

The Patient-Centered Medical Home

A Purchaser Guide

Understanding the model and taking action



Patient-Centered
Primary Care

COLLABORATIVE

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Dear Purchaser,

The last several years have been trying for purchasers of health care. A wide array of strategies to tame cost growth, reduce errors and improve quality appears to have achieved less impact than desired. It is now clearer than ever that the only way to address the ills that afflict our U.S. health care system is through truly transformative change in health care financing and delivery.

One emerging strategy for effecting such change is to redesign the manner of primary care delivery, and to re-emphasize the centrality of primary care. Compelling research indicates that our ever-increasing focus of resources on specialty care has created fragmentation, decreased quality, and higher cost. It also shows that if primary care practices restructure how they operate such that they are more accessible, promote prevention, proactively support patients with chronic illness rather than treating the symptoms of those illnesses, and engage patients in self-management and decision-making, they produce better care and lower costs.

The name attributed to this new conceptualization of primary care is “Patient-Centered Primary Care”, delivered through a model called the “Patient-Centered Medical Home.” It is an idea that has been endorsed by both the physician community and by some important leaders of the purchaser community. It is not likely to address all of challenges faced by our health care system—other complementary transformative initiatives, such as broader payment reform, will be necessary as well. Patient-Centered Primary Care offers significant promise for improving health care value, however, with sound research evidence supporting it.

This Purchaser Guide provides an overview of what is the Patient-Centered Medical Home, answers the question of why purchasers should consider supporting it, and then defines a list of potential strategies that purchasers should consider, including some recommended immediate steps that could be taken.

The Guide also provides supplemental resources, including detailed case study descriptions, and in the appendices, additional information regarding current and forthcoming pilots, and draft RFI and contract language for purchasers.

We encourage you to consider the Patient-Centered Primary Care Model, its potential benefits, and how your organization might take steps to encourage testing and evaluation of its impact.



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Section 1

What is a Patient-Centered Medical Home?



The concept of a “medical home” is not new. It was initially introduced by the American Academy of Pediatrics (AAP) in 1967 and referred to a central location for a child’s medical records; it was particularly important for children with special health care needs. This concept evolved over time from a centralized medical record to a method of providing comprehensive primary care for children at the community level. The American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) then developed their own conceptions of the concept, expanding its reach to care for adults.

In March 2007 these three specialty societies joined the American Osteopathic Association (AOA) and issued “Joint Principles of the Patient-Centered Medical Home”¹ in response to a request from several large national employers seeking to create a more effective and efficient model of health care delivery.

While the medical home has had several definitions, the currently emerging consensus definition is reflected in the Joint Principles. The Principles are defined as follows:

A. Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

B. Physician directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

C. Whole person orientation—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals.

This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

D. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

E. Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide

¹ www.medicalhomeinfo.org/Joint%20Statement.pdf. Accessed May 9, 2008.

patient centered services consistent with the medical home model.

- Patients and families participate in quality improvement activities at the practice level.

F. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

G. Payment appropriately recognizes the added value provided to patients who have a Patient-Centered Medical Home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

- It should allow for additional payments for achieving measurable and continuous quality improvements.

The National Committee for Quality Assurance's recognition standards for primary care practices titled "Physician-Practice Connections®—Patient-Centered Medical Home", or "PPC-PCMH" attempt to further operationalize this definition. A summary table of these standards is contained in Appendix A.²

NCQA reports that the initial NCQA PPC standards were developed based upon the Model for Effective Chronic Illness Care developed at HealthPartners in Minnesota and at Group Health Cooperative of Puget Sound³. The Chronic Care Model (CCM)⁴, as implemented at Group Health Cooperative of Puget Sound, identifies the essential elements of a health care system that encourage high-quality chronic disease care. Like the Patient-Centered Medical Home, it brings focus to how the primary care practice should restructure and reorient itself in order to provide improved clinical care to its patients.

NCQA staff then modified the standards after they worked closely with leaders of the four specialty societies (ACP, AAFP, AAP, AOA) and other interested stakeholders to develop the PPC-PCMH standards.

There are some who believe that the definition of the Patient-Centered Medical Home as defined by the Joint Principles, and as further defined by the NCQA PPC-PCMH standards, is in need of further refinement. For example, some believe that these documents do not adequately address behavioral and psychosocial issues, care coordination/case management, the re-orientation of the primary care practice into a multi-disciplinary team, the need for practices to document improved processes and outcomes as an indication of model implementation, shared decision-making or the role of nurse-led primary care practices. Others worry

²The full set of recognition standards and guidelines can be purchased from NCQA at www.ncqa.org/tabid/629/Default.aspx, as can the application tool for primary care practices to complete. A narrative overview of the standards can be accessed at www.ncqa.org/LinkClick.aspx?fileticket=MUTX9kXgi7M%3D&tabid=631&mid=2435&forcedownload=true.

³Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288: 1775–1779 and Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness, the chronic care model, part 2. *JAMA* 2002;288:1909–1914.

⁴Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Affairs* (Millwood).2001;20:64-78.

that the PCMH is becoming too inclusive and needs to be better focused on the practice changes that will make the biggest impact on outcomes and cost.

As with any relatively new documents, the Joint Principles and the NCQA PPC-PCMH standards will come under scrutiny and be subject to potential future revision. In fact, NCQA is drafting and making plans to test PPC-PCMH revisions in the fall of 2008 based on feedback on the initial version. A public comment period is scheduled for 2009.

Section 2

Why Should Purchasers Support the Patient-Centered Medical Home Concept?



In the context of past investments in other strategies to manage cost and improve quality, purchasers appropriately ask why they should endorse and invest in the latest strategy with which they are presented—the Patient-Centered Medical Home.

This chapter identifies some of the problems plaguing the U.S. health care system and why employers might have a role to play in solving them. It then lays out three potential answers to the question of why purchasers might consider endorsing and investing specifically in the Patient-Centered Medical Home concept.

I. The Magnitude of the Problem

The ills of our health care system can now be recited by rote by many employer health care purchasers who have struggled with the problem for years. Many of these can potentially be influenced through the provision of high quality primary care.

- Americans receive only about half of the recommended, evidence-based care they require when they see their doctor.⁵
- Experts estimate that somewhere between 20% and 50% of all U.S. health care spending produces no

benefit to the patient—and some of it produces clear harm.⁶ If we apply a mid-point (30%) to U.S. national health care spending, the waste totals \$700B annually.⁷

- The United States spends more on health care per capita than any other country in the world⁸, yet the health care system performs inconsistently across the states, and poorly when compared with other industrialized countries according to a report from The Commonwealth Fund⁹. Just a few of the failings cited by Commonwealth include the following:

- The U.S. is one-third worse than the best country on mortality from conditions “amenable to health care”—that is, deaths that could have been prevented with timely and effective care.
- National preventable hospital admissions for patients with diabetes, congestive heart failure, and asthma (ambulatory care sensitive conditions) were twice the level achieved by the top states.
- The current gap between national average rates of diabetes and blood pressure control and rates achieved by the top 10 percent of health plans translates into an estimated 20,000 to 40,000 preventable deaths and \$1 billion to \$2 billion in avoidable medical costs.

⁵ McGlynn E et. al. “The quality of health care delivered to adults in the United States.” *New England Journal of Medicine*. 2003 Jun 26;348(26):2635-45.

⁶ Wennberg JE, Fisher E and Skinner J. “Geography and the Debate over Medicare Reform.” *Health Affairs*, February 2002, Web exclusive, <http://healthaffairs.org>.

⁷ Brownlee S. *Overtreated*. Bloomsbury, New York, 2007.

⁸ World Health Organization. Core Health Indicators 2004. Accessed on May 15, 2008 at www.who.int/whosis/database/core/core_select_process.cfm?strISO3_select=ALL&strIndicator_select=nha&intYear_select=latest&fixed=indicator&language=english.

⁹ The Commonwealth Fund Commission on a High Performance Health System. “Why Not the Best? Results from a National Scorecard on U.S. Health System Performance”, September 2006.

