

Aligning Incentives and Systems

*Promoting Synergy Between
Value-Based Insurance Design
and the Patient Centered
Medical Home*



Patient-Centered
Primary Care
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AUTHORS:

A. Mark Fendrick, MD

Professor, University of Michigan Departments of Internal Medicine and Health Management & Policy, Center for Value-Based Insurance Design

Bruce Sherman, MD, FCCP, FACOEM

Cochair, PCPCC Center for Employer Engagement Director, Health and Productivity Initiatives, Employers Health Coalition of Ohio Consulting Medical Director, Goodyear Tire & Rubber Co.

Dennis White

Senior Vice President for Value-Based Purchasing, National Business Coalition on Health

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Errol Alden, MD, FAAP

Executive Director, American Academy of Pediatrics

John Crosby, JD

Executive Director, American Osteopathic Association

Paul Grundy, MD, MPH

Director, IBM

Edwina Rogers

Executive Director, Patient-Centered Primary Care Collaborative

Andrew Webber

President and CEO, National Business Coalition on Health

Cathy Baase

Global Director of Health, Dow Chemical Company

Susan Edgman-Levitan, PA

Executive Director, John D. Stoeckle Center for Primary Care Innovation

Douglas Henley, MD

Executive Vice President, American Academy of Family Physicians

John Tooker, MD, MBA, FACP

Executive Vice President and CEO, American College of Physicians



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Dear Employer:

As you well know, employers are deeply enmeshed in developing strategies to control health care costs and improve health outcomes. The current environment is not favorable to success. Medical care is fragmented, relying on obsolete paper-based management and fee-for-service payments that reward inefficiency, and employees are getting heavier and more sedentary even as more of them age into higher risk for chronic disease.

We believe employers are essential to turning this situation around. Employers must tackle both the supply side (e.g., services and incentives influencing provider behavior) and the demand side of health care, as well as the health behaviors that influence employee uptake of preventive and treatment interventions. This white paper explores two tools employers have used with much success to leverage improvements in the health care system. These are the patient-centered medical home (PCMH) and value-based insurance design (VBID).

The models and research evidence for both VBID and PCMH have been fully outlined in prior publications by the partnering organizations: the Patient-Centered Primary Care Collaborative, the University of Michigan VBID Center and the National Business Coalition on Health. The new element in this white paper is a discussion of how the two innovations can be aligned to augment the impact of each.

Good health care means that employees are prescribed evidence-based treatments and behavioral interventions and that benefit incentives are aligned to reduce barriers to evidence-based care. In every discussion of VBID, experts recognize that the model cannot work if employees are not made aware of essential evidence-based treatments. This is the role of high-quality primary care providers and one that could be fulfilled in a PCMH. In every discussion of PCMH, experts recognize that regardless of the quality of the medical practice, care cannot be effective unless employees adhere to treatment and follow up on behavioral recommendations. That is precisely the role of VBID—to use incentives to direct employees to the PCMH and thereby to PCMH-recommended, evidence-based treatments.

In short, we believe that the PCMH and VBID go hand in glove in aligning incentives on the delivery and demand sides to improve health care quality. We encourage employers to carefully peruse this white paper and accompanying case studies to identify incremental or wholesale approaches you can adopt. Meanwhile, our organizations are carefully tracking the research and growing evidence base on these two important strategies and will continue to report back to the employer community. We look forward to engaging further in this dialogue with you.

Andrew Webber

President and CEO

National Business Coalition on Health
Board Member, Patient-Centered Primary
Care Collaborative

John B. Crosby, JD

Executive Director

American Osteopathic Association
Chairman, Patient-Centered Primary
Care Collaborative

Edwina Rogers, JD

Executive Director

Patient-Centered Primary Care Collaborative

Paul Grundy, MD

Director of Health Care Transformation, IBM

President, Patient-Centered Primary
Care Collaborative

Executive Summary

In recent years, public and private employers have experimented with numerous strategies to achieve dual objectives of controlling costs and improving employee health. Two widely discussed innovations are value-based insurance design (VBID) and the patient-centered medical home (PCMH). Both approaches have been written about extensively, and research is emerging on their effectiveness at optimizing clinical outcomes and restraining cost growth. Despite growing momentum on both fronts, the approaches are usually examined separately and, therefore, obvious synergies go largely unnoticed.

VBID is an employer-driven benefit design strategy to optimize use of higher-value health care services and reduce use of lower-value services. The goal is to generate better results from employer health care expenditures. The underlying premise of VBID is getting more out of the health care dollar by removing barriers for essential, effective services. VBID is a demand-side initiative that focuses on patient incentives to enhance use of medical services of proven value.

The PCMH is a supply-side mechanism to enable clinicians to deliver better-quality care more efficiently. The PCMH fosters relationships between patients and providers, improves access and increases quality and consistency of care. PCMH incorporates re-created office processes and payment systems to reward an ongoing physician-patient relationship and high-quality, coordinated care. The PCMH requires an investment in financing, through either up-front payments or redesigned reimbursement, to help providers implement and sustain the model. Through better information management, use of guidelines and coordinated care, the PCMH theoretically may contribute to better quality, which in turn drives cost reductions through avoided hospitalizations and emergency department visits.

In this white paper, authors from the National Business Coalition on Health, the Patient-Centered Primary Care Collaborative (PCPCC) and the University Michigan Center for VBID present the conceptual foundation,

review the available clinical and economic evidence, and explore how the integration of these innovative health care strategies impact quality of care and health care costs. Case studies of health plans, employers and public purchasers who have adopted one or both strategies include the following:

- **City of Battle Creek, Mich.**—Starting in 2007, the city participated in a multistakeholder Pathways to Health initiative and implemented a VBID approach for employees to reduce access barriers. In a parallel initiative, providers initiating Pathways to Health have embarked on a PCMH pilot.
- **IBM**—This large private employer is engaged in multiple pilots, including the Taconic Health Information Network and Community collaboration in New York, and offers VBID-like first-dollar coverage for primary and preventive care.
- **Geisinger Health Plan**—This regional health plan in Pennsylvania offers the Health NavigatorSM PCMH program for population management with special focus on high-risk patients and has published outcomes of the initiative.
- **Roy O. Martin**—This small private company of 1,200 employees in Louisiana is in the process of establishing a new PCMH program and is designing program parameters to improve health and outcomes for dollars spent.
- **Whirlpool Corporation**—This large private employer has just launched a three-year PCMH model that builds on its strong occupational health infrastructure. The Whirlpool medical home is supported by and closely aligned with an innovative new plan design that reduces barriers to care and provides incentives to become engaged in maintaining better health.

Although employers often implement VBID and PCMH initiatives in sequence, they see the logic for using them

in tandem. From an employer's point of view, PCMH and VBID are complementary, used to simultaneously change provider and patient behaviors. The PCMH creates a system or means of health care delivery that offers high-value service. That value can be realized only if members use the medical home. VBID layers on incentives to steer individuals to high-value practices and adopt treatment and behavior change recommendations offered by physicians. The objectives of VBID and PCMH are clearly aligned to improve quality and continuity of care, and they are reinforced by incentives incorporated into both programs.

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In addition to real-world examples, this paper addresses initial steps toward execution and implementation challenges, as well as the potential clinical and financial benefits of a deliberate alliance of the VBID and PCMH approaches. The synergistic advantages of supply- and demand-side initiatives—as opposed to either alone—will interest employers looking to achieve more value from their health care dollars.

SECTION 1

Introduction

In this white paper we briefly review the evidence base underlying the emerging health care strategies of value-based insurance design (VBID) and the patient-centered medical home (PCMH). We also discuss the potential to align the strategies to influence both the availability and quality of care delivered to patients, and to improve financing of the system in a way that shifts employers' dollars to the care processes and treatments known to work best.

In recent years public and private employers have experimented with benefit design and payment strategies to help achieve dual objectives of controlling costs and improving health. Business health coalitions have played a convening role to bring innovations to their employer members, and states have been key in developing multipayer payment reform initiatives. Two widely discussed strategies are VBID and the PCMH. Both approaches have been written about extensively, with research findings supporting the value of both to improve the effectiveness of health care and potentially to control cost. For the most part, the approaches are seen as complementary, yet distinct. VBID is a demand-side strategy adopted by employers and health plans to increase patient access to and use of services proven to improve health. PCMH is a supply-side strategy in which physicians and other providers organize themselves into more effective systems to deliver higher-quality and more-efficient health care. PCMH is enabled by purchasers willing to invest in primary care, often working through health plans to administer payment innovations.

Purpose of the Paper

We believe that VBID and PCMH can be used synergistically to offer high-value benefits and ensure a high-quality health care encounter. This white paper briefly examines the underlying concepts of PCMH and VBID and reviews the empirical evidence supporting their use. It also examines the conceptual underpinnings and purchaser approaches to integrating these two strategies to achieve optimal health outcomes and cost-containment goals, using case studies

from public and private purchasers and health plans along a continuum of adoption.

To illustrate our points, we include case studies of plans, employers and public purchasers who have taken steps to adopt PCMH, VBID or both. The case studies illustrate a spectrum of alignment between VBID and PCMH. The case studies range from IBM, a pioneer first in VBID and then in PCMH, to a multistakeholder collaboration in Battle Creek that is developing a PCMH program in tandem with its VBID initiative, to Universal American, a Medicare health plan that offers medical homes and low-cost and free preventive services such as comprehensive annual wellness examinations, flu shots and generic drugs through the Part D coverage gap (the plan is prohibited by regulation from offering any additional VBID incentives that might be construed as variations in benefits).

The white paper concludes with a discussion of potential synergies resulting from combining VBID and PCMH approaches, and recommendations for employers on steps they can take to align their purchasing power to maximize the contribution of both strategies to improved health.

The Problem: Gaps in Care and a System That Doesn't Pay for the Right Care

Employers today are searching for strategies to increase the value of health-related benefits and mitigate the costs of poor health and lost productivity. Health costs continue to rise, and productivity suffers when employees experience poor health.¹

Many early employer initiatives were directed at cost control. Benefit innovations often involved increasing beneficiary cost sharing through higher premium contributions and deductibles and increased patient copays. The most widespread example of this tactic is the multitiered formulary for prescription drugs to discourage use of high-cost medications. More recently, consumer-directed health plans (also called high-deductible plans) have implemented first-dollar consumer cost sharing for most medical services to increase consumer awareness of

Figure 1. *A comparison of then and now.*

Attribute	1990's–Managed care	2009 and onward–PCMH
Primary stakeholders involved:	Health plans Employers	Health plans Providers
PCP role:	Gatekeeper	Medical home
Need to engage/involve:	Providers	Employers
Patients have...	Limited choices	Informed choices
Good health means:	Lower costs	Engaged individual
Employer focus:	Cost-reduction through appropriate utilization	Value-generation through appropriate utilization
Benefit design considerations:	In/out of network; copay used as financial disincentive	Value-based insurance design as financial incentive

the true costs of health care and help consumers use health care resources more judiciously. Figure 1 illustrates the evolution of pure cost containment approaches to value-based health care purchasing strategies.

Most recently, VBID has emerged as a strategy to set consumer cost sharing based on the clinical value—and not exclusively the cost—of the clinical service offering. The motivation of VBID is that current across-the-board benefit designs do not acknowledge that medical services differ in the amount of health (or value) gained per dollar spent. VBID is considered clinically nuanced, meaning that employers—usually through health plans—consciously identify health care treatments and services most likely to improve health and change benefit design to influence use of those services. **The basic premise of a clinically nuanced design is that when barriers to high-value medical services are kept low, more health is achieved at any price point.**

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Concurrent with more widespread adoption of VBID strategies has been the recognition that the health care delivery system is ill-equipped to provide the comprehensive, coordinated care known to be associated with better outcomes. The Institute of Medicine identified serious quality and coordination problems in 2001

when it called for a system that is safe, effective, efficient and equitable and that provides patient-centered care in a timely manner.² Employers now recognize that poor-quality and fee-for-service health care delivery is driving cost, often worsened by lack of coordination in the health care system.

Medical homes offer patient-centered care, or care consistent with the needs and expectations of the patients. This care is enabled by technology and other approaches to improve quality, care coordination and safety. A key component of the medical home is alignment of reimbursement so that physicians and other providers are compensated for the infrastructure and time investments needed to coordinate and deliver patient-centered care. Employers are increasingly partnering with providers and plans to promote coordinated high-quality care delivered through PCMH models of care. Employers view medical homes as a means to reduce quality-of-care gaps, improve access and enhance patient self-management. This approach represents a means to avoid wasted services and decrease health care expenditures.

SECTION 2

About Value-Based Insurance Design

VBID is an employer-driven benefit design strategy to optimize use of higher-value health care services and reduce use of lower-value services. The goal is to generate better results from employer health care expenditures. The underlying premise of VBID is getting more out of the health care dollar by removing barriers to essential, effective services.^{3,4} The VBID concept is based on three principles:⁵

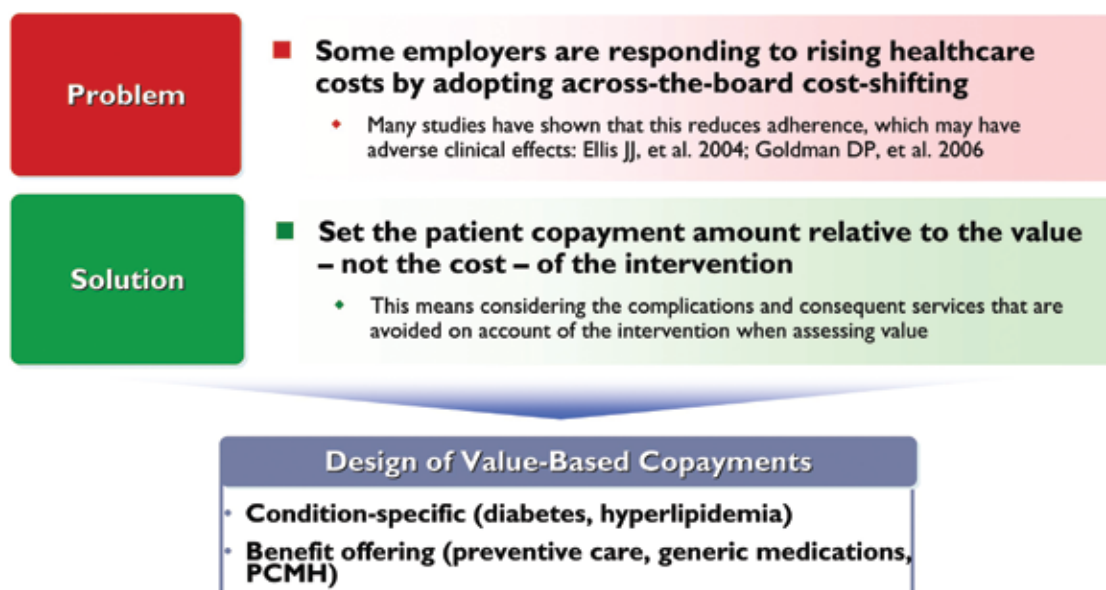
- Value equals the clinical benefit achieved for the money spent.
- Health care services differ in the health benefits they produce.
- The value of health care services depends on the individual who receives them.

