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Patient-Centered Medical Home Pilot Demonstrations in New York

No Longer a Leap of Faith

By Courtney Burke and Wendy Weller

Part I. An Overview of Patient-Centered Medical Homes

Introduction

Patient-centered medical homes (PCMHs) are receiving a lot of attention lately. PCMHs are an approach to primary care that is organized around the core relationship between patients and their primary care provider.[1] Although there is no standard definition of a medical home, there is agreement on many of the principles behind the medical home concept. Many of these principles are reflected in the 2007 Joint Principles of the Patient- Centered Medical Home, a collaborative effort of four major primary care specialties.[2] These principles include an ongoing relationship with a personal physician; enhanced access to care; whole-person-oriented care; safe and high quality care that is coordinated across the health care sys-

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tem; and payment systems that recognize the value of the PCMH. Although not explicitly stated in these principles, PCMHs are expected to lower costs of care and improve provider and patient satisfaction.

The joint principles provide an important descriptive and widely used guide to PCMHs. However, they do not provide an operational definition of PCMHs or specify the key elements required to identify a medical home. Many practices and demonstration projects rely on an operational definition of PCMHs developed by the National Committee on Quality Assurance (NCQA).[3] NCQA has developed a set of standards that are used to determine if primary care practices have met the definition of a medical home. NCQA recognizes three levels of PCMHs using 30 elements, 10 of which are mandatory for practices to be designated as a certified medical home.[4] By August 2010, some 5,000 physicians had received NCQA PCMH recognition. Other operational definitions have been developed by states, purchasers, and professional organizations.

Because there is no operational definition of a medical home, PCMHs can vary considerably according to how they are organized and structured, how they are reimbursed, and types of provider incentives. However, many medical homes do share some common elements, such as close patient contact with a primary care provider and the use of electronic health records. Nationally, at least 14,000 physicians caring for nearly 5 million patients were participating in PCMH pilots by mid-2010.[5] The majority are single payer and utilize a three-component payment model, including traditional fee for service, per member per month (PMPM) fixed payments, and bonus performance payments.[6] Although multiyear rigorous evaluations of the PCMH model are still largely underway, PCMHs are taking hold in policy circles as a way to transform health care delivery in part because they are included and encouraged under the new federal health reform law known as the Patient Protection and Affordable Care Act (PPACA).

Who Is Participating in PCMH in New York?

There are at least eight PCMH pilot demonstrations in New York State. Organizations involved in the demonstrations were recently convened by the New York State Department of Health, the American College of Physicians, the Primary Care Development Corporation, and the Rockefeller Institute of Government in an effort to understand the operation, challenges, and opportunities of using PCMHs. This paper describes what was learned about New York's PCMH pilots during the discussion and examines some of the policy implications of PCMHs.

The large majority of PCMH demonstrations in New York were initiated by insurance companies to test whether the use of PCMH could lower costs while improving health outcomes

for plan enrollees. In one instance, a pilot demonstration was initiated by a physician group, and in another, a federally qualified health center (FQHC) was a major driver in getting the pilot started. Most of the pilots are governed by multiple stakeholders including insurers, the New York State Department of Health, physician groups, and, in at least one instance, a private corporation.

The smallest PCMH pilot began with three physician practices, while the largest involves 50 practices and more than 500 physicians. Table 1 outlines the pilots, the timeframe for operating the pilot, the number of sites, and the number of participating practices and physicians.

Table 1. An Overview of PCMH Pilots and Participants

Pilot	*Number of Practices*	*Number of Physicians*
Adirondack Region Medical Home Pilot 2010-2014 (5 years)	40+ (3 geographic pods)	120 MDs, 96 PAs and NPs
CDPHP: Enhanced Primary Care (2008-2010)	24	87.75 MD FTEs
Catholic IPA WNY, Inc. (5+ years)	12 (20 by the end of 2010)	50
Emblem Health Medical Home High Value Network Project (2008-2010)	38	159
Independent Health (2008-2011)	18	130
Excellus and Preferred Care/MVP: Rochester Medical Home Initiative (2009-2012)	7	21
MVP: Onondaga County (began in 2008)	21	50+
THINC: Hudson Valley P4P Medical Home Project (3+ years)	50	500+

Quality Metrics

In order for a PCMH to qualify under the NCQA definition, the applicant must meet certain criteria related to access, quality, and care delivery. There are basic elements that practices must first pass and three levels of recognition are given. Most insurers aim to have a certain number of their sites reach Level II or Level III NCQA recognition. Most pilots have added quality metrics to their PCMH. Some of these metrics deal with patient satisfaction, while others deal with team vitality or medical chart data. A summary of some of the primary metrics used by the PCMH demonstrations in New York are summarized in Table 2.

