The rapid proliferation of patient-centered medical homes (PCMH) has placed tremendous pressure on hospitals to adapt to the payment and delivery system reforms brought about by these initiatives. Although there has not always been a clear role for hospitals in a PCMH, their absence as a partner can be detrimental to an initiative’s success given their place within the medical neighborhood. This State Health Policy Briefing, made possible through support from The Commonwealth Fund, makes the business case for hospital participation, clarifies roles for hospitals in a PCMH, and offers strategies to successfully secure hospitals’ support and participation.

By Charles Townley and Kimm Mooney

Nearly every Medicaid program in the country has pursued one or more patient-centered medical home (PCMH) initiative, and almost half are working with commercial payers in multi-payer initiatives. As PCMH models spread, hospitals face tremendous pressure to adapt to the payment and delivery system reforms brought about by these initiatives. The medical home is a model of team-based, advanced primary care that seeks to support patients, coordinate care and reduce unnecessary and inappropriate utilization of acute, specialty, and hospital care. Although the evidence is still emerging, recent literature indicates PCMH initiatives can reduce emergency and inpatient hospital utilization. While keeping patients out of the hospital is a welcome outcome for most patients, families, and insurers, hospitals face reduced revenue under many existing payment arrangements.
There has not always been a clear role for hospitals in a medical home initiative, yet their absence as a partner can detrimentally affect a PCMH initiative’s success. The purpose of this paper is threefold:

1. Make the business case for hospital participation within medical home initiatives;
2. Help the conveners and other stakeholders leading medical home initiatives to improve or clarify the roles for hospitals in PCMH initiatives; and
3. Offer conveners and other stakeholders strategies to successfully engage hospitals and secure their support and participation.

Overall, the objective is to help align the goals of hospital executives and primary care providers so the two sectors can become better partners and collaboratively support delivery models that improve outcomes, lower costs, and help all providers meet their bottom line.

**Making the Business Case for Hospital Participation in PCMH**

Depending on market conditions, a hospital’s business case for participation in PCMH can vary. The needs and motivations of a small critical access hospital that is the sole provider for a rural community can be very different from an urban medical center with multiple competitors within their service area. And while those interviewed for this brief generally believed that most hospital administrators are aware that payment and delivery system reforms are inevitable, some hospital leaders may still see PCMH as a model of care that will jeopardize their solvency.

**Reduced utilization does not always mean reduced revenues.** In some cases, reduced utilization is the business case for participation—particularly for hospitals that have a high level of uncompensated care. One goal of the Affordable Care Act (ACA) was to provide coverage to the uninsured, which would, among other things, reduce the amount of uncompensated care hospitals provide. However, the Supreme Court’s decision making Medicaid expansion optional for states has placed additional pressure on the safety net. Disproportionate share hospitals and other safety net hospitals could reduce costly and unnecessary emergency and inpatient services by diverting uninsured and underinsured patients to the appropriate care settings for primary care services.

Reduced utilization as a business case for participation in a PCMH extends beyond the safety net. Large and urban hospitals can also benefit from diverting unnecessary emergency room visits to primary care providers. Children’s National Medical Center in Washington, D.C., for example, negotiated contracts with two of their four Medicaid managed care plans to shift low acuity emergency room visits to the hospital’s seven NCQA-recognized PCMHs. As part of this initiative, Children’s National receives $1.50-4.00 per-member per-month (PMPM) payments, enhanced visit rates for extended hour visits and “ER redirects,” and volume-based incentive payments in addition to their existing primary care capitation rates. This approach has resulted in increased access to primary care as well as a reduction in the hospital’s risk of nonpayment or recoupment of charges for low acuity emergency room visits by state Medicaid programs and commercial providers.

“If better primary care after discharge reduces preventable readmissions, then hospitals participating in a PCMH initiative may face fewer readmission penalties.”
Also, while hospital initiatives to reduce readmissions predate the ACA, new payment incentives to reduce and prevent hospital readmissions may further make the case for a hospital to participate in PCMH. In fiscal year 2013, CMS penalized more than 2,200 hospitals by reducing Medicare payments to those hospitals by an average of $125,000. The maximum penalty for the first year was a one percent reduction in payments; these fines are to double to two percent in fiscal year 2014 and will rise to three percent in fiscal year 2015.

