



Patient-Centered

Primary Care

COLLABORATIVE

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Purchasers Guide:

Patient Centered
Medical Home



What Action Can Purchasers Take to Advance PCMH?

Many purchasers, providers and insurers agree that purchasers can play a pivotal role in the establishment of patient-centered medical homes across the U.S. They cite a number of reasons why this is the case:

- Primary care practices find it compelling to hear directly from employers about their needs for improved quality and decreased cost, and are pleased to find a commonality of interest regarding PCMH.

“...the atmosphere shifts completely once you approach a provider with a payer at your side. In Atlantic City, the Local 54 Trust Fund was able to approach AtlantiCare and say ‘we are one of your biggest customers and we want to work together to improve the care our sickest patients are getting’. The fact a customer was speaking was a real motivating force...fundamentally this effort has changed the traditional adversarial relationship between provider and payer – now it is more of a collaborative approach.”

- Rushika Fernandopulle, MD, consultant to the Trust Fund

- While many health insurers are expressing at least cautious interest in PCMH, their efforts increase in scope, intensity and timeliness when employer customers make it a priority.

“IBM told plans, ‘you need to do multiple patient-centered medical home pilots if you want to do business with us’.”

- Paul Grundy, MD, IBM and Chairman, Patient Centered Primary Care Collaborative

- Employers are one of the few market forces that are able to assemble the type of multi-payer, multi-stakeholder collaborative that is necessary to advance true change in primary care practice.

“Purchasers can push for an all-payer collaborative, and the state can play an important role in facilitating consensus.”

- Chris Koller, Rhode Island Insurance Commissioner

This section of the guide describes discrete actions that employer purchasers can take to support advancement of the patient-centered medical home. Recognizing that employers vary in size, health care market and purchasing leverage, the guide presents a range of options. This allows purchasers to select the actions that seem most appropriate at the present moment, while also identifying other actions that might be considered or planned for the future.

There are six types of strategies available to purchasers that seek to advance the patient-centered medical home

- participate in a regional pilot(s)
- incorporate PCMH into insurer procurement and performance assessment activity
- align payment strategy with PCMH adoption objectives
- build coalitions in support of PCMH
- engage consumers
- integrate PCMH into other corporate health strategies

Purchasers can pursue these strategies independently, and/or in concert with other employer purchasers through a coalition. A number of purchasers have united in their support of the PCMH to form the *Patient Centered Primary Care Collaborative* (PCPCC), a coalition tasked with demonstrating and implementing the PCMH in publicly administered health programs, private employer benefit plans and union trusts. The PCPCC has organized four “centers”, each of which is pursuing work that can support purchasers. The centers include:

- Center for Multi-Stakeholder Demonstrations
- Center for Benefits Redesign and Implementation
- Center for eHealth Information Exchange and Adoption
- Center to Promote Public Payer Implementation

Additional information and resources regarding the PCPCC and these centers can assist purchasers and may be found at the PCPCC web site (www.pcpcc.net/).

The remainder of this chapter reviews the actions available to purchasers in each of these categories.

Strategy #1: Participate in a regional pilot(s)

1. Encourage or require contracted insurers to participate in a multi-payer pilot. Write language into RFPs and contracts stating that contractors are required to participate in one or more multi-payer collaboratives that are piloting the PCMH model.
 - a. Utilize the draft contract amendment language in Attachment A as the basis for contract amendments.
 - b. Should it not be possible to modify a contract(s) in the near-term, communicate the purchaser's desire that the insurer participate in one or more such pilots. A draft insurer letter for this purpose has been enclosed in Attachment B.
 - c. Under either scenario, encourage integration of the four guiding principles developed for the Patient Centered Primary Care Collaborative (see www.pcpcc.net/content/joint-principles-patient-centered-medical-home).

Purchasers can learn about multi-payer pilots underway through the PCPCC's Center For Multi-Stakeholder Demonstrations.

2. Encourage your purchaser coalition to adopt a formal position supporting PCMH. Coalitions, because they represent the voice of many purchasers, can be an effective way to communicate to both insurers and to provider associations and practice groups and bringing greater market pressure to bear than might be possible through unilateral action in most cases.
3. Sponsor a PCMH pilot. Large employers with large, local market penetration may be able to initiate and sponsor their own pilot. Such employers can assume day-to-day management of the pilot or utilize a contractor for doing so. They can also invite other employers to join them prior to or after start-up.
4. Establish specific criteria that must be met for purchaser support of a pilot, including:
 - a. specific obligations of primary care practices so that the purchaser can confirm that a transformative effort is being pursued and not simply a minor adjustment to the existing model;
 - b. incorporation of case management¹ resources into the pilot in some fashion;