Finally, high and growing health care costs harm both employers and employees:

- **Employers:** Employers¹⁰ and research¹¹ have identified how the high costs of health care in the U.S. harm the competitiveness of American employers. Ford reports that the cost of providing health care benefits adds about \$1,200 to the sticker price of every Ford car and truck built in the U.S.¹²
- **Employees:** In order to manage cost growth employers have significantly increased cost sharing. While this can engender more thoughtful use of health care by employees, it also creates a barrier to necessary care for lower income workers and adds a financial burden to employees. An April 2008 survey by the Kaiser Family Foundation found that more than a quarter of Americans report a serious problem paying for health care and insurance.¹³

II. The Role of Purchasers in Improving Health Care

Employment-based coverage is the most prominent form of health insurance in the United States. The manner in which employer purchasers buy health insurance coverage for their employees and dependents directly influences how health care is delivered, and how patients fare.

Any efforts to address the profound problems in our health care system will require employer involvement and support, so long as the U.S. health care systems remains employer-based. Employers can, and many argue, must take action by:

- creating health insurance product design and health insurer performance requirements that will align incentives with goals of improved quality and efficiency, and
- engage health care providers in joint efforts that will transform health care delivery.

As a primary funding source for America's health care system, whatever actions purchasers take—including

no new action—will directly influence health care delivery. For this reason, it is important that employer purchasers evaluate the business case for the medical home and thoughtfully decide whether and how to incorporate the medical home into their purchasing strategies.

III. Decline of Primary Care

There is scarcely a region in the country now where employers do not hear about the increasing challenge for their employees and dependents to find a primary care practice that will accept new patients. When patients are able to see their primary care physician, the experience is too often a poor one, for both the patient and the physician.

“Patients are angry, and rightly so. They feel frustrated by the inability to get timely appointments with their physicians, rushed by the 15-minute visits and the seemingly harried doctors, ignored when they do not receive letters with lab results or follow-up phone calls. They feel disrespected when they come to their medical appointments on time and then sit in the waiting room for 45 minutes. All of these feelings are justified. We are not offering high-quality care.

Doctors feel angry, too. We have too many patients. It is not uncommon for a full-time primary care doctor to have upwards of 3,000 patients. It is impossible to know all of these individuals well, to give adequate focus to each person's unique situation, to sift through the piles of paperwork and lab data daily... We move frantically from exam room to exam room, trying desperately not to fall behind in our schedule.”¹⁴

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¹⁰ Connolly C. “U.S. Firms Losing Health Care Battle, GM Chairman Says” *Washington Post*, February 11, 2005.

¹¹ Nicols L and Axeen S. “Employer Health Care Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms” New America Foundation, May 2008.

¹² Ford Motor Company, as reported at www.ford.com/about-ford/company-information/public-policy/health-care/our-health-care-policy-808p. Accessed May 15, 2008.

¹³ Survey Brief: Economic Problems Facing Families. Kaiser Family Foundation, April 2008.

¹⁴ Brewster A. “The crisis of primary care physicians” *The Boston Globe*, May 29, 2008.

Research Evidence on the Effectiveness of the Patient-Centered Medical Home

There is significant effectiveness research that suggests that increased adoption of the Patient-Centered Medical Home, and increased use of it by patients, should yield significant measurable benefits. This research supporting the Patient-Centered Medical Home comes from:

- research evaluating the impact of patient affiliation with a primary care practice on patient health and expenditures, and
- research performed to evaluate the Chronic Care Model.

A summary of some of the research findings follows below.

► Primary Care Practice Orientation Research Findings

Dr. Barbara Starfield of Johns Hopkins University, and many others, have researched the impact of a primary care-oriented health care system on health care outcomes, costs, and equity. Dr. Starfield's research has found that a greater orientation towards primary care results in lower per capita health care costs and better outcomes. Conversely, a specialist-oriented health care system (like that of the U.S.) is associated with higher costs and poorer outcomes.

Her research and that of others has shown that adequate access to primary care provides the following specific health and economic benefits¹⁵:

- reduced all-cause mortality and mortality caused by cardiovascular and pulmonary diseases¹⁶;
- less use of emergency departments and hospitals^{17, 18};
- better preventive care¹⁹;
- better detection of breast cancer, and reduced incidence and mortality caused by colon and cervical cancer^{20, 21, 22};
- fewer tests, higher patient satisfaction, less medication use, and lower care-related costs^{23, 24} and
- reduced health disparities, particularly for areas with the highest income inequality, including

improved vision, more complete immunization, better blood pressure control, and better oral health^{25, 26, 27}.

Finally, and important to employers, there is evidence that primary care-oriented health care results in increased patient satisfaction.²⁸

► Chronic Care Model Research Findings

As noted earlier, the Chronic Care Model, like the Patient-Centered Medical Home, brings focus to how the primary care practice should restructure and reorient itself in order to provide improved clinical care to its patients. Considerable research has been performed and reported on the application of elements of the Chronic Care Model. A summary of the literature can be found at www.improvingchroniccare.org/index.php?p=Chronic_Care_Model_Literature&s=64.

In addition, evaluation research funded by Robert Wood Johnson Foundation and performed by RAND and the University of California at Berkeley as part of a four-year study of three Chronic Care Model collaboratives can be found at <http://rand.org/health/projects/icice/index.html>.

While the findings have varied from study to study, in part based on variation in the scope and focus of the research, studies have generally found that the application of elements of the Chronic Care Model improves quality of care and patient health status, and reduces costs. One effort to combine information on the Chronic Care Model from 112 different studies to derive an overall estimate of a treatment's effect ("meta analysis")²⁹ yielded the following results:

interventions that contain one or more elements of the CCM improve clinical outcomes and processes for patients with chronic illness and *multi-faceted interventions incorporating multiple elements of the Chronic Care Model have a greater impact on outcomes than single or simpler interventions designs incorporating a more limited number of model elements*

A second study³⁰ focused specifically on cost impact and found the following:

Congestive Heart Failure studies

- 3 positive for reduced health care use/costs
- 2 negative for reduced health care use/costs

Asthma studies

- 8 positive for reduced health care use/costs
- 5 negative for reduced health care use/costs

Diabetes studies

- 7 positive for reduced health care use/costs
- 2 negative for reduced health care use/costs

The research also found:

- Savings are achievable through reduced inpatient days and fewer ER visits.
- Targeting higher risk patients results in more significant cost improvements.
- Cost benefits of temporary programs may be short-lived.

- Financial savings require aligned incentives, and a favorable business case means savings **must accrue** to the same organization paying for chronic care improvements.

While there is no research on the effectiveness of the Patient-Centered Medical Home *as specifically defined* by the PCPCC Joint Principles or by the NCQA PPC-PCMH recognition standards, the above summary shows that there is plentiful research on core elements of each that demonstrate effectiveness in terms of both cost and quality.

This research should assure those employer purchasers who feel understandable caution about investing in a new concept such as the Patient-Centered Medical Home that the concept is, to a considerable degree, proven.

¹⁵Philips R, Starfield B. Why does a U.S. primary care physician workforce crisis matter? *American Family Physician*, August 1, 2004.

¹⁶Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Services Research* 2003; 38:831-65.

¹⁷Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Luri N, et al. Preventable hospitalizations and access to health care. *JAMA* 1995; 274:305-11.

¹⁸Wasson JH, Sauvigne AE, Mogielnicki RP, Frey WG, Sox CH, Gaudette C, et al. Continuity of outpatient medical care in elderly men. A randomized trial. *JAMA* 1984;252:2413-7.

¹⁹Bindman AB, Grumbach K, Osmond D, Vranizan K, Stewart AL. Primary care and receipt of preventive services. *J Gen Intern Med* 1996; 11:269-76.

²⁰Ferrante JM, Gonzales EC, Pal N, Roetzheim RG. Effects of physician supply on early detection of breast cancer. *J Am Board Fam Pract* 2000; 13:408-14.

²¹Campbell RJ, Ramirez AM, Perez K, Roetzheim RG. Cervical cancer rates and the supply of primary care physicians in Florida. *Fam Med* 2003; 35:60-4.

²²Roetzheim RG, Gonzalez EC, Ramirez A, Campbell R, van Durme DJ. Primary care physician supply and colorectal cancer. *J Fam Pract* 2001; 50:1027-31.

²³Greenfield S, Nelson EC, Zubkoff M, Manning W, Rogers W, Kravits RL, et al. Variations in resource utilization among medical specialties and systems of care. Results from the medical outcomes study. *JAMA* 1992; 267:1624-30.

