HEALTH POLICY

Structuring Payment to Medical Homes After the Affordable Care Act

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The Patient-Centered Medical Home (PCMH) is a leading model of primary care reform, a critical element of which is payment reform for primary care services. With the passage of the Affordable Care Act, the Accountable Care Organization (ACO) has emerged as a model of delivery system reform, and while there is theoretical alignment between the PCMH and ACOs, the discussion of physician payment within each model has remained distinct. Here we compare payment for medical homes with that for accountable care organizations, consider opportunities for integration, and discuss implications for policy makers and payers considering ACO models. The PCMH and ACO are complementary approaches to reformed care delivery: the PCMH ultimately requires strong integration with specialists and hospitals as seen under ACOs, and ACOs likely will require a high functioning primary care system as embodied by the PCMH. Aligning payment incentives within the ACO will be critical to achieving this integration and enhancing the care coordination role of primary care in these settings.

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The Patient-Centered Medical Home (PCMH)[1] is a care delivery model rooted in the core primary care principles of accessibility, whole-person focus, comprehensiveness, and coordination that promises to reinvigorate primary care practice through the use of multidisciplinary teams and a shift from reactive visit-based care, to proactive population health management. This transformation requires a new reimbursement system that rewards the full spectrum of care envisioned by the PCMH.

In 2009, Berenson and Rich described a set of payment models that could be used to support the PCMH,[2,3] many of which are being tested in ongoing PCMH demonstration projects (Table 1).[4] Almost all feature a blend of fee-for-service (FFS) payments, which continue to reward face-to-face encounters, with additional fees that support non-visit related work.[5] Since this review, however, there have been substantial changes in the policy environment resulting from passage of the Patient Protection and Affordable Care Act of 2010, which included a number of important provisions that seek to reorganize the delivery system by reforming payment. Among the most prominent is the adoption of "Accountable Care Organizations" (ACOs).[6] In this perspective, we discuss methods for paying for primary care services within the accountable care framework, relate these to the past work on PCMH reimbursement methods, and discuss implications for policy makers and payers considering ACO models.

OVERVIEW OF ACCOUNTABLE CARE ORGANIZATIONS

ACOs are defined as groups of providers, with or without an affiliated hospital, who accept joint responsibility for the costs and quality of care for an assigned group of patients.[7] ACOs typically continue to receive FFS reimbursement, but are then eligible for "shared savings" that are calculated against a budget based on historical spending, which is inflated to current year values. Thus, although ACOs are accountable for the entire continuum of care, the model also retains the limitations of FFS payments.[8] Eventually, however, ACOs may move toward more robust risk sharing arrangements with payers, such as full global payments. Currently, there are more than 350 ACOs participating in

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Table 1. Payment Models to Support the Patient-Centered Medical Home

Payment	Description
Enhanced Fee-for-service (FFS)	FFS payments augmented to practices recognized as PCMHs.
FFS with PCMH-specific billing codes	Practices able to bill for new PCMH-related activities.
Pay for Performance	Practices paid for meeting process measures (HEDIS), utilization targets (ED use, generic prescribing), or patient experience.
Per-member-per-month	Practices paid capitated monthly fee in addition to typical FFS billing, often adjusted for PCMH recognition level.
Shared Savings	Practices rewarded with portion of savings, if the total cost of care for their patient panel increases more slowly than a preset target.
Comprehensive Payment	Complete risk for cost of care with primary care practice.

Medicare and many commercial health plans are pursuing similar contracting strategies.[9]

Recent evidence suggests that physician organizations with higher proportions of primary versus specialty care providers demonstrate lower utilization (and associated spending) with the same or greater quality.[10] In addition, some early evidence suggests that PCMH demonstration projects can be associated with reductions in emergency department visits and hospitalizations,[11] and improved quality of care.[12] Thus, some have suggested that the PCMH may be a foundational element for ACOs.[13,14] In fact, some ACO projects evolved from PCMH demonstrations.[15] Although the theoretical alignment between reformed primary care and ACOs is strong, the discussion about payment for each model has remained distinct.

