REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
Sustain Patient-Centered Medical Home Practices
(Resolution 813-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, "Sustain Patient-Centered Medical Home Practices," which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked (1) that our AMA amend Policy H-160.918 to urge the Centers for Medicare & Medicaid Services (CMS) to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and (2) encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home (PCMH) designated practices.

The Council believes that primary care and the PCMH are bedrocks of high-quality, patient-centered health care. However, in order to make the transition to a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation. The Council notes that cultural and financial obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. To that end, the Council recommends a set of recommendations recognizing that it is critical to not only have financial support during the initial stages of practice transformation, but also to maintain ongoing funding and continuous cultural and monetary support for PCMH activities.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-18

Subject: Sustain Patient-Centered Medical Home Practices (Resolution 813-I-17)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee J (Steven Chen, MD, Chair)

At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, "Sustain Patient-Centered Medical Home Practices," which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked:

> (1) That our American Medical Association (AMA) amend Policy H-160.918, "The Patient-Centered Medical Home," by addition as follows:
>
> Our AMA:
>
> a. Will urge the Centers for Medicare & Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
> b. Will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
> c. Will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and
> d. Will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home; and
>
> (2) That our AMA work with and encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

This report provides background on Patient-Centered Medical Homes (PCMHs), outlines the costs of sustaining a PCMH, discusses the various payment methodologies employed with the model, provides an example of a PCMH, outlines relevant AMA policy and AMA advocacy efforts, and proposes policy recommendations.

BACKGROUND

The PCMH is a team-based practice that is led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.[1] The PCMH model emphasizes population management, team-based care, and care management, particularly for at-risk patients with the objective of having a centralized setting that facilitates partnerships between individual patients, their physicians, and, when appropriate, the patient's family.[2] The PCMH encompasses five functions and attributes: comprehensiveness, patient-centered, coordinated, accessibility, and quality and safety.[3] Evidence suggests that PCMHs improve quality, the patient experience and staff satisfaction, while reducing health care costs.[4]

While recognizing the utility of specialty care medical homes, the Council chose to limit the scope of this report to PCMHs. Improving and investing in primary care has become a major health policy objective, and, for many patients, primary care services are their entry point into the health care system.[5] As such, primary care is well positioned to help address the fragmentation in the health care system and optimize the delivery of health care. Moreover, the Council believes that primary care physicians are the touchstone of the physician-led health care team and are the gateway to health care.

Building a PCMH requires hard work from all stakeholders including physicians, practice teams, patients, and institutional partners. It requires time, money, dedication, sustained effort, and a cultural shift.[6]

COST OF SUSTAINING A PCMH

Identifying the costs of maintaining PCMH functions can contribute to effective payment reform and sustainability of transformation. The costs for a practice to implement these PCMH services vary depending on factors such as practice size, existing capabilities, characteristics of the patient population, and availability of low-cost or funded resources.[7]

Generally, the most significant cost to sustaining a PCMH is the ongoing cost of maintaining personnel. A recent study assessed the direct personnel costs to 20 primary care practices that differed in PCMH recognition status, ownership, payer mix, and patient populations. The study looked into the practice costs associated with the staffing necessary to deliver PCMH functions per the National Committee for Quality Assurance (NCQA) Standards. The NCQA is the most widely adopted PCMH recognition program.[8] The study looked at 20 differing primary care practices in Utah and Colorado and found that the incremental costs per full-time equivalent primary care clinician associated with PCMH functions varied across practices with an average of $7,691 per month in Utah practices and $9,658 in Colorado practices. Also, the study found that PCMH incremental costs per encounter were $32.71 in Utah and $36.68 in Colorado. The average estimated cost per member per month for an assumed panel of 2,000 patients was $3.85 in Utah and $4.83 in Colorado. In addition to finding that the staffing and care coordination requirements of a PCMH could have an average incremental cost of $8600 per month, the study found that smaller practices may be particularly susceptible to increased costs.[9]

Additional insight on practice transformation costs may be gleaned from the traditional cost of electronic health record implementation. According to an extensive study of EHR implementation in Texas-based primary care practices that were not PCMHs, it is estimated that the first-year cost of implementation is about $162,000 with about $86,000 in maintenance expenses for a five-physician practice.[10] This figure is likely a significant underestimate of the costs and challenges of

implementing a medical home.[11] Similar implementation and maintenance costs have been reported across the country including in Massachusetts and New York City.