²⁴Forrest CB, Starfield B. The effect of first-contact care with primary care clinicians on ambulatory health care expenditures. *J Fam Pract* 1996; 43:40-8.

²⁵Shi L, Starfield B, Politzer R, Regan J. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res* 2002; 37:529-50.

²⁶Lohr KN, Brook RH, Kamberg CJ, Goldberg GA, Leibowitz A, Keesey J, et al. Use of medical care in the Rand Health Insurance Experiment. Diagnosis- and service-specific analyses in a randomized controlled trial. *Med Care* 1986; 24(suppl 9):S1-87.

²⁷Shi L, Starfield B. The effect of primary care physician supply and income inequality on mortality among blacks and whites in U.S. metropolitan areas. *Am J Public Health* 2001; 91:1246-50.

²⁸Davis K. Learning From High Performance Health Systems Around the Globe, Invited Testimony: Senate Health, Education, Labor, and Pensions Committee Hearing "Health Care for All Americans: Challenges and Opportunities," January 10, 2007.

²⁹Tasi et al. "A Meta-Analysis of Interventions to Improve Chronic Illness Care." *American Journal of Managed Care*, 2005 11 478-88. Abstract available at: www.rand.org/health/projects/icice/tsai.html.

³⁰Bodenheimer T, Wagner E, Grumbach K. Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2, *JAMA*, October 16, 2002, 288:15, 1909-1914.

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This reflects a trend that has long been in development and has resulted in a physician workforce that is heavily weighted towards specialty care. Between 1997 and 2005, the number of U.S. graduates entering family practice residencies dropped by 50 percent.³¹ The reason for this is simple—money.

“Thirty minutes spent performing a diagnostic, surgical, or imaging procedure often pays three times as much as a 30-minute visit with a patient with diabetes, heart failure, headache, and depression. The median income of specialists in 2004 was almost twice that of primary care physicians, a gap that is widening.”³²

The true way to address this problem, and to address the inflationary incentives of fee-for-service payment, is through fundamental payment reform. Many are urging such change^{33,34}, but real change hasn’t even begun. In the interim, purchasers who wish to ensure continued availability of primary care physicians might consider a better compensated primary care system that may slow the erosion of primary care supply.

Even if one is skeptical about the effectiveness of the Patient-Centered Medical Home and the ROI that it will generate both in financial and health terms, there is little question that frequent use of specialists by Americans generates higher costs and is associated with worse outcomes. Dr. Starfield’s research demonstrates this. In addition, Dr. Eliot Fisher and colleagues at Dartmouth Medical School have shown³⁵ that in the Medicare population the regions of the country with the highest expenditures have greater use of specialists and poorer quality than those with dramatically lower expenditures.

IV. The Status Quo is Not the Answer

While there are some adherents of the Patient-Centered Medical Home who hold a high level of conviction that the model will deliver superior performance, many of those supporting application of the concept do so realizing that there is a risk that this might not be the case. These purchasers and payers, however, find the merits of the concept to be sufficiently compelling to warrant an investment in pilots or phased implementations that will be subject to formal assessment and evaluation for effectiveness.

For these purchasers and payers, the definition of insanity is truly doing the same thing over and over again and expecting a different result³⁶, and so they are compelled to explore new approaches, like the Patient-Centered Medical Home, that offer some reasonable likelihood of success in addressing some of the ills afflicting our health care system.

³¹ Bodenheimer, T. Primary Care—Will it Survive?. *NEJM* 2008; 358: 1064-1071.

³² Ibid.

³³ Network for Regional Healthcare Improvement. Creating Payment Systems to Accelerate Value-Driven Health Care. March 29, 2007. Accessed May 12, 2008 at www.nrhi.org/downloads/Summary_of_NRHI_Payment_Reform_Summit.pdf.

³⁴ Galvin R. We Can Get There From Here. Presentation to the Blue Cross Blue Shield of Massachusetts Health Care Excellence Award Luncheon, April 14, 2008.

³⁵ Fisher E, Wennberg D, Stukel T, Gottlieb D, Lucas F, and Pinder E. The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care. *Annals of Internal Medicine* 2003;138, pp. 273-287.

³⁶ This saying has been attributed to both Albert Einstein and Benjamin Franklin.

Section 3

What Actions Can Purchasers Take to Advance the PCMH?

This section of the guide describes discrete actions that employer purchasers can take to support advancement of the Patient-Centered Medical Home for those purchasers that find the concept sufficiently compelling to warrant their support. Even employers with a high degree of uncertainty might find that pursuing pilots with structured evaluation would be a worthwhile pursuit.

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:

STRATEGY 1: Participate in a regional pilot(s);

STRATEGY 2: Incorporate PCMH into insurer procurement and performance assessment activity;

STRATEGY 3: Align payment strategy with PCMH adoption objectives;

STRATEGY 4: Build coalitions in support of PCMH;

STRATEGY 5: Engage consumers, and

STRATEGY 6: 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

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

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. Purchasers should note that some of the actions could be implemented with limited if any net costs, whereas others require and up-front investment.

Purchasers that wish to consider a larger array of options should consider the following set of strategy options.

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 Appendix C 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.
- 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).

A listing of existing and emerging multi-payer PCMH pilots is provided in Appendix D. In addition, purchasers can learn about multi-payer pilots underway through the PCPCC’s Center For Multi-Stakeholder Demonstrations.

JUMPSTART

Quick recommended steps to get started

For purchasers who want to know where to begin, there are three recommended easy, immediate steps that a purchaser can take right away.

1. Write contracted insurers and ask them to participate in one or more multi-payer Patient-Centered Primary Care pilots that:
 - a. specify obligations of primary care practices;
 - b. incorporate care coordination (case management) resources into the pilot in some fashion;
 - c. use a payment methodology that will enhance payment to primary care practices, and
 - d. perform a rigorous independent evaluation of the pilot with a control group.

2. Educate employees and dependents about the benefits of affiliating with a primary care provider, and using the provider to help access needed advice and care.

3. Consider benefit modifications that provide incentives for use of the Medical Home.

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 often bring greater market pressure to bear than might be possible through unilateral action.

3. Sponsor a PCMH pilot. Very large employers with significant, concentrated, 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. Identify specific criteria that must be met for purchaser support of a pilot. Employer personnel directly, or working with its consultants and/or insurers, should specify requirements that must be

met if the employer is to support a PCMH pilot, including, for example:

- 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 care coordination (alternatively, “case management”) resources into the pilot in some fashion;
- c. use of technology for patient tracking and analysis (e.g., registry, EHR), identifying gaps in evidence-based care, patient communication (e.g., e-mail, e-consultation, and online patient-practice connectivity), and for e-prescribing;
- d. a payment methodology that will enhance payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain the practice³⁷ and produce an ROI, and ideally introduce broader payment reform that extends beyond primary care, and
- e. a rigorous independent evaluation of the pilot with a control group, including metrics for evaluating the achievement of improved outcomes and return on investment.

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.

NOTE ON TERMINOLOGY: *The terms “care coordination” and “case management” each carry multiple meanings, thus hampering their use. Please note that for the purposes of the PCMH, we mean a proactive primary care practice-based function that is performed by the members of the primary care team, and often not by a physician.*

We define PCMH care coordination/case management as having the following components: 1. periodic assessment of disease severity, medications, social support systems and ability to self-manage, 2. 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. medication review and adjustment agreements, 4. agreements for hand-offs back to the primary care physician, 5. patient education about his or her condition, and what is its meaning to and impact upon the patient, 6. intensive self-management support to patients, 7. intensive follow-up for patients, 8. assistance navigating patients across health care sectors for clinical aspects of patient care, and 9. arrangement for social support follow-up with social worker or similar community support personnel.³⁸

STRATEGY 2
Incorporate PCMH elements 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;

³⁷ 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.

³⁸ Source for the eight components: MacColl Institute for Healthcare Innovation’s literature, as reported by Michael Hindmarsh, personal communication, April 6 and June 23, 2008.)

- b. specific expectations the insurer/collaborative is placing on primary care practices (e.g., those identified above in STRATEGY 1, item 4);
- 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.

Many leading insurers are expressing support for the PCMH model. See Appendix C for a set of recommended questions to be used in an RFI or RFP.