Reimbursement

The majority of pilots in New York use a per member per month payment for the number of persons enrolled in a participating practice. The payments range from about $2.50 to $7 per member per month. Most pilots also provide additional

Table 2. New York's PCMH Pilots' Timeframes and Quality Metrics

Pilot/Timeline	*Metrics*
Adirondack Region Medical Home	Providers participating in the pilot will have to meet several standards of care, including NCQA recognition (Level 2 or 3), e-prescribing, quality improvement and cost reductions including a reduction in hospital readmission rates.
CDPHP: Enhanced Primary Care: The CDPHP Medical Home	18 HEDIS Quality Metrics – Five domains (population health, diabetes, cardiovascular, respiratory, imaging studies for lower back pain); efficiency metrics (population-based, episode-based, and utilization)
Catholic IPA WNY, Inc.	NQCA PCMH standards; success is Level 2 or 3 recognition; NCQA submission for 10 sites by the end of 2010; 2 practices have achieved Level 3 recognition
Emblem Health Medical Home High Value Network Project	Clinical quality; cost/efficiency; patient experience/satisfaction; qualitative process evaluation data
Independent Health	Quality: preventive, acute & chronic conditions; cost: PMPM by service category; satisfaction: patient experience-of-care & team vitality
Excellus and Preferred Care/MVP: Rochester Medical Home Initiative	Quality/effectiveness measures; satisfaction; efficiency measures
MVP: Onondaga County (Syracuse)	NCQA PPC-PCMH recognition; EHR/eRx implementation; ED utilization, extended hours, secure messaging; care management; provider/patient surveys
THINC: Hudson Valley P4P Medical Home Project	Clinical quality, cost/efficiency, patient experience/satisfaction, provider experience/satisfaction

bonuses or incentive payments to providers for improved clinical outcomes or performance. At least one provides a monthly stipend to help practices with developing initial administrative functions and at one least provides monthly care coordination payments. A summary of the reimbursement mechanisms of the pilots is outlined in Table 3.

Table 3. New York's PCMH Pilots' Reimbursement Methods

Pilot	*Reimbursement*		
	Per Member Per Month	*Bonus Component?*	*Other*
Adirondack Region Medical Home	$7.00	Yes	
CDPHP: Enhanced Primary Care	Depends on risk score	Yes	Risk based capitation plus bonus incentive based on quality and efficiency
Catholic IPA WNY, Inc.			Nine month stipend to cover administration, care coordination, & clinical & IT assistance for the practice
Emblem Health Medical Home High Value Network Project	$2.50	Yes	
Independent Health		Yes	No standard PMPM. Added funding is a prospective risk adjusted percentage of a global budget, and retrospective funding is based on quality and satisfaction metrics.
Excellus and Preferred Care/MVP: Rochester Medical Home Initiative	Excellus: ~$24.00 in Year 1	Yes	Excellus paid about $24 PMPM in the first year, but only for members with a chronic disease. (This is intended to prevent physicians from avoiding taking on new patients who are ill and to risk adjust payments to some extent. It was purposefully inflated for the pilot to cover the cost of patients on the physician's panel that are not being reimbursed for the project such as Medicare FFS).
MVP: Onondaga County	$4.00 for Level II, $5.00 for Level III	Yes	
THINC: Hudson Valley P4P Medical Home Project		Yes	

Part II. Challenges to PCMH Expansion

Despite the many promising attributes of PCMHs, there are challenges to their expansion. The second part of this policy brief outlines some of these challenges. It also describes how some pilots are addressing these issues.

Capital and Courage to Start

Provider and Insurer Value: One of the biggest challenges to the expansion of the PCMH is convincing physicians and insurers that the investment resources required to transform a practice into a PCMH is worth it. Most of the PCMH demos in New York State are relatively new and have not been evaluated over a multiyear period for their return on investment. Although initial results are promising, moving to a PCMH approach takes considerable upfront investment.

