In Pursuit of the Triple Aim
The need for health systems to double-down on primary care has been recognized as the key success factor in efforts to reach the Holy Grail of Reform -- the “Triple Aim” of improving patients’ experience of care, advancing population health, and reducing per capita costs. As part of this pursuit, the development and implementation of practice models and payment reforms to create Patient-Centered Medical Homes has passed the “tipping point” and become one of the most broadly accepted elements of primary care reform. To wit:

- Since 2008, the NCQA, which sets the standards for primary care transformation, has accredited over 5,700 primary care practice sites with more than 28,000 primary care physicians as Patient-Centered Medical Homes (PCMHs)
- An average of 150 new physician practices are applying for NCQA recognition every month
- The Department of Defense is currently working to transition all of its primary care practices in the VA System to become PCMHs
- About 50% of the states are implementing PCMHs for their Medicaid populations; more than 20 states have multiple medical home initiatives
- Commercial insurance companies are supporting PCMH initiatives in at least 46 states

As a result of the wide-spread acceptance of PCMHs, the national discussion has become focused not only on the transition of individual practices

---

1 Perhaps the most impressive endorsement of PCMHs is that the major health plans and industry partners have embraced the concept and in some cases are insisting on its adoption as part of their ACO partnerships. WellPoint, Aetna, Humana, and UnitedHealthcare have all adopted the models along with numerous Blue Cross plans and organizations such as Kaiser and Group Health of Puget Sound.
to PCMHs, but the development of clinically integrated, community-based services to surround medical homes and move towards population health management. This larger transition has been compared in the physician literature to establishing a “medical neighborhood” to support the PCMHs, particularly in coordinating the specialty, diagnostic, and post-acute services that make up a significant portion of the total cost of patient care. In hospital parlance, the concept of Clinically Integrated Networks (CINs), which participate in Accountable Care Organizations, have similar medical management and care coordination goals, even though the scale is much larger and the organizational structures are different.

CMS’ Comprehensive Primary Care Initiative, which was rolled out in 2012, has now defined the future for PCMHs with a payment model which compensates primary care practices with a blended payment of a risk-adjusted care management fee averaging $20 pmpm, continued fee-for-
service, and a shared savings component. It is a close fit with the payment models proposed for many CINs participating in ACOs. Many observers believe the objective of CMS is to reduce volume fee-for-service payments and back-end shared savings payments over time in favor of a single global capitation rate for patients attributed to the PCMH with incentives for quality. This is similar to what many observers believe is the long-term goal for value-based ACO reimbursement. In the meantime, the pmpm care management payments for PCMHs can provide a pathway for population health management. Organizations which do not yet have experience with value-based payments can learn how to adapt to capitated monthly payments without having to accept global risk contracts for the total cost of care, as long as they have invested in the necessary electronic records systems. In fact, multi-specialty physician groups already comprise a significant portion of the total Medicare ACOs approved by CMS. These groups function as medical neighborhoods funded through risk-sharing contracts.

Key PCMH Deliverables
The deliverables for effective PCMHs fit closely with the requirements of CINs. They are clearly defined and summarized in the CMS Comprehensive Primary Care Initiative. They are:

1. Long-term partnerships with clinicians
2. Expanded access and continuity
3. Planned care for chronic conditions
4. Risk-stratified care management
5. Patient and caregiver engagement
6. Clinician led teams to coordinate care and community supports

The importance of these factors in controlling costs in an ACO or population health environment can be seen in the first year results of the Pioneer ACO Shared Savings programs announced recently by CMS. Out of 32 Pioneer programs funded in 2011, 18 generated savings and 14 generated losses. Of the 18 programs which generated savings, 13 were able to share in those savings by clearing qualifying performance hurdles. Two of the most successful Pioneer programs earning several million in shared savings, Partners Healthcare in Massachusetts and Banner Health Networks in Arizona, credited their results from more coordinated care by providers, advanced population health technology, and according to Banner Health Networks, "by surrounding our most vulnerable and chronically ill
beneficiaries with supportive care management.”

Both Partners Healthcare and Banner Health Networks were early adapters of the PCMH concepts and it is possible to speculate that their success in the Pioneer program is at least partly due to their early, successful implementation of the primary care medical home care delivery model.

**Building the Medical Neighborhood**

Making the transition from the PCMH to a medical neighborhood requires the delineation of prospective roles of PCMHs and the various other providers — primarily specialists — who make up the other parts of the continuum of care. This will include development of systems and infrastructure for:

- Sharing clinical information between the PCMH and other practice sites needed for effective decision making and reduction of duplicative services
- Having care teams wholly responsible for a patient’s physical and mental health needs, including wellness, acute care, community services and other supports that are anchored by the PCMH and includes necessary specialists
- Having a dedicated care coordinator to assure continuity of acute and post-acute care when patients transition between settings
- Accessibility to allow patients to access services with reasonable waiting times, “after hours care,” 24/7 electronic or telephone access, and strong IT communications channels
- Focusing on patient preferences and engagement in decision making
- Having individual care plans and community linkages for both clinical and nonclinical care for dual eligible, frail, or chronically ill patients

In short, medical neighborhoods represent an expansion of PCMH principles beyond the practice sites to the community, and include the use of electronic medical records, nurse care managers, and interaction and coordination with specialists in treatment planning.