While these penalties are assessed on hospitals, research indicates that much of what determines a readmission is out of a hospital’s control, and investments in primary care can help lower readmissions that are not preventable by the hospital. If better primary care after discharge reduces preventable readmissions, then hospitals participating in a PCMH initiative may face fewer readmission penalties. Mount Sinai Hospital in New York City, for example, has partnered with a network of federally qualified health centers (FQHCs) and other community providers to expand their Preventable Admissions Care Team (PACT), a social worker-led program that reduced 30-day readmissions by 56 percent and emergency department use for high-risk patients by 51 percent. The program expansion included an emphasis on ensuring patients visit their primary care provider within 10 days of a discharge.

Participation may give a hospital competitive advantage. In competitive markets, participation in a PCMH initiative can illustrate a commitment to population and community health, which may create a competitive advantage by distinguishing a participating hospital from their non-participating competitors.

Strong partnerships established through PCMH participation can foster relationships that lead to greater resources, such as enhanced payment rates, preferred network status, or grant opportunities. Similarly, the relationships built through increased coordination between the hospital and independent providers may increase referrals for specialist and ancillary services not provided by those primary care practices.

If participation in a PCMH initiative improves a hospital’s quality metrics (improved outcomes, fewer readmissions, etc.), the hospital may attract new patients in states with public reporting programs (e.g., Illinois’ Hospital Report Card). Even in states without a public reporting program, consumers may use Medicare’s website or the Leapfrog Hospital Survey to identify high-performing hospitals. Furthermore, payers and purchasers can use value-based insurance design to steer their patients to high-performing hospitals by removing or reducing patient cost sharing. Results from one study, where a large self-insured manufacturer provided financial incentives for employees to choose hospitals deemed “safer” by the Leapfrog Group, showed evidence that these programs can influence patients’ choices in where they seek care.

Still, it is important for program leaders to recognize that one of the primary goals of PCMH (and other delivery reforms) is to reduce unnecessary hospital use, and some hospitals are better equipped to handle this revenue loss than others. Addressing this through the payment methodology (discussed later) may be the most critical component of securing hospital support and participation.

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**Roles For Hospitals in a PCMH as Identified by the American Hospital Association (2010)**

- Convening affiliated physicians and building relationship between providers;
- Offering information technology and capital resources to primary care providers;
- Leveraging staff resources to assist in care coordination and transitional care;
- Providing leadership and administrative expertise; and
- Administering bundled payments—particularly in accountable care models that build on PCMH.

The Role for Hospitals in Patient-Centered Medical Home Initiatives

In 2010, the American Hospital Association (AHA) wrote: “The definition and structure of most PCMH initiatives do not include a unique role for hospitals.” However, the AHA went on to identify five key—although primarily administrative—ways that hospitals are able to support PCMH development (see text box, page 3). The rapid proliferation of public, private, and multi-payer PCMH initiatives has given hospitals ample opportunity to demonstrate both the capabilities discussed in the 2010 report and well as new and expanded roles. These can be grouped into three main categories:

1. Providing direct PCMH services;
2. Engaging patients, providers and the community; and
3. Influencing the market as an employer.

Providing Direct PCMH Services

PCMH initiatives emphasize comprehensiveness, patient-centeredness, coordination, accessibility, quality, and safety. Hospitals have an integral role to play in ensuring these care features, both as providers of primary care and as a partner in the medical neighborhood.

Hospital Clinics as Participating PCMH Providers and Neighbors. If a PCMH initiative’s goal is to reach as many patients as possible, stakeholders will need to consider the proportion of primary care services already being provided by hospital outpatient departments. The growth of accountable care organizations (ACOs) and integrated delivery systems has caused a resurgence in hospitals’ acquisition of primary care practices, and as a result, hospitals are providing a higher percentage of direct primary care services. For example, the primary care clinic at Boston Children’s Hospital serves more children than any other primary care practice in Boston.