Payment Adequacy and Model: Many primary care practices already face increasing costs and flat or declining reimbursement that may make transforming care delivery difficult. New reimbursement models that realign payment systems to encourage and support PCMH adoption may be necessary. Several potential payment models have been suggested; PCMH pilot programs in New York and across the country currently are using a number of them (e.g., capitated monthly payments, bonus payments for improved clinical outcomes and efficiency, separate financial assistance to help cover start-up costs). One of the many challenges in establishing an appropriate payment system will be to balance the potentially conflicting short-term and long-term expectations of multiple stakeholders. For example, an initial financial investment may result in improved health outcomes and costs savings in the long run, but insurers are under pressure to control costs in the short run.

Multiple Insurers and Payment Models: It may be particularly challenging to align payment systems within a multipayer system, particularly as the PCMH expands. Providers may contract with multiple insurers with differing financial incentives and expectations for the PCMH. This could create frustration and additional administrative burdens on the part of both providers and payers.

Practice Changes: The PCMH has the potential to strengthen many of the traditional roles of primary care, such as care coordination. However, some features of the PCMH may require significant changes in the way that care is organized and delivered. For example, most PCMH models rely on some use of electronic health records (EHRs). For some practices, using EHRs will require new investments in hardware and software as well as time to learn how to use and maintain EHRs. Other features of the PCMH, such as team-based care, may require cultural changes in the way that care has traditionally been delivered. To address these challenges, PCMHs are using different techniques. One technique is to embed care managers within physician practices. Other

techniques involve using learning collaboratives, peer networks, or national technical assistance organizations to assist practices with transforming into a PCMH.

Keeping the "Patient" in PCMH

The current PCMH pilot demonstrations are largely focused on changing the way providers practice medicine. Patient involvement is usually considered a key component of the PCMH. But many patients may be unaware they are in a medical home setting or may be unfamiliar with the PCMH concept and what it means for them. Educating patients on their roles within the PCMH and teaching them new skills and pathways to become informed and active in their health care will likely be necessary. Currently, there are few, if any, direct incentives for patients to engage more fully in managing their own care. In many respects, patients must be retrained to use the health care system as a means to prevent and manage illness rather than treat illness. Teaching patients self-care management can be challenging and time intensive for practices. Several of the PCMH models in New York are using midlevel practitioners or case managers to help with patient education and engagement.

Fitting PCMH with Health Care Reform

Another challenge for the PCMH is determining how the concept fits with changes in health care reform, such as the formation of accountable care organizations (ACOs). An ACO is an entity comprised of different, locally based providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.[7] ACOs have the potential to lower health care costs in a way that distributes some of the financial gain to physicians and other providers. It is not yet clear how PCMHs will be incorporated into ACOs, but this is likely to vary by local region. Within the PCMH, patient care is centered around a single practice or provider; in an ACO, there tends to be many practices within one organizing entity. But because PCMH focuses on care and coordination for a patient, it may fit well as a building block for an ACO.

Although there are currently no recognized ACOs, the PPACA has established a Medicare shared savings program for ACOs to take effect no later than January 2012.[8] This change will begin to allow different payment models and disbursements of savings to organizations that qualify as ACOs. For providers currently participating in PCMH demonstrations, becoming part of an ACO may actually be easier because patient care will already be geared toward better outcomes and cost savings.

Looking Ahead

The PCMH pilots examined in this policy brief will continue to evolve and their benefits will be more fully assessed as time

passes. Presumably, if they continue to show promising results, insurers will expand them further, and more and more practices will seek PCMH designation. As they evolve, there may be other aspects of the PCMH worth examining. For instance, because of their use of paraprofessionals, PCMHs may actually improve primary care capacity. This would be particularly helpful to health care delivery given the current and predicted continued shortages of primary care physicians. In the interim, it is worth watching and learning more about the PCMH — and allowing those PCMHs currently operating in New York to continue to learn from one another about payment methods, quality measures, and physician practices that are most successful at decreasing costs and improving patient care.

Endnotes

1 Melinda Abrams and Karen Davis,"Can Patient Centered Medical Homes Transform Health Care Delivery?" The Commonwealth Fund, March 27, 2009. Available at http://www.commonwealthfund.org/Content/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx.

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3 Mark W. Friedberg, Deborah J. Lai, Peter S. Hussey, and Eric C. Schneider, "A Guide to the Medical Home as a Practice-Level Intervention," *The American Journal of Managed Care* 15, no. 10 (December 2009): S291-9.

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5 Leigh Ann Backer, L. "The Patient-Centered Medical Home: Still a Work in Progress," *Family Practice Management* 17, no. 5 (September/October 2010): 30-5.

6 Ibid.

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