CATALYST FOR PAYMENT REFORM

Establishing Medical Homes

Action Brief

WHAT IS A MEDICAL HOME?

A Medical Home (alternatively, "Patient-Centered Medical Home") is a primary care practice that organizes and delivers care to broaden access, while improving care coordination, in a manner fundamentally different than is commonplace today.

WHAT PROBLEMS DO MEDICAL HOMES TRY TO SOLVE?

The fee-for-service payment system, coupled with significantly higher pay for specialist physicians, has produced care that is fragmented, specialist-centric, expensive and of suboptimal quality.[1] Primary care practices, rather than supporting patients and coordinating their care, are often bypassed as patients directly gain access to specialists. When patients do seek care from their primary care clinicians, primary care practices are often reactive, fail to track the patient across care settings, and in general, don't practice consistently with Medical Home core competencies.

Research shows, however, that health care that is primary care-centric is lower cost, higher quality, and produces fewer disparities than specialist-centric care delivery.[2] Further, primary care mastery of just some of the core competencies yields higher quality for sick patients and in most cases, utilization reductions and/or cost savings.[3]

While widespread piloting and evaluation of the Medical Home concept only commenced in the past few years, there are emerging reports of impact that suggest that the model produces significant cost and quality benefits.

It is important to note, however, that significant variation exists in the target population (e.g., focus on all patients, high-risk patients, Medicare beneficiaries, patients with diabetes, etc.) and the specific medical home strategy (i.e., which competencies are emphasized, how practices are supported, etc.) across the examples.

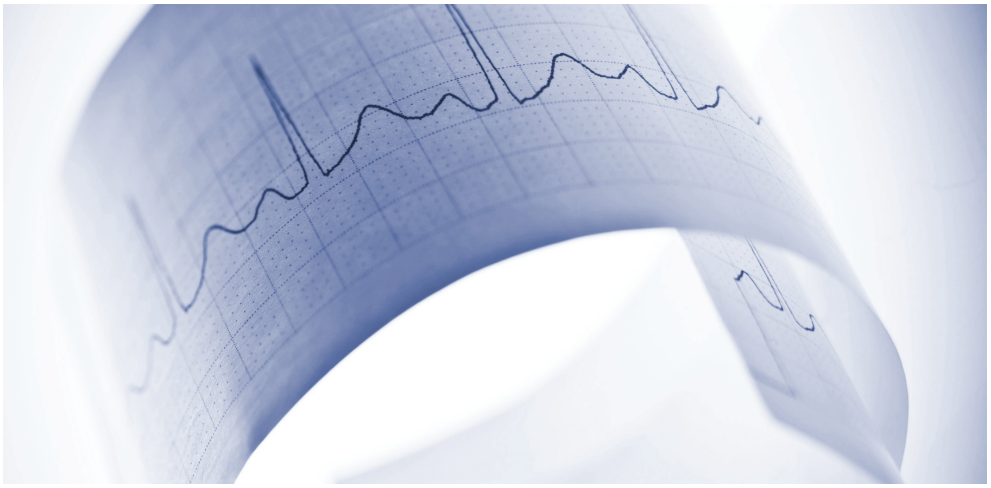
Some believe that more integrated forms of care delivery, including Accountable Care Organizations, will require a foundation of primary care practices operating as Medical Homes. Others believe that a Medical Home strategy is important for a more basic reason – without increased investment in primary care and making it a more professionally fulfilling profession, we are fast on our way to severe primary care shortages across the U.S.

Medical Homes master the following core competencies:[5]

FOR EXAMPLE:

- The Boeing Company conducted a pilot of a Medical Home focused upon care for its highest-risk employees.
  - costs dropped 20% relative to a comparison group;
  - missed work days dropped 57% compared to baseline; and,
  - physical and mental function improved compared to baseline.[4]

1. Patient/family/peer/advocate/caregiver-centeredness: Longitudinal care is delivered with transparency, individualization, respect, and linguistic and cultural competence.
2. Multi-disciplinary team-based approach to care: Care delivery is neither physician-centric nor hierarchical, as is found in traditional primary care practice. Instead, internal practice communication is bi-directional, responsibilities are allocated among team members and collaboration is commonplace.
3. Planned visits and follow-up care: In contrast to traditional episodic, reactive care, the practice tracks patients on an ongoing basis so that the practice is informed and ready to address the patient's needs whenever the patient makes contact, and follows up with patients after encounters, as necessary.
4. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, the practice has information tracking capacity in the form of a freestanding or EHR-based patient registry with reporting functionality.
5. Care coordination across settings, including referral and transition management: The practice assumes responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with medical and non-medical service providers
6. Integrated clinical care management services focused on high-risk patients: A clinical care manager, integrated into the practice, provides special focus and attention to support the



at-risk patients in a practice who would benefit from care manager support.