Moreover, a recent RAND study found that overall PCMH transformation costs are likely anywhere between $83,829 and $346,603 per year and that practice transformation could take several years.[12] Further, the report found that the costs per clinician ranged from $18,585 to $93,856, with ongoing median costs at $147,573 per practice and nearly $65,000 per clinician.

PCMH PAYMENT

PCMHs are a care delivery concept rather than a defined payment model and do not have a defined payment structure. However, many PCMH payment models have similarities. For example, PCMHs often receive payment based on an established fee schedule and supplemental payments for care coordination. The structure of PCMH payment is intended to support and promote practice activities that traditionally do not qualify for payment such as e-mail and phone communications, care coordination, and workflow changes. Therefore, the supplemental payments may be adjustment payments for traditionally non-reimbursed care management services. Other models' supplemental payments are simply additional lump sum payments to incentivize care management. Other models use a capitation-based payment that may include enhanced payment to support medical home activities.[13] Additionally, many models participate in shared savings.

EXAMPLES OF A PCMH

Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer CMS PCMH initiative intended to strengthen primary care.[14] In initiating CPC, CMS recognized concerns that primary care has been traditionally underfunded and that sufficient payment is critical for the practice-wide changes needed to transform primary care.[15] CPC launched in 2012, and in the ensuing years of the program CMS has partnered with commercial and state health insurance plans to offer population-based care management and shared savings opportunities to participating primary care practices to support the delivery of CPC functions.

A recent study that looked at the cumulative results of CPC over four years found that CPC practices reported improved primary care delivery, such as care management for high-risk patients, enhanced access, and improved coordination after care transitions.[16] Moreover, CPC slowed growth in emergency department visits by two percent and hospitalizations by two percent relative to the comparison group. Importantly, CPC fostered substantial local collaboration wherein payers and practices came together to collectively work on solutions.[17] This has signaled a paradigm shift wherein payers are now working together in communities to build primary care capacity, and some payers are funding community resources such as data aggregation to drive success. All CPC regions are sharing the lessons learned and best practices to drive further innovation.

In 2015, the CPC initiative generated $57.7 million in gross savings for Medicare Parts A and B. Moreover, over half of the participating CPC practices shared in savings of over $13 million. In addition to generating overall savings, practices in the CPC program exhibited improvement in quality measures including a lowering of hospital admissions and readmission rates. Stakeholders believe that CPC demonstrates the potential for primary care clinicians to redesign their practices to deliver better care to patients and improved outcomes to patients.

However, despite decreased utilization and improved outcomes, CPC did not reduce Medicare spending enough to cover care management fees or appreciably improve physician or beneficiary experience or practice performance on a limited set of Medicare claims-based quality measures.[18] Comprehensive Primary Care Plus (CPC+), which qualifies as an advanced alternative payment model (APM), was built on the CPC structure and is a five-year PCMH model that launched in 2017 in 14 regions across the country. While CPC practices had to achieve savings in total cost of care for their state, CPC+ practices have to achieve good performance on metrics such as reducing ambulatory care sensitive admissions. CPC+ has two tracks. One track is for practices building medical home capabilities, and the second track is for those practices that are already delivering advanced primary care.[19] Moreover, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the Secretary of Health & Human Services a proposal developed by the American Academy of Family Physicians (AAFP) for Advanced Primary Care, and the AMA supported this proposal. There is now a second round of CPC+ which expanded the program to more regions.

CPC+ provides primary care practices with up-front and improved payment in addition to technical assistance.[20] Its payment components de-emphasize fee-for-service (FFS) and increase payment to support practice improvement and delivery transformation. Both CPC+ tracks offer three payment components. The first component is a care management fee (CMF) paid per-beneficiary-per-month. The CMF is paid prospectively on a quarterly basis and is based on the complexity of the patient population. The second component is a performance-based incentive payment (PBIP) that is received as a prospective payment at the beginning of each program year in order to meet patient needs and build practice capacity. At the end of the year, if practices do not meet the quality and cost benchmarks, they will repay some or all of the PBIP. The third component is a payment under the Medicare fee schedule. Track 1 practices continue to receive FFS payments while Track 2 practices receive a hybrid payment with a prospective portion paid quarterly called the Comprehensive Primary Care Payment (CPCP) coupled with a reduced FFS payment. The CPCP and FFS payments taken together are larger than the practice's historical FFS payment.