2. Measure insurer performance. Require ongoing insurer reporting on support of PCMH using a set of quantitative metrics. Reporting may occur through a coalition or collaborative, or 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 PCMH formal recognition
 - i. *% of in-network primary care sites in the geographic area currently recognized by NCQA through its PPC-PCMH³⁹ program at Levels 1, 2, and 3, respectively*
 - ii. *change in the percentage of the preceding measure relative to the prior year*
- b. care coordination adoption
 - i. *% of geographic area primary care sites that have implemented care coordination functionality through:*
 - *the use of an employed case manager;*
 - *a contracted care coordinator, or*
 - *care coordination support from a dedicated or partially dedicated insurer-based care coordinator.*
- ii. *change in the percentage of the preceding measure relative to the prior year*
- c. pharmaceutical care management adoption
 - i. *% of geographic area primary care sites that have implemented pharmaceutical care functionality through:*
 - *the use of a professional trained in pharmaceutical care and education of patients in drug therapy use and identification of drug therapy problems including OTCs and herbal remedies;*
 - *a contracted professional trained in pharmaceutical care, or*
 - *pharmaceutical care support from a dedicated or partially dedicated insurer-based professional trained in pharmaceutical care.*
 - ii. *change in the percentage of the preceding measure relative to the prior year*
- d. use of technology for patient tracking, communication and prescribing
 - i. *% of geographic area primary care sites that utilize:*
 - *an EHR that generates point-of-service and outbound alerts for gaps in care, integrating evidence-based guidelines with medical record information;*
 - *e-mail for patient-clinician communications, and*
 - *e-prescribing.*
- e. relative volume at NCQA recognized practices
 - i. *% of geographic area primary care visits in the past year at NCQA recognized practice sites*
 - ii. *change in the percentage of the preceding measure relative to the prior year*
- f. 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*

³⁹ “Physician Practice Connections—Patient-Centered Medical Home”.

- 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
- g.** patient experience
 - i.* % of patients who report satisfaction with their primary care or who report receipt of care consistent with PCMH principles, using validated survey instruments⁴⁰

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 to assess the model's clinical impact and ROI. 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 physicians 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);

- d.** direct purchaser enhanced funding of practices with demonstrated practice transformation as indicated by NCQA PPC-PCMH recognition at Level 1, 2 and/or 3, or some other defined metric, and
 - e.** any of the above linked to estimated, demonstrated or guaranteed savings.
- 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 to primary care practices.
- 2. Convene and facilitate a multi-stakeholder effort with insurers, 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

⁴⁰ Examples include the CAHPS Clinician and Group Survey (see www.cahps.abrq.gov/content/products/PROD_AmbCareSurveys.asp?p=102&s=21) and the Patient Assessment of Chronic Illness Care (PACIC) Survey (see www.improvingchroniccare.org/downloads/2004pacic.doc.pdf).

coalition, Quality Improvement Organization (QIO)⁴¹, 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 Medicaid⁴² 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 the provider community.** Purchasers can reach out directly to leaders within 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 them in dialogue about working together to implement the Patient-Centered Medical Home model.

STRATEGY 5 Engage consumers

1. **Educate employees.** Purchasers can educate employees⁴³ 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 recognized Patient-Centered Medical Home practices.** Potential incentives include:

- a. elimination of preventive care or all office visit co-payments;
- b. elimination of chronic care medication (including smoking cessation) co-payments;
- 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 recognized Patient-Centered Medical Home *or* requiring that they do so with a primary care practice. Potential incentives include those listed above in #2, as well as reduced employee payroll deductions.

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 illness self-care plan;
- c. participation in practice-initiated care coordination encounters;
- d. 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.**

Such tools may include:

⁴¹ Purchasers can contact their state QIO by accessing this page: http://www.abqa.org/pub/connections/162_694_2450.CFM.

⁴² 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.

⁴³ The National Partnership for Women and Families is currently developing consumer educational materials regarding the PCMH.

- a. a pre-populated personal health record (PHR) with self-management prompts;
- b. coverage of community-based self-management support programs, and
- c. questions to ask of primary care physicians during office visits (e.g., “Ask Me 3”⁴⁴).

support of the employee and the Patient-Centered Medical Home, again, with the concurrence of the employee.

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

⁴⁴See www.npsf.org/askme3/. Accessed May 19, 2008.

Section 4

Case Studies of
PCMH Initiatives

While the Patient-Centered Medical Home concept is relatively new, there are examples of its application, and of the application of the closely related concept defined as The Chronic Care Model, from which purchasers can

draw knowledge and guidance. Purchasers will note that these case studies vary significantly in their design and implementation.

Community Care of North Carolina⁴⁵

Start Date: 1998

Purchaser Involvement: Medicaid

Results: An actuarial study from Mercer Human Resource Consulting Group found, when comparing what the program would have cost in SFY04 without any concerted efforts to control costs in SFY04, the program saved approximately \$124 million.⁴⁶

This program was initiated as a way to manage Medicaid patients in rural areas using a medical home model. It was particularly designed for small practices. The goal was to link them with a local hospital and other safety net providers. Today, the program is statewide, and involves more than 3,000 physicians in 13 networks. Using care managers and medical management staff, local area networks identify high-cost patients and services and develop plans to manage utilization and cost. Safety net providers comprise the non-profit networks.

This is a pay-to-participate program. Providers receive \$2.50 PMPM payment for working with one another to

create a medical home and giving the state their data. In addition, local networks receive \$3.00 PMPM to support local case and disease management activities and staff. NC has concentrated on local system development as a “team sport”—incentives are community-based first before the provider level. There are four quality improvement program areas that each network is required to address: disease management; high-risk and high-cost patients; pharmacy management; and ED utilization. The state uses the special payments to help networks put resources into the community (e.g., initially case managers, now they’ve added a clinical pharmacist⁴⁷). The initial focus was asthma, diabetes, and CHF. Accountability is achieved through chart audits, practice profiles, care management reports on high-risk and high-cost patients, scorecards, and monitoring of progress toward benchmarks. The state is now launching a Healthcare Quality Alliance using Area Health Education Centers to help standardize care across the state for five of the most common and costly chronic conditions by getting payers to agree on one set of quality measures; providing support to physician practices to implement the evidence-based guidelines; and collecting and reporting data on provider performance relative to these measures.⁴⁸

⁴⁵Based on personal communication with Allen Dobson of NC DMS, October 15, 2007. For more information, see www.communitycarenc.com/PDFDocs/CCNC%20AT%20A%20GLANCE.pdf.

⁴⁶See www.communitycarenc.com/PDFDocs/Mercer%20SFY03.pdf. More recent evaluations also indicate net savings (see www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf).

⁴⁷Each network has access to a Pharm D who helps patients with adherence and informs physicians to what their patients are actually taking, and what they should be taking. Based on personal communication with Terry McInnes of GlaxoSmithKline, June 16, 2008.

⁴⁸States in Action: Innovations in Health Policy, June/July 2008, The Commonwealth Fund, Volume 15, June 23, 2008.

Horizon Blue Cross Blue Shield of New Jersey/Partners in Care^[1]

Start Date: 2007

Purchaser Involvement: State of New Jersey Health Benefits Program

Results: Partners in Care reported that patients with diabetes in the one-year pilot program substantially increased compliance with several key evidence-based care measures both specific and non-specific to diabetes. Preliminary results for patients of participating practices also indicated medical cost reductions.^[2]

This initiative was initially a one-year pilot involving Horizon, Partners in Care, a physician-owned management services organization, and the New Jersey State Health Benefits Program. The pilot focused on state employees and dependents with diabetes, and was directionally consistent with other national medical home initiatives.

The initiative elected to motivate and reward practice transformation through reimbursement of traditionally non-reimbursed care coordination based activities, e.g., reviewing a chart when an appointment is not scheduled, making a telephone call to a colleague about a referred patient, office staff follow-up activity to “chase” a patient who has been non-compliant with required tests, etc. In addition, the pilot recognizes the value of activities at the

IPA/MSO level to support resource-constrained, small practices.

Partners in Care feels strongly that tying payment to specific patients and documented interventions is more effective than a monthly case management fee (an alternative not adopted in the pilot) which may lead to money changing hands without specific results having to be achieved—it loses the connection between action and the reimbursement.