VBID is frequently a tailored approach that crafts an employer-specific benefit strategy based on an assessment of an employer's population of covered beneficiaries and

health care use patterns. The strategy often uses employer data to identify important health issues and cost drivers. Benefits are then modified to create incentives for members to use high-value services.

VBID emerged from the observation that short-term employer cost savings resulting from increased cost sharing—such as an across-the-board increase in pharmaceutical copayments—may decrease patient health and in certain circumstances *increase* aggregate health care cost expenditures. This concept is illustrated in Figure 2. For example, if a covered employee with asthma uses a controller medication less often because of higher out-of-pocket cost, exacerbations may increase, possibly leading to costly emergency room visits and hospitalization. Moreover, these negative health effects of higher cost sharing are also likely to adversely impact indirect health care costs, such as productivity and long- and short-term disability costs.

Figure 2. A case for value-based insurance.



Adapted from Fendrick AM and Chernew ME. Value-based insurance design: aligning incentives to bridge the divide between quality improvement and cost containment. *Am J Manage Care.* 2006;12:SP5-SP10.

The implications of VBID for health benefit purchasers have been well described in several publications. Important publications include the *Value-Based Insurance Design Landscape Digest*, available from the Center for Value-Based Insurance Design at www.vbidcenter.org, and *Value-Based Benefit Design: A Purchaser Guide and Health Plan Capabilities to Support Value-Based Benefit Design*, available from the National Business Coalition on Health (NBCH) at www.nbch.org. These publications highlight in greater detail the research evidence underpinning VBID and identify practical steps forward for employer purchasers.

Business Case Rationale for VBID

Poor health care costs money. Researchers know that wasted health care services are a major driver of health care costs. A PriceWaterHouseCoopers examination of the topic estimates that \$1.2 trillion per year in health care costs (almost half) is waste. The study attributed \$210 billion to defensive medicine (duplicate or unnecessary services) and \$200 billion to preventable conditions.⁶ Patient behaviors also play a role in higher costs. There is not *enough* consistent patient demand or use of treatments known to be effective. For example, as many as 60 percent of chronically ill patients have poor adherence to essential, evidence-based treatments. Poor treatment adherence costs the system money when patients get sicker as a result of poor disease control. Nonadherence results in up to one-quarter of all hospital and nursing home admissions. Costs resulting from poor medication adherence have been estimated to exceed \$100 billion annually.⁷ On the flip side, there is a demand for many treatments and services that *do not* have an impact on health and that should be discouraged. An example is the overuse of antibiotics. Many patients expect and receive antibiotics for viral infections and other nonbacterial conditions that aren't helped by antibiotics. When antibiotics are prescribed unnecessarily, not only do health care costs increase, but antibiotic overuse leads to development of resistant microbes, which are more difficult and often more costly to treat. VBID is positioned to trim some of this waste by incentivizing use of services to improve control of chronic conditions and creating disincentives through the application of higher cost for lower-value services.

True cost is more than just health care expenses. Health care costs can be quantified in terms of direct and indirect costs. Direct health care spending on diagnostic and treatment services is projected at \$2.5 trillion in

2009, 17.6 percent of the country's gross domestic product. Indirect costs, including lost productivity from absenteeism or while at work (presenteeism), are enormous.⁸ One study of employees at Dow Chemical calculated that lost productivity costs of chronic conditions were equal to almost 11 percent of labor costs.⁹ Others have calculated the impact of lost time and presenteeism at 10 to 60 percent, depending on the condition.¹⁰ VBID design is influenced by the factors driving the combination of health care and lost productivity costs in an employer organization. For example, if diabetes is highly prevalent in the employee population, the employer could examine claims experience to identify cost drivers such as hospitalization or emergency room use. The employer might therefore target the VBID strategy to specifically improve diabetes care to prevent avoidable hospitalizations and other complications. This goal might be achieved through a combination of copay reductions for diabetes medications and supplies, along with additional incentives for ongoing participation in a medication therapy management program.

Employees are influenced by out-of-pocket costs and incentives. Considerable experience and research show that employer changes in cost sharing of medical care services can impact the use of services and medications.^{11,12,13} For example, use of mammography services for breast cancer screening decreases when cost sharing increases (this is particularly true for low-income women).¹⁴ Adherence to medication and other treatment recommendations is a critical factor in the effective management of chronic diseases and avoidance of costly exacerbations. Cost shifting to individuals that decreases use of essential medications can have a negative health impact on chronic conditions^{15,16,17} and can increase costs for acute services, such as hospitalizations. The inefficiency of the archaic one-size-fits-all approach is the driving momentum behind the VBID strategy. VBID employs financial incentives in the form of lower copays to increase use of essential pharmaceuticals¹⁸ or other treatments. Short-term benefit cost increases for the copay incentive are potentially offset by better treatment adherence, resulting in overall medical cost reductions.¹⁹ Chernew and colleagues recently reported that increased drug costs resulting from a VBID program that reduced copayments for five classes of medications for the treatment of asthma, diabetes and heart disease were offset by reduced use of nondrug services, suggesting no increase in total, systemwide medical expenditures.²⁰

Mechanics of VBID

The four basic approaches to VBID outlined in the *Value-Based Insurance Design Landscape Digest* include the following:

1. **Design by service.** Waive or reduce copayments or coinsurance for select drugs or services, such as statins or cholesterol tests, no matter which patients use them. This is the strategy employed by Pitney Bowes, which in 2002 reduced the copayments for drugs that treat asthma, diabetes and hypertension. Marriott International, Inc., adopted a similar approach for drug classes used to treat diabetes, asthma and heart disease.
2. **Design by condition.** Waive or reduce copayments or coinsurance for medications or services, based on the specific clinical conditions with which patients have been diagnosed. This approach is illustrated by the University of Michigan Focus on Diabetes Program, which lowered copayments for selected evidence-based medications and services for all employees with diabetes.
3. **Design by condition severity.** Waive or reduce copayments or coinsurance for members with a particular condition who are believed to be at high risk for excessive health care costs in the near future.
4. **Design by disease management participation.** An extension of the third design approach, this VBID solution provides reduced or waived copayments or coinsurance to high-risk members who actively participate in a disease management program. The City of Asheville Project highlighted this approach by offering free medications and testing equipment only for diabetics who attended educational sessions.²¹

These approaches implemented by early VBID adopters focus on chronic care. Other VBID strategies adopted by some employers address acute care and provide selection. For example, some employers provide incentives for the most cost-effective treatments (e.g., laparoscopic rather than open surgery for specific procedures) or copay incentives for patients to select the most cost-effective doctors or hospitals. The *NBCH Purchaser Guide and Health Plan Capabilities* publications offer more details on these approaches.

What VBID Means to Employers

Starting with Pitney Bowes, private and public employers have been incrementally adopting a variety of VBID

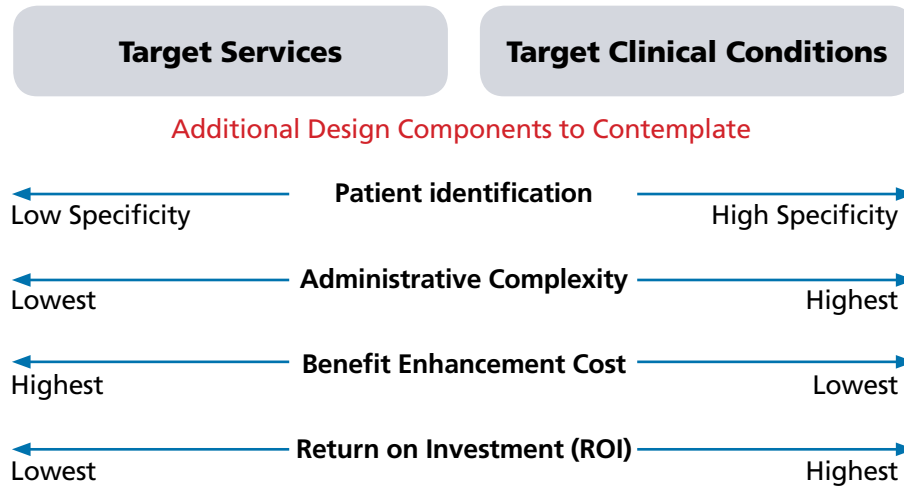
strategies. These range from reducing copays on essential medications²² to implementing free flu shots and health screenings. In many circumstances there is an underlying return-on-investment expectation.²³ IBM recently announced that it will cover all primary care and preventive services with no copayment, a clear sign that the company is investing in a preventive strategy.²⁴

VBID is scalable, depending on the investment an employer wants to make and the expected return. It draws heavily on employer data to identify areas of opportunity. Employers have implemented VBID at different price points for the benefit design intervention and with varying levels of intensity. For example, some employers offer reductions in copayments for chronic disease medications only to the most severely ill population of employees or those enrolled in disease management, while others offer the financial incentive to all patients with a condition such as diabetes. Figure 3 (see next page) illustrates the elements of a VBID approach that can each be scaled to influence the cost of a VBID effort, its population-wide reach and, potentially, its impact on health care outcomes.

The potential value for the employer electing to implement a VBID program depends on the number of individuals and the projected cost and benefit targeted by the VBID design. Thus, the economic lift for the employer is variable, as are the economic risks. That lift depends for the most part on the employee population size and benefit cost targeted by the employer. For example, employers can target a benefit incentive to the entire employee and dependent population, which may mean a large initial outlay. Another strategy is to target the benefit incentive to a select high-risk group, which may mean a smaller outlay with a greater anticipated yield in cost reduction. A growing body of evidence suggests that the timeliness and magnitude of the return on investment are tied to the ability to offer incentives to only those patient groups likely to benefit—clinically and economically—from incentives.²⁵

VBID is most effective as an information-driven endeavor based on either the employer's data or the use of predictive modeling tools. For the most part, the more effort expended to ensure the right population is receiving the benefit, the more likely that group is to have improved health outcomes as a result of the VBID design. For example, smoking cessation yields a return on investment in health and productivity cost savings,²⁶ and more people can be encouraged to attempt smoking cessation with benefit incentives.

Figure 3. VBID Continuum



Many employers have turned to health plans administering their benefit policy for support in both designing and administering VBID approaches. Plans are developing capability to identify high-needs patients, communicate with them about essential services, and administer variable, value-based benefits. The health plans profiled in this white paper for medical home activities have also tested a variety of VBID approaches—some alone and some in combination with medical home activities. NBCH's eValue8 Request for Information offers employers detailed information on health plan capability and sets the expectation that plans will implement evidence-based practices and innovations in services and programs.²⁷

The implementation of a particular VBID offering should be based on employer calculations that a targeted health benefit based on an identified health care cost driver, coupled with communications to engage employees, will have the intended impact. When the equation works, the employer achieves slower health care cost growth and/or higher productivity because of improved employee health. To make sure the benefit is working as designed, employers need to design in a rigorous evaluation that includes cost, quality and member experience metrics.

Employers seeking details on specific VBID programs are encouraged to review the case studies available in this publication and online.²⁸

Economics of VBID

VBID represents a calculated risk to employers that an investment to promote prevention and wellness or

reduce poor outcomes for those already sick will have either a financial or productivity return. There is some evidence that this is the case. As we have said elsewhere, however, VBID is a value purchasing strategy, not simply a low-cost purchasing strategy. Employers can expect higher expenses in some cost centers, particularly at the start of a VBID initiative. The financial impact of VBID programs depends on program design features, including the direction and magnitude of copayment changes and the extent of targeting. Available evidence suggests that programs that raise cost sharing for low-value services are most likely to save money, particularly in the short term. When increased cost sharing for specific services is considered, it is important to acknowledge that there are specific clinical instances in which a previously designated low-value service is clearly indicated (and therefore should be considered high value). Thus, the likelihood of clinical and economic success of a VBID program is related to the ability to link real-time clinical information to benefit design elements.

The ability of a VBID program to offset the full cost of the extra spending on high-value services (and the administrative costs of such a program) depends on 1) the underlying clinical risks in the population treated, 2) the effectiveness of the program at increasing the use of high-value services, 3) the ability of those high-value services to mitigate the risks and 4) the cost of the services averted. Depending on the relative magnitude of these factors, it appears clear that the better targeted the program, the more likely that the up-front spending to improve health will fully offset its costs.

SECTION 3

About the Patient-Centered Medical Home

Patient-centered medical homes are the provider (or supply-side) response to many of the health care quality issues employers identified. These issues include fragmentation, high cost and low quality, many of which are attributable to a meager primary care infrastructure.²⁹ Proponents believe that the PCMH is an essential evolution for the health care system.

Although the PCMH was first described and sometimes implemented decades ago,³⁰ only recently have there been systematic attempts to cultivate medical homes as an approach to solving some of the quality and inefficiency concerns of today's health care system. The PCMH has strong roots in pediatric settings, in large part because children's health care is preventive and proactive, and success of pediatric care management often relies on strong collaborative relationships between parents and providers.³¹

The Patient-Centered Primary Care Collaborative is a convening body for stakeholders, and the PCMH is gaining traction to improve care for chronically ill adults. Current iterations of the PCMH intend to transform medical practices: the PCMH fosters relationships between patients and providers, improves access, and increases quality and consistency of care. PCMH incorporates re-created office processes and payment systems to reward an ongoing physician-patient relationship, which may also improve physician and patient satisfaction.

In addition to enhanced infrastructure, the PCMH incorporates payment reform. It shifts funding back to primary and preventive care and reduces costs of higher-intensity services. A high-quality, coordinated medical home can help patients avoid hospitalizations and emergency department visits, thereby reducing costs. Most pilot programs under way for the PCMH have vigorous cost analysis embedded in the research design.

