HEALTHCARE JOURNAL of Baton Rouge
Quality Correspondent

The Patient Centered Medical Home:

A More Cost Effective and Efficient Model of Health Care

by: Shannon Robshaw, MSW, Executive Director
Louisiana Health Care Quality Forum

It is widely acknowledged that the current U.S. health care system is unsustainable due to dramatically increasing costs and poor health outcomes. Dr. Craig Weber, in a recent presentation at the Louisiana Health Care Quality Forum's Spring Summit, cited the following statistics on the U.S. from IBM Healthcare and Life Sciences, IBM Institute for Business Value:

Costs are rising dramatically:
• $2.3 trillion (16% of GDP) was spent in 2007 on health care
• $4.0 trillion (almost 20% of GDP) will be spent in 2015

There is no link between higher costs and quality and safety:
• 98,000 to 195,000 people died per year as a result of medical mistakes
• 57,000+ dying from inadequate care
• 4-fold variation in costs between providers with similar quality
• U.S. ranked 37th in overall health system performance by the World Health Organization

There are significant access issues:
• 45+ million uninsured
• 5+ million under-insured, most of whom are working

Primary care is acknowledged as the key component to improving the care of people with chronic disease, lowering cost, and improving access to and satisfaction with care. Access to primary care has clear benefits to cost, quality, and patient outcomes, particularly those with chronic illness *(Wagner, E.H., Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness)*. Additionally, studies have established that having a regular and continuous source of care with the same physician, over time, has been associated with better health outcomes and lower total costs *(Starfield, B., L. Shi, and J. Macinko, Contribution of Primary Care to Health Systems and Health, 2005)*. Further, the 2004 Future of Family Medicine study: A Collaborative Project of the Family Medicine Community, found that care organized around a primary care relationship results in better outcomes at lower cost with higher satisfaction.

As a result of this focus on the importance of primary care, the Patient Centered Medical Home (PCMH) is increasingly being looked to as the model to address the crisis in our health care system, both locally in Louisiana and nationally. The PCMH is defined as an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. The PCMH model has been promoted by a national employer coalition, identified by both political parties as a component of national health care reform, and has been included in Louisiana's Medicaid waiver application.

The Joint Principles of the PCMH adopted in February 2007 by the AAFP, ACP, AAP, and the AOA state that the patient-centered medical homes should have the following characteristics: a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, and enhanced access and adequate payment. The National Committee on Quality Assurance (NCQA) has developed measures of these principles and a tool for evaluating the PCMH. The tool clearly defines the PCMH for patients, providers and payers. It consists of nine standards with associated elements, each with corresponding points. (Although much of the language in these national standards focuses on the "physician," there is a recognition that in rural communities with physician shortages, at times the PCMH may not be physician directed.)

Louisiana is leading the nation in NCQA-certified PCMHs, with the highest density of PCMHs in the nation. Thirty-four practices in Greater New Orleans have been recognized; others are emerging in North Louisiana and other areas of our state. The practices that have been able to achieve this recognition have been largely nonprofit safety-net clinics and not dependent on the traditional “fee-for-service” payment structures that leading health policy experts have cited as a major barrier to improving care and reducing cost. Their grant funding has been structured as global per patient payments allowing them to invest in the infrastructure and services not typically supported by traditional insurance reimbursements. DHH’s pending Medicaid reform also includes payment restructuring to support the non-traditional services of a PCMH.

With Louisiana’s progress in the nonprofit and public sector, more and more, the question now being raised is how can commercially insured individuals gain access to the PCMH? How can employers benefit from the increase in efficiency and effectiveness of this model of primary care? The answer is payment reform.

Implementation of the PCMH in the commercial market will require a payment model that sustains the team-based approach and coordination of care. Incentives must be aligned to drive the quality of care and change the way primary care is delivered. The payment formula must strongly incent providers to achieve clearly defined quality processes and objectives. Further, the payment model must create long-term financial sustainability for the patient centered medical home in Louisiana.

There is increasing consensus nationally and in Louisiana that a blended payment model is needed to implement the PCMH in the current private sector. The model consists of four key components:

1) Up-Front Investment
Support is needed to cover the costs of new technology and technical assistance to educate and guide the necessary change in care processes, data collection, management, and reporting at the practice level.

2) Fee-For-Service
To practically achieve transformation in significant numbers of practices within a reasonable time frame, it will be necessary to utilize the existing reimbursement structures as the financial base on which to build needed additional financing streams. For most of Louisiana, this is the traditional fee-for-service system.

3) Care Management Fee
A monthly or quarterly fee per member is needed to cover new provider services and expanded care of patients, which have not traditionally been reimbursed, such as coordination of patient care across the continuum of services and inclusion of prevention, wellness, and chronic disease management.

4) Incentive Payment
Payment should be designed to reward providers for successfully achieving targets related to care processes and interim and long-term health outcomes, and may be aligned with process outcomes such as attaining NCQA recognition as well as with clinical outcomes.

There is growing recognition by Louisiana purchasers and employers of the advantages of the PCMH. As the agency responsible for insuring state employees and retirees, the Louisiana Office of Group Benefits (OGB) has recognized the need for this reformed insurance model and is in the process of contracting with an insurance plan to implement the PCMH in north Louisiana beginning this fall. As more insurance purchasers begin to assert themselves into the health care reform debate and demand more value-driven care, they will exercise their purchasing power to drive market change. Then we will see the needed broad restructuring of the traditional insurance model to support the redesigned delivery and payment needed to reform our health care system. ❖