Rhode Island is one state that has formally engaged hospital-based primary care practices in a multi-payer PCMH initiative—both Memorial Hospital Family Care Center and South County Hospital Family Medicine receive PCMH payment incentives and supports through the Rhode Island Chronic Care Sustainability Initiative (CSI-RI). Engaging hospital clinics with PCMH designation—or those willing to undergo practice transformation—can increase the number of patients served by the initiative.

Furthermore, hospitals can ensure that their outpatient specialty clinics work closely with affiliated and non-affiliated primary care providers to ensure warm handoffs and follow-up after patient referral. State policymakers can foster linkages between community hospitals and FQHCs to strengthen the safety net’s capacity for providing comprehensive and coordinated care. In Lincoln, Nebraska, two competing hospitals partnered to form a new FQHC to serve as a PCMH for low-income and uninsured residents when it became cost-prohibitive for the local public health department to continue providing those services.

Transitional Care. Hospitals can develop and implement care transition protocols designed to provide seamless care that engage primary care providers during admissions, discharges, and transfers. Studies have shown that only 17-20 percent of primary care providers reported receiving routine notification of hospital discharges, and less than half reported receiving discharge summaries within two weeks of their patient leaving the hospital. Further, when sent, discharge summaries often lack important information on pending tests, discharge medications, and follow-up plans. States are actively working to improve care transitions between hospitals and primary care practices through new and expanded staff roles and better use of health information technology:

- Rhode Island’s two health home programs for individuals with behavioral health conditions require participating community mental health organizations and opioid treatment programs to employ hospital liaisons that provide transitional care services and assist in discharge planning.
- As part of the Michigan Primary Care Transformation Demonstration Project (the state’s multi-payer PCMH initiative), practice-embedded care managers are receiving real-time hospital admission, discharge, and transfer notifications through a new program.
**SOUTH COUNTY HOSPITAL (WAKEFIELD, RHODE ISLAND)**

South County Hospital’s participation in the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) began with their outpatient primary care clinic, South County Hospital Family Medicine. Motivated by a mission of improved community health and an understanding that broad delivery and payment reforms were on the horizon, the hospital expanded its role in CSI-RI and implemented a “Patient-Centered Medical Community (PCMC).” The hospital hired nurse care managers and shared their services across both the outpatient primary care clinic and independent CSI-RI practices. South County Hospital received a $90,000 grant from the Rhode Island Foundation to launch the PCMC. Under the original CSI-RI contract, the hospital also received $1.50 per-member per-month from public and private payers to cover the nurse care managers’ time—although the hospital has supplemented these payments with their own funds. A behavioral health care manager was added to the PCMC after an additional $65,000 in grant funding was received in 2013, and the hospital received an additional $75,000 from CSI-RI as part of a community care team pilot.


Note: A sample copy of the South County PCMC/Specialty Compact can be found at: [http://www.pcmhri.org/files/uploads/04%20Sample%20Compact-South%20County_0.pdf](http://www.pcmhri.org/files/uploads/04%20Sample%20Compact-South%20County_0.pdf).

that leverages the state’s health information exchange.32

**Shared Care Coordination and Case Management Services to Independent Primary Care Practices.** The investments and infrastructure needed for a primary care practice to undergo PCMH practice transformation are significant, and many smaller independent primary care providers simply lack the resources to hire care managers or invest in a new interoperable health information technology. Hospitals may be in a position to create an economy of scale for smaller practices by reallocating or hiring new staff and offering shared services across the different providers in the community. These services can either be provided centrally at the hospital or co-located within the primary care practices.

**“Hospital-based care team members can help identify patients who may be eligible or benefit from the model and connect them to primary care.”**

In addition to Rhode Island (see text box, above), Vermont is an example of a state where hospitals provide shared wrap-around services for smaller practices—particularly those in rural settings. The Vermont Blueprint for Health requires that one multidisciplinary community health team (CHT)—comprised of five full-time-equivalent staff—operate within each of the state’s health service areas. Public and private payers share the $350,000 annual funding for each CHT, which assist local PCMH providers and provide a connection between primary care and community-based services.33,34 Local hospitals have primarily undertaken this role.35

**ENGAGING PATIENTS, PROVIDERS, AND THE COMMUNITY**

Given their size and scope, hospitals have ample opportunities to engage patients, providers, and the local community as a whole. By leveraging these opportunities, hospitals can take on communication roles that have the potential to both improve the design of a PCMH initiative and increase patient participation.