Evidence-Based Rationale for PCMH

Patients do not routinely receive high-quality care. The gaps in outpatient care quality have been well

established. For example, a study by McGlynn showed that, on average, patients receive recommended preventive and treatment services for medical conditions about half the time.³² Quality gaps exist in acute care settings too, resulting in higher costs: a 2009 study of Medicare patients found that 20 percent of patients are rehospitalized within 30 days after discharge. Readmissions are often preventable and are attributable to lack of follow-up and coordinated care. The cost of these system lapses was estimated at \$17.4 billion.³³ From a provider perspective, PCMH integrates the concepts of establishing standards of care, auditing records to identify patients who need care, and augmenting outreach to ensure that physicians and the health care team deliver recommended care in a coordinated manner. Several studies have shown that PCMHs are able to drive improvements in quality of care and patient experience.^{34,35,36}

Patient-physician partnerships are important to care outcomes. Lack of a personal physician is associated with lower rates of use of preventive services and higher rates of preventable illness and complications.³⁷ Across all chronic diseases, long-term adherence to a medical treatment plan is complex and often inconsistent.³⁸ Many experts believe that patients who develop a treatment plan in collaboration with their physician or other provider will be more adherent and have better outcomes. For example, a 2006 Commonwealth Fund study found that for individuals who have both health benefits and medical homes, quality-of-care gaps were reduced and access and self-management improved. Patients in this study were more likely to report having a care plan, check their blood pressure and report controlled blood pressure when they had a medical home than when they had no usual source of care.³⁹ A study of patient-provider connectedness also found that the development of a relationship between individuals and their primary care physician led to improved use of preventive care services and increased medication adherence.⁴⁰

Information management is essential to care coordination. Lack of information is often an underlying factor in poor-quality care. For example, when using paper-based

records, physicians often have difficulty quickly identifying what preventive services are needed or recalling information about the patient's medical history. Physicians can rarely identify all of the patients in their practices with a certain condition, such as diabetes, and determine if they are receiving recommended condition management and preventive services. Lack of information sharing between specialists and primary care providers is often a root cause of lost or duplicated tests and inadequate follow-up after hospital discharge. This results in higher costs or avoidable readmissions. These care management failures could be remedied through effective information management systems, a core attribute of the PCMH. In fact, several research reviews have shown that information management systems, if they are implemented appropriately and contain the necessary information and decision support elements, can improve efficiency and effectiveness of health care.^{41,42}

Delivery system improvement is relevant to employer-purchasers because even the best-designed benefits cannot succeed at improving health outcomes unless the care delivered is outcomes-driven, efficient and evidence-based. Further, unless care is delivered in a systematic manner, wasteful redundancies and readmissions will make benefits progressively more cost prohibitive—and also take a toll on employee productivity.

Mechanics of the PCMH

The NBCH and the Patient-Centered Primary Care Collaborative, *The Patient-Centered Medical Home: A Purchaser Guide*, outlines the model and specific implementation steps that could be adopted by interested purchasers.⁴³ The PCMH is defined variously by different organizations, with common threads. The National Committee for Quality Assurance defines it as follows:

The patient-centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.⁴⁴

Physician organizations, including the American Academy of Pediatrics, American College of Physicians, American Academy of Family Physicians and American Osteopathic Association, have agreed on common principles for a medical home that include the following attributes:⁴⁵

- Personal relationship with physician (many now recognize that other disciplines, including advanced practice nurses, can provide medical home care)
- Physician-directed teams of care
- Whole-person orientation toward the patient
- Coordinated care across settings that include hospitals and specialists
- Enhanced quality and safety through adoption of evidence-based protocols and information technology to manage information
- Enhanced access to care by improved communications and scheduling
- Improved physician payment that reflects infrastructure investments and participation of health care team members in the care process

More recently organizations have included other licensed primary care practitioners (such as nurse practitioners and physician assistants) in the definition of a medical home. The common theme among definitions is that PCMH is a systems-based approach to optimizing delivery of coordinated, evidence-based care under the auspices of primary care providers using information management approaches. As the core concepts of medical homes are adopted, it is likely that medical homes will emerge among specialty practices that treat cohorts of chronically ill individuals with specific clinical diagnoses, such as congestive heart failure or end-stage renal disease.

What PCMH Means to Employers

Delivery system improvement is relevant to employer-purchasers because even the best-designed benefits cannot succeed at improving health outcomes unless the care delivered is outcomes-driven, efficient and evidence-based. Further, unless care is delivered in a systematic manner, wasteful redundancies and readmissions will make benefits progressively more cost prohibitive—and also take a toll on employee productivity.

As a strategic approach, the PCMH model comprehensively integrates a number of separate health care components that employers have previously purchased as stand-alone offerings. An effective medical home integrates

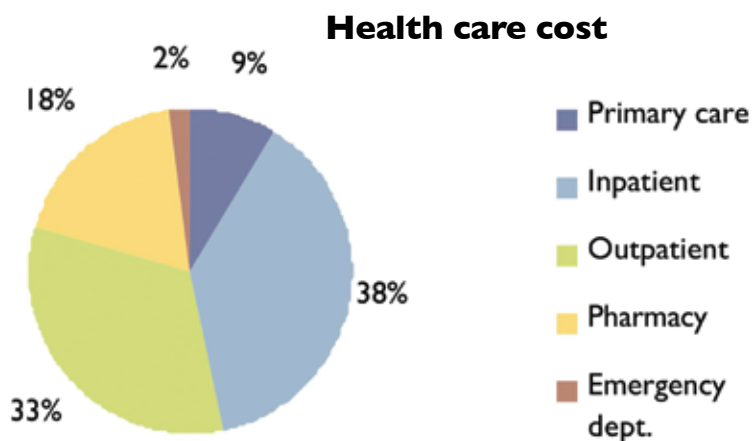
or coordinates disease management, wellness and health promotion, and behavioral health. Provider incentive strategies, including pay-for-performance, are integrated to reward the comprehensive care provided by a medical home.

Many employers believe that use of the PCMH will help them more effectively manage costs and improve health care quality and treatment outcomes⁴⁶ by better aligning and integrating disparate health care offerings into a single, coordinated approach. Figure 4 shows that employer costs for primary care are now relatively small. By boosting the investment in primary care, an employer may reduce the investment in higher-cost, higher-intensity care. The IBM case study shows how a large employer, which already offered first-dollar preventive care benefit coverage and recently added first-dollar primary care benefit coverage, believes that ensuring access to a comprehensive, qualified provider setting such as a PCMH is an essential component of a value-based purchasing strategy.

Multiple private employers as well as the federal government, through the Centers for Medicare and Medicaid Services (CMS), have implemented PCMH pilot studies. The medical home is widely discussed in the current health care reform debate. Several early demonstrations have shown significant improvements over traditional models of care. For example, published reports show the following:

- The Group Health Cooperative (GHC), an integrated delivery system in Seattle, Wash., has experimented with the medical home model as part of its ongoing effort to improve the quality of care for chronically ill patients. The Chronic Care Model developed at GHC includes the elements of evidence-based care, patient self-management education and provider decision support, among other elements.⁴⁷ GHC recently published results of a quasi-experimental evaluation of a medical home program designed to improve patient experience, improve access and quality, and control costs. In the study, PCMH patients reported slightly higher satisfaction than usual-care patients, along with improved access to phone, e-mail and specialist visits. The PCMH group also had lower use of emergency visits. The GHC study reported no significant differences in overall costs. The authors concluded that the PCMH model can improve quality and patient experience without a significant change in overall cost after the first year of implementation, but cautioned that there may be challenges in widespread replication of the model.⁴⁸
- Among the most mature PCMH programs is the Geisinger Health System in Pennsylvania, one of the few that have published results. Participating Geisinger practices create profiles for chronically ill patients before each visit to increase physician awareness and delivery of recommended services.

Figure 4. Typical U.S. employer health care cost distribution.



- By improving care quality with a PCMH, primary care costs will increase.
- However, implementation of PCMH has been shown to result in lower hospitalization rates—and will likely lead to lower health care costs.

Geisinger uses improved electronic information to identify patients who need care, creates physician incentives to deliver evidence-based care according to treatment standards, and makes access easier for patients by providing after-hours care and Internet scheduling. Results from the Geisinger pilot showed important improvements of care for people with diabetes and heart disease.⁴⁹ Medical home patients had reduced hospitalization rates, and the percentage of patients who receive recommended care for chronic diseases increased.⁵⁰ A case study in the Appendix discusses Geisinger's preliminary work to address demand by working with purchasers on additional elements to align financing and delivery system improvements.

- Public sector tests of PCMH have also shown promise. One of the most widely known early initiatives is that of Community Care of North Carolina. It began as a demonstration program in 1998 to improve the quality of care under North Carolina's primary care case management Medicaid system. Using foundation and other grants, the state created a partnership to improve Medicaid services and involved hospitals, social services and health departments to collaborate with community physicians. The program is credited with reducing duplicate costs and unnecessary hospitalization, along with helping the state meet quality goals.⁵¹

Additional case studies featured in this white paper examine other public and private employer strategies. In one of the most far-reaching experiments under way, the state of Minnesota in 2008 enacted a medical home provision as part of a statewide health care reform initiative and instructed the Department of Health to establish medical home criteria and begin certifying practices. Once the state certification program is operational, the state employee insurance program likely will begin to direct members to these coordinated care practices through incentives built into benefit design.

Economics of the PCMH

The current reimbursement model for primary care practitioners does not pay for qualitative services and enhanced care management, and has become a de facto financial disincentive to delivery of primary care services. Like VBID, PCMH incorporates financial incentives to act as levers that promote delivery of appropriate, valued health care services. In this case, provider payments reward coordinated care focused on early intervention and

prevention. Physician incentive payments in the medical home model encourage provider adoption of integrated systems for tracking and delivering evidence-based care. This contrasts with the current system that rewards volume of care and specialty care services and offers physicians no capital for investment in information technology. Medical home initiatives reengineer health system incentives to shift care to information-driven care.

Developing a generally accepted payment model for PCMH remains one of the challenges to widespread implementation. As is the case with VBID, there is now no single, generally accepted payment approach to support the medical home model. The payment reform elements of the PCMH—shifting dollars into primary and preventive care with the goal of averting preventable high-cost complications—requires collective action by payers. States, including Washington and Minnesota (profiled in this white paper), have played an important role in convening multipayer pilot tests that experiment with payment reform without violating state antitrust regulations.

Results from PCMH demonstration programs do show reductions in high-intensity, high-cost services. For example, America's Health Insurance Plans, summarizing results from a number of pilot programs reported by the PCPCC, found the following (cited in figures 5 and 6):⁵²

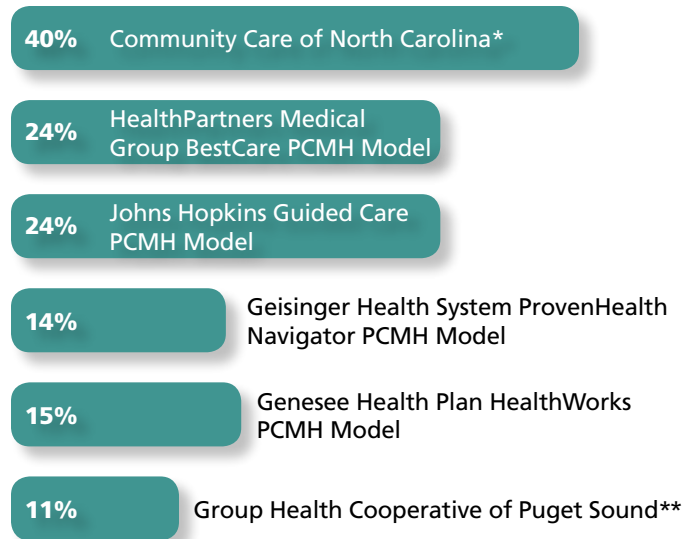
Still unresolved is how to channel dollars from savings into primary care or make the investment in primary care with only the expectation of future savings. While several PCMH financing models exist in pilot settings, it needs to be determined which are most likely to be sustainable. One important step is to create a universally available method for identifying enhanced medical home practices. Once purchasers can reliably know which plans offer comprehensive medical home services, they will be technically able to direct payments to those practices.

The National Committee for Quality Assurance (NCQA) has developed a promising approach to identifying medical homes through its recognition programs. NCQA standards identify three levels of practice integration; 416 physician practices including more than 4,000 physicians had been recognized by late 2009.⁵³ The tiered recognition approach allows physicians to make incremental progress toward comprehensive medical home services. To obtain NCQA recognition, provider practices conduct chart audits and an examination of office infrastructure. When a practice reaches a specified threshold of providing the infrastructure and care quality delivery, NCQA designates

Figure 5. *Reductions in emergency room visits*



Figure 6. *Reductions in hospitalizations*



*Study of asthma cases only **Study of ambulatory sensitive care admissions

SOURCE: Patient-Centered Primary Care Collaborative. (Ed.). (2009). *Proof in practice: a compilation of patient centered medical home pilot and demonstration projects*.

Results may reflect differences in definitions among different studies.

the provider as a recognized practice. Several pilot programs described in this white paper link enhanced payments to NCQA recognition. Many health plan pilots make NCQA recognition or progress toward recognition a condition of pilot participation. Recognition enables health plans to identify PCMH practices for the purpose of paying incentives or rewards.

Another recognition-reward model for PCMH services is in development by Bridges to Excellence (BTE), a national initiative to pilot rewards and incentives for better health care quality. BTE has implemented the BTE Medical Home program, a turnkey program for employers and plans that offers a specific incentives system to providers who achieve NCQA or other recognition for medical home activities and additional clinical quality activities.⁵⁴ BTE is also working on an evidence-based case rate approach called Prometheus Payment Inc.⁵⁵ that shifts financial incentives toward primary care and preventive services, consistent with medical home practice.

Other organizations have also proposed models for enhanced payment of medical home practices.⁵⁶ The American College of Physicians recommends paying for care coordination services in addition to per-visit

physician fees, with the added incentive of a performance bonus to promote physician engagement in producing better patient outcomes.⁵⁷ CMS has proposed a payment methodology for PCMH pilot sites recommended by its Resource-Based Relative Value Scale (RBRVS) Update Committee. The new methodology addresses some shortcomings of the RBRVS methodology, although some physicians argue that even the proposed PCMH payment model does not factor in the costs of a high-functioning PCMH.⁵⁸

As with VBID, financing the medical home incorporates some risk to employers, who may be called on to subsidize office practice improvements to create a PCMH practice. Employers should appreciate that their investments in enhanced primary care will presumably yield longer-term reductions in health care costs. Financial outcomes of PCMH pilots are now being evaluated. Preliminary indications based on improvements in evidence-based care delivery and clinical outcomes provide compelling, albeit circumstantial, evidence for meaningful cost savings.

SECTION 4

Why Employers Should Care About Both PCMH and VBID

Value of an Integrated Strategy

From an employer's point of view, PCMH and VBID should be viewed as complementary strategies used to change provider and patient behaviors, respectively, to impact the supply- and demand-side drivers of health care services. The logic is this:

- Medical home is a system or means of health care delivery.
- Medical home is a high-value service.
- Unless individuals are encouraged to use a medical home, there is no value generation for employers.
- Financial incentives can steer individuals to use high-value services (value-based insurance design).
- Incorporation of a value-based insurance design to promote medical home use can drive PCMH use.

The objectives of VBID and PCMH are clearly aligned to improve quality and continuity of care, and they are reinforced by incentives incorporated into both programs. Employer interest in VBID is based on the premise that strategically using incentives embedded in benefit design can encourage employees to adopt higher-value health care services—including medications, health behaviors or treatment protocols. In the case of PCMH, the employer's goal is to create incentives for physicians to deliver and employees to use more effective primary care services. Paying for prevention and chronic disease management is a better value than paying for treatment of acute-care problems. Both PCMH and VBID rely on evidence-based practice to improve health care quality. Together, the benefit strategy and the delivery system improvements offer greater health at any price. They can be deployed with incentives to increase uptake, resulting in high-quality, coordinated, effective and accessible care.

Although many programs are under way that incorporate aspects of both VBID and PCMH, only a handful include intentional strategic integration of these two components. Our premise is that when they are implemented together, these approaches can be mutually reinforcing. For example, as financial barriers are removed for recommended

services—including office visits—patients are more likely to receive necessary education, counseling and self-management support in a medical home care practice.