Practices are not required to qualify for the supplemental payments. The practices are given great latitude to innovate as they see necessary in order to better serve their patients and produce improved clinical outcomes. Practices receive consultative support from Partners in Care nurses, physicians and administrative staff. The program is viewed as a complement to Horizon’s disease management program, rather than as a substitute for it, through improved collaboration and partnering with physician directed teams.

The pilot was expanded from 1,374 patients to 8,000 patients as of June 2008, and involves over 400 practices, including practices outside of Partners in Care. A third-party evaluation is planned for the future. Partners in Care has expanded its program to include 30,000 covered lives across Horizon, Aetna and additional employer groups.

^[1] Based on personal communication with Kevin O’Brien of Partners in Care, May 30 and June 3, 2008 and “Partners In Care/Horizon State Health Benefits Program Pilot: Patient Centered Medical Home and Care Coordination Entity—Summary and First Year Accomplishments”, April 2008. See www.horizonblue.com/community/community_press.asp?article_id=836&urlsection.

^[2] As of April 2008, Horizon actuarial staff considered these results as immature due to Professional Actuarial Standards.

Pennsylvania Chronic Care Initiative

Start Date: 2008

Purchaser Involvement: Medicaid, state employees group and organized labor

Results: not yet evaluated

Pennsylvania has initiated a phased, statewide rollout of an initiative that integrates the concept of the Patient-Centered Medical Home and the closely related Chronic Care Model.⁴⁹

The effort was initiated by the state's Chronic Care Commission⁵⁰ and is facilitated by the Governor's Office of Health Care Reform. The Southeast Regional Rollout involves 32 Philadelphia-area primary care practice sites and six insurers—Aetna, AmeriChoice (a Medicaid plan), CIGNA Healthcare, Health Partners (a Medicaid plan), Independence Blue Cross, and Keystone Mercy Health Plan (a Medicaid plan).

Participating practices will be expected to participate in a four-session, seven-day learning collaborative, work with assigned practice coaches, utilize a patient registry or EMR to report performance data and achieve at least Level 1 NCQA PPC-PCMH recognition within 12 months. Most importantly, they are expected to redesign their practices to better support their patients,

with a special focus initially on those with diabetes, or for pediatricians, asthma.

Insurers will cover a significant portion of the practice costs associated with time spent at the learning collaborative, costs to acquire, set up and populate the patient registry or modify EMR reports, and fees associated with NCQA's recognition program. They will also fund the practice coaches and will provide supplemental payments to practices based on the level of NCQA recognition that they achieve. The state has established the payment schedules and each insurer and practice has signed a participation agreement with the state. Insurers are expected to expend approximately \$13M over three years on the initiative.

The state is covering the costs of the learning collaborative, is funding and managing an evaluation by a third party, and is also providing project management support.

Additional regional rollouts are scheduled for later in 2008 and in 2009, beginning with the South Central (Lehigh Valley/Capital Area) Region. Each regional rollout requires participating insurers and providers to make a three-year commitment. Other planned activities include the introduction of additional consumer engagement strategies and development of multi-payer primary care profile reports.

THINC RHIO Pay-for-Performance/Medical Home Project⁵¹

Start Date: 2009

Purchaser Involvement: IBM and Hannaford Brothers

Results: not yet implemented

The Taconic Health Information Network and Communities (THINC) Regional Health Information Organization (RHIO) will be overseeing what it terms

a pay-for-performance/medical home project in the Hudson Valley region of New York State. IBM has played a major role in the initiative's formation and launch.

THINC RHIO is currently recruiting up to 250 physician practices. Those that achieve NCQA PPC-PCMH recognition will be eligible for enhanced payments based on a) structural measures: NCQA PPC-PCMH Level 2 recognition, implementation of a CCHIT-certified EHR, and interfaces with the regional health information

⁴⁹Goldstein J. "Insurers pay caregivers to track patients" *Philadelphia Inquirer*, May 13, 2008.

⁵⁰The Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Strategic Plan, February 2008. Accessed May 14, 2008 at www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf.

⁵¹Based on information received from John Blair of the Taconic IPA (personal communication, March 31, 2008) and Paul Grundy of IBM (personal communication, December 18, 2007).

exchange (HIE) and b) performance on 10 HEDIS clinical process and outcome measures.

Six insurers are providing funding—Aetna, Capital District Physicians Health Plan, Empire Blue Cross Blue Shield, Hudson Health Plan (a Medicaid plan), MVP Health Care, and Empire Plan (UnitedHealthcare). A state Department of Health grant is providing matching funding to the insurer payments. Maximum potential

insurer/state funding for the project, should all practices excel, is \$3M. Finally, area employers IBM and Hannaford Brothers will each pay an additional \$1PMPM to qualifying practices for their employees and dependents. Initial payments will occur in 2009.

The project is designed as a five-year pilot with a control group, and is to be evaluated by Cornell University researchers.

Colorado Multi-Payer Demonstration⁵²

Start Date: 2007

Purchaser Involvement: Colorado Business Group on Health and its member employers

Results: not yet implemented

While still at a design stage, Colorado is the site of an emerging multi-payer PCMH demonstration with employer coalition participation. Participating organizations include the Colorado Business Group on Health, employers (IBM and others), insurers (UnitedHealthcare, Anthem-WellPoint, Aetna, CIGNA Healthcare, Humana, and Rocky Mountain Health Plan), and provider organizations such as the American College of Physicians, Colorado Medical Society, and the American Academy of Family Physicians are working with a convening organization, the Colorado Clinical Guidelines Collaborative. Colorado's Medicaid program is also participating in the discussions.

The participants have elected to employ the Joint Principles for the Patient Centered Medical Home as their framework for a two-year pilot in the Denver-Colorado Springs-Fort Collins regions. Colorado is planning to recruit 10-15 physician practices to participate during the summer of 2008, provide the practices with technical assistance for practice transformation and

help them become NCQA PPC-PCMH recognized by January 1, 2009.

The reimbursement model will be consistent with the Joint Principles, with an enhanced case management fee and a pay-for-performance payment. Colorado is considering qualifying practices for supplemental payment based on NCQA PPC-PCMH Level 1 recognition, and then making supplemental payments to each recognized practice, the amount to be determined by each participating insurer.

Because the Colorado Business Group on Health already utilizes Bridges to Excellence for quality incentives, this collaborative effort is considering adopting the Bridges to Excellence (BTE) Medical Home Program⁵³ for the pay-for-performance component. The BTE Medical Home Program allows physicians to receive an annual bonus payment of \$125 for each patient covered by a participating employer, with a suggested maximum yearly incentive of \$100,000.

Employer participants have worried that the NCQA PPC-PCMH recognition standards are more about systems than outcomes, and have therefore advocated for the incorporation of outcomes into the enhanced payment methodology, and into the protocol for an independent evaluation.

⁵²Based on information received from Julie Schilz of the Colorado Clinical Guidelines Collaborative (personal communications, March 18, April 30, and May 15, 2008) and document titled "Colorado Multi-Stakeholder/Multi-State PCMH Pilot: CCGC Convener Organization and CCGC Technical Assistance Overview Document: Role Definition and Budget Consideration, April 2, 2008, DRAFT.

⁵³See www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=124 for information about this program. Accessed May 15, 2008.

