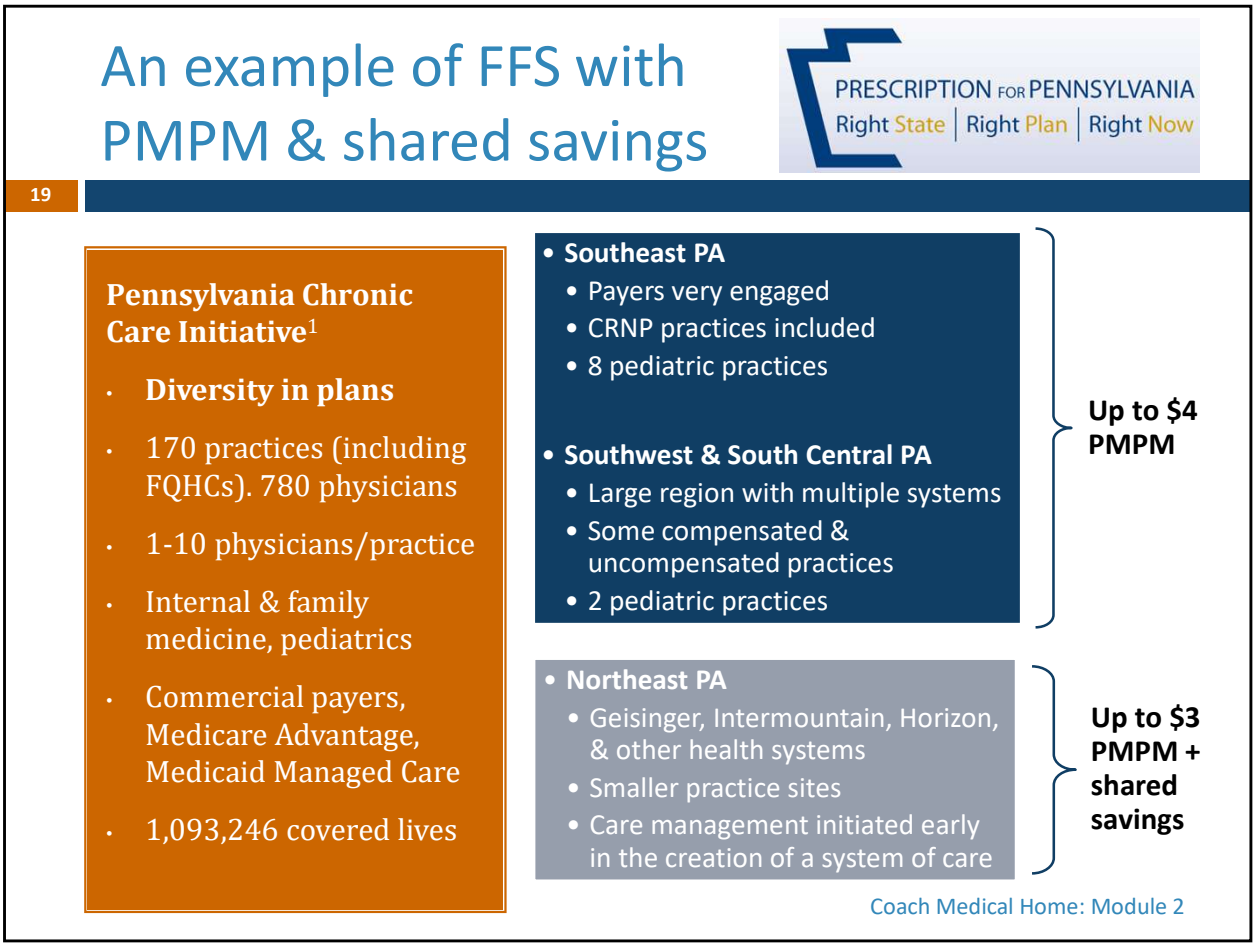
An example of **"FFS Plus" (FFS plus P4P)** comes from Blue Cross Blue Shield of Michigan (BCBSM), whose PCMH program focuses on improving health outcomes for patients with chronic conditions. The program is a collaborative partnership between BCBSM and physician organizations across Michigan, with the goal of optimizing patient care and transforming the state's health care delivery system.[2]

Operating on a FFS Plus model**,** BCBSM provides financial incentives to physicians who achieve quality and outcome goals. [2]

BCBSM's PCMH practices have documented lower rates of hospital admissions, emergency department visits, and high-tech radiology usage compared to non-PCMH practices.

1. Blue Cross Blue Shield Michigan. Blue Cross Blue Shield of Michigan changing the role of the primary care physician through its Patient-Centered Medical Home Program. August 17, 2011.

2. Patient Centered Primary Care Collaborative. Blue Cross Blue Shield of Michigan: Patient Centered Medical Home Program. Accessed December 2015.



The Chronic Care Initiative in Pennsylvania provides another **FFS Plus model**: FFS plus PMPM and shared savings. Practices receive initial infrastructure payments as well as supplemental payments based on NCQA PCMH™ recognition and practice size.[2]

Rollout has occurred incrementally across the state, based on geographic region and payer representation.[3] Approximately 35% of patients in the Initiative are Medicaid enrollees.[2]

1. Patient Centered Primary Care Collaborative. Pennsylvania Chronic Care Initiative. Accessed December 2015.
2. Gabbay R, Bailit M, Mauger D, Wagner E, Siminerio L. Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model. Joint Commission Journal on Quality and Patient Safety. 2011; 37(6): 265-73.
3. Governor's Office of Health Care Reform Commonwealth of Pennsylvania. Pennsylvania's Chronic Care/Medical Home Initiative: Transforming Primary Care. July 2010. Accessed July, 2012.