CareFirst

In 2011, a PCMH program operated by CareFirst BlueCross BlueShield launched, which is the largest coordinated care program of its kind. The program is structured around groups of primary care providers organized into panels of between five to fifteen physicians. These physicians are grouped together to coordinate the care of CareFirst members with the most pressing health care needs, and how the panels operate is largely up to them.[21] As teams, panels are eligible to earn Outcome Incentive Awards that are paid as increases to their fee schedules based on the level of quality and the savings achieved against projected costs.

Recognizing that coordinated care often involves services that are not typically compensated under traditional insurance arrangements, CareFirst's PCMH provides for an across-the-board 12 percentage point increase in compensation for primary care services. Additionally, the insurer also pays physicians $200 per patient to develop care plans for high-risk patients and $100 for every time a care plan needs to be updated.[22]

Importantly, the program is designed to appeal to solo and small group practices. CareFirst understands that the needed investments, particularly IT investments, to create and maintain a PCMH are often cost-prohibitive to physicians in solo or small practice arrangements. Therefore, the program provides physicians with access to all necessary IT to participate in the PCMH. Additionally, CareFirst has dedicated more than 100 nurses across the region to help coordinate care and ensure that the program runs smoothly.[23]

Over the course of the program, it has lowered the expected cost of care for CareFirst members by nearly $1.2 billion.[24] In 2017 alone, the CareFirst PCMH helped save $223 million against the expected cost of care. The savings was largely driven by reductions in hospital admissions and the length of hospital stays. Since the program's inception, all CareFirst members experienced 21.3 percent fewer hospital admissions; 22.5 percent fewer emergency department visits; and 7.8 percent fewer days in the hospital.[25]

AMA POLICY

Relevant to the subject of this report, Policy H-160.918 addresses the financial aspects of the PCMH model. It urges CMS to work with the AMA and national medical specialty societies to enhance care coordination among providers who provide medical care for patients outside the medical home and urges CMS to assist physician practices seeking to qualify for medical home status with financial and other resources. Specifically, Policy H-160.918 calls for Medicare incentive payments associated with the medical home model to be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule. Moreover, it calls for all health plans and CMS to use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.

Policy H-160.919 articulates principles of the PCMH and adopts the Joint Principles of Patient-Centered Medical Homes developed and endorsed by primary care societies including the American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, and AAFP, among others. The organizations initially developed these principles to emphasize the patient-physician relationship, physician leadership of a care team and physician responsibility for care coordination, supported by other qualified providers. The policy states that payment should appropriately recognize the added value provided to patients who have a PCMH. The policy calls for the AMA to recognize the value of physician work associated with remote monitoring of patients and clinical data and states that PCMH payment models should allow for separate payments for face-to-face visits. Consequently, Policy H-160.919 supports physician payments that reflect the value of care management work outside of the face-to-face visit and calls for additional payments for achieving measurable and continuous quality improvements and supports a structure for shared savings. The policy promotes a voluntary recognition process for medical homes and supports integrated care across all elements of the health care system. It advocates for quality and safety, patient-centered outcomes, evidence-based decision making, physician engagement in achieving medical outcomes and utilization of information technology (IT). Further, the policy also advocates for access to care through systems such as open scheduling, expanded hours and new options for communicating with patients.

Policy H-450.931 supports the move to APMs and calls for the AMA to provide physician practices with support and guidance in the transition. Policy H-385.908 calls for the AMA to work with organizations to improve the availability and use of health IT, including continuing to expand technical assistance and developing IT systems that support and streamline clinical participation. Policy H-385.908 also urges CMS to limit financial risk to costs that physicians participating in APMs have the ability to influence or control.

AMA ACTIVITY

The AMA continues to work to assist physicians with the requirements and incentives contained in the Medicare Access & CHIP Reauthorization Act (MACRA), which includes the development and

successful implementation of PCMHs. The AMA has been active in educational activities including webinars and regional conferences for physicians and staff and will be continuing these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs to reduce practice barriers and enable more physicians to participate. The AMA has urged CMS to enhance proposals that provide credit for and promote medical homes and APMs. Therefore, the AMA has repeatedly advocated for CMS to extend the CPC+ model nationwide for all of Medicare. Further, the AMA has called for an increase in medical home flexibility and to expand medical home eligibility to specialty medical homes. Additionally, the AMA has called for the lower financial risk requirements available for patient-centered primary care medical homes to be extended to specialty medical homes. Moreover, the AMA continues to advocate for proper risk adjustment in APMs and has urged CMS to prevent stringent two-sided risk requirements from being extended to primary care medical homes serving vulnerable populations, such as children with Medicaid coverage.