UNIT OF ORGANIZATION

In PCMH initiatives, the unit of organization and payment are primary care practices, though some PCMH initiatives include payments to regional entities for care coordination[16], and others exist within large integrated delivery systems.[17,18] Thus, the primary care practice plays the central role in the delivery of high value care, and benefits directly from additional payments.

ACOs typically consist of larger organizational units and are accountable for the full continuum of health services, not only primary care. ACOs represent a range of organizations, from independent practice associations to large group practices and hospital based health systems that vary in size, regional dominance, payer mix, and experience with risk sharing.[15] The inclusion of providers across the continuum of care can theoretically allow ACOs to more effectively integrate care delivery, but in reality these disparate providers will operate in the context of their specific local priorities and expectations. Therefore, it is unclear if ACOs will prioritize transformation to advanced primary care models. As the goal of cost savings is explicit and immediate in ACO contracts, ACOs may focus on programs they perceive to have more short-term impact on costs than primary care transformation, such as hospital based efforts to improve transitions in care or centralized case management directed at the highest risk individuals. As primary care and specialist physicians in most ACOs continue to be paid fee-for-service with reconciliation against the budget occurring at the end of the year, ACOs may continue to focus on high margin, high cost services.

PHYSICIAN PAYMENT AND INVESTMENT IN PRIMARY CARE

In PCMH initiatives, primary care practices typically receive payments directly from payers, including new forms of reimbursement such as per-member-per-month care management fees.[19,20] Hence, individual practices can choose how to invest this additional revenue, such as hiring a care manager or increasing take-home pay.

Within ACOs, payments to primary care practices vary. In many ACOs, primary care providers (PCPs) continue to receive fee-for-service payments, as ACO contracts typically do not include enhanced payment for PCPs, or incentives for practices to reach PCMH recognition targets, as these decisions are delegated by the payer to the ACO. Nonetheless, ACOs still have the opportunity to provide resources to primary care beyond those generated by fee-for-service revenue.

In other ACOs, the organization may have more direct control over PCP compensation. Currently, many large medical groups pay PCPs using FFS-type incentives such as relative value units (RVUs) or by salary, but few reimburse based on objective measures of quality or patient experience.[21] Under these ACOs, PCPs could be paid using metrics that fit better with the population health, team-based approach and focus on quality in PCMHs, such as salary based on risk-adjusted panel size. Such non-visit-based payments could encourage other modes of patient engagement, such as email, telephone or e-visits. How these organizations choose to measure and reward physician productivity is critical to ensure that physician incentives are aligned with those of the ACO.

ACOs also have other ways to invest in primary care resources. For instance, ACOs could invest in care managers that span multiple practices, or in electronic registries and advanced data management capabilities to aid with population management. The breadth of services that the ACO provides may make it well positioned to create a

common infrastructure that supports primary care practices throughout the organization.

SCOPE OF ACCOUNTABILITY

Practices in PCMH initiatives typically receive payment for primary care services only, and take on minimal risk for the total cost of care. ACOs, in contrast, are accountable for the entire continuum of care, and thus total costs.

More recently some PCMH initiatives have integrated responsibility for total cost of care through "shared savings" programs, blurring the line between PCMH initiatives and ACOs.[22] In general, however, there are several important distinctions between shared savings programs aimed at ACOs and those aimed at PCMHs. First, under PCMHs, the primary care practices receive the shared savings, whereas under ACOs the organization has flexibility in determining how shared savings payments are distributed, and may not necessarily direct these payments to support enhanced primary care or reward primary care practices' efforts to attain ACO goals (although some of them undoubtedly will). Second, any individual primary care practice has many fewer attributed patients than an ACO, rendering calculations of shared savings less reliable. Hence, payment or penalty under the shared savings agreement is more likely to be due to random variation, and PCMHs may face higher minimum savings thresholds before they qualify for shared savings. This could create disincentives for both payers and smaller PCMH initiatives to enter into shared savings arrangements.[23] Finally, in PCMH shared savings programs, practices can share in potential savings calculated against the budget, but typically are not at risk for potential losses if spending exceeds the preset budget, whereas many ACOs models will eventually be at risk for these losses.