**Results to Date**

The reports from the field have been promising. The Patient Centered Medical Home Cost and Quality Results, 2010-2011, issued by the Patient-Centered Primary Collaborative, an industry advocacy group, report positive results in reduction of costs and utilization including impact of hospital admissions and readmissions, avoidable ED visits, and impact on health care
costs. The report also includes evidence of improvement in quality of care, access to care, and patient experience in 46 different PCMH initiatives across Medicare, Medicaid, and commercially insured patients. (See Figure # 2)

Despite program successes, there have been some unrealistic expectations about PCMHs, with some organizations underestimating the complexity of the organization and transitioning physicians from individual private practice entrepreneurs to team care providers. There have also been several barriers to PCMHs attaining full clinical and financial success.\(^2\) The methods by which physicians are paid to participate in the programs have varied, and it is still unclear which payment models or which payment structures, levels, or timing are ideal for PCMH performance. It is clear that payment incentives need to be aligned with program goals. Some PCMHs have stumbled because the physicians were still primarily being reimbursed on volume; whereas, the organizations were primarily earning shared savings based on value. Since only 10% of physician incomes in most markets are incentive based, there can be conflicting incentives for organizations who see PCMHs primarily as vehicles for reducing utilization and driving down costs.

---


---

**Figure #2: Patient Centered Medical Home Results**

- **Geisinger’s Proven Health Navigator Model** serving Medicare Patients in rural Pennsylvania reported 7.1% savings over expected costs from 2006-2010 with an ROI of 1.7
- **Genesee Health Plan** in Flint, Michigan, reported PCMH services helped reduce ER visits by 51% between 2004 and 2007 and reduced hospital admissions by 15% between 2006 and 2007
- **WellPoint’s** PCMH model in New York yielded risk-adjusted total PMPM costs that were 14.5% lower for adults and 8.6% lower for children enrolled in the medical home
- **CareFirst Blue Cross Blue Shield** of Maryland yielded an estimated 15% pmpm savings in the first year and $98 million in savings over two years
- **Group Health of Washington** reported overall cost savings of $17 PMPM including 29% fewer ER visits and 11% reduction in hospitalizations for ambulatory sensitive conditions
- **Oklahoma Medicaid** reported $29 PMPM savings
- **HealthPartners** in Minnesota reported 39% reduction in ER visits, 24% fewer hospitalizations, 40% reduction in readmission rates and 20% reduction in inpatient costs
insurance company, launched its first PCMH in 2009, and since then, has gone through several iterations coming up with a current model similar to CMS’ Comprehensive Primary Care Initiative. The Horizon model requires intensive and targeted patient care coordination supported by committed primary care leadership, and provides, in addition to traditional fee-for-service payments, a monthly care coordination fee and outcomes based incentives. Horizon’s experience also indicates that “considerable non-monetary support” is needed for an effective medical home organization. This includes training for physicians in medical home organization and additional supports such as an education program for population health coordinators, a medical home guide that offers a roadmap to transform practices to PCMHs, and training in useful data sharing to improve the quality of care and reduce costs.³

Many small and medium-sized physician practices lack the resources to seek PCMH qualification. A national survey of small and medium-sized physician practices published in 2011 indicated that among the 1,300 practices surveyed, only one-fifth used PCMH core processes such as care managers, systems to incorporate patient feedback, nurse care managers, or care planning.⁴ Some PCMH models reward practices for establishing electronic health records, but with little focus about how well they integrate with other provider systems and leave coordination entirely up to the primary care physicians.⁵ The federal Office of the National Coordinator for Health Information Technology Supporting Meaningful Use has also given primary care practices grants of up to $70,000 to acquire electronic medical records, although this covered only a fraction of the nation’s small to medium-sized practices. Until the CPCI program was launched to provide a model, incentives for other physicians or providers to share information with the PCMH were limited. To the extent that government and commercial payers attempt to keep the overall pool of funds for physician care constant, any increase of payment to primary care physicians will draw down payments to other physicians - a likely


nonstarter in efforts to build a broader medical neighborhood.

To the extent that the PCMH and medical neighborhood business models are layered on top of fee-for-service reimbursement, it will be difficult for the PCMH to influence care if this causes the incomes of specialists or the hospitals to decline. It may be that a core requirement for PCMH success may be the context in which incentives are aligned. Given the discretionary nature of medical care, particularly in the treatment of chronic illness, or to order diagnostic tests, the response of specialists in the medical neighborhood is likely to be to increase the volume or intensity of services to other patients if the referrals from the PCMH are cut. The secret of success for a PCMH is not to make the pie bigger, or to take money from other specialists, but to focus on eliminating systemic inefficiencies and lowering costs. It is estimated that 30% to 40% of the costs in the continuum of care are caused by inefficiencies in the system providing adequate opportunity for savings without penalizing specialists.

