Patient-Centered Medical Home | Benefits of participation

The Patient-Centered Medical Home (PCMH) is a practice **model** for the organization and delivery of healthcare that helps to improve the patient's experience of care, improve the health of populations and reduce or control the costs of healthcare. The **PCMH care delivery model** allows the primary care provider and the patient to be the center of the healthcare system, to know what is going on and help the patient be in control of their health.

For 2022, Arkansas Blue Cross is offering two programs that follow the **PCMH care delivery model**, **Patient-Centered Medical Home (PCMH)** and **Primary Care First (PCF)**. Participating practices will receive per-member, per-month (PMPM) payments to support practice redesign and care coordination efforts. Practices that qualify will also receive a performance-based adjustment (PBA).

Patient benefits

The **PCMH care delivery model** combines the expertise of medical staff with the efficiency of electronic health records (EHR) to manage and coordinate the patient experience through the entirety of the continuum of care. This integrated approach makes navigating the complicated healthcare system easier for individual patients. In addition to saving time and frustration, patients enjoy:

- Enhanced access to care
- A greatly improved patient experience
- Improved quality of care
- Better outcomes
- Coordinated care

Provider benefits

While integrating new responsibilities and technology can be challenging, it can also be very rewarding. The team approach allows physicians to shift many of their patients' preventive and maintenance needs to support team members. In turn, physicians can focus their attention on the patients who truly need medical attention, resulting in:

- Greater job satisfaction
- Improved population management techniques
- Improved patient and staff satisfaction
- Improved office efficiency
- Improved clinical quality performance

The **Patient-Centered Medical Home care delivery model** does not replace the existing practice foundation. Rather it builds upon it, coordinating services for the medical neighborhood to provide access to care on multiple levels. This shift results in benefits for both patients and physicians.

Care management fees

Practices participating in PCMH and PCF will receive per-member, per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are monthly payments (not based on the volume of office visits) to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses and lower PMPM for patients with lower risk.

Professional population-based payments

Practices participating in PCF will receive a monthly, risk-adjusted professional population-based payment to allow flexibility in caring for patients, in exchange for a reduced fee-for-service payment per visit.

Performance-based adjustments (PBA)

We will pay a performance-based adjustment (PBA) to encourage and reward accountability. The performance-based adjustment will be based on a combination of utilization measures and clinical quality metrics.

2022 PCMH and PCF Performance-based adjustment	
Utilization	▪ Emergency Department utilization ▪ Inpatient admission ▪ Generic prescribing rate
Clinical Quality	▪ 8 clinical quality metrics ▪ 8 clinical quality metrics specific to pediatricians

- Utilization includes three measures: emergency department utilization, hospital admissions and generic prescribing rates.
  - Performance on utilization measures will be calculated quarterly, and adjustments will be applied to monthly care management fees. Practices that meet at least one target will receive a positive adjustment. **PCF** practices are at risk for a negative adjustment if they do not meet at least one target.

- Clinical Quality performance will be based on submitted claims.
  - Clinical Quality performance will be calculated and paid annually.
  - Clinic Quality metrics will be the same for both **PCF** and **PCMH**, but targets may be different.
  - Physicians and Advanced Practice Providers in Family Practice, General Practice, Internal Medicine and Geriatric specialties will have eight clinical quality metrics.
  - Pediatricians will have eight clinical quality metrics specific to children. Providers eligible for the pediatrician measures include pediatricians and advance practice providers working in collaboration with a pediatrician.

Frequently asked questions and overview

What is the purpose of PCMH?

A Patient-Centered Medical Home is a care team that manages overall health and coordinates the care of a patient. Both **PCMH** and **PCF** programs are designed to assist primary care practices in transitioning to PCMHs, through guidance and support, while rewarding them for high-quality, coordinated and efficient care.

Will other Arkansas Blue Cross and Blue Shield plans participate?

Health Advantage fully insured plans, Arkansas Blue Cross and Blue Shield fully insured plans and some self-funded plans participate.

Who is eligible to enroll as a PCMH?

Primary care providers that are credentialed with Arkansas Blue Cross and its affiliates (including Health Advantage and BlueAdvantage Administrators of Arkansas) who practice in the following specialties family medicine, general practice, geriatrics, internal medicine and pediatrics. Clinics can enroll primary care nurse practitioners, physician assistants and clinical nurse specialists in the **PCMH** or **PCF** programs.

What is the difference between PCMH and PCF?

Both programs follow the same basic structure. **PCF** rewards participants with additional revenue for taking on limited risk, based on easily understood, actionable outcomes. **PCF** practices receive monthly, risk-adjusted professional population-based payments to allow for greater flexibility, in exchange for reduced fee-for-service payments per visit.

Why enroll now?

Healthcare reform in Arkansas has introduced a large number of previously uninsured patients into the marketplace. In addition to dealing with a larger patient population, programs promoting the **PCMH care delivery model** will require practices to:

- Enhance access to care
- Identify and coordinate care for high-risk patients
- Use data to guide improvements
- Coordinate care with other community providers, inclusive of hospitals, specialists and patient support agencies and organizations
- Meet state and federal standards and reporting requirements

These changes will come with the opportunity for enhanced quality outcomes and cost containment. Transitioning your practice now will give you a competitive edge and better prepare you and your team for these increased demands.

Better quality outcomes and cost savings

Quality outcomes are achieved through a team-based, comprehensive, coordinated approach to care, following evidence-based guidelines.

- A **team approach** allows physicians to concentrate on patients who need their focused attention, while allowing team members to work at the top of their license, providing preventative and maintenance care to high-risk patients.
- Utilizing a team approach, referrals and tests are tracked to ensure the primary care team receives records and test results. Patients are contacted following hospitalization to ensure **follow-up care** is received.
- Medical homes follow evidence-based guidelines to provide better **quality of care**, track outcomes and results and continually work to improve care.
- Offering increased access to care, such as an after-hours phone line or extended hours, leads to a **reduction in healthcare costs** by lowering the number of emergency department visits. Since 2015, PCMH practices experienced an average decrease in cost of care of $31.67 per-member, per quarter (PMPQ)* compared to practices not participating in value-based programs. In 2019, PCMH clinics outperformed non-program clinics, achieving decreased emergency department utilization and decreased total cost of care of $25 PMPM.

  *(https://www.milbank.org/publications/value-based-primary-care-insights-from-a-commercial-insurer-in-arkansas/)

Care coordination

Care coordination facilitates communication, coordinates services, addresses barriers and promotes resources, while balancing clinical quality and cost management. Each clinic may handle care coordination differently, and the role may include medical assistants, registered nurses and even nontraditional multidisciplinary team members, including social workers and registered dietitians.

Key activities of care coordination include connecting patients with community resources, transitions of care from the hospital/emergency department setting, identifying care opportunities/gaps and patient outreach and education.

Members of a PCMH care team may include:

- Patient
- Provider
- Clinical staff
- Office staff
- Community resources
- Hospitals
- Specialists
- Family members
- Social workers
- Pharmacists
- Dietitians
- Other healthcare professionals

Changing the way primary care is delivered

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