An example of PMPM, P4P, & shared savings:

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Maryland Multi-Payer PCMH Pilot

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

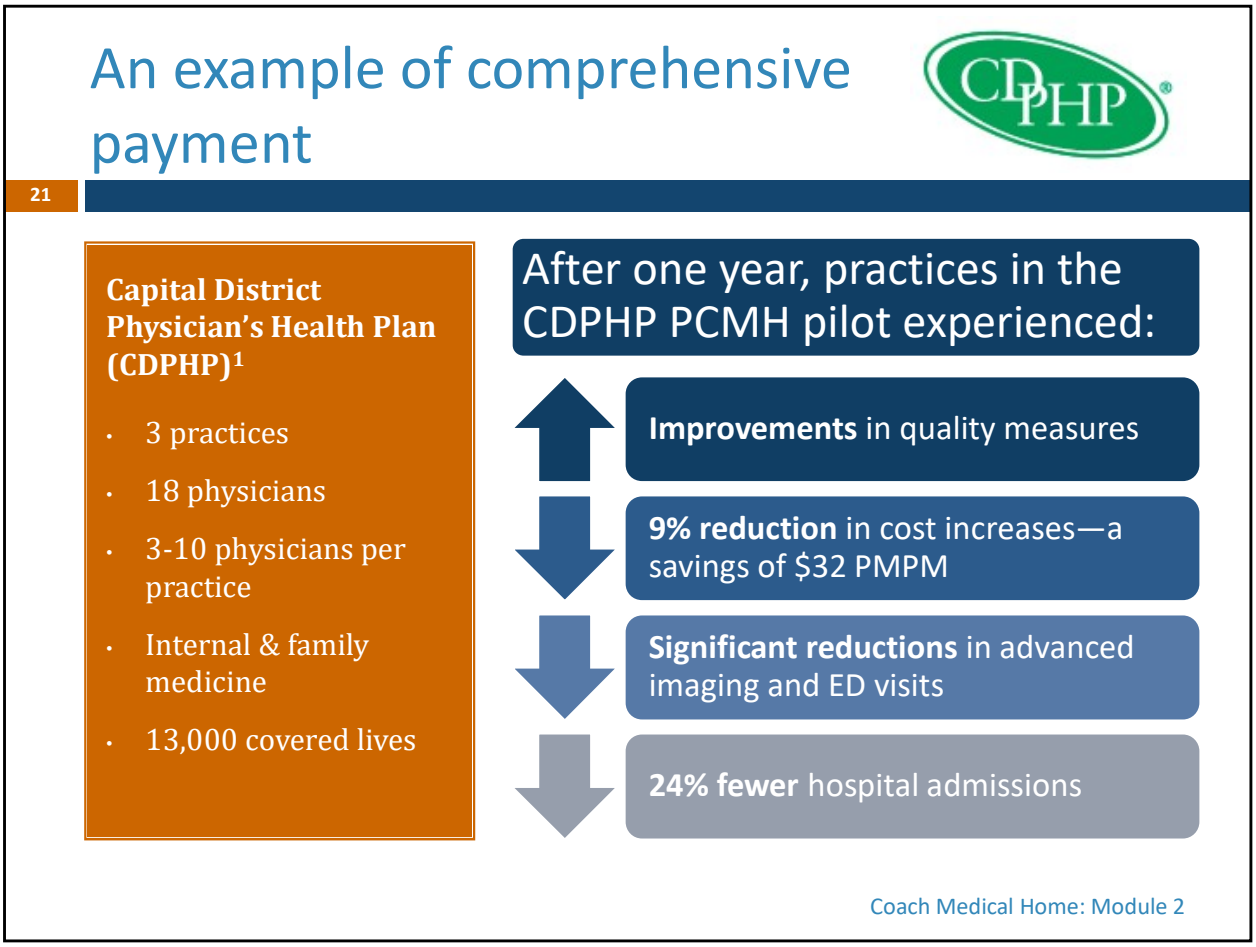
*Year 1: Level 1 or higher
Year 2: Level 2 or higher

	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*		

Coach Medical Home: Module 2

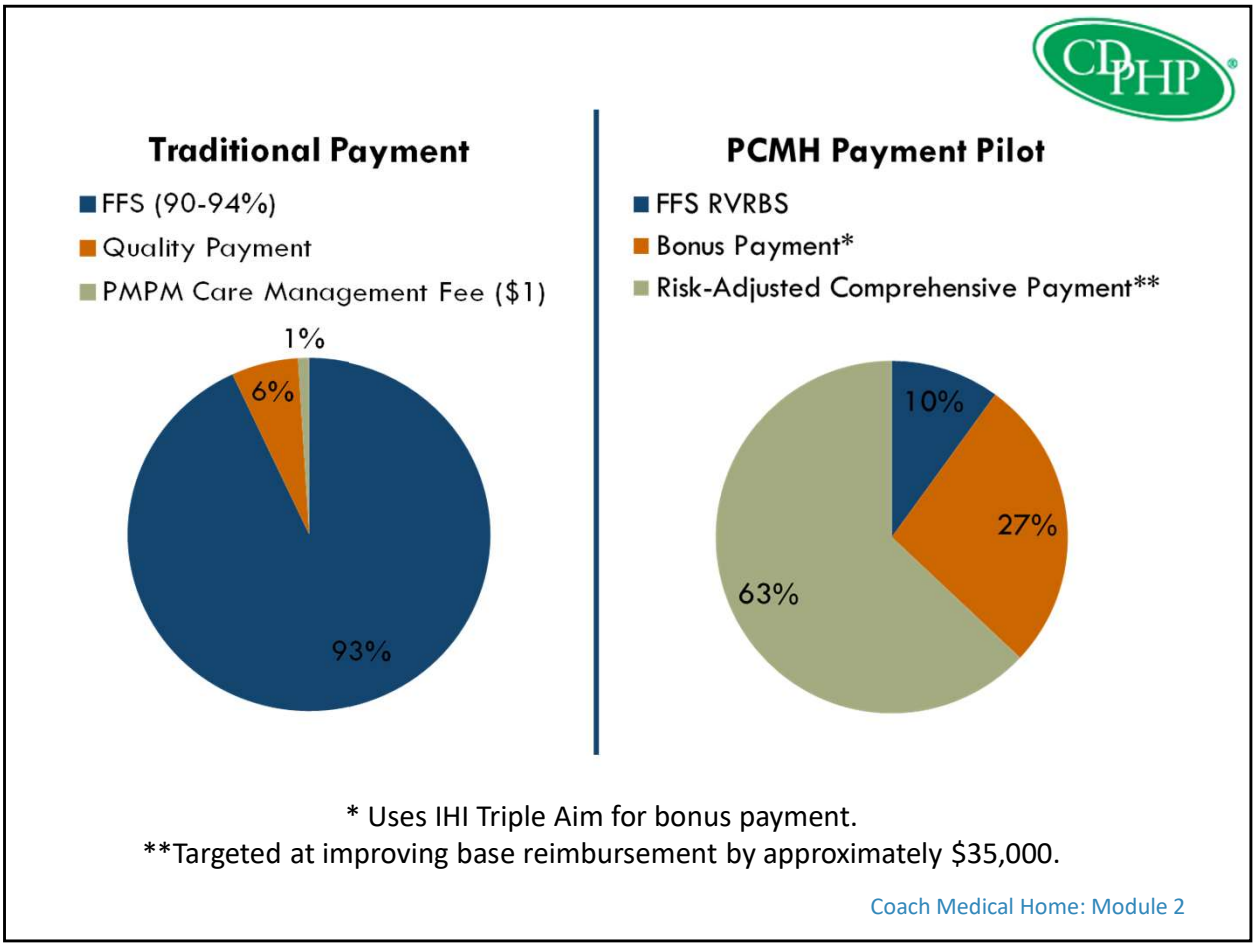
Maryland's Multi-Payer PCMH Pilot **combined a PMPM payment with the opportunity for shared savings**. All participating practices—including federally qualified health centers (FQHCs)—are eligible for incentive payments if they meet specific performance criteria. Practices that meet performance criteria receive payments of 30%-50% of savings, and FQHCs are eligible to receive up to 65% of the savings specifically generated from their Medicaid population. A unique payment methodology has also been developed that makes special accommodation for small practices.