INTEGRATION WITH SPECIALISTS AND HOSPITALS

PCMH programs typically only include PCPs. Hence, PCMH practices can focus on providing highly coordinated and comprehensive primary care, which may lead to fewer specialist referrals, emergency department visits, and hospital admissions, without concern about the potential loss of revenue further downstream in the health system.

In contrast, as ACOs typically include specialists and often include hospitals, ACOs may experience conflicts as strategies to achieve budgetary savings may adversely impact the revenue of some parts of the system. While an ACO is trying to achieve an overall decrease in cost growth by improving coordination and reducing low value care, specialists and hospitals within the ACO may resist changes that alter current utilization patterns, particularly if they continue to be reimbursed under standard fee-for-service payments through which their potential gain from high utilization may continue to exceed any potential share of shared savings.[8] As specialists make up a majority of the physician workforce, and are often highly visible in their communities, some specialist support would seem critical to the success of any ACO. If primary care practices and the ACO are in conflict with key local specialty care providers (specialists and hospitals), this may lead to the perception of primary care practices as "gatekeepers" who ration care, which backfired dramatically in the 1990s.

INTEGRATING THE PCMH INTO ACOS

The PCMH and ACO are complementary approaches to reformed care delivery, as the PCMH ultimately requires strong integration with specialists and hospitals as seen under ACOs, and ACOs likely will require a high functioning primary care system as embodied by the PCMH. There are a number of strategies that could be used to further integrate the two models.

First, ACO contracts could include explicit payments to support enhanced primary care such as those included in many PCMH initiatives, and ACOs arrangements for compensating primary care could expand to include different payment arrangements such as additional per person payments that are more aligned with ACO goals. This could potentially speed primary care transformation within ACOs. However, the delegation of resource allocation from payers to ACOs is inherent to the ACO model; thus, prescribing a particular structure for physician payment could impede ACOs from developing their own strategies for meeting shared saving targets.

Second, ACOs could invest in the developing the PCMH model internally. ACOs could expand access to primary care by hiring PCPs, increasing hours, and dedicating more resources to meeting urgent care needs. ACOs could also invest in practice coaching and learning collaboratives to accelerate practice transformation. Finally, ACOs could invest in health information technology and a care coordination infrastructure, to support PCPs with population health management.

Third, ACOs could change the way physician performance is measured and how resources are allocated internally to support achievement of PCMH principles. For instance, primary care physicians could be paid based on the size and complexity of their patient panels, with additional bonuses for achieving quality metrics, enhanced access, reductions in expected hospital use, and patient experience.[24] Non-visit based care coordination activities, measures of effective teamwork, and measures of patient interactions that are not visit based, such as email or telephone encounters, could be integrated into measurement of physician performance. Specialists could have their compensation augmented for participating in or coordinat-

ing with ACO-based medical homes, or ACOs could pay for e-consultations with specialists.[25] Shared savings payments could be distributed to primary care physicians and specialists, to align the incentives of individual physicians with that of the ACO.

CONCLUSION

The PCMH can serve as an effective foundation of care delivery in an accountable care-based health system, but to do so, ACOs must actively promote and support the development of enhanced primary care such as envisioned by the PCMH. Without meaningful payment reform that supports core primary care principles, primary care practices within ACOs will continue to struggle to transform into medical homes. Other challenges for ACOs include ensuring that primary care and specialist physicians have incentives aligned with the value mission of the organization. Such alignment is both critical to success and difficult to achieve, given that ACO payment models set up a zero-sum game among the various participants. The PCMH continues to be a promising model of delivery reform, and can serve as a lynchpin of ACOs, but these efforts will require ACOs to support enhanced primary care models within their organizations.

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