Additionally, the AMA is advocating for PCMHs to earn more credit in the Merit-Based Incentive Payment System (MIPS). PCMHs can be recognized by a variety of organizations and have this recognition count as their Improvement Activity under MIPS. However, because the Improvement Activity score is only weighted at 15 percent of the total score so it does not count for a significant percentage of overall score. However, the AMA has advocated that practices that go to the effort of transforming to PCMHs should be able to utilize their PCMH status for more credit in MIPS.

AMA advocacy efforts are also focused on the PTAC and Physician-Focused Payment Models (PFPMs). The AMA attends and makes public comments at meetings of the PTAC, submits comments on its draft documents and stakeholder proposals, and works with specialty societies developing APM proposals to help address challenges they face in APM design. Additionally, the AMA convenes workshops and a workgroup to bring together many of the leading physicians who are working on PFPM proposals to discuss potential solutions to these issues.

In its advocacy efforts, the AMA has highlighted that some practices are effectively doing the work of the PCMH but are not being compensated for its activities or recognized because the certification process is arduous and expensive. To that end, the AMA has advocated for CMS to recognize programs that accredit medical homes based on the advanced primary care functions, including state-based, payer-sponsored, and regional medical home recognition programs. Moreover, the AMA has stated that physicians should not be required to pay a third party accrediting body to receive recognition as a PCMH. Recognition or certification by an accrediting body may not necessarily capture the actual advanced primary care functions.

DISCUSSION

The value of primary care is often underemphasized relative to other parts of the health care system.[26] However, payers and other stakeholders are increasingly recognizing the need to strengthen primary care and to help reduce overall health care costs and improve care quality. Accordingly, the Council recommends reaffirming Policy H-160.919 that contains principles of the PCMH including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. The Council also recommends reaffirming Policy H-385.908 stating that physicians should only be held responsible for costs that they can reasonably control.

Additionally, recognizing that flexibility is integral to ensuring that PCMHs are designed in ways that improve care for patients and are feasible for physicians to implement, the Council recommends rescinding Part 4 of Policy H-160.918, which states that the AMA will advocate that

all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a PCMH because the AMA has continued to support increased medical home flexibility. Rescinding this section of the policy would support flexibility in practices to implement medical home functions with methods best suited for their practice designs and patient populations.

As Resolution 813-I-17 recognizes, adequate compensation for ongoing and incremental costs is critical for practices to sustain PCMH functions. Not only are the costs of implementation and maintenance significant, but also, care innovations such as telemedicine that increase access and improve care quality also may be expensive. Therefore, the Council recommends advocating that all payers support medical home transformation and maintenance efforts recognizing that payer support is crucial to the long-term sustainability of delivery reform. Similarly, the Council believes many stakeholders have a role to play in assisting PCMHs and thus recommends encouraging health agencies, health systems, and other stakeholders to support and assist medical home transformation and maintenance efforts. The Council believes that these stakeholders have a critical role to play in supporting PCMHs financially, with technical assistance, and culturally by increasing awareness of the PCMH and improving patient education.

Primary care and the PCMH are acknowledged as bedrocks of high-quality, patient-centered health care. However, in order to make the transition to a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation. The cultural and financial obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. It is critical to not only have financial support during the initial stages of practice transformation but also to maintain ongoing funding and continuous cultural and financial support for PCMH activities.

The Council recognizes that both PCMHs and specialty care medical homes play an increasingly important role in an evolving payment and delivery system. As such, the Council will continue to monitor primary care and specialty medical homes.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-17 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains principles of the Patient-Centered Medical Home (PCMH) including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs that physicians have the ability to influence or control. (Reaffirm HOD Policy)

3. That our AMA amend Policy, H-160.918, "The Patient-Centered Medical Home," by addition and deletion as follows:

   Our AMA:

   a. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;

b. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and

c. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule.~~; and~~

d. ~~will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.~~ (Modify Current HOD Policy)

4. That our AMA advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform. (New HOD Policy)

5. That our AMA encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care. (New HOD Policy)

Fiscal Note: Less than $500

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