Source: National Academy for State Health Policy. Maryland. June, 2012.



An excellent example of a **comprehensive payment** model is the Capital District Physician's Health Plan (CDPHP). Early results from the CDPHP's pilot implementation of the PCMH showed that practice transformation support and payment changes made a difference in the way care was provided. Quality measures improved and overall costs decreased.

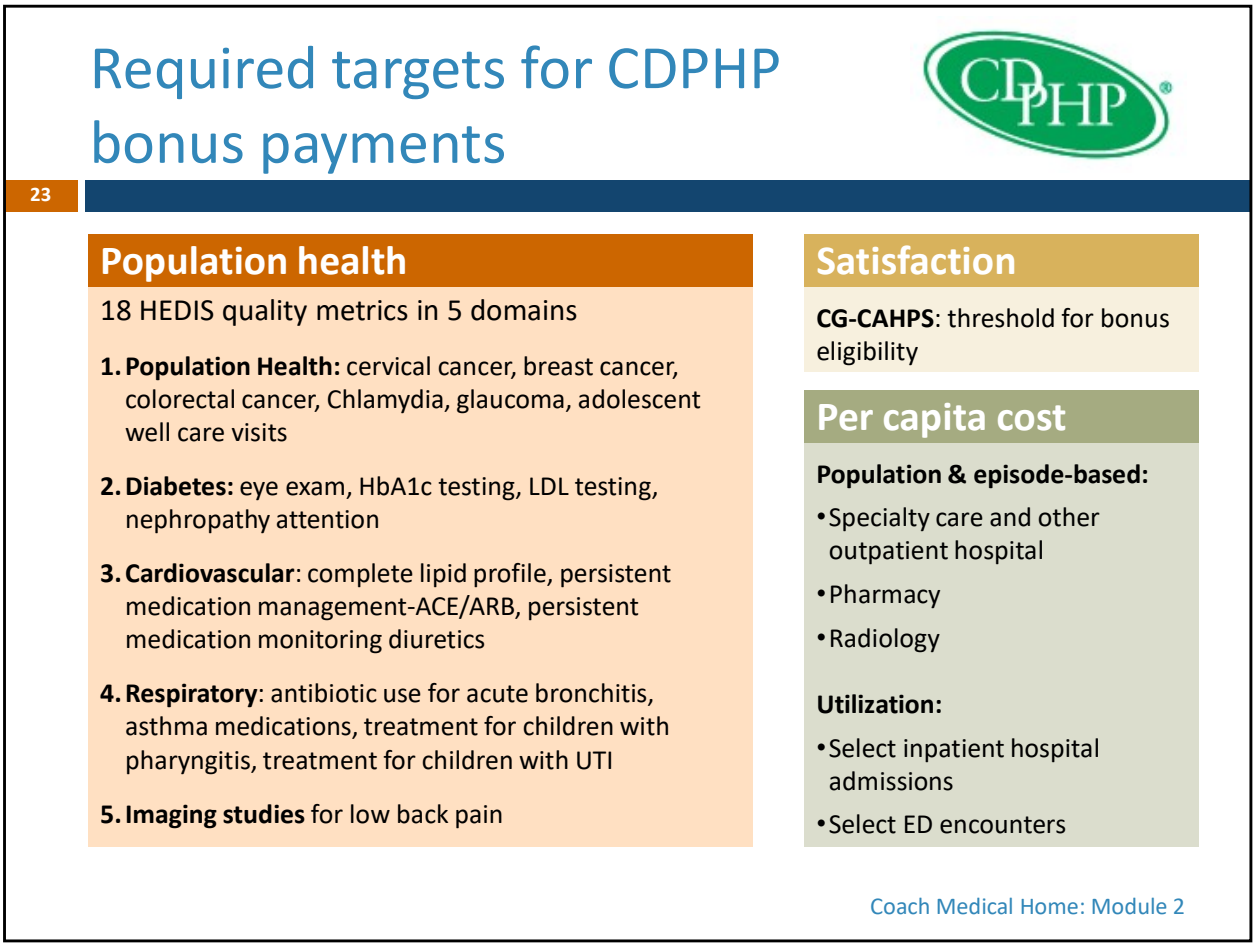
1. Capital District Physicians' Health Plan Inc. CDPHP Medical Home Pilot Reduces Cost Growth for Primary Care Practices. March, 2011.



These pie charts show how practice revenue changed under CDPHP's pilot. CDPHP did maintain some FFS, but the percentage of practice revenue from FFS fell dramatically. Revenue from bonus payments (P4P) and the risk-adjusted comprehensive payment went up.

What does this mean? The CDPHP pilot is an example of a payer moving from volume to value. Practices no longer receive most of their revenue from billing for office visits; instead, they receive revenue from comprehensive and bonus payments, which provide more flexibility. The program was designed to increase overall primary care practice revenue by approximately $35,000.

Source: Nash B. Comprehensive Payment to Support Comprehensive Care (slides). Capital District Physicians' Health Plan, Inc. Published: March 2, 2010 http://www.ehcca.com/presentations/medhomesummit2/nash_2b.pdf Accessed: January 5, 2011.



Performance payments are typically based on attainment of specific targets or goals. The specific measures vary: They may be participation measures (e.g., Submit 100% of required data), process measures (e.g., X% of patients with diabetes receive foot exam at least once per year), or outcome measures (e.g., X% of patients with hypertension have controlled BP). In some models, practices are required to meet a certain number of targets or meet targets in multiple categories in order to be eligible for bonus payments. Outcome measures typically come from nationally-recognized sources (e.g., HEDIS, Healthy People 2020), but participation and process measures may come from other sources or be developed by the payer for a specific demonstration/pilot.

