catalyst FOR PAYMENT REFORM

Action Brief
Establishing Medical Homes

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 that is fundamentally different than is commonplace today.

WHAT PROBLEMS DO MEDICAL HOMES TRY TO SOLVE?

The fee-for-service payment system, coupled with significantly higher payments 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 gain access directly to specialists. Moreover, 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.

However, research shows that health care that is primary care-centric is lower cost, higher quality, and produces fewer disparities than specialist-centric care delivery.[2] Further, mastery of just some of the Medical Home core competencies yields higher quality care 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 during the last decade, there are emerging reports that suggest that the model produces significant cost and quality benefits.

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

Some believe that more integrated forms of care delivery, such as Accountable Care Organizations, should have a foundation of primary care practices operating as Medical Homes. Others believe that a Medical Home strategy is important for an even more fundamental reason— without increased investment in primary care and making it a more professionally

fulfilling field, we are moving quickly down a path toward severe primary care provider shortages across the U.S.

MEDICAL HOMES MASTER THE FOLLOWING CORE COMPETENCIES

According to the Massachusetts Patient-Centered Medical Home Initiative (MA PCMHI) Council, a Medical Home should have these foundational elements:[6]

1. PATIENT/FAMILY/PEER/ADVOCATE/CAREGIVER-CENTERDNESS: 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 practices. 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 it 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 MANAGEMENT SERVICES FOCUSED ON HIGH-RISK PATIENTS: A clinical care manager, integrated into the practice, provides special focus and attention to at-risk patients who would benefit from care manager support.

FOR EXAMPLE:

Blue Cross Blue Shield of Rhode Island conducted a five-year study of Patient Centered Medical Homes for Medicare Advantage members between 2009-2014

- PCMH practices were 5% less costly, saving $30 million overall compared to standard primary care providers.
- Patients with complex medical conditions were 16% less likely to be hospitalized or need emergency treatment.
- Hospital readmissions were 30% lower compared to someone seeing a standard primary care physician.[4]

Geisinger Health System piloted patient-centered medical home clinics for Medicare patients from 2006-2013

- On average, PCMH exposure led to $53 savings in per member per month total costs of care per site, translating to an average of 7.9% in total cost savings over the ninety-month period.
- Acute inpatient care spending accounted for the largest change, decreasing by 19% per member, or $34 per member per month.
- Longer patient exposure to PCMH clinics was associated with lower acute inpatient admission rates.[5]

7. PATIENT AND FAMILY EDUCATION: The practice educates patients and family members on primary and 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, values, and needs.

10. EVIDENCE-BASED CARE DELIVERY, INCLUDING STEPPED CARE PROTOCOL: Care is evidence-based whenever 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 coverage.

HOW DOES A MEDICAL HOME INITIATIVE WORK?

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

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 practice with the greatest financial support as each payer agrees to pay "its share" (i.e. cover costs consistent 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 AR, CO, HI, ID, MA, MD, ME MI, MN, MT, NC, ND, NE, NJ, NY, OK, OR, PA, RI, TN, VT, and WA.[7] Employer-purchasers sometimes, but not always, have played a role in the formation and governance of these initiatives.

There are at least 1,200 NCQA accredited medical homes in the U.S. at present.[11]

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

PAYMENT

There are a multitude of payment models being applied to Medical Homes,[8] 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 a myriad of traditionally 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 the historical service utilization 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 processes to certify a practice as having achieved medical home status (such as the state of Minnesota). Most, however, require recognition by the National Committee for Quality Assurance (NCQA).[10]

- **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 A MEDICAL HOME INITIATIVE PRODUCE?

- Physicians could participate because of the promise of increased revenue without a true commitment to and realization of improved quality or lowered costs.
- Employees could view employer support for a medical home as implicitly supporting a limitation on 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.
- Payers may not fully engage themselves in achieving success because they gain no competitive advantage by doing so.

WHAT STEPS CAN A PURCHASER TAKE TOWARD A MEDICAL HOME INITIATIVE?

ASK your insurer or third-party administrator (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 if no steps have been taken. Make sure that the following are addressed:

- Adequate practice transformation support - most practices are not capable of doing this by themselves;
- Payment that supports infrastructure costs, but also creates incentives to save money and improve quality;
- An ongoing process to study the impact of the initiative and make course corrections, as 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 employers' interests are given attention if your insurer or TPA is involved in a single or multi-payer effort.

ADDITIONAL EXAMPLES OF MEDICAL HOMES

CMS' Comprehensive Primary Care Plus (CPC+): National primary care medical home model testing in 2,932 practices across 61 payers in 18 regions.
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus/

ACA Section 2703 Health Homes Initiative: National program allowing states to design and implement primary care coordination programs for Medicaid beneficiaries with chronic conditions. Participants include AL, KS, MD, MO, NJ, OK, WA, WV.
https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/Health-Home-Information-Resource-Center/index.html

RESOURCES

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ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

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