A number of potential employer benefit strategies to promoting PCMH use through VBID-like incentives are included in Figure 7. Some VBID initiatives already reflect these approaches. For example, a number of pilot VBID programs offer copay reductions to patients to use identified high-performing physicians and/or hospitals. It would take only a small program modification to apply the same financial reductions or waivers in copays for individuals seeking care from their PCMH. This would lower financial barriers to PCMH use. This rationale can be more broadly applied to include lower copays for PCMH-generated specialist referrals. For example, the member would have a relatively higher copay for self-referral to a specialist than if referred through a PCMH. Further analysis of existing PCMH pilots will help determine whether such steps are necessary to generate the desired improvements in quality and efficiency of health care delivery.

Figure 7. Value-based insurance design includes more than lowering medication copays

Employer considerations for PCMH-related benefits

- ▶ **Copay reductions for:**
 - ▶ Medical home visits
 - ▶ Specialist consults when referred by PCMH
 - ▶ Ambulatory services when referred by PCMH
 - ▶ Contributions to HRA/HSA for PCMH provider selection
- ▶ **Compliance with recommended care:**
 - ▶ Tiered employee benefit contributions
 - ▶ HRA/HSA contributions

Current Alignment of PCMH and VBID

For this white paper, the research team identified a number of employers, plans and public purchasers known to have implemented innovations in benefit design strategies.

The efforts reflect a spectrum of activity to align the approaches of PCMH and VBID. The case studies show that many organizations are now working to develop complementary strategies to either align a VBID approach with a PCMH initiative or develop PCMH capability to maximize the impact of an already-implemented VBID design. Most frequently these initiatives have been implemented sequentially, rather than concurrently.

The case studies highlighted below are described in more detail in the Appendix:

- **City of Battle Creek, Mich.**—In 2007, the city began collaborating with community partners in a multistakeholder initiative comprised of employers, insurers, providers and consumers. It began as a VBID program that waives copayments for many chronic care services. Physicians participating in the initiative developed Chronic Care Model collaboratives in tandem with the VBID initiative to align the delivery system with patient demand. Now 40 physician teams are leading a Pathways to Health Initiative that includes a patient registry and improved care management processes.
- **Whirlpool Corporation**—As a large private employer, Whirlpool launched a three-year PCMH model in 2010 designed to build on the 10-site occupational health infrastructure the company developed. The initial pilot will encompass 2,000 employees and dependents and 20 practices including 42 physicians. The model will offer improved access, member engagement, a patient registry and physician incentives. Whirlpool has an existing VBID program that offers premium and deductible discounts for treatment adherence and incentive payments for preventive care.
- **IBM**—As a large private employer, IBM is engaged in multiple medical home pilots, including an initiative with the Taconic Health Information Network and Community collaboration in New York. The pilot includes one million lives, 13 medical practices and 220 participating physicians. The practices offer enhanced access, improved information management and improved care quality and planned to seek NCQA PCMH recognition by the end of 2009. IBM is allocating \$3 million in incentive dollars based on PCMH performance on measures. For a VBID strategy, IBM offers first-dollar primary and preventive care coverage.
- **Minnesota**—The state of Minnesota developed the Minnesota Advantage Health Program in 2002 to improve on specific cost and quality goals for the 120,000 lives in the State Employee Group Insurance Program (SEGIP). The state network includes 1,200 clinics and 55 care systems with a biennial budget of \$1.5 billion. The state created tiered provider networks and uses VBID-like incentives to direct members to high-value providers that offer more efficient care based on cost, prevention and chronic care metrics. The state is developing an initiative to measure all care systems on explicit quality measurements, which will be incorporated into the tiered program in 2011. In addition, the state will define and certify medical homes to be offered to all SEGIP members in 2010.
- **Roy O. Martin**—A private employer in Louisiana with 1,200 employees, the company is establishing a new PCMH program designed to improve health and outcomes for dollars spent. It will feature improved care coordination, information technology and increased access. The company is considering options for structuring and administering the new program. The PCMH effort will complement current VBID strategies that provide discounts on premium contribution for health improvements and offer some chronic care medications at a discount.
- **Aetna**—This national health plan is conducting a three-year pilot PCMH collaboration with other plans in commercial and Medicare markets. The initiative, begun in August 2008, offers \$20,000 in initial support for PCMH certification by physician practices and performance rewards after certification. The plan sponsors a care team coordinator placed on-site at the medical practices. Aetna has also tested VBID approaches and expects the concepts to be reinforcing although they are not now linked.
- **CIGNA**—This national health plan is engaged in a number of pilot PCMH projects, including an initiative begun in 2008 with the Dartmouth-Hitchcock Clinic, a multispecialty, 1,000-doctor group practice and hospital serving 15,000 eligible CIGNA members. CIGNA provides analytic capability and support to providers, and providers assume more care management responsibility. PCMH is being tested separately from VBID, but if results warrant, the plan could potentially use VBID-like incentives for patients to encourage them to use medical home providers.
- **Geisinger Health Plan**—This regional health plan in Pennsylvania offers the Health NavigatorSM, a PCMH model that has redesigned primary care and provides population management with case manage-

ment focused on high-risk patients. The program, offered since 2007, includes 37 PCMH sites, 25,000 eligible commercial members and 40,000 eligible Medicare beneficiaries. The program uses predictive modeling and allows for core care management elements to be deployed to physician practices. Practices are offered additional stipends based on their size and are eligible for financial incentives linked to patient satisfaction, quality and value goals. Geisinger developed its own value-based purchasing strategy by paying for episodes of care for selected procedures, and it builds in quality indicators.

- **Universal American**—This large Medicare health plan has two million members in a variety of products. Universal American applies a medical home shared savings model to promote care coordination for Medicare beneficiaries. The company works with providers to focus on reducing hospital admissions and readmissions. The company offers a number of special programs to meet unique member needs. The plan offers a variety of low-cost and free services, such as a comprehensive annual wellness examination, flu shots and generic drug coverage through the Medicare Part D coverage gap to all members. Medicare prohibits variations in benefits to beneficiaries based on member category, so VBID approaches are not allowed.

Considerations for Implementation

We believe enough evidence exists for employers interested in a more progressive and proactive health benefits program to move forward with PCMH or VBID and to consider how the two approaches could complement each other. Before starting, employers should avail themselves of the many resources identified in this publication to support design work and perform necessary analytics. Employers should also be aware that early experience has also revealed some issues on which caution and careful planning are needed.

VBID: For many employers who have incorporated VBID into their benefits design, the process has not been complicated. Copay reductions for under-used high-value services have been implemented to create a financial incentive to drive use. Areas of focus have included preventive care services, medications for chronic condition management and health promotion programs.

But in its most extreme form of individualizing benefits to patients, VBID could introduce tremendous administra-

tive complexity. An ideal and highly complex approach would require a plan design that is not only tailored to the individual's circumstances (e.g., an individual's diagnosis and perhaps participation in condition management programs), but that also tracks both the ongoing diagnoses and medical services use of that individual to update specific benefit eligibility. Less-complex and potentially less-targeted approaches still require an employer to assess the value of services and make actuarial assumptions about uptake and impact.

Done incorrectly, VBID could increase plan administrative costs with little impact on health and productivity value. This was addressed earlier in the Economics of VBID subsection.

PCMH: Experiences at several PCMH pilot sites have shown that there may be challenges to fully implementing the model, particularly if physicians are not fully involved.⁵⁹ For example, a United Healthcare pilot of PCMH in Florida was called off after providers expressed opposition. Providers came out against the plan when they were asked to make infrastructure changes and intensify care processes up-front before any financial incentives had been offered.⁶⁰ United engaged physicians early in the process in a later demonstration program in Arizona. United Healthcare offered up-front payments to physicians to support process changes and involved physicians in the program design. This illustrates the need for practitioner engagement early in the process.

A 2009 study evaluating PCMH practices in multiple states also urged some caution in adopting the model. There can be some downside to provider practice transformation, and it may take years to fully recognize a change in provider culture.⁶¹ Others have warned that the emphasis on using the PCMH to improve working conditions and reimbursement for physicians must not be at the expense of patients, who should actually be the focus of systems redesign.⁶²

Other publications have discussed some of the implementation challenges to VBID and PCMH,⁶³ so the following highlights only a subset that emerged from the case studies:

- **Federal compliance:** Employers must be cautious in implementing benefits perceived to violate Health Insurance Portability and Accountability Act privacy standards or that appear to discriminate on the basis of a chronic illness.
- **Differential benefits:** Employee perception of

differential benefits and federal regulations both factor into a need to ensure that all employees can take advantage of benefits offered, or that the benefit is designed and communicated in a nondiscriminatory manner.

- **Business model:** A single, optimal business model for the PCMH has not yet been established. At this point revenue models are still in the pilot stage, making it somewhat risky for providers to invest in the infrastructure and human capital needed to deliver medical home-type care. Multistakeholder support and collaborative planning can help address these concerns. Rather than market PCMH services, providers must still be cautious not to engender adverse selection, in which the sickest patients gravitate to the practice and overwhelm available resources.
- **Critical mass:** Like providers, plans are wary of selling products related to the medical home. Plans have concerns that there is not a critical mass of providers to deliver medical homes if the plans tout them. Plans do not expect to be able to offer a tiered network product to their employer customers for many years, simply because the supply of medical home providers is limited.

VBID and PCMH: No research has yet examined the impact of combined VBID and PCMH because the concept is in its infancy. Employers considering a dual strategy should consider the right balance to financial incentives that accrue to the employee (VBID) and financial incentives that accrue to the provider (payment changes through PCMH). Using a strict return-on-investment measure of success, it is possible that employers and plans could design a combined approach that ended up paying too much in the combined incentives for the value (or outcome) produced. Alternatively, the combined effect could multiply the health effect synergistically. The value of the outcome should be balanced between employee and provider incentives. Theoretically, these combined incentives should not exceed the value of the outcome. An evaluation strategy would need to examine not just the individual effect, but the combined effect.

SECTION 5 Next Step for Employers

Employers, providers and plans have proceeded with implementation of combinations of VBID and PCMH using a broad variety of definitions and program models. As the case studies in this report show, many employers have incorporated both supply- and demand-side incentives to augment their programs. We argue that the synergies of the approaches suggest there is reason to adopt a more systematic approach to maximize the benefit—and value—of these strategies.

When compared to the status quo, both VBID and PCMH ultimately have the potential to increase the value of employer investments in health care.

Role of Plans, States and eValue8

From the employer perspective, while both PCMH and VBID strategies are directed at the desirable goals of improving health outcomes and cost containment, the methods to promote them are different. VBID is an employer-driven initiative and can be implemented through benefit design changes. PCMH comes from the health care delivery sector. Employers rarely have direct financial relationships with physicians, and payment reform underlying the PCMH may be most efficiently effectuated by all payers, rather than a single plan or employer. As such, medical home adoption and financing must be mediated by one or many health plans.

States have an important role in convening or authorizing multipayer medical home initiatives. Both Minnesota and Washington State have been critical in involving national health plans such as Aetna, CIGNA and United Healthcare in PCMH demonstration programs. In the area of multiple-payer medical home pilots, states, because of antitrust concerns, play a critical convening and facilitating role. Multipayer initiatives are necessary to provide sufficient leverage of a provider's practice to fully transform care delivery. Examples in Pennsylvania, Vermont, Colorado, New York and Rhode Island show states convening and overseeing PCMH activity to maintain antitrust compliance. States rely heavily on other stakeholders for partners in the program design and implementation. In a reform bill passed in 2009 (House Bill 2009), the state

of Oregon requires both VBID and PCMH principles for health benefit packages approved by the state Health Policy Board. The bill requires state agencies to do the following:

1. Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.
2. Require little or no cost sharing for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illnesses.
3. Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.
4. Require a greater contribution by an enrollee to the cost of elective or discretionary health services.
5. Include a defined set of health care services that are affordable, financially sustainable and based on the prioritized list of health services developed and updated by the Health Services Commission.

Health plans have a role in establishing proof of concept for the PCMH and in helping to build a critical mass of PCMH sites needed to move from pilot evaluation to mainstream implementation. Employers have leverage to engage health plans as intermediaries, both in designing the provider network and negotiating payment rates. Employers can leverage their activities and dollars by working collectively with other employers through coalitions and can use NBCH's eValue8 Request for Information (RFI) to assess plan performance on both VBID and PCMH activities. Concurrent with incorporation of PCMH into health plan offerings, employers can then incorporate specific incentives into benefit design to promote PCMH use. Many plans are involved in medical home pilots and, with increasing employer demand, are positioned to implement the concept more broadly when pilot results reveal favorable outcomes.

Health plan data are and will be essential for identifying high-performing practices and administering value-based payments. To make medical home-centric networks available for mass distribution, however, plans require a critical mass of PCMH practice sites. They also depend

on employers to develop or purchase the plan designs to support such service offerings. As evidence supporting the value of PCMH accumulates, employers will need to encourage plans to provide product offerings such, as tiered networks of PCMH providers, and work with plans to design clinically and quality-sensitive benefit options.

One tool available to employers is the NBCH eValue8 RFI.⁶⁴ As an annual standardized RFI, eValue8 sets expectations for health plan performance. eValue8 examines VBID administrative capabilities as well as plan involvement in PCMH programs, and expects plans to experiment with designs and physician relationships that make good clinical and economic sense. The eValue8 RFI captures detailed information about health plan service offerings, quality measures and functional capabilities. eValue8 embeds the philosophy that by requiring plans to document capabilities and track uptake by employers, plans can be motivated to accommodate demands of purchasers and innovate on their behalf. Purchasers use eValue8 to compare plan offerings, which prompts plans to participate more actively in VBID and PCMH pilot programs.

Findings from eValue8 do in fact show both progress and variation in plan implementation of VBID and PCMH. More detailed data are available in NBCH publications.

Stakeholder Collaboration

Many of the most active collaborations around the PCMH have been undertaken at the regional or local level. This is illustrated by case studies in this white paper. Case studies of Washington and Minnesota also illustrate the important leadership role that states can play, particularly in payment

reform. States can serve a convening function that permits collaboration among plans and providers that might otherwise be prohibited under antitrust laws. Leaders of these initiatives emphasize the importance of involving stakeholders—employers, physicians and plans—early and often, and also point to the need for a real commitment by participants to address the needs and views of all stakeholders. Many of the case study organizations credit a multistakeholder approach as a factor in their success.

In the future, business health coalitions may increasingly engineer community-wide initiatives to adopt or replicate VBID and PCMH initiatives. Coalitions representing multiple employers add efficiency to implementation of the model and leverage the purchasing power of the participating employers. Employers and employer coalitions can help move discussions forward with health plans and can develop collaborative solutions that successfully integrate attributes of both VBID and PCMH. Use of eValue8 could also help develop regional approaches. eValue8 assesses health plan activity regionally, and could help employers address the limitation of one purchaser or one plan attempting to implement these programs.

