The Business Case for a Patient Centered Medical Home

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News flash: *The Patient Centered Medical Home delivers superior health, health care and cost savings…but, can physicians afford it?*

This article will dissect the 2012 business case for a patient centered medical home (PCMH) from the perspective of the practicing primary care physician. We will see that the business case is about more than "doing the right thing." Let us begin with the data that overwhelmingly shows that the medical home, an advanced model of primary care as typified by the National Committee for Quality Assurance (NCQA) PCMH 2011 Recognition Program, will transform health care.

In a recent report that evaluated 34 medical home initiatives over the past several years, the medical home model affects health care costs by reducing emergency department (ED) visits by 10 to 50 percent, hospitalizations, by 15 to 53 percent and overall health care costs, by 11 to 20 percent or $17 to 89 per member per month (PMPM)[1]. More importantly, these health care savings were accomplished while dramatically improving the care of medical home patients across the spectrum of primary care delivery: improvements included diabetes care (with a 49 percent reduction in Hemoglobin A1c), heart disease ("optimal care" improved by 48 percent), influenza vaccinations (increased by 112 percent), mammography screening (increased by 25 percent), colorectal cancer screening (increased by 39 percent), cholesterol levels (decreased by 27 percent) and patient engagement (self-management goals, increased by 56 percent.[1,2] My twelve-provider family practice participated in the Colorado Multi-Payer Multi-Stakeholder Medical Home pilot and at the end of the three-year initiative, analysis of these outcomes and cost savings performance data confirmed the national experience above. The jury is in; the medical home works.

But what does it cost to build and maintain a medical home? The data here is much less robust. With the emerging standards defined by NCQA and others, it is clear that "walking the talk" is not cheap. In 2004, the Future of Family Medicine Task Force predicted that the cost of transitioning to a medical home model would range from $23,000 to $90,000 per physician.[3] A recent study of federally funded health centers documented the association between PCMH rating and operating costs, with key medical home attributes—such as access, care management, test/referral tracking—evaluated and scored on a scale of zero to 100; a 10-point higher score was associated with a $2.26 higher operating cost PMPM.[4] Preliminary findings from an analysis out of the Colorado PCMH pilot are consistent with these findings: the incremental cost, above that required of a traditional though electronic health record-powered primary care practice, of maintaining the systems unique to a mature Level III NCQA 2011 PCMH is at least $4 PMPM.[5] This is sobering if you do the math. For a primary care provider with a patient panel of 1800, this amounts to added operational costs of $90,000 per provider per year.

Impossible, you say? Peanuts, I say! Remember the proven downstream health care system payoff of $17 to 89 PMPM savings or for added punch, $367,200 to $1,922,400 savings per FTE physician per year.[1] The trick is in the PCMH payment modeling that connects the dots between those that benefit (patients, employers, government and payers) and those who do the heavy, patient-centered lifting (physicians and their teams). The good news is that payment reform is an unstoppable force with PMPM "medical home management fees," pay-for-performance and shared savings programs spreading across the nation. The federal government is on board with the Center for Medicare & Medicaid Comprehensive Primary Care Initiative, which pays an average $20 PMPM fee, in addition to a shared

savings program. Payers are in it, too. Multiple payers that have realized the impact of the medical home on their bottom lines are rolling out both PMPM and shared savings programs nationally. The Patient-Centered Primary Care Collaborative published a study of 26 medical home initiatives showing PCMH-powering PMPMs as high as $11 with the Colorado Pilot rate for a Level III medical home at $7.25.[6]

The ultimate business case for PCMH rests on the return on investment (ROI). Interestingly, this has been studied in two exemplary accountable care organizations. The Group Health Cooperative showed total savings PMPM of $10.3 and an ROI of 1.5[2] and the Geisinger Health System studied its PCMH cost savings from 2006 to 2010 to show an ROI of 1.7.[1] Although many primary care physicians do not work in large integrated health care systems, these data define the medical home rallying cry to ensure progressive payment modeling becomes standard operating procedure. It makes sense.

Finally, the notion of a business case for PCMH is not limited to the clinical outcomes and cost dimensions that compel physician investment. There is also the urgency for primary care to reinvent itself. Perhaps this reinvention is the most important part of the business case: primary care practices must become data-driven learning organizations that make "meaningful use" of EHRs and data and effective systems of team-based care creating value for both our patients and the primary care teams themselves. This is the "Triple Aim" primary care, the defining calculus of market relevant value and what ultimately makes our business case.

References:

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