¹ By using the term "case management", this guide means a primary care practice-based function, and not the one customarily performed by insurers. For the purposes of this document, case management is defined as inclusive of the following clinician services: 1. conduct periodic assessment of disease severity, medications, social support systems and ability to self-manage, 2. develop communication and care coordination agreements with the primary care physician around treatment planning and process for just-in-time adjustments to the care plan, 3. develop medication review and adjustment agreements, 4. develop agreements for hand-offs back to the primary care physician, 5. provide intensive self-management support to patients, 6. provide intensive follow-up for patients, 7. provide assistance navigating patients across health care sectors for clinical aspects of patient care, and 8. arrange for social support follow-up with social worker or similar community support personnel. (Source: MacColl Institute for Healthcare Innovation's review of case management literature)

- c. a payment methodology that will, in part, enhance payment to primary care practices for the specific purpose of incurring necessary costs to transform the practice², and
 - d. a rigorous independent evaluation of the pilot with a control group.
- 5. Participate in the collaborative pilot design process. Provide input on key components of the pilot design to contracted insurers or to a multi-stakeholder coalition. Specifically, provide input on one or more of the following topics:
 - a. the operational definition of PCMH, including the specific components of the transformation of the primary care practice;
 - b. reimbursement model;
 - c. areas of clinical concern to the purchaser (e.g., diabetes, depression, etc.);
 - d. the pilot's design, and
 - e. the pilot's evaluation.

Strategy #2: Incorporate PCMH into insurer procurement and performance assessment activity

1. Incorporate new questions into RFIs, RFPs and into the eValue8 tool from the National Business Coalition on Health to assess insurer support of patient-centered medical homes. RFP questions should ideally address the PCPCC joint principles and also minimally assess:
 - a. the extent and nature of any insurer participation in insurer-sponsored or multi-payer sponsored PCMH programs;
 - b. specific expectations the insurer/collaborative is placing on primary care practices;
 - c. specific support (e.g., education, training, tools, provision of data relevant to patient clinical care management) that the insurer/collaborative is providing to practices to support their efforts at transformation;
 - d. use of consumer incentives;
 - e. the model used to modify reimbursement and the extent of any payment enhancement, and
 - f. evaluation methods and metrics.

See Attachment C for a set of recommended questions.

2. Measure carrier performance. Require ongoing carrier reporting on support of PCMH using a set of quantitative metrics. Reporting may occur through a coalition or collaborative, or

² The Patient-Centered Primary Care Collaborative recommends a three-part payment methodology, including a) a monthly care coordination payment for the physician work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes, b) a visit-based fee-for-service component that recognizes visit-based services that are currently paid under the present fee-for-service payment system, and c) a performance-based component that recognizes achievement of quality and efficiency goals. For more information, see www.pcpcc.net/content/proposed-hybrid-blended-reimbursement-model.

directly to the employer. Because PCMH initiatives are just beginning in most regions of the U.S., purchasers should not expect strong measurement findings at the outset, but *should* expect to see steady insurer progress over time.

Sample measures include:

- a. *network certification*
 - i. % of in-network primary care sites in the geographic area currently certified by NCQA through its PPC-PCMH³ program at Levels 1, 2, and 3, respectively
 - ii. change in the percentage of the preceding measure relative to the prior year
- b. *case management adoption*
 - i. % of geographic area primary care sites that have implemented case management functionality through:
 - the use of an employed case manager;
 - a contracted case manager, or
 - case management support from a dedicated or partially dedicated insurer-based case manager
 - ii. change in the percentage of the preceding measure relative to the prior year
- c. *relative volume at certified practices*
 - i. % of geographic area primary care visits in the past year at NCQA certified practice sites
 - ii. change in the percentage of the preceding measure relative to the prior year
- d. *reimbursement*
 - i. % of geographic area primary care practices receiving enhanced reimbursement to support PCMH functions
 - ii. % of geographic area primary care practices receiving enhanced reimbursement to support PCMH functions that equated to 10% or more of total practice revenue
 - iii. % of geographic area primary care practices receiving enhanced reimbursement to support PCMH functions that equated to 20% or more of total practice revenue
 - iv. % of geographic area primary care practices receiving enhanced reimbursement to support PCMH functions that equated to 30% or more of total practice revenue
 - v. change in the percentages of the preceding measures relative to the prior year

³ “Physician Practice Connections – Patient-Centered Medical Home”