The case studies in this report reflect early adopters, organizations that have taken concerted action to improve either the supply side (PCMH) or the demand side (VBID) of the health care equation. Several, including IBM, the city of Battle Creek, Roy O. Martin Lumber and the state of Minnesota, have cumulative initiatives under way, having started with a single strategy and layered on another approach. Participants have noted that once patients, providers, plans and purchasers are at the table, new ideas are generated and participants recognize gaps to be filled.

Figure 8. *The importance of benefit design.*



Next Steps

Detailed discussions of medical home and VBID implementation steps are outlined in the *Purchaser Guides* available on the NBCH and PCPCC Web sites. Employers who have adopted either a VBID or PCMH approach should consider augmenting it with a complementary strategy, potentially one developed through participation in a multistakeholder collaboration or through the collective action of a business health coalition. Self-insured employers have the greatest leverage to take action and adopt innovations. For employers, exploratory steps forward to align the systems include the following:

- Partner with regional health coalitions and/or other employers and health plans to increase the impact and feasibility of supply and demand approaches such as PCMH, VBID and integrated pilots of both.
- Use data to determine the business value of PCMH and VBID (assess the population to determine prevalent conditions, identify adherence issues, identify high-volume physicians, practices and clinics, etc.).
- Develop effective communications to convey the purpose and value of the VBID and PCMH programs to employees.
- Engage employees and providers in program design.
- Emphasize carrots over sticks and incentives over penalties.
- Introduce appropriate member support, such as self-management tools, personal health records, shared decision support for specific conditions and provider performance summaries.
- Support provider-directed initiatives around PCMH development.
- Assess health plan capability and maturity in implementing VBID and PCMH by using tools such as eValue8.
- Communicate effectively and regularly with stakeholders in a collaboration.
- Engage health plans in PCMH pilots.
- Consider a targeted VBID strategy, such as starting with employees with chronic conditions.
- Encourage evidence-based specialist referrals from primary care practitioners.
- Rely on external validation of quality where possible, such as NCQA recognition, the BTE recognition and/or reward system, or eValue8.
- Define evaluation metrics before program implementation.

As this and other reports have shown, plans and employers are actively engaged in evaluating these supply- and demand-side strategies. It is critical that employers continue to promote rigorous evaluation of pilot programs to determine their impact on health, productivity and organizational costs. Results of employer and plan pilots will provide additional details on the effectiveness of these VBID and PCMH strategies.

Conclusion

This nation is in the throes of debate on health care reform. While there is little agreement on the specific mechanisms, there is general consensus that the health care system is not delivering acceptable value in clinical outcomes for the dollars spent.^{65,66,67} Many of the solutions proposed are highly consistent with the underlying principles of VBID and PCMH:

- Better delivery of evidence-based practices
- Increased reliance on information management in health care
- Cost sharing and reimbursement aligned with high-value services
- Coordinated, multidisciplinary care
- Increased engagement of and attention to patients

Employers need to engage with other stakeholders to move the health care system forward in delivery system and benefit design improvements. There is no off-the-shelf medical home plan available to buy. Instead, employers and employer coalitions need to be involved in developing medical home models that truly add value to health benefits employers offer. VBID may well be part of an effective benefit design strategy that creates incentives for high-value health care, and the medical home may prove to be a key ingredient. Once more clinical and financial results of PCMH pilots are in, PCMH practices are likely to become more widely available. Meanwhile, employers can educate their employees and deploy incentives for higher-value health care because the status quo is not acceptable. By aligning delivery system improvements with benefits created around value, employers can move the system toward the critical, yet elusive, goals of quality improvement and cost containment. We look forward to watching these innovations mature.

RECOMMENDED READING

The Patient-Centered Medical Home: A Purchaser Guide

Patient-Centered Primary Care Collaborative, 2008
<http://pcpcc.net/content/purchaser-guide>

Proof In Practice: A Compilation Of Patient-Centered Medical Home Pilot And Demonstration Projects

Patient-Centered Primary Care Collaborative,
October 2009
www.pcpcc.net/files/PilotGuidePip.pdf

Value-Based Benefit Design: A Purchaser Guide

National Business Coalition on Health, January 2009
www.nbch.org/NBCH/files/ccLibraryFiles/Filename/000000000222/VBBD%20Purchaser%20Guide.pdf

Value-Based Insurance Design Landscape Digest

A. Mark Fendrick, Center for Value-Based Insurance Design, July 2009
www.sph.umich.edu/vbidcenter/pdfs/NPC_VBIDreport_7-22-09.pdf

Health Plan Capabilities to Support Value-Based Benefit Design

National Business Coalition on Health, October 2009
www.npcnow.org/Files/ResearchMediaLibrary/VBBD_Report_for_Health_Plans.pdf References

REFERENCES

¹Loeppke R, Taitel M, Haufler V, Parry T, Kessler RC, Jinnett K. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med.* 2009 Apr;51(4):411-28.

² Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* 2001 National Academy Press, Washington, D.C.

³ Fendrick AM, Chernew ME. Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment. *American Journal of Managed Care.* Vol.12, 2006: 12:SP5-SP10.

⁴ Fendrick AM, Chernew ME. Value-Based Insurance Design: A Clinically Sensitive Approach to Preserve Quality of Care and Contain Costs. *American Journal of Managed Care.* 2006 12(12). 5-10.

⁵ Excerpted from Fendrick, AM. *Value-Based Insurance Design Landscape Digest.* July 2009. Center for Value-Based Insurance Design. Available at: <http://www.sph.umich.edu/vbidcenter/>.

⁶ PriceWaterhouseCoopers Health Research Institute. *The price of excess: Identifying waste in health care spending.* 2007. Available at: http://www.pwc.com/en_CZ/cz/verejna-sprava-zdravotnictvi/prices-of-excess-healthcare-spending.pdf.

⁷ Dunbar-Jacob J, Mortimer-Stephens MK. Treatment Adherence in Chronic Disease. *Journal of Clinical Epidemiology.* 54 (2001) S57-S60.

⁸ United Biosource Corporation. *The Burden Of Disease: The Economic Case For Investment In Quality Improvement and Medical Progress, A Literature Review and Synthesis.* August 2009.

⁹ Collins JJ, Baase CM, Sharda CE, Ozminkowski RJ, Nicholson S, Billotti GM, Turpin RS, Olson M, Berger ML. The assessment of chronic health conditions on work performance, absence, and total economic impact for employers. *J Occup Environ Med.* 2005 Jun;47(6): 547-57.

¹⁰ Goetzel RZ, Long SR, Ozminkowski RJ, Hawkins K, Wang S, Lynch W. Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. employers. *J Occup Environ Med.* 2004 Apr;46(4):398-412.

¹¹ Huskamp, HA, Deverka PA et al. The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending. *New England Journal of Medicine* (2003). 349(23): 2224-2232.

¹² Goldman DP, Joyce GF, Escarce JJ et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA.* 2004;291:2344-2350.

¹³ Huskamp HA, Deverka PA, Epstein AM et al. The effect of incentive-based formularies on prescription-drug utilization and spending. *NEJM.* December 4, 2003 Number 23 Volume 349:2224-2232.

¹⁴ Trivedi AN, Rakowski W, Ayanian JZ. Effect of cost sharing on screening mammography in Medicare health plans. *N Engl J Med.* 2008 Jan 24;358(4):375-83.

¹⁵ Gibson, TB, Mark TL, McGuigan KA et al. The Effects of Prescription Drug Copayments on Statin Adherence. *Am J Manag Care.* 2006;12:509-517.

¹⁶ Heisler M, Langa KM, Eby EL, Fendrick MA, Kabeto MU, Piette JD. The Health Effects of Restricting Prescription Medication Use Because of Cost. *Medical Care.* July 2004.42(7):626-634.

¹⁷ Rice T, Matsuoka KY. The impact of cost-sharing on appropriate utilization and health status: a review of the literature on seniors. *Med Care Res Rev.* 2004 Dec;61(4): 415-52.

¹⁸ Chernew ME, Shah MR, Wegh A, Rosenberg SN, Juster IA, Rosen AB, Sokol MC, Yu-Isenberg K, Fendrick AM. Impact of decreasing copayments on medication adherence within a disease management environment. *Health Aff (Millwood).* 2008 Jan.-Feb.;27(1):103-12.

- ¹⁹Berger J. Economic and clinical impact of innovative pharmacy benefit designs in the management of diabetes pharmacotherapy. *Am J Manag Care*. 2007 Apr; 13 Suppl 2:S55-8.
- ²⁰Chernew ME, Shah MR, Wegh A, Rosenberg SN, Juster IA, Rosen AB, Sokol MC, Yu-Isenberg K, Fendrick AM. The Financial Effects of a Value-Based Insurance Design Program. *Health Affairs*. 2010. Published online at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2009.0119>.
- ²¹Excerpted from Fendrick, AM. *Value-Based Insurance Design Landscape Digest*. July 2009. Center for Value-Based Insurance Design. Available at: <http://www.sph.umich.edu/vbidcenter/>.
- ²²Berger J. Economic and clinical impact of innovative pharmacy benefit designs in the management of diabetes pharmacotherapy. *Am J Manag Care*. 2007 Apr;13 Suppl 2:S55-8.
- ²³National Business Coalition on Health. *Value-Based Benefit Design: A Purchaser Guide*. 2009 Washington, D.C. Available at: <http://www.nbch.org/NBCH/files/ccLibraryFiles/Filename/000000000222/VBBD%20Purchaser%20Guide.pdf>.
- ²⁴*Wall Street Journal*. IBM to Drop Copay for Primary-Care Visits. 29 October 2009.
- ²⁵Fendrick AM, Chernew ME. Value-Based Insurance Design: maintaining a focus on health in an era of cost containment. *American Journal of Managed Care*. 2009 Vol. 15 No. 6, 338-339.
- ²⁶Kahende JW, Loomis BR, Adhikari B, Marshall L. A review of economic evaluations of tobacco control programs. *Int J Environ Res Public Health*. 2009 Jan;6(1): 51-68. Epub 2008 Dec 28.
- ²⁷Houy, M. *Health Plan Capabilities to Support Value-Based Benefit Design*. National Business Coalition on Health. October, 2009 Washington, D.C. Available at: http://www.npcnow.org/Files/ResearchMediaLibrary/VBBD_Report_for_Health_Plans.pdf.
- ²⁸Center for Health Value Innovation. *Value In Action: How Five Public Sector Employers are Managing Cost and Improving Health using Value-Based Design*. 2009. Available at: <http://www.vbhealth.org/wp-content/uploads/2009/09/A-FINAL-Value-Based-Design-in-Action-8-25.pdf>.
- ²⁹Bodenheimer, T. Primary care—will it survive? *NEJM*. 2006 Volume 355 (9):861-864.
- ³⁰American Academy of Family Practice. *The Patient-Centered Medical Home History, Seven Core Features, Evidence and Transformational Change*. 2007. Available at: <http://www.adfammed.org/documents/grahamcentermedicalhome.pdf>.
- ³¹Wegner SE, Antonelli RC, Turchi RM. The medical home—improving quality of primary care for children. *Pediatr Clin North Am*. 2009 Aug;56(4):953-64.
- ³²McGlynn E et al. The quality of health care delivered to adults in the United States. *NEJM* 2003. June 26:348(26) 2635-45.
- ³³Jencks SE, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program 2009. *NEJM*. Volume 360(14) 1418-1428.
- ³⁴Rosenthal TC. The medical home: growing evidence to support a new approach to primary care. *J Am Board Fam Med*. 2008 Sep-Oct;21(5):427-40.
- ³⁵Homer CJ, Klatka K, Romm D et al. A review of the evidence for the medical home for children with special health care needs. *Pediatrics*. 2008 Oct;122(4):e922-37.
- ³⁶Reid RJ, Fishman PA et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before-and-after evaluation. *Am J Manag Care*. 2009 Sep 1;15(9):e71-87.
- ³⁷Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-26.
- ³⁸Ali RC, Melloni C, Ou FS et al. Age and Persistent Use of Cardiovascular Medication After Acute Coronary Syndrome: Results from Medication Applied and Sustained Over Time. *J Am Geriatr Soc*. 2009 Sep 15.
- ³⁹The Commonwealth Fund. *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey*. June 27, 2007 Volume 62. Available at: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Closing-the-Divide—How-Medical-Homes-Promote-Equity-in-Health-Care—Results-From-The-Commonwealth-F.aspx>.
- ⁴⁰Atlas SJ, Grant RW, Ferris TG, Chang Y, Barry MJ. Patient–Physician connectedness and quality of primary care. *Annals of Internal Medicine*. Vol 150, 3 March 2009 325–335.
- ⁴¹Chaudhry B, Wang J, Wu S, Maglione M, Mojica W, Roth E, Morton SC, Shekelle PG. Systematic review: impact of health information technology on quality, efficiency, and costs of medical care. *Ann Intern Med*. 2006 May 16;144(10):742-52. Epub 2006 Apr 11.
- ⁴²Shekelle PG, Morton SC, Keeler EB. Costs and benefits of health information technology. *Evid Rep Technol Assess (Full Rep)*. 2006 Apr;(132):1-71.
- ⁴³Bailit M, Hughes, C. *The Patient-Centered Medical Home A Purchaser Guide*. Understanding the model and taking action. 2008. PCPCC, Washington, D.C.
- ⁴⁴Excerpted from the National Committee for Quality Assurance. *Physician Practice Connections—Patient-Centered Medical Home*. <http://www.ncqa.org/tabid/631/Default.aspx>.
- ⁴⁵Patient-Centered Primary Care Collaborative and the National Business Coalition on Health. *The Patient-Centered Medical Home. A Purchaser Guide*. 2008.

Washington, D.C. Available at: <http://www.pcpcc.net/content/purchaser-guide>.

⁴⁶ Sepulveda MJ, Bodenheimer T, Grundy P. Primary care: can it solve employers' health care dilemma? 2008 *Health Aff (Millwood)*. Jan-Feb;27(1):151-8.

⁴⁷ See The Chronic Care Model. Available at: http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18 Accessed October 15, 2009.

⁴⁸ Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Patient-centered medical home demonstration: a prospective, quasi-experimental, before-and-after evaluation. *Am J Manag Care*. 2009 Sep 1;15(9):e71-87.

⁴⁹ The Commonwealth Fund. Continuous Innovation in Health Care: Implications of the Geisinger Experience. Available at: <http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Sep/Continuous-Innovation-in-Health-Care—Implications-of-the-Geisinger-Experience.aspx>.

⁵⁰ Paulus RA, Davis K, Steele GD. Continuous innovation in health care: implications of the Geisinger experience. 2008 *Health Aff (Millwood)*. Sep-Oct;27(5):1235-45.

⁵¹ Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dobson LA Jr. Community Care of North Carolina: improving care through community health networks. *Ann Fam Med*. 2008 Jul-Aug;6(4):361-7.