The slide above shows some examples of the types of categories and specific targets or goals payers use in PCMH performance payment models:

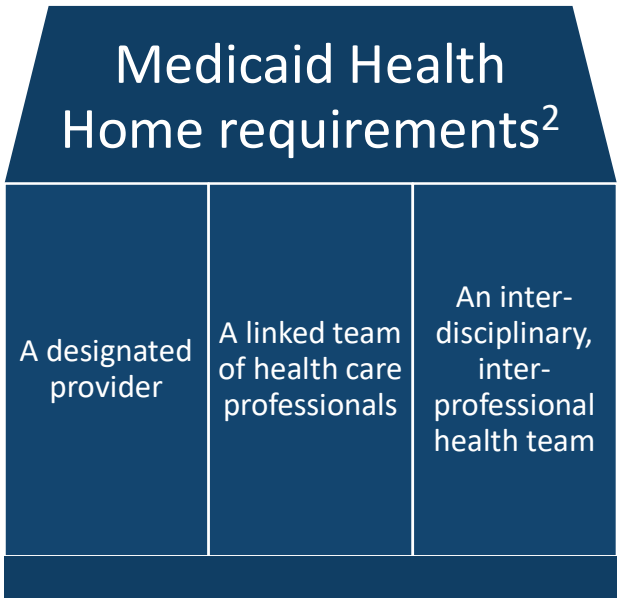
- Population health (in this case HEDIS metrics – clinical quality process and outcome measures)
- Patient satisfaction/experience measures (in this case, CAHPS)
- Cost (in this case, specialty and pharmacy services and hospital/ED utilization)

Source: Nash B. Comprehensive Payment to Support Comprehensive Care (slides). Capital District Physicians' Health Plan, Inc. Published: March 2, 2010 http://www.ehcca.com/presentations/medhomesummit2/nash_2b.pdf Accessed: January 5, 2011.

Other opportunities: Medicaid Health Home

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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.



Coach Medical Home: Module 2

Even if a practice is not eligible for a PCMH payment demonstration/pilot in their area, most practices are eligible for other funding or resource support that can support PCMH transformation work either directly or indirectly.

Encourage practices to investigate other resources to support their transformation efforts, including Medicaid Health Home payments—a new Medicaid option included in the Patient Protection and Affordable Care Act (PPACA Section 2703).

Requirements for the Medicaid Health Home include[2]:

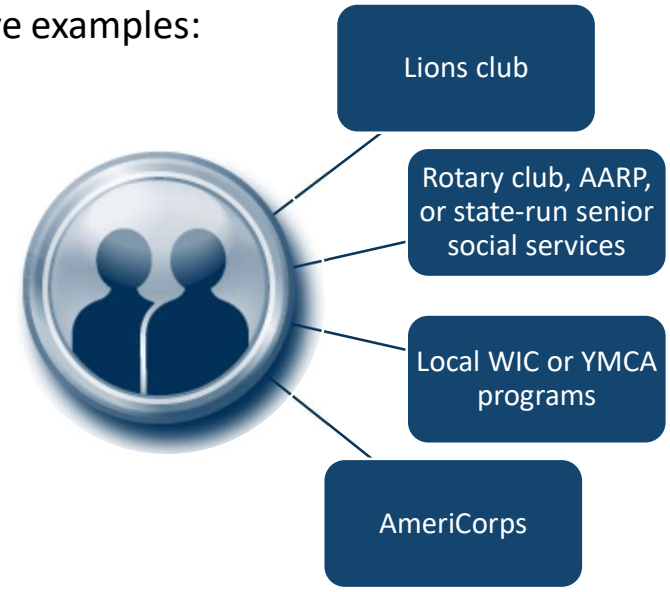
- Designated provider: physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, another entity or provider.
- Team of health care professionals that links to a designated provider.
- Interdisciplinary, inter-professional health team, which must include: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers as well as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners, and physicians' assistants.

1. The Commonwealth Fund. States in Action Archive Health Homes for the Chronically Ill: An Opportunity for States. December 2011. Available at. Accessed December 2015.
2. Affordable Care Act, Section 2703 and CMS Health Home Letter to States, November 16, 2010, pp 7 – 8.

Other opportunities: Community partnerships

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Innovative examples:



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Community partners can also be helpful in supporting PCMH efforts. Encourage practices to think broadly about their community partners and ways they may be able to leverage expertise or resources in their communities

Innovative examples include:

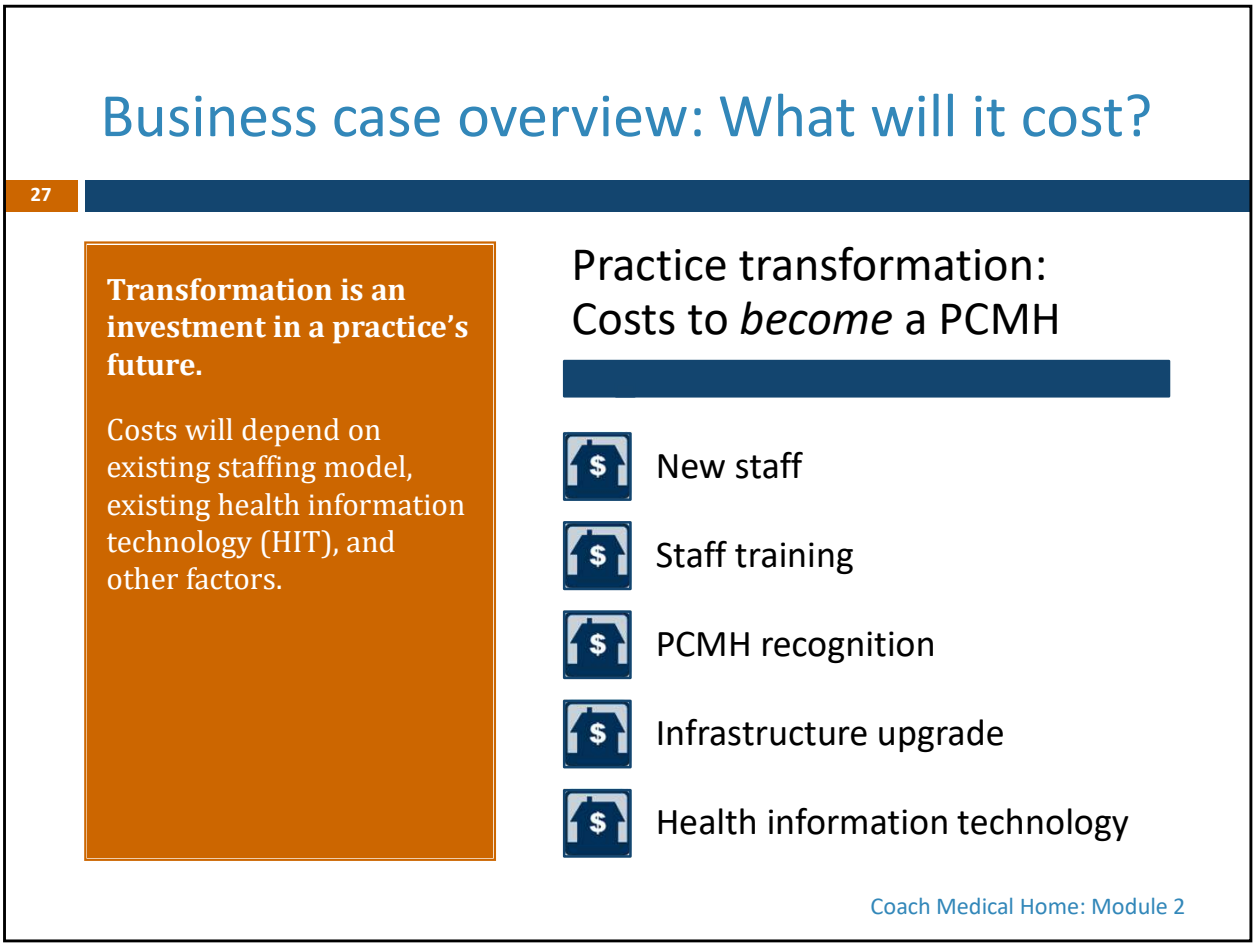
- Eye health/vision care, equipment, or referrals from Lions Club
- Patient transportation from Rotary Club, AARP, or State-run Senior Social Services
- Diabetes education/nutrition counseling from local WIC or YMCA programs
- Patient education or registration support from trained AmeriCorps Volunteers

