Overall Analysis: Growing Support for PCMH

The National Committee for Quality Assurance (NCQA) analyzed the rapidly growing number of financial incentive programs that help primary care clinicians and practices become Patient-Centered Medical Homes (PCMH). This analysis includes commercial/private, public and multi-payer initiatives offering financial incentives for practice transformation across all 50 states, Puerto Rico and the District of Columbia.

This is a snapshot of a rapidly evolving landscape, subject to limitations of time and information available. Key themes include:

- **The number of PCMH initiatives across the country is rapidly growing.** Edwards (et al) found just 26 PCMH initiatives in only 18 states as of 2009. Today, there are more than 160 active PCMH initiatives across 48 states, Puerto Rico and DC.[1]

- **Per-member, per-month payments are the most common incentive.** Payments often increase based on recognition levels to cover the cost of PCMH activities not traditionally reimbursed, such as care coordination or enhanced patient access.

- **Only 1/3 of the initiatives we found provide adequate financial support.** PCMH initiatives are offering a wide range of monthly incentive payments. However, the majority of incentives do not meet the $6-8 PMPM that research suggests is necessary to sustain transformation and reflect the true value and cost savings delivered by the model.

- **The majority of incentives are tied to a national PCMH recognition program.** Across both regional payers and larger national entities, PCMH recognition is recognized or required for participation in many initiatives. At least 24 initiatives explicitly require NCQA recognition; another 87 recognize NCQA recognition as fulfilling programmatic goals.

- **Many PCMH initiatives use multiple incentive structures.** To accommodate the diverse needs and readiness of practices to adopt PCMH, payers often use multiple incentive structures to drive transformation.

- **Payment reform is an integral component of successful PCMH implementation**. Ongoing financial incentive payments are necessary to drive and sustain practice transformation. Incentives are critical for producing the demonstrated improvements in cost and quality that PCMH implementation can achieve.

[1] Multi-state initiatives are counted as a separate discrete initiative for every state in which they are active.

Structuring Incentives:

PCMH initiatives are using an array of incentive structures ranging from one to a combination approach. Others offer non-financial incentives such as a care coordinator or participation in a learning collaborative. A key takeaway, however, is that ongoing infrastructure support – in the form of regular payment and other practice transformation resources – is critical to successful PCMH implementation.

In an effort to better understand how all these disparate models overlap and interact, we created five distinct structures based on what we found among the programs. These five structures exist on a "continuum" to reflect the evolution and sophistication of the model, as well as its ability to sustain practice transformation. We captured the incentives tied to each program using the following groups:

1. **Transformation Payment:** These include single or lump sum payments intended to cover costs of transformation. Importantly, they do not include the incentives or resources needed to sustain the enhanced capabilities of PCMH.

2. **FFS with Adjustments:** These are payments based on an enhanced fee schedule or additional codes specific to PCMH activities not traditionally reimbursed, such as care planning or enhanced patient access, that are critical aspects of a PCMH.

3. **FFS Plus:** These include models that pay additional fees to a medical home, primarily in the form of per-member, per-month payments.

4. **Shared Savings:** These include any model with a payment structure that allows practices to share in savings produced by PCMH; however, they are not at risk for losses.

5. **Comprehensive Payment:** As yet rare, this approach is similar to capitation, with practices sharing in both savings and losses. Practices assume highest level of risk relative to other models.

Limitations:

Change in the rapidly evolving landscape of PCMH will only accelerate. As CMS implements the value-based reform under the Medicare and CHIP Reauthorization Act, and other public and private payers fulfill their commitments to PCMH, this information will change. To that end, this analysis should be considered a "point in time."

We were also limited by the availability of information at the time of analysis, as many initiatives do not publish granular programmatic details. We directly contacted many of those organizations and gained some specificity but only documented what we could confirm.

State Innovation Model (SIM) grants are reflected in this analysis. States are in various stages of implementation and a significant number are planning to utilize the PCMH model as part of delivery system and payment reform. Many have indicated their intent to incentivize providers based on meeting Patient-Centered Medical Home requirements. With the exception of a few states, the specifics of those arrangements are not yet available.