⁵² Miller G. PCMH Effectiveness: The Proof Is In. *AHIP HI-WIRE*. January 04, 2010. Available at: http://www.ahiphiwire.org/News/default.aspx?doc_id=483773&page=1. Citing data from Patient-Centered Primary Care Collaborative. *Proof in Practice: A compilation of patient-centered medical home pilot and demonstration projects*. October 2009. Available at: <http://www.pcpcc.net/files/PilotGuidePip.pdf>.

⁵³ NCQA personal communication with BWS 11/30/09. See NCQA Web site at www.ncqa.org for the latest information.

⁵⁴ Bridges to Excellence. BTE Medical Home Program Description. Available at: <http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=124>. Accessed October 15, 2009.

⁵⁵ De Brantes F et al. *Sustaining The Medical Home: How Prometheus Payment® Can Revitalize Primary Care*. (2008?) Washington, D.C. Available at: <http://www.prometheuspayout.org/publications/pdf/STMH%20Full%20with%20Apps.pdf>.

⁵⁶ Goldfield N, Averill R, Vertrees J et al. Reforming the Primary Care Physician Payment System: Eliminating E & M Codes and Creating the Financial Incentives for an Advanced Medical Home. New Directions in Ambulatory Care Financing. *Journal of Ambulatory Care Management*. 2008. 31(1):24-31.

⁵⁷ American College of Physicians. A System in Need of

Change: Restructuring Payment Policies to Support Patient-Centered Care. Philadelphia: American College of Physicians; 2006: Position Paper. Available at: http://www.acponline.org/advocacy/where_we_stand/policy/change.pdf.

⁵⁸ See American College of Physicians. Medicare Medical Home Demonstration Project. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/cms_demo.htm.

⁵⁹ Carrier E, Gourevitch MN, Shah NR. Medical homes: challenges in translating theory into practice. *Med Care*. 2009 Jul;47(7):714-22.

⁶⁰ *Internal Medicine News*. United Health expands medical home program. April 1, 2009. Available at: http://findarticles.com/p/articles/mi_hb4365/is_7_42/ai_n31612038/.

⁶¹ Nutting PA, Miller WL, Crabtree BF et al. Initial lessons from the first national demonstration project on the practice transformation to a patient-centered medical home. *Ann Fam Med*. 2009;7(3):254-260.

⁶² Berenson, RA, Hammons T, Gans DN et al. A House is not a Home: Keeping Patients at the Center of Practice Redesign. 2008 *Health Affairs*, 27, no. 5: 1219-1230.

⁶³ See *Value-Based Insurance Design Landscape Digest* and *NBCH Purchaser Guide* publications cited earlier.

⁶⁴ See for example www.evalue8.org and various eValue8 related publications at www.nbch.org.

⁶⁵ Porter ME. A Strategy for Health Care Reform—Toward a Value-Based System. 2009. *NEJM* 361;2. 109-112.

⁶⁶ Teisberg EO, Wallace S. Creating a high-value delivery system for health care. *Semin Thorac Cardiovasc Surg*. 2009 Spring;21(1):35-42.

⁶⁷ Institute of Medicine. Value in Health Care. Accounting for Cost, Quality, Safety, Outcomes and Innovation: Preliminary Discussion Brief. March 2009 Available at: <http://www.iom.edu/CMS/28312/RT-EBM/57756.aspx>.

Employer and Plan Case Studies

LARGE PRIVATE EMPLOYER

Whirlpool Corporation

Business description: Whirlpool Corporation is the world's leading manufacturer and marketer of major home appliances, with 70,000 employees worldwide. It is headquartered in Benton Harbor, Mich.

Initiation of Program: A five-year strategic plan and the introduction of a new synergistic global benefits discipline—medical management—were the main impetuses behind the development of a patient-centered medical home (PCMH) at Whirlpool. The stage was nearly set; Whirlpool began to invest in its 10 occupational health centers supported by coaches, pharmacists and employee assistance program counselors, realizing there wasn't sufficient participation in disease management programs. "As a large employer, we feel confident that we can influence the community and add value," says Chris McSwain, director, global benefits. "If our employees and their families receive better care through the PCMH pilot, they will raise the level of care received by others in the community." The implementation of the three-year PCMH pilot is slated for Jan. 1, 2010, in Findlay, Ohio, the site of one of the company's manufacturing facilities.

PCMH Program Objectives:

- Coordinate care of medical home participants with all clinicians, including the on-site resources at Whirlpool, ensuring continuity of care and support in meeting individualized care plan goals.
- Use quality engineers and change management coaching to redesign physician practices to accommodate PCMH structure and become more patient-centered.
- Establish clinical practice guidelines for care based on national best practices.

- Reward physicians for delivering value to participants and employer.
- Align the PCMH with other company health care strategies.
- Arrest the rising costs of diabetes, hypertension and chronic obstructive pulmonary disease/asthma.
- Emphasize preventive services for all participants.
- Create access to a comprehensive team of health care professionals.
- Develop end-to-end care model with the primary care physician at the center.

Program Features: Initially, the employer-sponsored and -driven model will include about 2,000 employees and dependents and 20 practices, representing 42 physicians. Other area employers will join the medical home in 2011. Employee participants will have improved access to care and receive outreach reminders about services and medications, systemwide care coordination and follow-up, as well as individualized care planning and educational support. Physicians will earn incentives for each PCMH participant. In addition, the PCMH will house a patient registry to promote care coordination and outreach.

Lessons Learned:

- "Medical home" has many meanings; adapt meaning to meet the needs of the community.
- Community buy-in is critical to launching and sustaining a PCMH.
- Adopt creativity in working with all constituents and exploring all resources.
- Make a business case for employers to join a PCMH.
- Accelerate adoption of PCMH and value-based insurance design (VBID) through proactive communications to plan members and providers explaining how and why changes are being made.

PCMH/VBID Alignment: "We have developed creative incentives and disincentives to drive desired behavior, to make our employees better health care consumers,"

McSwain says. If employees are more compliant with appropriate medical care, they receive more favorable co-pays and deductibles than those who are not. In addition, employees can earn quarterly incentives for taking advantage of preventive services. Whirlpool also grants incentives to employees who choose minimally invasive procedures over surgery and offers a range of prescription medications at no charge to members with chronic conditions. Finally, Whirlpool developed a program targeting diabetes, in which office visits, supplies and medications require no copayment.

“We have developed creative incentives and disincentives to drive desired behavior, to make our employees better health care consumers.”

*—Chris McSwain, Director, Global Benefits,
Whirlpool Corporation*

“VBID is the cornerstone of our PCMH,” adds Susan Pavlopoulos, manager, medical management. “The design drives employees to access the medical home.”

Future Plans: “If the pilot is a success, we hope to roll it out to other Whirlpool communities,” Pavlopoulos says. “The combination of on-site care and trust in clinicians should enable the medical home’s success.” Whirlpool also anticipates expanding VBID to other conditions, such as asthma and chronic obstructive pulmonary disease.

Contact:

Chris McSwain, chris_m_mcswain@whirlpool.com

Susan Pavlopoulos, susan_a_pavlopoulos@whirlpool.com

Washington State

Business Description: The Public Employee Benefit Board (PEBB) provides insurance coverage to eligible employees, retirees and their dependents, and other eligible groups for the state of Washington. PEBB is two-thirds self-insured and one-third fully insured, with 300,000 covered lives and a budget of \$1.2 billion.

Initiation of Program: PEBB's programs are aligned with Governor Christine Gregoire's health agenda being carried out by the Washington Health Care Authority (HCA). HCA is the umbrella agency that includes PEBB and has a variety of value-based purchasing and care improvement programs. Three components of the state's value-based purchasing strategy are worksite wellness, evidence-based medicine and a medical home initiative. HCA executes a legislatively enabled program called Washington Wellness, which has the goal of improving employee health through a uniform wellness initiative across state agencies. HCA administers a program for a state-preferred drug list and a health technology assessment program that uses a community clinical committee to evaluate evidence-based reviews of new and emerging medical technologies and renders a coverage decision. The state-preferred drug list and coverage decisions apply to HCA's self-funded plan, Medicaid fee-for-service and the state's workers' compensation program. The medical home project is a community-wide multistakeholder initiative jointly established with Medicaid and the Puget Sound Health Alliance with HCA as the lead.

Program Objectives: HCA programs are aligned with the health care goals established by a 2006 Blue Ribbon Commission cochaired by the governor:

- Access to health coverage
- Becoming one of the top 10 healthiest states in the nation
- Achieving consistent health across race, gender and income levels
- Increased use of evidence-based care
- Controlling the rate of increase in total health care spending

Program Features: PEBB emphasizes use of a health risk assessment (HRA) and increased prevention behaviors. Preventive care visits and immunizations are offered with no copay, as is the Free and Clear smoking cessation program. In addition, PEBB has implemented a polypharmacy initiative to help coordinate care and a Health Counts program with incentives for healthy behaviors. Members get points for participation in the HRA and can earn up to a \$60 gift certificate. PEBB also engages local pharmacies to deliver vaccines; employees get the vaccine free with a coupon from the employer. PEBB has a carve-out Disease Management program for the self-insured health plans contracted to ActiveHealth that enhances coordination of member health status with appropriate service utilization. HCA sponsors the Washington Wellness Healthy Worksite Initiative, which focuses on health and wellness promotion at state agency worksites and the integration of worksite activities with the employees' health benefits.

VBID/PCMH Alignment: HCA has a multipayer PCMH project in development with multiple stakeholders, including PEBB, the Puget Sound Health Alliance, purchasers, providers and plans. The program has legislative authorization to waive antitrust provisions for the plans to enable them to collaborate on reimbursement strategies. The participant group is designing a risk-adjusted reimbursement model for the PCMH and identifying necessary practice transformation elements. Pilot test sites will be selected in mid to late 2010. Aligned incentives and consumer engagement are important elements of the pilot.

Results: PEBB is early into the value-based purchasing initiative and does not yet have reliable results. The Puget Sound Health Alliance is part of eValue8 and will look at Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to assess results. They are also part of Community Checkup, which includes data agreements with purchasers. They contribute claims data to a data warehouse that produces a HEDIS report for the community based on multiple payers. Data come from health plans and include the major employers. As data suppliers, participating employers receive the data reports and can compare their own data to community performance.

Lessons Learned:

- Try to learn from value-based purchasing and PCMH initiatives around the country.
- Drill down on other pilot projects to learn about the implementation details.
- Evaluate options for relevance to your population.
- Consolidate the information, such as the “who, what and why,” to help those who are just getting started.
- Pick a target: medication, disease or population of members.
- Evaluate the specific impact of each implemented strategy.

Three components of the state’s value-based purchasing strategy are worksite wellness, evidence-based medicine and a medical home initiative.

Future Plans: The PCMH pilot project will be fully implemented in 2010. Once the PCMH pilot is under way, PEBB may look at how to align benefit design. PEBB will examine VBID approaches around the country and understand how new initiatives might apply to Washington. In January 2010 PEBB will implement a three-year action plan for procurements with health plans. Procurement and plan negotiations will determine specific approaches.

Contact:

PEBB—John Williams, john.williams@hca.wa.gov
HCA (PCMH)—Richard Onizuka, richard.onizuka@hca.wa.gov

City of Battle Creek, Michigan

Business Description: The city of Battle Creek, located in Calhoun County in south-central Michigan, has a population of about 53,000 and a budget of \$120 million. It sponsors a self-insured health plan, administered by Blue Cross Blue Shield of Michigan, and covers 2,100 employees, retirees and dependents.

Initiation of Program: The seeds for a PCMH were planted in 2007, when Calhoun County developed a multistakeholder collaboration working together to close the health care delivery gap for those with chronic disease. Several visionary employers, including the city of Battle Creek, Kellogg and Battle Creek Health System, implemented a VBID initiative with support from Blue Cross Blue Shield of Michigan. Partners include Trinity Health, Kellogg and Integrated Health Partners (IHP). Physicians from IHP—a physician hospital organization—developed the Pathways to Health program. Pathways to Health includes a PCMH experiment designed to align delivery system care.

“With the support of employers and health plans, physicians have their first opportunity to look at their practices and determine how they could do things differently and more effectively,” says Rick Hensley, the city of Battle Creek’s risk manager. Hensley says that at least 20 percent of the city’s workforce is subject to some kind of chronic condition, with 10 percent suffering from diabetes—a rate 20 percent higher than for the state.¹

VBID Program Objectives:

- Remove financial barriers to care for health plan beneficiaries.
- Increase enrollment in disease management.
- Increase the use of high-value services.
- Increase employee productivity.

PCMH Program Objectives:

- Transform the delivery of care to focus on outcomes.
- Adopt the Chronic Care Model.

- Engage employees in their health care.
- Develop collaboration between a proactive care team and informed, motivated patients.
- Improve the use of information technology to coordinate care and support population-based care.
- Use evidence-based guidelines to ensure quality care.

Program Features: In May 2007, 10 physician teams committed to creating a patient-centered model of care by learning how to implement the Chronic Care Model encompassing self-care, delivering care across the continuum, decision support, using evidence-based guidelines, ensuring quality care, improving health information technology and developing community support. In addition, IHP developed patient registries for Battle Creek employees with diabetes and coronary artery disease, tracking 10,000 patients. The initiative has provided flexibility since “the medical home is local,” says Mary Ellen Benzik, MD, IHP medical director. Another 28 physician teams have joined the second wave of learning collaboratives.

Incentives are not yet available for creating a medical home, but physicians may earn rewards for participation in and performance improvement for selected initiatives through the Physician Group Incentive Program, a state-wide initiative.

PCMH/VBID Alignment: The Battle Creek VBID and PCMH programs are complementary and are developing in parallel. As Dr. Benzik explains, “The VBID piece is geared toward employers, while the PCMH is the physician part.” Enrollment for a value-based diabetes program started in November 2009, and will be followed by other chronic conditions. The VBID program for diabetics waives all copayments for diabetes and cholesterol-lowering drugs, labs, exams and supplies for employees who participate in the care management program for the condition, attend scheduled appointments with their doctors and adhere to their drugs.

Results: All PCMH teams showed improvement in measures of processes and outcomes of care, including those who received retinal exams (up 44 percent) and foot exams (77 percent). Rates rose 102 percent for flu vaccinations and 347 percent for pneumonia vaccines, and depression screening rose dramatically. Treatment outcomes for blood pressure, A1c and LDL improved by 8.5 percent,

¹“Employer Snapshot: Battle Creek, Michigan.” The Center for Health Value Innovation. 2009.

“With the support of employers and health plans, physicians have their first opportunity to look at their practices and determine how they could do things differently and more effectively.”

—Rick Hensley, Risk Manager for the city of Battle Creek, Michigan

5.7 percent and 22 percent, respectively, when compared to baseline values.

Lessons Learned:

- Involvement of multiple employers has a greater impact on the market than a single employer could.
- Engage at the highest level of the organization for support, but assign people at the grassroots level to actually do the work.
- This work is more challenging than anyone from the outside can understand.
- Return on investment can be difficult to measure.
- Create a real vision and get buy-in from all stakeholders, especially physicians.
- Choose a physician champion.
- Create real partnerships that collaborate to create and execute the vision.