Appendix A

NCQA PPC-PCMH Standards



Standard 1: Access and Communication	Points	Standard 5: Electronic Prescribing	Points
<ul style="list-style-type: none"> Has written standards for patient access and patient communication** 	4	<ul style="list-style-type: none"> Uses electronic system to write prescriptions 	3
<ul style="list-style-type: none"> Uses data to show it meets its standards for patient access and communication** 	$\frac{5}{9}$	<ul style="list-style-type: none"> Has electronic prescription writer with safety checks 	3
Standard 2: Patient Tracking and Registry Functions	Points	<ul style="list-style-type: none"> Has electronic prescription writer with cost checks 	$\frac{2}{8}$
<ul style="list-style-type: none"> Uses data system for basic patient information (mostly non-clinical data) 	2	Standard 6: Test Tracking	Points
<ul style="list-style-type: none"> Has clinical data system with clinical data in searchable data fields 	3	<ul style="list-style-type: none"> Tracks tests and identifies abnormal results systematically** 	7
<ul style="list-style-type: none"> Uses the clinical data system 	3	<ul style="list-style-type: none"> Uses electronic systems to order and retrieve tests and flag duplicate tests 	$\frac{6}{13}$
<ul style="list-style-type: none"> Uses paper or electronic-based charting tools to organize clinical information** 	6	Standard 7: Referral Tracking	Points
<ul style="list-style-type: none"> Uses data to identify important diagnoses and conditions in practice** 	4	<ul style="list-style-type: none"> Tracks referrals using paper-based or electronic system** 	$\frac{4}{4}$
<ul style="list-style-type: none"> Generates lists of patients and reminds patients and clinicians of services needed (population management) 	$\frac{3}{21}$	Standard 8: Performance Reporting and Improvement	Points
Standard 3: Care Management	Points	<ul style="list-style-type: none"> Measures clinical and/or service performance by physician or across the practice** 	3
<ul style="list-style-type: none"> Adopts and implements evidence-based guidelines for three conditions ** 	3	<ul style="list-style-type: none"> Survey of patients' care experience 	3
<ul style="list-style-type: none"> Generates reminders about preventive services for clinicians 	4	<ul style="list-style-type: none"> Reports performance across the practice or by physician ** 	3
<ul style="list-style-type: none"> Uses non-physician staff to manage patient care 	3	<ul style="list-style-type: none"> Sets goals and takes action to improve performance 	3
<ul style="list-style-type: none"> Conducts care management, including care plans, assessing progress, addressing barriers 	5	<ul style="list-style-type: none"> Produces reports using standardized measures 	2
<ul style="list-style-type: none"> Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities 	$\frac{5}{20}$	<ul style="list-style-type: none"> Transmits reports with standardized measures electronically to external entities 	$\frac{1}{15}$
Standard 4: Patient Self-Management Support	Points	Standard 9: Advanced Electronic Communications	Points
<ul style="list-style-type: none"> Assesses language preference and other communication barriers 	2	<ul style="list-style-type: none"> Availability of Interactive Website 	1
<ul style="list-style-type: none"> Actively supports patient self-management** 	$\frac{4}{6}$	<ul style="list-style-type: none"> Electronic Patient Identification 	2
		<ul style="list-style-type: none"> Electronic Care Management Support 	$\frac{1}{4}$

**Must Pass Elements

Appendix B

Sample Insurer Contract Language



Purchasers may wish to utilize one or more of these requirements in insurer contract language.

The insurer shall:

1. Participate in single or multi-insurer PCMH pilots in one market (single state insurer) or three markets (national insurer) with specific objectives of improving clinical outcomes, patient experience, and net savings across the continuum of services.
2. The insurer's PCMH pilot(s) shall provide explicit parameters for practice redesign and operation as a PCMH.
3. The insurer's PCMH pilot(s) shall provide participating primary care practices with technical support, such as through practice coaches or a learning collaborative, to assist the practices in their transformation to medical homes.
4. The insurer's PCMH pilot(s) shall provide those practices with verified evidence of PCMH practice transformation with supplemental payments that are intended to support specific practice costs necessary to implement and sustain the PCMH model.
5. The insurer shall verify that practices have achieved the necessary parameters prior to the provision of any enhanced payments.
6. The insurer shall provide patients served by PCMH pilot practices with incentives for chronic illness self-management and evidence-based guideline adherence.
7. The insurer's PCMH pilot(s) shall be subject to a statistical evaluation to assess the impact of the pilot on clinical outcomes, patient experience and cost.

Appendix C

Template Request for Information (RFI)



The following questions may be used in whole or in part by a purchaser within an RFI (or RFP). For some of the questions, additional, more detailed questions can be found within the National Business Coalition on Health's eValue8 RFI tool. References to the relevant eValue8 question are indicated in parentheses.

- 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 designation⁵⁴
 - iii. Insurer-based program (please describe)
- c. Which of the following capabilities are uniformly present AND USED in the practices designated as Medical Homes?
 - i. At the time of an office visit, member-specific gaps in care are identified for members needing preventive and chronic care services enabling them to be addressed at the visit.
 - ii. For members who do not schedule a visit, but have gaps in care, there is an outbound mechanism to remind them (e.g., IVR, mail, care manager calls, e-mail, etc.)
- iii. ePrescribing (eValue8 4.5.2)
 1. Office computer and/or PDA is present with ePrescribing software
 2. Member plan design-specific formulary resides on the computer/PDA
 3. Software includes decision support that
 - a. Identifies generically equivalent drugs
 - b. Directly or through integration with global software supports evaluation of clinical alternatives
 - c. Accesses the member's pharmacy history and automatically checks for duplication, conflicts, etc.
 - d. Is integrated with the EHR and automatically cross-references medical history, lab results, etc.
 - e. Calculates member out-of-pocket costs for alternative choices of prescriptions
 - f. Transmits paperless prescription directly to pharmacies or electronic "hub"
 - g. Receives and integrates into the EHR pharmacy or PBM confirmation of Rx fills completed by the patient
 - iv. How is care management handled by the designated practices? (indicate all that apply)
 1. Nurse or other clinical personnel are dedicated to care management
 2. Non-clinical resources are the primary personnel dedicated to care management
 3. Personnel resources are employed by each practice individually
 4. Personnel resources are shared among practices

⁵⁴Physicians 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.

5. The plan provides personnel resources that can be shared by the practices.
6. Use of personnel (shared or not) dedicated to care management is a requirement of PCMH designation.
- v. Does the plan designate a range of chronic clinical conditions which the PCMH practice must be able to adequately case manage? If so, which ones (eValue8 6.2.4)?
- vi. Does the plan require the PCMH practice to be capable of providing specific interventions for members with chronic conditions? If so, which ones (eValue8 6.5.4)?
- d. 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): _____
- e. What methods are used to modify reimbursement and enhance payment?
- i. Payment in recognition of provider costs related to:
 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
 4. Other (specify): _____
 - 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. (eValue8 3.6.3–3.6.6)
- f. What types of measures are used to determine the performance-based payments? (eValue8 3.5.3, 3.6.3–3.6.6)
- 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)
 - vii. Measurement of patient satisfaction
 - viii. Other (specify): _____
- g. What is the expected value of the provider payments referenced in response to “f”? (eValue8 3.6.5)
- 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
- h. 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 (specify): _____
- i. Are there any consumer incentives contained within the PCMH program? (eValue8 1.6.2, 1.6.3)
- i. Agreement with employer on waived or decreased premium share for use of the medical home
 - ii. Waived or decreased co-payments/deductibles for use of the medical home (specify)
 1. Office visits

- 2. Pharmaceuticals for chronic conditions
- 3. Tests recommended for chronic conditions, etc.
- iii. Waived or decreased co-payments/deductibles for reaching biometric goals (e.g., BMI level or change, HbA1c improvement or levels, etc.)
- iv. Waived or decreased co-payments/deductibles for enrollment or affiliation with a medical home in non-HMO products
- v. Waived or decreased co-payments/deductibles for use of selected chronic care medications
- vi. Incentives to adhere to evidence-based self-management guidelines
- vii. Incentives to adhere to recommended care coordination encounters
- j. What support mechanisms (tools) are available in the PCMH program to support decisions and self-management, and who provides them?
- k. How is the PCMH program promoted to members?
 - i. General education materials to members
 - ii. Enrollment meetings coordinated with purchasers
 - iii. Performance reports comparing PCMH practices with non-PCMH practices
 - iv. Designation in the physician directory of PCMH status
 - v. Linked messages with web-based tools to support decision-making

Consumer Support	% PCMH Member Participants Affected	Who Provides
Evidence-based shared decision tools (e.g., Health Dialog, Healthwise Decision Points)		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Specialist performance reports		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Hospital performance reports		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Electronic personal health record		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Reminders about gaps in preventive care		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Reminders about gaps in Rx fills		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Reminders about non-Rx gaps in management of chronic conditions		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
Web-based consultations		1. Plan 2. PCMH Practice 3. Plan-Practice Shared
E-mail with physician office		1. Plan 2. PCMH Practice 3. Plan-Practice Shared