SECTION 3

Business case for practice transformation

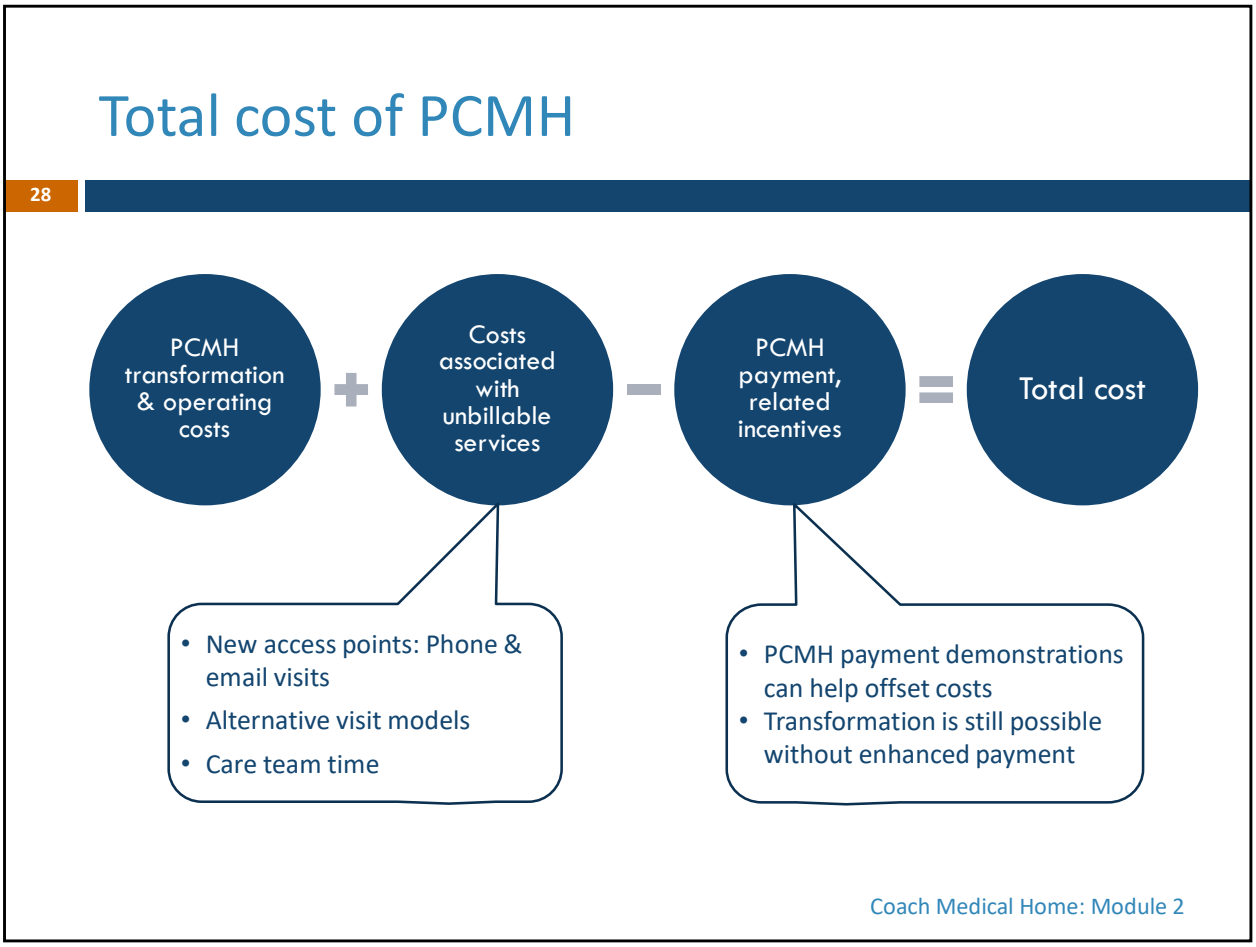
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As practices embark on the PCMH transformation journey, many will have concerns about the cost of transformation—that is, the specific expenses they will incur during the transformation process. The following section provides information on the business case for practice transformation and includes coaching tips on how to help practices understand the business case for investing in PCMH transformation.



It's important that a practice understand and plan for the expenses associated with practice transformation. Even more important is that they understand that PCMH is an investment in their future.

The cost of transformation depends on many factors, such as the existing staffing model, existing health information technology (HIT). **Participating in a PCMH payment demonstration or pilot can help a practice defray costs and/or increase revenue—but many practices have successfully transformed without enhanced payment.**



There are also costs associated with providing services and activities that the PCMH model of care requires—but that aren't reimbursed in most FFS models, including:

- New access points that provide alternatives to face-to-face visits, such as phone and email visits
- Alternative visit models, such as group visits, multiple visits in single day, nurse-only visits, health educator-only visits
- Care team time for QI (meetings, data review) and patient engagement, coordination and referral management, and proactive outreach for preventive and chronic care

Thus the total cost of PCMH includes: PCMH transformation and operating costs, plus costs associated with unbillable services. **Participating in a PCMH payment demonstration or pilot can help a practice defray costs and/or increase revenue.**

High-performing PCMHs offer innovative forms of access (e.g., phone/email visits) and support. If services are not billable, and the practice does not receive flexible funding that can support the work (e.g., comprehensive payment, PMPM), the cost of providing such services will hit the practice's bottom line. However, many payers are beginning to pay for services such as group visits, nurse visits, and provider time for care coordination activities. **Encourage your practices to ask their payers if these and other services are billable.**

PCMH ROI Calculator

Is it more expensive to operate as a PCMH?