Strategy #3: Align payment strategy with PCMH adoption objectives

1. Provide financial support or incentives in promotion of the PCMH model to insurers and/or primary care practices. There are a number of ways that purchasers can provide financial support to the adoption of the patient-centered medical home. Financial commitment can be expressed through:
 - a. explicit endorsement of insurer use of insured premium or ASO trust fund dollars to fund enhanced primary care practice reimbursement;
 - b. application of a risk/reward metric to the ASO fee or premium that the purchaser is paying its insurer based on the degree to which network primary care sites have transformed to patient-centered medical homes and the degree to which members are using the homes;
 - c. direct purchaser funding of bonus payments to practices with demonstrated practice; transformation and proficiency relative to quality and cost metrics through a program such as Bridges to Excellence's Medical Home recognition program (for information about this program, see www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=124), and
 - d. direct purchaser enhanced funding of practices with demonstrated practice transformation as indicated by NCQA PPC-PCMH certification at Level 1, 2 and/or 3, or some other defined metric.
2. Promote alignment of performance incentive programs across insurers. Many believe that once primary care practices transform themselves to patient-centered medical homes, it will be appropriate to place greater emphasis on performance-based reimbursement and less on payments to support the costs of the transformed practice. In order for this transition to occur and be effective, performance-based payment metrics will need to be aligned within a market.

Strategy #4: Build coalitions in support of PCMH

1. Educate, advocate and increase awareness. Purchasers can build support for and adoption of PCMH by educating other employers and their own employees about the concept. In addition, purchasers can convey support and encouragement for practice change with primary care practices.
2. Convene and facilitate a multi-stakeholder effort with carriers, employers, providers and labor. Employer purchasers are particularly well positioned to initiate such collaborative efforts.
3. Approach a respected organization to convene and facilitate a multi-stakeholder effort. Many purchasers may lack the resources to convene and facilitate a large undertaking such as building a coalition to design and implement a multi-stakeholder PCMH initiative. Under such circumstances, an existing employer coalition, Quality Improvement

Organization (QIO)⁴, or multi-stakeholder governed organization may be well-suited to accept and execute the role.

4. Partner with states. State government sometimes plays the role of initiator or convener through legislation or executive branch initiative. Employer purchasers can capitalize on this by participating in such efforts. In other circumstances, employers can invite the state to play a convening role. There are several potential benefits, including the state's ability to bring in Medicaid⁵ and its contracted insurers (when applicable) to participate, solve certain anti-trust problems through the state's role as convener, and play a valuable facilitator role.
5. Work directly with provider community. Purchasers can reach out directly to leaders with the provider community (e.g., state chapters of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, the state medical society, large primary care medical groups, etc.) to engage the in dialogue about working together to implement the patient-centered medical home model.

Strategy #5: Engage consumers

1. Educate employees. Purchasers can educate employees regarding:
 - a. the medical home concept and the benefit of establishing a strong relationship with their medical homes;
 - b. self-management of chronic illnesses;
 - c. questions to ask of primary care physicians during office visits, and
 - d. how to assess primary care practices on medical home performance dimensions.
2. Provide incentives for employees and dependents to either a) obtain services that support good primary care and chronic condition self-care, and/or b) obtain services from certified patient-centered medical home practices. Potential incentives include:
 - a. elimination of office visit co-payments;
 - b. elimination of chronic care medication co-payments, and
 - c. elimination of co-payments for an initial intake (assessment) visit.
3. Encourage employee selection of a PCMH or require employee selection of a primary care clinician. Insurers estimate that between 30 and 50% of their members lack an established relationship with a primary care practice. There will be a large missed opportunity if primary care practices transform themselves into patient-centered medical homes, but consumers don't affiliate with them. Employers can address this problem by encouraging employees and dependents to affiliate with a certified patient-centered medical home or requiring that they do so with a primary care practice. Potential incentives include those listed above in #1, as well as reduced employee payroll deductions.

⁴ Purchasers can contact their state QIO by accessing this page:
http://www.ahqa.org/pub/connections/162_694_2450.CFM.

⁵ Employers should recognize that Medicaid, while a large purchaser, operates in a different environment than employers, and may sometimes need accommodations as part of any collaborative or coalition.

4. Provide incentives for employees and dependents to adhere to guidelines for evidence-based care. Potential services to which incentives could be tied include:
 - a. receipt of prescribed well-care visits and screens;
 - b. adherence to a chronic care self-care plan, and
 - c. maintenance of good self-management for employees and dependents with chronic illness.

5. Provide tools to help employees and dependents to adhere to guidelines for evidence-based care
 - a. pre-populated PHR with self-management prompts, and
 - b. coverage community-based self-management support programs.

Strategy #6: Integrate PCMH into other corporate health strategies

1. Coordinate employer-contracted health benefit carve-out services with the medical home (e.g. pharmacy benefit manager, disease management, behavioral health). Fragmentation of the management of health benefit services can compromise the ability of a primary care practice to serve as a patient-centered medical home. Concerted efforts to have contracted vendors coordinate and integrate their services with a medical home can minimize this risk.

2. Coordinate employer-contracted non-health benefit services with the medical home (e.g., employee assistance program, health and wellness, and disability management). Coordination of these services with those provided by the medical home can enhance the ability of the medical home to support the needs of its members and assure the delivery of comprehensive, coordinated care.