- vi.** Messages in EOB if member not using PCMH practice
- vii.** Steerage at times of interaction with telephonic or in-person interaction with wellness or disease management programs.
- viii.** Steerage at times of telephonic interaction with nurseline or telephonic treatment support
- ix.** Financial incentives unavailable through other plan options
- l.** Who is evaluating the pilot?
 - i.** The insurer
 - ii.** An independently funded evaluator
 - iii.** Other (specify): _____
- m.** What is the evaluation method?
 - i.** Pre/post evaluation
 - ii.** Matched control group
 - iii.** Randomized control trial
- n.** 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

Appendix D

Existing and Emerging Patient-Centered Medical Home Initiatives



Purchaser and Multi-Payer-Based Efforts—Implemented or Near Implementation

Name	Overview	Type of Initiative	Region	Project Contact(s)
COLORADO Colorado Clinical Guidelines Collaborative Improving Performance in Practice (IPIP)	2-year pilot to reduce fragmentation and implement systems and processes, using evidence-based clinical guidelines and improve health care in Colorado. Funded, in part, by a \$2.5M grant from RWJ Foundation. More detail provided in Section IV of the Guide.	Multi-payer: United, Wellpoint-Anthem, Humana, Aetna, CIGNA, Rocky Mountain Health Plan	Denver-Colorado Springs-Fort Collins regions	Julie Schilz <i>jschilz@coloradoguidelines.org</i>
NORTH CAROLINA North Carolina Division of Medical Assistance (Medicaid)	Started in 1998 as way to manage Medicaid patients in rural area—medical home model—particularly targeted at small practices that did not have a lot of resources—goal was to link them with a local hospital and other safety net providers—gave payment to providers and to networks for them to put resources into the community (e.g., case managers, recently added a clinical pharmacist)—goal is organizing MDs. Has documented savings. More detail provided in Section IV of the Guide.	Medicaid	statewide	Jeffrey Simms <i>jeffrey.simms@ncmail.net</i> (919) 855-4100 Allan Dobson, MD <i>Adobson@cabarrusfamily.com</i> (704) 721-2073
NEW YORK (Hudson Valley)	5-year pilot to demonstrate improved cost and quality of care in NY State Mid-Hudson Valley medical home practices. Funded by insurers, employers and a \$1.5M grant from NY DOH. More detail provided in Section IV of the Guide.	Multi-payer: Aetna, CDPHP, United HealthCare, MVP, WellPoint, Hudson Health IBM is playing a major supporting role	Mid-Hudson Valley region of New York	John Blair, III, MD <i>jblair@taconicipa.com</i> (845) 897-6359

Name	Overview	Type of Initiative	Region	Project Contact(s)
<p>PENNSYLVANIA</p> <p>Chronic Care Management, Reimbursement and Cost Containment Commission</p>	<p>Statewide implementation of the Chronic Care Model (a PCMH-like model) involving learning collaboratives, practice coaches, an incentive alignment strategies for providers and consumers. Led by the Governor's Office of Health Care Reform. More detail provided in Section IV of the Guide.</p>	<p>State-initiated, multi-payer: Aetna, Ameri-Choice, CIGNA, Health Partners, Independence Blue Cross, Keystone Mercy</p>	<p>statewide initiative, implemented through regional rollouts, beginning with the Philadelphia region in May 2008, and South Central PA in the fall of 2008</p>	<p>Phil Magistro <i>pmagistro@state.pa.us</i> (717) 214-8174</p> <p>Michael Bailit <i>mbailit@bailit-health.com</i> (781) 453-1166</p>
<p>RHODE ISLAND</p> <p>Chronic Care Sustainability Initiative for Rhode Island (CSI-RI)</p>	<p>2-year pilot to demonstrate that PCMH model is sustainable. Working with 5 practices. Insurers providing or funding dedicated nurse for practice support. \$3PMPM funding for practices NCOA PPC-PCMH recognized (Level 1 in 6 months, Level 2 in 18 months). Being facilitated by the state insurance department.</p>	<p>Multi-payer: BCBSRI, United, Neighborhood Health Plan of RI, Medicaid.</p>	<p>statewide initiative</p>	<p>Thomas Bledsoe, MD (401) 444-3483</p> <p>Deidre Gifford <i>dgifford1@riqio.dspd.org</i></p> <p style="text-align: right;"><i>(continued)</i></p>

Name	Overview	Type of Initiative	Region	Project Contact(s)
<p>RHODE ISLAND</p> <p>Medicaid Connect Care Choice Program</p>	<p>The Connect Care Choice program is a primary care case management program for adults with multiple chronic conditions (not also eligible for Medicare) who are enrolled in Rhode Island's fee-for-service Medicaid program. To participate in the program, practices must meet the PCMH Joint Principles.</p> <p>Physician practices that meet the patient-centered medical home criteria and use EMRs are paid a \$10 per-member, per-month fee for treating chronically ill adults in Medicaid fee for service enrolled in the Connect Care Choice Program; practices without an EMR that meet the patient-centered medical home criteria are paid \$5 per member, per month. The program also pays for a nurse case manager to work cooperatively with physicians onsite in the practice to help support enrolled patients. Since Rhode Island Medicaid payment rates were among the lowest in the country, the state concurrently increased reimbursement for certain primary care visits for Connect Care Choice program enrollees. The program began enrolling patients and physician practices in September 2007 and plans to rely on savings from avoidable hospitalizations and emergency department visits to fund the program.</p>	Medicaid	statewide initiative	<p>Ellen Mauro emauro@dhs.ri.gov (401) 462-6311</p>
<p>UNITE HERE</p> <p>HERE is the former Hotel Employees and Restaurant Employees International Union</p>	<p>Ambulatory Intensive Caring Unit model focused on providing better primary care to those with significant chronic care needs—top 20% population—involved directly in the management of all aspects of their health. Providing incentives to participants to try this model—they have eliminated co-pays for RX and intensive primary care services.</p>	Organized labor (sponsoring organization is a Taft Hartley trust fund)	Two sites, one in Atlantic City, NJ and the other in Las Vegas, NV	<p>Elizabeth Gilbertson ebg@herefund.org</p>

Name	Overview	Type of Initiative	Region	Project Contact(s)
VERMONT	<p>State-initiated implementation of the Chronic Care Model begun in 2003 ("the Vermont Blueprint").⁵⁵ Six communities now have funding for local project managers, self-management regional coordinators, community physical activity initiatives, and additional provider education (e.g., Clinical Microsystems Training).</p> <p>A state-mandated pilot in three communities with approximately 10 practice sites is beginning in the summer of 2008 to determine whether a) payers providing practices infrastructure and financial incentives to operate a PCMH through a public/private, and b) multi-payer funding of five-member Community Care Teams to support practices results in performance improvement.</p> <p>Practices receive \$1.35PMPM or \$.90 PMPM (depending on practice size) for NCQA PPC-PCMH Level 1. Thereafter, practices can earn .09/PPPM / unit, where 1 unit = 5 NCQA points. Above 50 pts must meet all 10 "must pass" criteria. Total possible payment: \$1.80 or \$2.70 (depending on practice size).</p>	state-initiated, multi-payer: BCBSVT, CIGNA, MVP and OVHA (state Medicaid program). Funding also through state general revenues through Blueprint appropriation.	Vermont	<p>Craig Jones, MD <i>Craig.Jones@state.vt.us</i> (802) 828-1354</p> <p style="text-align: right;"><i>(continued)</i></p>

⁵⁵See <http://healthvermont.gov/admin/legislature/documents/VTBlueprint2007.pdf> for additional information. Accessed May 21, 2008.