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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]

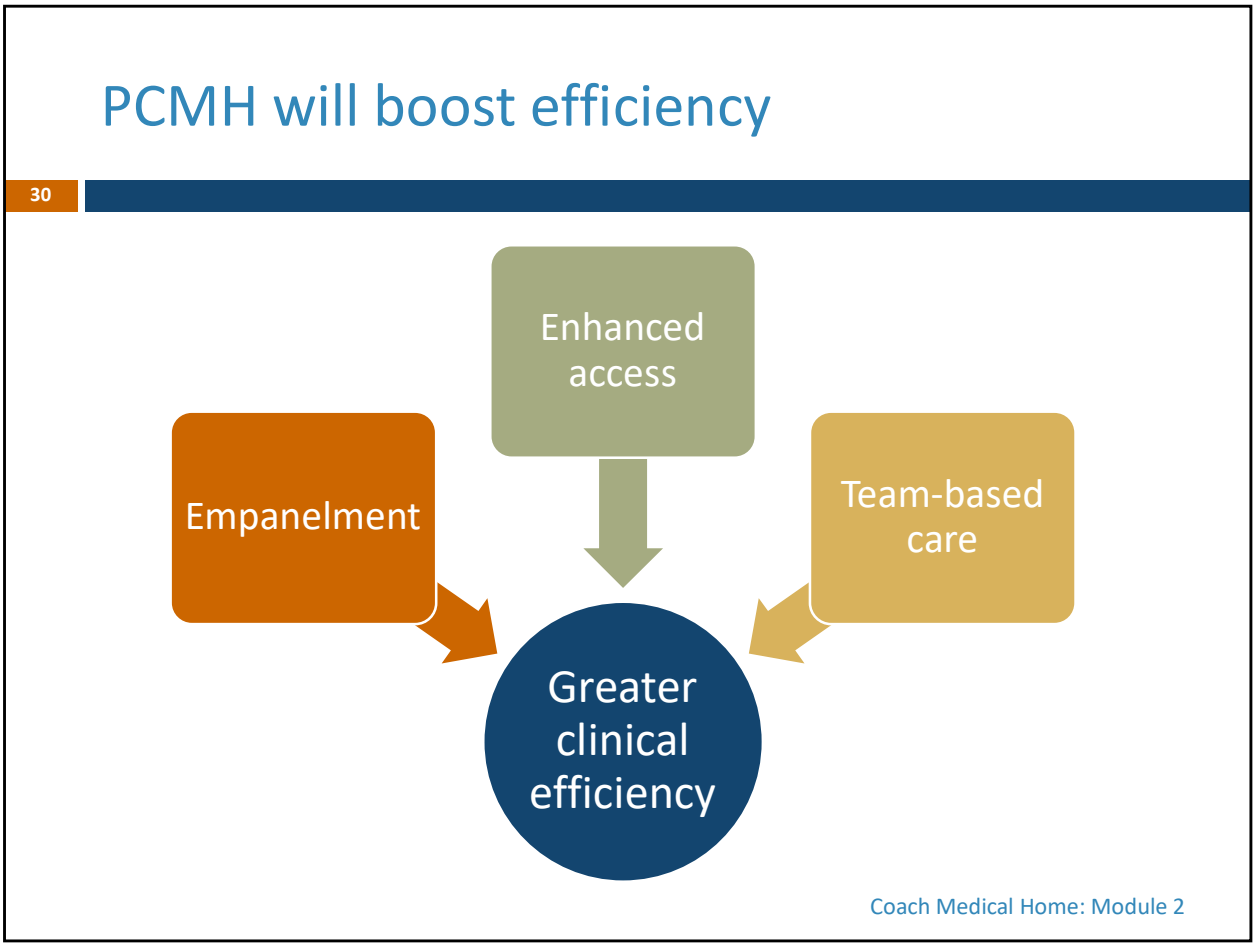
- FQHCs with more PCMH attributes had higher overall operating costs.
- Some subscale scores were associated with higher operating costs (e.g., patient tracking) while others (e.g., access and communication) were associated with lower operating costs.
- A 10-point-higher *overall* PCMH score was associated 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.

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Data from 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers suggest that **operating as a PCMH is more expensive**. But investing in PCMH transformation should result in better practice efficiency—and for some, this results in financial gains. As discussed, payment reform and/or enhanced payment are important for the long term.

The bottom line is that any increased operating costs are small relative to potential overall savings for the healthcare system.

1. Zuckerman S, Merrell K, Berenson R, Gans D, Underwood W, Williams A, Erickson S, Hammons T. Incremental Cost Estimates For The Patient-centered Medical Home. *Commonwealth Fund.* 2009. Available at http://www.commonwealthfund.org/publications/fund-reports/2009/oct/incremental-cost-estimates-for-the-patient-centered-medical-home. Accessed December 2015.
2. Nocon RS, Sharma R, Birnberg et al., Association Between Patient-Centered Medical Home Rating and Operating Cost at Federally Funded Health Centers, *Journal of the American Medical Association*, published online June 24, 2012.