3. Integrate worksite wellness programs into medical home activity. Worksite wellness programs can potentially, with the employee's consent, integrate with the efforts of the patient-centered medical home, specifically for employees with chronic illness who have established a self-management plan with the patient-centered medical home.

4. Make employer on-site clinics PCMH-oriented. For those employers offering on-site clinics, when those clinics are primary care sites, they should evolve to patient-centered medical homes. When they are not serving as medical homes, they can potentially work in support of the employee and the patient-centered medical home, again, with the concurrence of the employee.



Appendix A

PCPCC- National Business Coalition on Health

Purchaser Guide to the Patient Centered Medical Home

Draft PCMH RFI Questions: 4-11-08

- a. What is the extent and nature of the insurer's participation in PCMH programs in the market?
 - i. Single-insurer sponsored pilots with primary care practices.
 1. number of involved physicians: _____
 2. number of involved patients: _____
 - ii. Multiple-insurer sponsored pilots
 1. number of involved physicians: _____
 2. number of involved patients: _____
- b. What are the specific expectations that the insurer or multi-insurer collaborative are placing on primary care practices?
 - i. NCQA PPC-PCMH certification
 1. Level 1
 2. Level 2
 3. Level 3
 - ii. Bridges to Excellence Medical Home designation⁶
 - iii. Insurer-based program (please describe)
- c. What is the specific educational support that the insurer or multi-insurer collaborative is providing to practices to support their efforts at transformation?
 - i. Coaching by practice coaches trained in the PCMH
 - ii. Participation in a multiple session learning collaborative focusing on PCMH
 - iii. Other (specify): _____
- d. What methods are used to modify reimbursement and enhance payment?
 - i. Payment in recognition of provider costs related to:

⁶ Physicians who achieve a Level 2 or Level 3 in BTE's Physician Office Link (POL) Program as well as a Level 2 in two other BTE programs - Diabetes Care Link, Cardiac Care Link or Spine Care Link, qualify for BTE Medical Home designation.

1. Application and preparation for NCQA certification or BTE recognition
 2. Provider participation in learning collaborative, including recognition of lost revenue while participating in learning collaborative sessions
 3. Registry licensure and set-up and EHR report customization
- ii. Payment enhancement in recognition of the added labor and labor-related costs incurred to implement a PCMH
 - iii. Performance-based payments based on process and outcome measures reflective of good primary and chronic care.
- e. What types of measures are used to determine the performance-based payments?
- i. Measurement of achievement relative to a target or peers for NQF-endorsed process measures
 - ii. Measurement of achievement relative to a target or peers for NQF-endorsed outcome measures
 - iii. Measurement of improvement over time for NQF-endorsed process measures
 - iv. Measurement of improvement over time for NQF-endorsed outcome measures
 - v. Measurement of practice efficiency relative to a target or peers
 - vi. Measurement of the application of specific medical home practices (e.g., intensive self-management support to patients, action plan development, arrangement for social support follow-up with a social worker or other community support personnel)
- f. What is the expected value of the provider payments referenced in response to "d"?
- i. 0-5% of primary care practice annual payment
 - ii. 6-10% of primary care practice annual payment
 - iii. 11-15% of primary care practice annual payment
 - iv. 16-20% of primary care practice annual payment
 - v. 21-25% of primary care practice annual payment
 - vi. >25% of primary care practice annual payment
- g. Are there any defined expectations of the health plan for the practices as to how the added payments should be used?
- i. None other than those defined in response to "b."
 - ii. Funding employment of, or contracting with, clinical case managers within the practice.
 - iii. Providing group visits
 - iv. Providing group education on self-management
 - v. Other: _____

- h. Are there any consumer incentives contained within the pilot?
 - i. Waived or decreased co-payments for use of the medical home
 - ii. Waived or decreased co-payments for enrollment or affiliation with a medical home in non-HMO products
 - iii. Waived or decreased co-payments for use of selected chronic care medications
 - iv. Incentives to adhere to evidence-based self-management guidelines

- i. Who is evaluating the pilot?
 - i. The insurer
 - ii. An independently funded evaluator

- j. What is the evaluation method?
 - i. Pre/post evaluation
 - ii. Matched control group
 - iii. Randomized control trial

- k. Which variables are being evaluated?
 - i. Evidence-based processes of preventive care
 - ii. Evidence-based processes of chronic care
 - iii. Evidence-based outcomes of chronic care (including experience of care measures)
 - iv. Utilization of services
 - v. Cost
 - vi. Primary care practice organization and care delivery
 - vii. Primary care clinician experience

**For More Information on the Patient Centered Primary Care Collaborative or the
PCPCC Center for Benefit Redesign and Implementation**

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