Insurer-Based Efforts—Implemented or Near Implementation

Name	Overview	Type of Initiative	Region	Project Contact(s)
BCBS OF MICHIGAN	<p>Initial 2005 pilot to reward medical groups for infrastructure improvement to measure and improve the care of patients with 4 chronic illnesses. The initial pool was based on 0.5% of physician payment.</p> <p>Current program is for PPO. 1% of physician payment is set aside. Provider payment is based on performance, improvement, degree of physician participation, and collaborative efforts.</p> <p>BCMSMI pays T-Codes for practice-based care management, including:</p> <ul style="list-style-type: none"> • services by RN, dietitian, diabetes educator, MSW, clinical pharmacist, or respiratory therapist, and • patients with care plan in medical record and diagnosis of persistent asthma, COPD, HF, diabetes, CAD, or major depression. <p>In mid-2009 BCBSMI will begin implementation of differential E&M reimbursement (10% higher) for practices that meet criteria for BCBSMI designation as a Basic PCMH. BCBSMI expects approximately 20% of PCPs to qualify for PCMH designation in 2009. May add third tier in future.</p> <p>Will also begin payment for delegated Disease Management for patients with chronic disease in late 2009.</p>	Single insurer	Michigan statewide	<p>Margaret Mason mmason@bcbsm.com (248) 448-5723</p> <p>David Share, MD dshare@bcbsm.com (248) 448-6142</p>

Name	Overview	Type of Initiative	Region	Project Contact(s)
BCBS OF VERMONT	<p>Pilot Pay for Quality Program is aligned with The Chronic Care Model and the VT Blueprint for Health. P4Q pilot program started in 2005 with diabetes and was roughly built off of the structure of the NCCA Diabetes Physician Recognition Program</p> <p>MD participation in the P4Q program requires the proactive adoption of practice infrastructure changes, derived from the Health System component of The Chronic Care Model.</p> <p>Increased reimbursement is available for office-based E & M, consultations, preventive medicine and counseling codes. The enhanced reimbursement applies to all of the practices patients, not just those with select chronic conditions.</p> <p>Practices may utilize some BCBSVT tools and services to satisfy program entry requirements, or use enhanced funding to support development of their own infrastructure and systems.</p>	Single insurer	Phasing in across Vermont	Sharon Winn winns@bcbsvt.com (802) 371-3230
CAPITAL DISTRICT HEALTH PLAN (ALBANY, NY)	<p>Two-year pilot program called The Medical Home Project to start in 2009. Doctors from three medical practices will run their practices in the medical home manner, e.g., working in a team with others such as a nutritionist, a health educator, and/or a nurse practitioner, depending on a patient's needs.</p> <p>All of the practices' patients—not just those covered by CDPHP—will take part in the changes. The physicians and CDPHP are still working out the details of the program, including how the reimbursement would work, but CDPHP has pledged \$1 million to the effort.</p>	Single insurer	Albany, NY region	Bruce Nash, MD (518) 641-3000

(continued)

Name	Overview	Type of Initiative	Region	Project Contact(s)
CIGNA	<p>Three-year pilot—start date 6-1-08—involving all CIGNA patients receiving primary care at the Dartmouth-Hitchcock Clinic in Lebanon, NH. The purpose of the pilot is to further enhance coordination of care and to test the concepts of PCMH. Goal is improving quality and affordability of care with no benefit changes for members at this time. Includes enhanced payment to physicians and a bonus model for quality performance.</p>	Single insurer	New Hampshire	<p>Harriet Wallsh <i>Harriet.Wallash@cigna.com</i> (407) 691-0103</p>
EMBLEM HEALTH	<p>2-year demonstration of the PCMH model by Emblem Health (including Group Health Inc, and Health Plan of New York) began during the first quarter of 2008 (practice recruitment) and will be concluded by 2010. The pilot will include a total of 50 adult primary care practices—the majority of which will be solo/small practices—randomized into experimental and control groups.</p> <p>The project will use the NCQA PPC PCMH survey and supplementary questions for assessing medical homeness of participating practices.</p> <p>The proposed payment model consists of:</p> <p>A. Care management payment—equal to a maximum of 7% of the average physician’s revenue from the covered patients adjusted for the severity of risk of the physician’s panel and the practice’s level of Medical Home recognition.</p> <p>B. Fee-for-service</p> <p>C. Performance-based payment—equal to a maximum of 7% of the average physician’s revenue from covered patients based upon results on performance measures related to clinical quality, efficiency and patient experience.</p>	Single insurer	New York City and the immediate surrounding counties	<p>William Rollow, MD <i>wrowl@aol.com</i></p> <p>Judith Fifeld <i>fifeld@ns01.uchc.edu</i> (860) 331-0761</p>

Name	Overview	Type of Initiative	Region	Project Contact(s)
GEISINGER HEALTH PLAN	<p>Four-part strategy to transform care delivery:</p> <p>A. Move primary care to FFS to create incentives for more primary care delivery</p> <p>B. Additional \$1500 stipend per physician per month to support providing or arranging for care for patients 24 hours at all sites of care, e.g., seeing patients at 4pm on Friday, etc.</p> <p>C. Additional \$10,000 per practice per month for developing necessary office systems and staff resources</p> <p>D. Piggybacking on CMS Physician Group Practice Demonstration—additional payment if expenditures are below expected and meet quality thresholds</p> <p>E. P4P payments for performance on HEDIS, Rx and efficiency measures</p> <p>Grounding beliefs: a) more than P4P is needed to transform care delivery and to make primary care providers agents for health care value and b) insurers have to make a bet and make some money available up front</p>	Single insurer	North Central PA	<p>Rick Gilfillan <i>rgilfillan@thehealthplan.com</i></p>
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY	<p>In partnership with Partners in Care, a management services organization owned by United Medical Group, practices are paid for additional time spent performing tasks necessary to the operation of a medical home. Preliminary one-year pilot results indicate significant quality improvement and also cost reduction. Aetna recently joined the initiative. More detail provided in Section IV.</p>	Single insurer initially. Now a multi-payer initiative.	New Jersey	<p>Kevin O'Brien <i>kobrien@piccorp.com</i> (732) 246-0291</p> <p>Richard Popiel <i>richardpopiel@horizonblue.com</i> (973) 466-7300</p> <p style="text-align: right;"><i>(continued)</i></p>

Name	Overview	Type of Initiative	Region	Project Contact(s)
HUMANA	<p>1-year pilot began May 1st 2008. Includes two physician practices and an integrated delivery system. Application of PCMH principles within an integrated delivery system to improve quality of care for patient population.</p> <p>FFS model with care coordination fee. No benefit design changes at this point. Using NCQA tool for objective criteria. Focused on collecting the data and working with others to determine the formula for what works.</p>	Single insurer	<p>Atlanta, GA</p> <p>(Also participating in planning for both the Memphis and Colorado Collaboratives)</p>	<p>Michael Sherman <i>msherman@humana.com</i></p> <p>Chris Corbin <i>ccorbin@humana.com</i> (502) 580-3820</p>

Patient-Centered Medical Home Pilots—In Development

Name	Overview	Type of Initiative	Region	Project Contact(s)
ANTHEM-WELLPOINT	Looking at finding a sister state for the CO collaborative—evaluation piece potentially being funded by the Commonwealth Fund	Multi-payer	Potential sister projects for CO: Maine, New Hampshire, Ohio Starting to talk (>12 months from implementation): Missouri	Eric Walker Eric.Walker@anthem.com (804) 378-7045
HUMANA	Discussions of PCMH pilot have begun with MD practices in these states.	In development; initially beginning as single insurer initiatives	FL, AZ, KY/Southwest OH	Chris Corbin ccorbin@humana.com (502) 580-3820
MAINE	A 6-8 month planning process began in June 2008 to design a three-year PCMH pilot involving 5-10 primary care practices. The initiative is co-sponsored by the Maine Health Management Coalition, the Maine Quality Forum and Quality Counts. All of the state's major insurers (Aetna, Anthem, CIGNA and Harvard Pilgrim) and Medicaid are participating in discussions, as are the large medical groups and largest employers.	Multi-payer	Selected practices in Maine	Doug Libby dlibby@mehmc.org (207) 883-8141
MINNESOTA	2008 health reform legislation, signed into law on May 29, 2008, promotes the use of "health care homes" to coordinate care for people with complex or chronic conditions, by establishing standards for state certification of health care homes. Health care homes will receive care coordination payments from public and private health care purchasers.	Legislative	Minnesota	Scott Leitz Scott.Leitz@state.mn.us (651) 201-5000 See Article 2 of SF 3780 as enacted for legislative language at www.senate.leg.state.mn.us
WASHINGTON	Coalition to promote and provide practical support for medical homes—family centered, comprehensive coordinated primary health care—for children and youth with special health care needs. Goal to provide a medical home for every Washington child with special health care needs by 2010.	Public sector	Washington	MaryAnne Lindeblad lindem@dshs.wa.gov (360) 725-1630



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