Future Plans: Battle Creek’s future ambitions are many, says Dr. Benzik. She anticipates that the city will develop capabilities to compare the implications of a system with and without a VBID in place, further develop the PCMH and add incentives, and evolve VBID to include medium-sized employers, not just self-funded companies.

Contact:

PCMH—Mary Ellen Benzik, MD, mebstork@aol.com

VBID—Rick Hensley, rlhensley@ci.battle-creek.mi.us

IBM

Business Description: IBM is a multinational computer and information technology corporation headquartered in Armonk, N.Y., with more than 388,000 employees worldwide.

Initiation of Program: Four years ago, IBM had an “aha” moment when it realized it needed to start addressing the real issues affecting health care in its organization and designing appropriate benefits. Paul Grundy, MD, director of health care transformation for IBM and president of the Patient-Centered Primary Care Collaborative (PCPCC), says IBM decided that to get more value for the organization’s health care dollars, it needed to demand care integration and pay for it. The Taconic Health Information Network and Community Regional Health Information Organization (THINC-RHIO) pilot is one of several under way with IBM sponsorship. IBM was one of the founders in 2006 of the PCPCC, whose principles are directing many of the programs addressing the medical home model: transform how primary care is delivered and financed to provide better outcomes; enhance access; develop appropriate reimbursement to physicians; and improve value, accountability and transparency to purchasers and consumers.

Program Objectives:

- Develop a comprehensive primary care environment with a care coordination team approach to care.
- Support adherence to evidence-based care.
- Foster relationships between providers and patients.
- Incent physician and patient behaviors encouraged by IBM.
- Develop a mechanism for capitation.
- Improve health care accessibility.
- Leverage use of technology, such as electronic medical records, and patient registries
- Help providers become more efficient.

Program Features: IBM is helping to create medical homes through partnerships with providers, payers and employers. Dr. Grundy says that VBID supports the principles of PCMH by delivering the services needed to achieve optimal individual and population health.

One of the earliest projects, a four-year pilot started in 2008, is a collaboration among IBM, six health plans (Aetna, CDPHP, Hudson Health Plan, Empire Blue Cross Blue Shield, MVP, United Healthcare and WellPoint) and Taconic IPA in New York’s greater Hudson Valley. The PCMH addresses one million lives and has 13 medical practices with 220 participating physicians. The THINC-RHIO project emphasizes the transition from episodic care to ongoing care orchestrated by primary care physicians. The project promotes open-access scheduling, additional and later office hours, and enhanced communication tools and coordinates care through registries, electronic health records, a health information exchange and a dedicated care coordination staff. “With the help of technology, we need to drive communications and encourage trust,” he says.

THINC is working closely with physicians to help them achieve Level 2 certification for medical homes from the National Committee for Quality Assurance (NCQA). The pilot will collect data from electronic medical records and chart reviews, derive utilization data from aggregated claims, and obtain patient and physician feedback through surveys. Data will include clinical quality, cost, and provider-patient experience and satisfaction. Participating physicians may receive a total of \$3 million in incentives collectively, with 20 percent derived from process and outcomes measures from aggregated administrative data from plans and the other 80 percent from earning the NCQA Level 2 recognition for PCMH. IBM will pay an additional \$1 per member per month to qualifying practices for their employees and dependents.

PCMH/VBID Alignment: The company has already ventured into VBID by providing first-dollar coverage for primary care and preventive services, promoting physician-patient relationships and discounting medications for chronic diseases.

Results: Three of the practices participating in THINC have already submitted PCMH applications to NCQA with another eight on target by Nov. 1, 2009. NCQA was expected rule on the applications by Dec. 31, 2009. Another PCMH pilot shows that the model has affected savings by reducing incremental expenditures when compared to a system without medical homes, and several others have not yet generated results.

Lessons Learned:

- Pilots must have a significant population to change the practice.
- Pilots need multistakeholders, including insurers, employers, providers and patients.
- Incentives must be aligned appropriately.
- Physician buy-in is necessary.

“With the help of technology, we need to drive communications and encourage trust.”

—Paul Grundy, MD, Director of Health Care Transformation for IBM and president of the Patient-Centered Primary Care Collaborative

Future Plans: As the current PCMH pilots continue, IBM anticipates continuing its participation, along with its technology, financial contributions and expertise.

Contact: Paul Grundy, MD, pgrundy@us.ibm.com

State of Minnesota

Business Description: The Minnesota State Employee Group Insurance Program (SEGIP) is the largest employer in the state. The program has 120,000 lives (90 percent union) insured, covering the judicial, executive and legislative branches of Minnesota government, and a \$1.5 billion biennial budget. The delivery system includes 1,200 clinics and 55 care systems. SEGIP participates on many public-private purchasing coalitions, including the Buyers Health Care Action Group, the Smart Buy Alliance and the Labor/Management Health Care Coalition of the Upper Midwest.

Initiation of Program: SEGIP created the Minnesota Advantage Health Plan in 2002, which ranked all care providers and incented its members to seek more efficient care systems. SEGIP implemented additional value-based purchasing initiatives in 2005 and continues to expand on the VBID concept. The delivery system component, including a specific medical home initiative, was enacted in 2008 as part of a state health care reform initiative. The state of Minnesota will develop standards and begin certifying PCMHs in 2010. Minnesota was looking for broader health care reform, and the SEGIP program wanted to align with state initiatives.

Program Objectives:

- Use plan design to improve cost and quality.
- Improve employee outcomes.
- Increase use of high-value services.

Program Features: SEGIP doesn't necessarily define the program as VBID, but it tries to direct members to the best line of care. The Minnesota Advantage Health Advisor program is a one-stop phone-based benefit and health care advisory program that helps members identify the best providers and access the benefits that will work best for them. The plan offers 100 percent prevention coverage, medication therapy management, free smoking cessation, telephone counseling, a diabetic program, coaching and waived copays for selected diabetes medications. Elements of the program include the following:

- Tiered networking
- Centers of excellence
- Prevention care
- Health risk assessments
- Medical therapy management
- Minnesota Advantage Health Advisors
- Pay-for-performance programs (Bridges to Excellence)

"Minnesota has had a major emphasis on tiered networks as a strategy to address the cost and quality variation observed between providers and provider groups," says Director Nathan Moracco. "We incentivize patients by offering a lower copay when patients use more efficient providers." SEGIP ranks providers on efficiency and uses plan design to try to direct members to the better providers. Efficiency is defined as either lower cost or more effective care (e.g., more prevention). The equation is based on claims data so it indirectly captures quality. No providers are excluded from the network, but the program works to increase transparency of provider performance and align patient incentives with efficiency. It will move to explicit quality measures in 2011, which will use all payer claims data to develop quality reports that will be factored into the tiering incentive program.

VBID or PCMH Alignment: SEGIP has always believed in the medical home concept, but hasn't specifically defined it as such. It considers health maintenance organizations (HMOs) very similar to medical homes, and the current SEGIP plan design model, which requires members to choose primary care providers, has many elements. PCMH is slightly different from an HMO model of care because there is provider-level accountability for outcomes. For the diabetic Medication Therapy Management (MTM) program initiated in 2007, SEGIP waived copayment for drugs, labs and office visits.

Results: The data-driven approach and incentives to encourage members to use more efficient providers has had an economic impact. The data clearly show that not all clinics are the same. SEGIP saved 7 percent (\$53 million in today's costs) on Minnesota Advantage. Clinically, SEGIP has seen changes in costs because of better care as well. A total of 776 members joined the MTM program. These members had 39 percent fewer emergency room

visits and 24 percent fewer hospital admissions. In terms of provider performance measures, they had a 20.4 percent to 34.9 percent improvement (compared to 20.7 percent) in optimal diabetes scores in the first six months.

Lessons Learned: Incentives can have varying impact on members. For example, SEGIP achieved a 74 percent participation rate on health assessments by offering a \$5 reduction in office visit copays, yet had less than 25 percent participation in a diabetic MTM program that waived all copays for office visit, drug and lab costs (including drugs and medical services related to any comorbid conditions). The latter program had a much higher cost savings potential than the health assessment incentive, but members were cautious about the motives related to the incentives. In addition, pilots are great ways to flush out administrative issues with VBID before rolling out to the masses. A good customer experience is key to widespread adoption.

“Our reform strategy is to make sure that purchasing and the delivery system are lined up to ensure members have a coordinated, high-quality care system.”

—Nathan Moracco, Director of the Minnesota State Employee Group Insurance Program

Future Plans: According to Moracco, “The state of Minnesota wants to ensure that the entire system redesign applies to all patients—care process shouldn’t be applied according to payer, but should be applied to all patients. Our reform strategy is to make sure that purchasing and the delivery system are lined up to ensure members have a coordinated, high-quality care system.” Moracco sees SEGIP’s VBID and PCMH activities as an interim step in overall reform. The goal is to create awareness among members of the value of a medical home and what it means to the member, and create a more integrated care approach.

Contact: Nathan Moracco, nathan.moracco@state.mn.us

Roy O. Martin Lumber

Business Description: The company, based in Alexandria, La., is a wood products manufacturer with 1,200 employees. Besides its headquarters, Roy O. Martin has two other facilities within 30 miles of Alexandria. It has successfully kept the organization's health care cost trend at 3 percent annually.

Initiation of Program: Roy O. Martin anticipates that its PCMH model will start formally in February 2010, once the company decides the route it plans to take: outsource the administrative portion of the model or partner with a vendor and assume a more hands-on approach to operating the medical home. As a smaller employer, Roy O. Martin knows the benefits of collaboration, says Diane Davidson, benefits manager. "That's why we plan to join forces with other employers." The company's successful wellness program is a testament to collaboration, born out of a partnership with four other Central Louisiana companies and spearheaded by each company's occupational health nurse.

Program Objectives:

- Give our employees and their dependents access to quality care with measurable outcomes.
- Emphasize preventive and primary care.
- Create a healthier population more cost-effectively.
- Demonstrate how an up-front investment in health can lead to better outcomes in the long term.
- Provide one-stop shopping complete with lab, pharmacy, preferential referrals to specialists and less waiting time.

Program Features: Although the model's design is not yet finalized, Davidson says the major pieces are in place. According to Davidson, "We have designed programs to improve outcomes and health. We are in the process of establishing a medical home, but we've had a successful wellness program in place for a long time and we are building on that." The PCMH will incorporate an electronic medical record, which Davidson says will set the model one step above a regular clinic and eliminate the perception by employees that the PCMH is a "doc-in-the-box" approach. In addition, the PCMH will use physician

performance scorecards, provide incentives to physicians, rely on care coordinators for making appointments and follow-up, integrate an on-site pharmacy with lower copayments and work toward NCQA Level 3 certification for PCMH.

Roy O. Martin still has a few decisions to make, including determining if the out-of-pocket expense for health care will be less for employees participating in the medical home and if the new model will be open to just employees enrolled in the company's self-insured, self-administered health plan or to all employees. Davidson says that the company's health plan and, for that matter, its soon-to-be medical home are straightforward and not rocket science. "What we have is working well; we just need to do some tweaking," she says.

PCMH/VBID Alignment: Although Davidson may not call two benefits the company provides value-based insurance design, they most certainly are aligned with a value-based strategy. In the wellness program, employees can set goals to lose weight, stop smoking and lower blood pressure. They can work one-on-one with nurse educators to earn incentives and premium discounts for accomplishing a certain number of goals. The other benefit is a 90-day supply of diabetes medications for as low as \$15.

Lessons Learned:

- You can't build a PCMH alone.
- Both the medical and business communities have expressed more interest than anticipated.
- Businesses are looking for a solution to a real problem and understand that an up-front investment will pay off later; however, they need to see concrete evidence (i.e., decrease in claims and dollars for a chronic condition).
- Return on investment is not easy to tally.

Future Plans: Davidson says she hopes that Roy O. Martin will be able to share its successful model with other employers in the next two years.

Contact: Diane Davidson, diane.davidson@royomartin.com

CIGNA

Business Description: CIGNA is a national health plan with 10 million members and a staff that includes 230 physicians, 1,900 nurses, 400 behavioral health professionals and 200 pharmacists. Eighty percent of members are in open-access plans in which no designated primary care practitioner is required. The company has developed advanced analytics to provide patient-specific actionable information and performance reports. It also has a robust health advocacy program that includes health risk appraisals, telephonic and Internet-based wellness coaching, disease management and case management.

CIGNA has partnered with the Dartmouth-Hitchcock Clinic, a multispecialty group practice of about 1,000 doctors and one hospital. The clinic has 1.5 million annual visits in urban, suburban, rural and academic practices. The clinic has a fully integrated electronic health record system and cares for 15,000 individuals enrolled in a CIGNA health plan.

Initiation of Program: CIGNA views this PCMH pilot program as an opportunity to combine health plan resources with physician resources to produce a better outcome. CIGNA also incorporates payment reforms into the PCMH model by paying providers a care management fee based on their impact on the quality and affordability of health care for the population they serve. The plan participates in numerous PCMH pilots across the United States. In addition to the incentive, key aspects of CIGNA PCMH pilot sites are the following:

- **Clinical integration:** This entails shifting responsibility for case management from the health plan to the medical group practice, and ensuring ideal clinical coordination between the group practices and the plan offerings. By moving care to the physician office, CIGNA representatives hope that there will be more face-to-face patient engagement. CIGNA offers care management support to complement physician activities, including a health risk assessment, health advocacy, coaching tools and online resources.
- **Informatics:** PCMH sites have modern electronic health records capability and registries to identify people in need. CIGNA uses its analytic capability

to provide clinicians with a monthly patient-specific actionable “gaps in care” electronic report. Practitioners also receive trend reports on cost and quality of the group compared to the total population in the pilots.

Program Objectives:

Improve performance on the following metrics:

- **Clinical:** Increase guideline compliance in a broad array of measures, including preventive care: mammography, chronic care: hemoglobin A1C, hospital admissions: total and avoidable, hospital readmissions: total and avoidable, emergency visits: total and avoidable, and other results: specialty referral rates, high-tech imaging rates, and pharmacy generic and preferred rates.
- **Cost and productivity:** Total savings, total medical cost trend compared with market, change in cost per patient, cost per practice and other results: productivity and self-management skills.
- **Satisfaction:** Patient, physician, nurse and other clinicians.

Program Features: The essence of the Dartmouth-Hitchcock pilot project is to develop an incentive program for physician groups committed to improving outcomes on affordability, quality and patient experience. In particular, the Dartmouth-Hitchcock Clinic offers coordinated care and disease registry information, methods to assure care is provided according to evidence-based guidelines, e-prescribing capability, inpatient and discharge care transition assistance capabilities, and lab test and referral follow-up capability. It will seek NCQA PCMH certification.

PCMH/VBID Alignment: CIGNA’s strategy to encourage use of higher-quality, higher-value providers is operationalized through the use of tiered networks, which offer a lower copay to individuals who use higher-quality health care professionals. CIGNA is considering how to alert and incentivize patients to complement the development work going on at the physician level.