To be fully successful, it would seem necessary for PCMHs to operate in an environment where the Patient-Centered Medical Home business model is imbedded in an overall ACO reform effort, or where there is a Risk Sharing Total Cost of Care contract, where hospitals and physicians are aligned under an overall bundled contract. Patients and other healthcare providers have an essential role to play in PCMH success—which is an important motivator for building a comprehensive medical neighborhood in support of PCMHs.⁶

Organizational Lessons Learned
Current market experience indicates that the rollout of ACA will increase the pressure to create medical homes, since many of the 500 plus ACO organizations which have been formed since 2010 organized their clinically integrated networks without transitioning their primary care practices to PCMHs.

Assuming reasonably positive results from the CPCI, the expansion of PCMHs and medical neighborhoods can be expected to increase. These initiatives can serve as the building blocks for the development of more comprehensive Accountable Care programs serving broader geographic areas. Organizations moving down the path of reform will need to take into consideration several organizational issues in developing their PCMHs and in building out their medical neighborhood.

• **Building a PCMH Involves Transformation, not Incremental Change.** Many of the initial practices tried to start incrementally, focusing on gaining recognition from the appropriate accrediting organization, and going sequentially from one organizational task to the next. They were often overwhelmed by complexity midway through the process, having failed to think through their entire transition and what the change would mean to their style of practice before they started. Organizations who recognized up front that PCMHs required a fundamental reimagining and redesign of their practice, with continuous quality improvement, team-based care, and the enhancement of patient experience fared better and had a lot more fun.

• **Systems Integration Generally Takes Longer than Planned.** Most practices need an operative Electronic Health Record (EHR) before they start the transition, but don’t assume that adding the additional systems, such as a disease registry, prescribing, or patient portals will be simply plug and play. The multiple systems marketed in the practice environment are frequently a hodgepodge, and may be difficult to start or interface with legacy practice management systems. Many times, it is necessary to reengineer work processes before new systems can be installed, so be realistic about the time and resources that will be required to go live. Developing a realistic practice technology strategy before starting the transition is a sensible planning step.

• **PCMH Development Requires Individual Physician Practice as well as System Transformation.** One of the major conclusions of the 2009 National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home was that launching a PCMH required not only the implementation of sophisticated new office and care management capabilities, but the transformation from an individual physician practice approach to a clinical team approach. This requires a change of focus from one patient at a time to a population-based focus -- particularly for patients with chronic illnesses, or for preventive services. Based on industry experience, this has frequently been difficult, challenging physicians to re-examine their identity and practice philosophy.

• **Transformation Requires Change Management Strategy.** The pace and magnitude of change to become an effective PCMH and medical
neighborhood should not be underestimated. We recommend clear-eyed consideration of practices’ ability to adapt to change with a clear-eyed assessment of any dysfunction in the practice infrastructure, communication strengths and weaknesses, and tensions among physicians and practice staff. As noted, a substantial barrier to the conversion to a PCMH can be the need for individual physicians to adapt the ways they currently practice to the new model. This can require the development of new tools and personal development formats to help bridge the gap between the old model and the new.

- **Timetable and Approach Tailored to Fit the Practice.** The approach to developing the PCMH and medical neighborhood will vary depending on the practice. Either over-specification of the model or rigid prescription of the pathway for change can be counter-productive. Practices will vary in terms of the assistance they may require in making the transformation and building out the medical neighborhood, but the decisions of what, when, and how to change must be owned by the practice. Finally, it is important to establish realistic expectations of the time and effort that will be required. Practice transformation can be a lengthy process taking as long as two years (some people think three years more realistic). Moving towards a PCMH involves overall practice redesign and should not be confused with incremental quality improvement. Above all, building an effective PCMH and medical neighborhood will require that everyone in the practice—physicians to office staff—be involved.

**Conclusion**

The notion of building a medical neighborhood for the medical home makes intuitive sense and is supported by significant results from early program initiatives. We believe a medical neighborhood is a necessary adjunct to a PCMH, enabling the medical home to more effectively support the core functions of primary care and the realization of savings through enhanced medical management. While it is not yet finally proven that PCMHs will lower overall spending, there is substantial positive evidence that PCMHs are helping physicians and hospitals move towards the Triple Aim of improving population health, enhancing patient experience, and reducing per capita costs. The discussion of clinically integrated networks has been current in the hospital world since the 1990s.
Placing medical home in the broader context of a clinically integrated medical neighborhood provides the tool set which will help physicians align their incentives with their hospital partners and foster shared accountability across the entire continuum of care. This is the recipe for successful healthcare reform.

For more information, contact:

Terry McGeeney, MD
Director
913.544.6086
terry.mcgeeney@bdcadvisors.com

About The Author

Terry McGeeney, MD, MBA, is a Director with BDC Advisors, where he advises clients nationally on issues of physician organization and compensation strategies in the accountable care marketplace. He was formerly CEO of TransforMED, an organization that provides ongoing support and consultation to physicians and groups of physicians who want to transform their practice models to Patient-Centered Medical Homes. From 2008 to 2012, Terry assisted over 8,000 practices across the nation to reorganize and become recognized as Patient-Centered Medical Homes. Dr. McGeeney is also Visiting Scholar, Economic Studies, at the Brookings Institute, Washington, D.C.