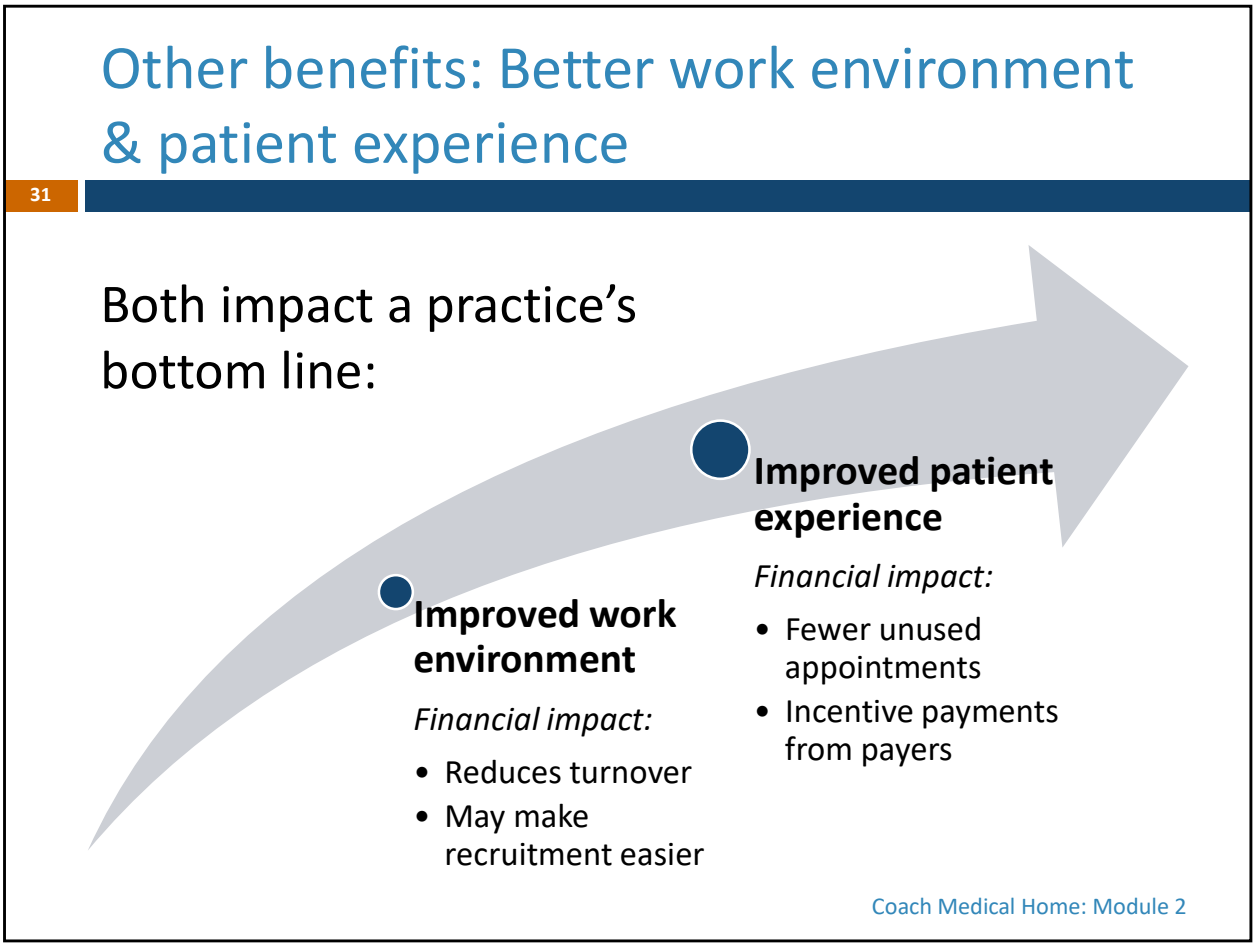
PCMH transformation should have positive impacts on practice efficiency and provide both short- and long-term financial benefits to the practice.

Empanelment allows practices to predict patient demand and staff accordingly, resulting in fewer unused appointment slots and thus fewer opportunities for lost revenue.

Enhanced access, specifically same-day appointment scheduling, allows practices to be more responsive to the needs of patients and has been shown to reduce no-shows and deferments (to ED or other facilities), reducing the likelihood of lost revenue and lost productivity. Telephone, email, and group visits also allow physician time to be protected for acute and complex care services, which typically have higher reimbursement rates.

Finally, **team-based care** supports proper reallocation of nonclinical work to non-provider staff—increasing overall staff productivity. By optimizing care and preventing care gaps (max packing), practices reap higher visit revenue.[1]

1. Span SJ, et al. Report on financing new model family medicine. Annals of Fam Med. 2(3): 2004.



PCMH has other, more indirect financial benefits as well—achieved through improvements in the work environment and in patient experience.

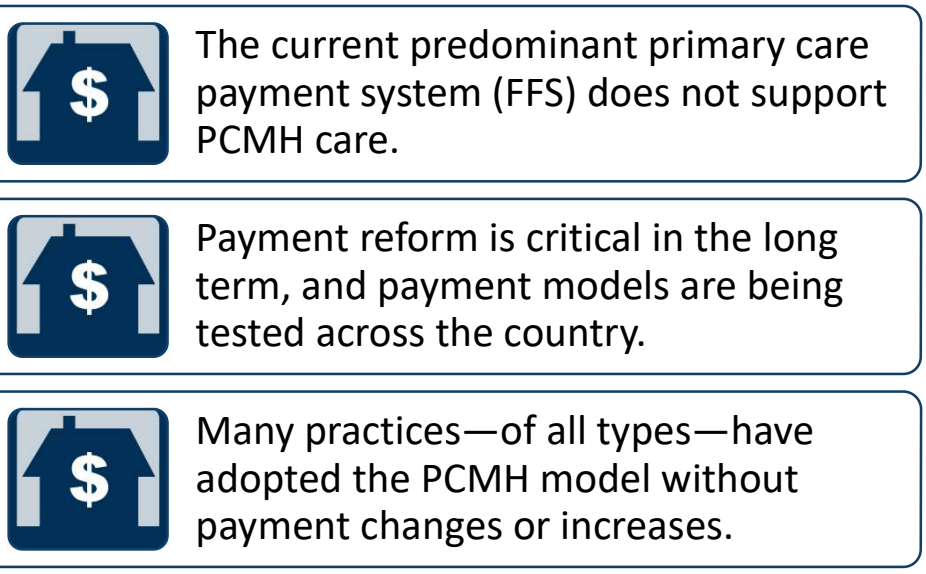
A 2012 study published in the *Archives of Internal Medicine* found that higher PCMH scores are correlated with higher provider and staff morale and job satisfaction.[1] Turnover is expensive for practices—and anything a practice can do to limit unnecessary turnover has a positive impact on the practice's bottom line.

Across diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield improvements in patient experience and access.[2] This could also have a positive financial impact on practices through fewer unused appointment slots and potential incentive payments from payers.

1. Lewis SE, Nocon RS, Tang H, et al. Patient-Centered Medical Home Characteristics and Staff Morale in Safety Net Clinics. Arch Intern Med. 2012;172(1):23-31.
2. Bodenheimer T, Grumbach K, Grundy P. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies. *Patient-Centered Primary Care Collaborative.* April 2009. Accessed December 2015.

Summary of the business case

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For PCMH to be successful in the long run, practices will need to be paid by a system that rewards health outcomes, not the volume of face-to-face visits. They will need enhanced payment in order to make the type of investments in their practices that will lead to improved access and evidence-based care. They will need a system that is more flexible, rewards patient education, and recognizes the time involved in advanced care coordination. Payment models are being tested by different payers and in different practice settings all across the country.