7. Patient and family education: The practice educates patients and family members on primary preventive care, and on self-management of chronic illness.
8. Self-management support by members of the practice team: Extending beyond education, self-management support assists the patient and/or family/peer/caregiver with the challenges of ongoing self-management, directly and/or through referral.
9. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Care planning and related activities focus on a patient's specific circumstances, wishes and needs.
10. Evidence-based care delivery, including stepped care protocols: Care is evidence-based wherever evidence exists, and follows stepped protocols for treatment of illness.
11. Integration of quality improvement strategies and techniques: The practice utilizes the improvement model emphasized by the Institute for Healthcare Improvement to measure performance, identify opportunities for improvement, test interventions, and reassess performance.
12. Enhanced access: There is easy and flexible access to the practice, including alternatives to face-to-face visits, such as e-mail and telephone, and 24 hours-per-day/seven-days-per-week practice coverage.

FOR EXAMPLE:

- BCBS of North Dakota and medical group MeritCare conducted a pilot focused on care of diabetic patients, with the following results:
  - total costs per member per year were $530 lower than expected in the intervention group based on historical trends; and,
  - there was an 18% increase in the proportion of diabetics who received a bundle of five recommended services.[6]

Several other pilots have recently reported results.[7]

How does a Medical Home initiative work?

There are at least 50 medical home pilots underway in the U.S. at present – perhaps more.

Medical Home initiatives take different forms as sponsors and participants experiment with different approaches. There are some common components, however.

SPONSORSHIP

Medical Home initiatives require an organizer or sponsor. They can be internally sponsored by a provider organization (medical groups, integrated delivery systems), by an individual payer (e.g., BCBSMI, UnitedHealthcare, Humana, CIGNA) or foundation supporting a selected group of primary care practices, or by coalitions of payers who work together with practices to design, implement and govern the initiative.

Multi-payer initiatives are particularly attractive to practices because they provide the practices with the greatest financial support as each payer agrees to pay "its share", i.e., cover costs consist with its proportion of the practice's patients. To address anti-trust concerns, state government sometimes provides an oversight role. Multi-payer initiatives currently operate in CO, MA, ME, NH, OH, PA, RI, VT, WA and elsewhere.[8] Employer purchasers sometimes, but not always, have played a role in formation and governance.

PAYMENT

There are a multitude of payment models being applied to Medical Homes,[9] but in almost every case the practice receives some form of supplemental payment to cover what many believe to be added costs for a primary care practice to operate as a medical home. One such cost is for the practice-based clinical care manager. Practice time spent on myriad traditional non-reimbursable activities (e.g., patient outreach, care coordination, patient education, etc.) comprise the other costs. This payer investment is predicated on the belief that net savings will result.

Supplemental payments are made on behalf of patients who have either selected the practice as part of an HMO design, or who the payer has attributed to the practice based on historical service usage patterns as reflected in claims.

Other complementary payment strategies can include increased service rates, creation of new billing codes, pay-for-performance and shared savings arrangements.

PRACTICE TRANSFORMATION

At the heart of a Medical Home initiative is an effort to transform primary care delivery. Medical Home initiatives use one or more of the following tools to facilitate transformation:

- **Certification or recognition:** Some programs use their own standards and process to certify a practice as having achieved medical home status (State of MN, BCB-SMI). Most, however, require recognition by the National Committee for Quality Assurance (NCQA).
- **Learning collaborative:** Some programs provide an intensive, multi-session off-site group learning experience for the participating practices, with data reporting and feedback and other forms of ongoing support.
- **Practice coach or facilitator:** Some initiatives provide an expert in Medical Home and practice transformation to work with the practice and support its work to become a Medical Home.

WHAT PROBLEMS COULD IT PRODUCE?

- Physicians could participate because of the promise of increased revenue without commitment and realization of improved quality or decreased net cost.
- Employees could view employer support for a medical home as implicitly supporting a limitation of access and choice.
- Medical Homes will need to reduce hospital, ER, specialist and testing use to be cost effective. Affected providers may not receive this well.
- Exclusive focus on Medical Home could curtail necessary payment reform involving other types of providers.
- Payers may not fully engage themselves in achieving success because they gain no competitive advantage by doing so.

What steps can a purchaser take?

At the heart of a Medical Home initiative is an effort to transform primary care delivery.

- ASK your insurer/TPA what steps have been taken to support and test the Medical Home concept.
- ENCOURAGE or require participation in a multi-payer pilot of at least three years in duration if no steps have been taken. Make sure that the following are addressed:
  - adequate practice transformation support – most practices can't do this by themselves;
  - payment that supports infrastructure costs, but also creates incentives to save money and improve quality;
  - an ongoing process to study impact and make course corrections – most initiatives won't get it all right the first time; and,
  - a comprehensive evaluation.
- REQUEST a seat on the governance body and make sure that employer interests are given attention if your insurer/TPA is involved in a single or multi-payer effort.

ADDITIONAL RESOURCES

The Patient-Centered Medical Home: A Purchaser Guide. Patient Centered Primary Care Collaborative, 2008. www.pcpcc.net/files/Purchasers-Guide/PCPCC_Purchaser_Guide.pdf, and other information available at www.pcpcc.net.

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