



Payment Matters: The ROI for Patient-Centered Medical Home Payment

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What is a Patient-Centered Medical Home (PCMH)?

A patient-centered medical home is a primary care practice that gives patients the individualized care and support they need to stay healthy. In a medical home, the patient, the primary care physician, and a medical team work together to develop and implement a plan of care for the patient that details the patient's optimal medication use, diet, exercise, behavioral health treatments, etc. to get and keep the patient healthy. Insurance companies and other payers pay the primary care practices a certain amount of money per patient per month to provide this enhanced outreach, communication and coordination. In exchange, the practices are required to meet certain performance measures.

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— Col. Donald Hickman,

75th Medical Group at Hill Air Force Base

Patient-Centered Medical Homes: Good Return on Investment for Employers

As the largest purchaser of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are switching from the inefficient fee-for-service model of paying for care, which encourages high volume and low quality, to payment models that reward high value.

For example, there is emerging evidence that patient-centered medical home (PCMH) payment programs are yielding a good return on investment for employers. In this brief, we highlight the early successes of the Tri-Service PCMH project and describe the plans of Cleveland area employers who are working together to develop and implement a PCMH project. In addition, many other organizations have been impressed with the results of patient-centered medical home programs and have begun to pursue the model, including the Centers for Medicare and Medicaid Services (CMS).¹

Case Study #1: Success and Savings at Hill Air Force Base – Improving Quality While Reducing Costs

Beginning in 2009, the U.S. Air Force, Army, and Navy began working together to implement a Tri-Service Patient-Centered Medical Home project to transform care at all primary care practices throughout the Department of Defense (DOD). Among the DOD project sites that demonstrated positive results is Hill Air Force Base in Utah. Since the implementation of PCMH at Hill, the Air Force has saved money and improved the quality of care. By offering team-based care with individualized care plans for patients, encouraging continuity of care, and providing care management and rapid access to care, the project has improved blood sugar control for 77 percent of the diabetic population and stayed at or above 98 percent symptom control for patients with asthma. The Air Force estimates that the project has saved \$300,000 per year just by improving their diabetes care.² According to Col. Donald Hickman, “Health care costs go up 8 to 15 percent per year nationwide and we have managed to drive down our network care costs about 4.5 percent over the last two fiscal years.”³ Additionally, patients were extremely satisfied with the program, reporting 95 percent satisfaction.



Case Study #2: Cleveland Area Employers Collaborate

Tim Kowalski, M.D., is the Chief Medical Officer of Progressive Insurance and is passionate about the need to change incentives for health care providers. Convinced by data for the Progressive Insurance employee population that those employees who receive care through medical homes have lower overall costs than those without them, Progressive, Lubrizol Corporation, and the Lake County School District, working through the Health Action Council of Ohio and Better Health Greater Cleveland, are pursuing a medical home arrangement with Lake Health System, a health system in Northeast Ohio. Lake Health System has agreed to achieve NCQA PCMH recognition for all of its primary care sites. The three employers have agreed that they, in turn, will fund nurse care coordinators to support care of their employees and dependents within the Lake Health system beginning in 2013. In addition, the parties have agreed that in the future they will implement a shared savings arrangement whereby Lake Health will be able to share some of the savings that its PCMH practices, augmented with employer-funded nurse care coordinators, are expected to generate.⁴

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Endnotes

1. Centers for Medicare and Medicaid Services. Multi-payer Advanced Primary Care Demonstration www.cms.gov/Medicare/Demonstration-Projects/Demo-ProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf; and Comprehensive Primary care Initiative www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html (accessed January 12, 2013).
2. Statement of Lieutenant General (Dr.) Charles B. Green, The Surgeon General of the Air Force, FY 2012 Medical Programs, Testimony Before the House Appropriations Committee, Subcommittee on Defense, May 11, 2011. www.afms.af.mil/shared/media/document/AFD-110804-017.pdf. DOD savings calculations were self-reported and have not been verified by the Robert Wood Johnson Foundation. Results may not necessarily be replicated by other employers.
3. Dearstone, M. "75th MDG Patient Centered Medical Home excellence." Hill Air Force Base website. December 7, 2011. www.hill.af.mil/news/story.asp?id=123282544. Accessed December 14, 2012.
4. Telephone interview with Tim Kowalski, M.D., Progressive Insurance, November 8, 2012.

How You Can Implement a Patient-Centered Medical Home Program (PCMH)

1. Speak with your plan administrator about his or her experience with such programs. Most health insurers are now piloting or operating medical home programs.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group and/or health system that serves your population and ask about their experience with Patient-Centered Medical Homes, and their willingness to apply their program or develop a new one to serve your employees.
3. Learn more about PCMH programs from the Patient Centered Primary Care Collaborative's website. <http://www.pcpcc.net/guide/purchaser-guide>
4. Read about PCMH success stories, including the work of this Aligning Forces for Quality (AF4Q) community in Maine. <http://qid.mainequalitycounts.org/project/maine-patient-centered-medical-home-pilot>
5. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. <http://forces4quality.org/a/6/payment-reform#featured-resource>