SECTION 4

NCQA PCMH™ Recognition: Ties to payment

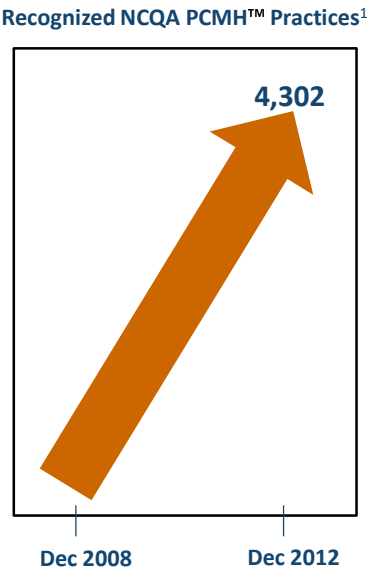
Coach Medical Home: Module 2

The PCMH model of care has been defined differently by different organizations and constituencies, and this has made it a challenge for payers and policymakers to understand what it means when a given practice says "I am a medical home." Formal recognition programs provide standard criteria from which to build a shared definition. There are several types of PCMH recognition through both national and state programs. This section provides information on NCQA PCMH™ Recognition—the most common type of PCMH recognition as of 2011.

The case for recognition: Ties to payment

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- 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



Coach Medical Home: Module 2

Why do payers and policymakers encourage or require recognition? Much like other accreditation or certification programs, NCQA PCMH™ Recognition instills confidence among payers that a practice has made important improvements and will deliver better care.

PCMH recognition is often required by PCMH payment demonstrations or pilot projects. Practices must achieve recognition within the project timeframe, or enter the project already recognized. PCMH recognition is also a factor in calculating enhanced payments or shared savings. Demonstrations/pilots often have categories (or "tiers") of payment based on level of recognition achieved. Practices that achieve higher levels of recognition (e.g., NCQA PCMH Level 2 or 3) are eligible for higher payments. This provides an incentive for attaining higher levels of recognition and rewards practices for making necessary investments (e.g., HIT).

Sometimes, level of recognition plays a small part in determining payment amounts. But in many demonstrations, level of recognition is the predominant factor and attaining a higher level of recognition can have a huge impact on practice revenue (e.g., $1.50 PMPM for Level 1 Recognition versus $7.00 PMPM for Level 3 Recognition).

In addition, more and more stakeholders, including patient groups and health plans, are highlighting PCMH recognition in recommendations or ratings. PCMH recognition, like other types of recognition or rewards, can motivate staff and acknowledge their efforts. Lastly, and most importantly, most practices find value in the process of recognition. Transformation and recognition are synergistic and mutually reinforcing. For more information on the interplay between transformation and recognition, see Module 1: Getting Started.

1. Adapted from: NCQA. NCQA's Patient-Centered Medical Home (PCMH) 2011. http://www.ncqa.org. Accessed June, 2012.

Overview: NCQA PCMH™ Recognition levels

35

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	

Coach Medical Home: Module 2

Source: NCQA. NCQA's Patient-Centered Medical Home (PCMH) 2011. http://www.ncqa.org. Accessed June, 2012.

NCQA PCMH™ Recognition standards

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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

Coach Medical Home: Module 2

Source: NCQA. NCQA's Patient-Centered Medical Home (PCMH) 2011. http://www.ncqa.org. Accessed June, 2012.

Program design: Who becomes recognized?

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- **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).

Coach Medical Home: Module 2

Source: NCQA. NCQA's Patient-Centered Medical Home (PCMH) 2011. http://www.ncqa.org. Accessed June, 2012.

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SECTION 5

Coaching tip summary

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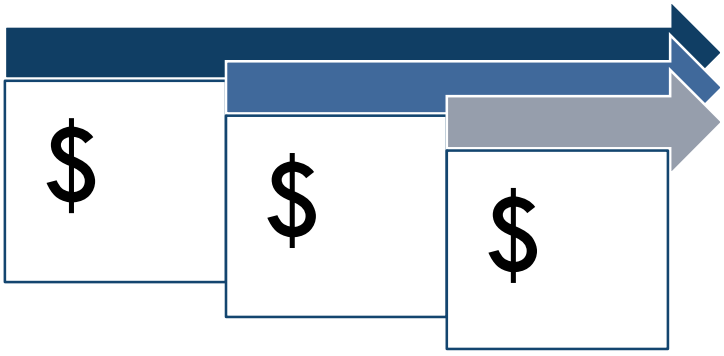
This section provides additional tips and tools to help you understand your role as a coach, how to tailor payment and policy information to different audiences, and how to deal with practice push-back.

Your role as a coach: Understand the PCMH environment

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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.



Coach Medical Home: Module 2

As a coach, you're not expected to be a payment or policy expert. But understanding the environment in which a practice operates will help you better understand its challenges, barriers, and resource needs. Most importantly, it can help you identify sources of support to help the practice transform.

The "environment" includes the payment environment, whether the practice operates on FFS or the prospective payment system (PPS), and if it has access to a PCMH payment demonstration/pilot. It also includes the policy environment, the presence or absence of directives or incentives (e.g., HRSA's PCMH goals for FQHCs), local delivery system reforms (e.g., ACOs), and other factors that could make PCMH transformation even more compelling.

Understanding the basics of PCMH payment demonstrations/pilots and recognition programs should also help you (or the organization you work for) partner with payers and policymakers to advocate for alignment across programs.

Coaching tip summary

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- 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

Coach Medical Home: Module 2



Business Case Talking Points for Coaches: Dealing with Practice Push Back PCMH ROI Calculator

Tailoring the message to your audience

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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.

Coach Medical Home: Module 2

PCMH transformation, including payment and policy topics, should be relevant to *all* staff at a practice site. But people in different positions/roles will key into different parts of your message. Tailor the information and the examples you provide in a way that allows each staff member to *engage* with the information and see how investing in PCMH will benefit *their* practice and *their* position/role.

Practice leadership and financial staff will likely want to hear more about how PCMH transformation will help the practice's bottom line and how it will allow the organization to be competitive into the future. Clinical staff may be more interested in how PCMH transformation will benefit their patients (e.g., improved access) or their work life (e.g., satisfaction).



If a practice continues to push back—for example, with comments like "PCMH transformation will be too expensive for my practice," or "My margins are thin and I can't invest the resources for staff time outside of direct patient care"—use talking points tool from the previous page to show practice leadership the financial costs and benefits of PCMH transformation.