Results: The Dartmouth-Hitchcock project has completed one year of implementation and results are being evaluated. The clinic has developed additional capabilities,

The essence of the Dartmouth-Hitchcock pilot project is to develop an incentive program for physician groups committed to improving outcomes on affordability, quality and patient experience.

and Dartmouth-Hitchcock is in the process of seeking NCQA PCMH certification.

Lessons Learned: The PCMH pilot evaluation is still in its early stages.

Future Plans: If the results do show that the PCMH can improve cost and quality, CIGNA could potentially develop a tiered network that includes medical homes and offer incentives for patients to access those medical home providers. Such incentives could be through lower copays or deductibles. This offering would be implemented only when the PCMH model is mature and there is enough penetration of medical homes to assure patients could have access.

Contact: Dick Salmon, MD, dick.salmon@cigna.com
Medicare Health Plan

Universal American

Business Description: Universal insures two million Medicare beneficiaries through a variety of plans—Medicare Advantage HMOs, preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans, as well as Medicare Part D prescription drug plans.

Initiation of Program: Universal American has adopted a PCMH model or what Patricia Salber, MD, chief medical officer and executive vice president, calls a “healthy collaboration.” In practice, the company has been evolving its medical home model for 10 years through its flagship Medicare Advantage HMO in Southeast Texas, with highly collaborative relationships and customized services for network physicians.

Program Features: Universal American’s Healthy Collaboration model supports the PCMH in the following ways:

- Funding for services that take place outside of the exam room (e.g., care coordination, case management, medication adherence)
- Fair payment to providers for comprehensive annual wellness examinations
- Support for innovations, such as office-based infusion clinics and the development of senior centers in low-income neighborhoods that provide access to a PCMH for members who may not have had one
- Provision of member-specific data to physicians to facilitate identification of members with care needs (e.g., annual exam, case management) and to reduce gaps in care (e.g., tests and medications that should be ordered)
- Collaboration among plan, providers and pharmacists to enhance member outcomes
- Technical assistance for new groups to help transform their practices to PCMHs

Dr. Salber says the plan’s philosophy about physician reimbursement for medical home efforts is to share in any savings that are generated through efficiencies. As a Medicare Advantage plan, savings are also shared with the member, which helps lower financial barriers to care.

Program Objectives:

- Build relationships between health plans and physicians.
- Establish buy-in from physicians.
- Develop physician leadership for the model.
- Provide relevant and credible data to medical groups.
- Ensure care coordination.
- Align incentives between plans and providers, resulting in equitable physician reimbursement.
- Develop infrastructure for medical home models in new markets.

“In a typical practice, physicians are running from one patient to another with little opportunity to develop care coordination or to study their entire patient population,” Dr. Salber says. “We will do whatever it takes to support our network physicians outside of the examination room. Our plans are working with physicians, not telling them what do.”

Results: While Universal American cannot cite specific results, Dr. Salber says the plan measures success through traditional utilization measures, quality measures such as hospital readmissions and member satisfaction. Based on a study reported in the *New England Journal of Medicine*, 19.6 percent of Medicare beneficiaries who had been discharged from the hospital were readmitted within 30 days. Dr. Salber says that her plan’s results are four percentage points below that benchmark.²

VBID PCMH Alignment: As a Medicare insurer, Universal American is not allowed to employ the full range of VBID approaches (e.g., designs by condition, condition severity or disease management participation) because regulations prohibit VBID incentives that could be construed as variations in benefits by member category. “If there is a pilot for VBID in a Medicare plan, I’d apply in a minute,” says Dr. Salber.

² Jencks SE, Williams MV, Coleman EA. “Rehospitalizations Among Patients in Medicare Fee-For-Service.” *The New England Journal of Medicine*. Vol. 360; No. 14. pp. 1418-28. April 2, 2009.

“We will do whatever it takes to support our network physicians outside of the examination room. Our plans are working with physicians, not telling them what do.”

—Patricia Salber, MD, Chief Medical Office and Executive Vice President, Universal America

Lessons Learned:

- Physician buy-in is essential.
- The plan or employer sponsor must serve as the glue between itself and the physicians in building relationships and solving problems.
- Providing data is an integral part of the medical home infrastructure.
- Make goals realistic; don't ask too much of physician groups.
- Align incentives.
- Promote transparency.

Future Plans: Universal American hopes to export its model on the medical management side to new markets.

Contact: Patricia Salber, MD, psalber@universalamerican.com

Geisinger Health System/ Geisinger Health Plan

Business Description: Founded in 1915, Geisinger Health System, headquartered in Danville, Pa., is one of the nation's largest integrated health services organizations. Serving more than 2.6 million lives throughout central and northeastern Pennsylvania, the physician-led organization is comprised of two medical center campuses, three hospitals, an 800-member group practice, a not-for-profit health insurance company and the Henry Hood Center for Health Research.

Initiation of Program: Working hand in hand, the Geisinger Health System and the Geisinger Health Plan built the framework for their PCMH in 2006 and implemented the model in 11 primary care practices in 2007. Today there are a total of 37 sites, including five non-Geisinger physician practices. The PCMH, called Health NavigatorSM, is an initiative under Geisinger's ProvenCare umbrella. It has redesigned the care delivery model for 25,000 commercial members and 40,000 Medicare beneficiaries.

Program Objectives:

- Transform primary care from a transaction-based to a value-based model focused on improving quality, experience and efficiency.
- Eliminate fragmentation in the system; enhance the patient experience and health status through coordination of care.
- Ensure that patients receive appropriate care to decrease waste and improve outcomes.
- Create a partnership between PCPs and Geisinger Health Plan that provides 24/7 care and guidance to the practice population.

Program Features:

Janet Tomcavage, vice president, health services for Geisinger Health Plan describes the five primary components of the PCMH:

1. **Patient-centered primary care.** This effort not only puts the patient in the middle of the care

process, but also includes disease registries, health information technology, clinical process plans, teaming and role delineation, informed decision-making and development of an individualized care plan for high-risk patients.

2. **Integrated population management.** Geisinger uses predictive modeling to identify and segment the member population in order to design benefits and interventions to meet needs. Predictive modeling enables the care team—nurse case managers, primary care physicians, mid-level practitioners and front office staff—to focus on members at highest risk to prevent exacerbations. Population management strategies are provided across the health care spectrum, including preventive care services, disease management intervention and case management for complex, comorbid conditions.
3. **Value-based care system.** This strategy emphasizes partnerships among all of the levels of health care system, from outpatient to lab to inpatient. It involves identifying and working with nursing homes, emergency departments, home health agencies and community-based pharmacies to ensure safe and effective transitions of care as well as high-quality, efficient care. "By developing these relationships, we are able to maximize connections to deliver the level of care we want and patients deserve," Tomcavage says.
4. **Quality outcomes programs.** They are comprised of 10 targeted metrics, agreed on by stakeholders, for physicians to measure and achieve. Examples include goals for diabetes and coronary artery care, preventive care, early follow-up after discharge and individualized care plans.
5. **Value-based reimbursement model.** To encourage participation in the PCMH, Geisinger provides practice-based, monthly payments of \$1,800 per physician and stipends of \$5,000 per 1,000 Medicare patients to help finance additional staff. Physicians also may receive financial incentives linked to patient satisfaction, quality and value goals.³ Geisinger is transitioning to an outcomes value-based model that will drive better quality, member experience and results through a shared

³ Paulus RA, Davis K, Steele GD. "Continuous Innovation in Health Care: Implications of the Geisinger Experience." *Health Affairs*. 27(5): pp. 1235-45. Sept./Oct. 2008

savings model. Tomcavage considers this new model a pay-for-value model.

Results: Preliminary two-year results reveal an improvement of 74 percent for preventive care, 35 percent for diabetes care and 22 percent for coronary artery disease. The PCMH also has generated \$3.7 million in net savings for a return on investment of 2:1, a 14 percent reduction in total hospital admissions, a 20 percent decrease in hospital readmissions and a trend toward a 9 percent reduction in total medical costs at 24 months.⁴

"If we can control expenses while improving quality and reimburse based on value, we can drive down premiums and push the savings to consumers. It's win-win for everyone."

—Janet Tomcavage, Vice President, Health Services, Geisinger Health Plan

VBID/PCMH Alignment: Geisinger also is a pioneer in value-based design, having introduced an unusual model addressing acute episodes of care. It developed 40 discrete steps in performing a coronary artery bypass graft surgery. If a step is omitted, physicians are notified. The health plan devised a price for the single episode of care, including a preoperative evaluation and work-up, hospital and professional fees, routine discharge care and management of related complications occurring up to 90 days after surgery, "We are paying for outcomes, not the process," Tomcavage says. Four months after Geisinger implemented the new model, the number of patients receiving all 40 components of care jumped from 59 to 100 percent. The model has been extended to cataract surgery and hip replacements.⁵

"If organized correctly, PCMH can be a value-based care delivery and payment model," Tomcavage says. "If we can control expenses while improving quality and reimburse

based on value, we can drive down premiums and push the savings to consumers. It's win-win for everyone."

Lessons Learned:

- Transitioning to a PCMH takes committed, focused physician leadership.
- The case manager on-site at the clinic is critical.
- Primary care may be the foundation of the medical home, but integration with other components of the health care system is critical to drive success and make this a sustainable model for health care reform.

Future Plans: Tomcavage predicts that the successful model will be deployed in many other clinics—a horizontal approach—while also building the system vertically by driving further integration with hospitals, nursing homes and efficient specialists.

Contact: Janet Tomcavage, jtomcavage@thehealthplan.com

⁴Geisinger Health System. Presentation at Whitehouse Roundtable on Advanced Models of Primary Care. Aug. 10, 2009.

⁵Paulus RA, Davis K, Steele GD. "Continuous Innovation in Health Care: Implications of the Geisinger Experience." *Health Affairs*. 27(5): pp. 1235-45. Sept./Oct. 2008

Aetna

Business Description: Hartford, Conn., -based Aetna is one of the nation's leading diversified health care benefits companies, serving about 36.8 million people. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities and health care management services for Medicaid plans.

Initiation of Program: Beginning operation in May 2008 in southeastern Pennsylvania, Aetna is participating in a three-year PCMH pilot as part of the Pennsylvania Governor's Office of Health Care Reform's Chronic Care Initiative to improve accessibility, affordability and quality of health care in the state. The 32 primary care practices participating in this program are required to attend seven days of on-site training as part of a learning collaborative organized by the MacColl Institute, work with an assigned practice coach to implement the care coordination activities that reflect transformation to a patient-centered medical home, achieve NCQA PCMH recognition (at least at Level 1) by the end of the first year, and establish and meaningfully use a patient registry for diabetes and asthma. Aetna is one of six health plans collaborating in this effort.

Program Objectives:

- Improve chronic care with an initial emphasis on diabetes and asthma.
- Improve the infrastructure of medical practices to promote care coordination.
- Recognize the value and costs of performing care coordination.
- Improve member satisfaction and engagement in care.
- Improve physicians' professional satisfaction with the delivery of care.
- Assess the costs and benefits of PCMH.
- Determine the practical potential for transforming the delivery of care to the PCMH model.

Program Features: While this program does not prescribe a set operational structure, most of the practices have

identified a nonphysician employee in the practice as the key care team coordinator, responsible for managing registries, finding gaps in preventive care from the registry data, ensuring that physicians are made aware of those gaps and helping patients coordinate appointments and referrals. Thirty-two practices, representing 150 physicians and serving more than 175,000 patients, are engaged in this program. This represents about 3 to 5 percent of the primary care-eligible population in the region. The practices are diverse in terms of geography, payer mix, size and teaching status. Three nurse practitioner-led practices are included. There is no patient election involved in this program; patients who receive care from the participating practices become subject to this model of care delivery by virtue of the practice's transformation into a PCMH. There are no changes to benefit design, gatekeeper requirements or other managed care controls as a result of this program; it is an overlay to the existing delivery system.

This program pays primary care practices \$20,000 in the first year to cover registry development, the NCQA application fee and survey tool, and lost revenues while attending the learning collaborative sessions. Once practices are NCQA-certified, they are eligible for significant payments (\$35,000 to \$85,000, depending on the level of certification and the size of the practice, per physician per year) for the three years of the program. These payments are in addition to the payments these practices receive for delivering typical primary care and are allocated across the participating health plans according to the percentage of total revenue to each practice from each health plan. "One of the explicit goals for the pilot is to identify outcome measures that would replace these lump sum payments and would become a basis for paying for primary care in the future," says Don Liss, MD, regional medical director.

Dr. Liss says three more features will be integral to success if PCMH is to become a more broadly accepted model for delivering primary care: 1) primary care practices need to be paid based on similar incentives by all of the health plans in which they participate, 2) all health plans in a given area must participate in proportion to their penetration in a primary care practice so there is no cost shifting, and self-insured employer plans must participate and contribute funding in proportion to their employees' penetration in the primary care offices, and 3) Medicare must contribute to funding of the PCMH, given the large

“These initiatives should become mutually reinforcing—offering appropriate incentives coupled with practices prepared to deliver good care in a coordinated way.”

—Don Liss, MD, Regional Medical Director, Aetna

number of patients in most primary care practices covered by Medicare.

Results: This program has not yet reported any financial outcomes, but various clinical outcomes are positive—improvement in blood pressure control, increased use of preventive services such as foot exams, appropriate use of aspirin to prevent cardiovascular events and an increase in the number of children with asthma who have a documented care plan in place. In addition, almost half of the practices have earned Level 3 NCQA certification—the highest level of certification.

Lessons Learned:

- Physicians are professionally satisfied when their offices are organized to deliver care in a more coordinated and patient-centered way.
- It is possible to transform physician practices, but it requires discrete financial incentives.
- It is harder than one expects to transform a practice into a PCMH, and this entails an ongoing effort.
- It is essential to clearly establish the funding to finance the PCMH.
- Do ensure that participating plans are willing to make the investment in enhanced payments for primary care, anticipating that the financial benefits from reduced emergency room visits, hospitalizations and readmissions may offset these investments.
- Do clearly and objectively identify the expectations for care coordination by primary care practices.
- Don't underestimate the importance of establishing simple, organizational tools for coordinating care for diabetes, starting with use of a registry to identify patients with the condition and obvious gaps in care.
- An objective evaluation of the program is necessary before additional implementation.

PCMH/VBID Alignment: Dr. Liss admits that Aetna's existing VBID efforts in this local market mostly revolve around formulary and are independent of the PCMH. “Both VBID and PCMH are still immature, but I am confident that we will find our way. These initiatives should become mutually reinforcing—offering appropriate incentives coupled with practices prepared to deliver good care in a coordinated way,” Dr. Liss says.

Future Plans: Aetna and the other participating health plans are anxious to evaluate the results, both in terms of clinical improvements and impact on overall medical costs. Lessons learned will be leveraged to establish more effective financial incentives to promote primary care.

Contact: Don Liss, MD, lissd@aetna.com



Patient-Centered Primary Care Collaborative

The Homer Building • 601 Thirteenth Street, N.W. • Suite 400 North
Washington, DC 20005

Phone: (202) 724-3332 • Fax: (202) 393-6148
www.pcpcc.net

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