**Patient Outreach and Enrollment.** Hospitals are in a unique position to identify, educate, and enroll patients in a PCMH initiative, particularly those patients that inappropriately utilize the emergency room. Hospital-based care team members can help identify patients...
who may be eligible for or benefit from the model and connect them to primary care. States have begun to pay for outreach; for example, New York Medicaid pays health home providers (which include hospitals) 80 percent of the full care management payment for up to three months to fund patient outreach and engagement activities.36

Reducing unnecessary and inappropriate use of the emergency department is especially beneficial for hospitals that provide a disproportionate share of uncompensated care. Hospitals have had nurses, social workers, and community health workers identify super-utilizers and connect them to primary care. For example, community health workers at the University of Cincinnati Medical Center identify patients with 25 or more annual visits to the emergency department. These patients are connected with a local non-profit community service provider that works to address the patients' health care needs and connect them to a PCMH to reduce inappropriate trips to the emergency department.37,38

**Provider Training.** Successful PCMH initiatives require a workforce trained to operate in inter-professional care teams. Hospitals are well positioned to educate their staff on the roles and responsibilities in such an initiative. In particular, teaching hospitals have a unique opportunity to incorporate PCMH education into their curricula for residents and fellows in both primary care and specialties. The New York Department of Health received a $250 million grant from the Centers for Medicare & Medicaid Services (CMS) to launch a Hospital-Medical Home Demonstration program, which provides funding for the state's teaching hospitals to train primary care residents and transform their outpatient primary care clinics to meet National Committee for Quality Assurance (NCQA) PCMH recognition standards.39

**Community Engagement.** Ongoing community engagement during program planning and implementation is integral to a successful PCMH initiative. Due to greater available resources and a broader scope, hospitals may be better equipped than primary care providers to survey the needs of the community (see text box, above). This is particularly true after the ACA, which required tax-exempt non-profit hospitals to conduct similar community health needs assessments and adopt an implementation strategy to address those needs at least every three years.40

Furthermore, hospital discharge staff may have existing relationships with community-based service providers and most hospitals already employ social or community health workers familiar with resources available to patients. Northeastern Vermont Regional Hospital, for example, leveraged their Community Connections program when launching the state's first CHT (described earlier). As part of their work, the hospital employs community health workers who assist at-risk patients navigate the health care system, including helping patients obtain insurance, find a primary care provider, and connect with financial and transportation support services.41

**Influencing the Market as an Employer**

As discussed in a previous NASHP issue brief, individual organizations with size and clout have the power to influence the marketplace.42 As the second largest source of private sector jobs in the nation,43 hospitals have tremendous purchasing power that may be leveraged to promote and grow PCMH.
Promising evidence shows PCMH provides a return on investment for employers. In their roles as large employers and purchasers of health care, hospitals have an opportunity to design their employees’ benefit packages to promote PCMH by waiving or reducing cost sharing when seeking care from participating providers. For example, South County Hospital in Rhode Island has designed their employees’ benefits package so that co-payments are waived when visiting designated PCMH providers.

**Key Considerations to Inform Hospital Engagement and Participation**

Before discussing how policymakers and other stakeholder can engage hospitals in a PCMH initiative, it is important to address a few key considerations that inform the process. Specifically, PCMH program leaders need to understand which types of hospitals are being engaged, determine whether the PCMH initiative will take place within a larger accountable care program, and identify and address any legal concerns that would arise from their participation.

**Unique Roles and Considerations for Different Types of Hospitals**

There are many different types of hospitals, and each hospital’s role within a PCMH initiative can vary depending on circumstances (see Table 1). For example, rural and critical access hospitals are likely to have very different priorities and resources compared to large urban hospitals. Nearly a quarter of all Americans receive care from rural hospitals, which are often the sole source of care in a community. As such, these hospitals already provide a greater share of non-traditional outpatient services, including primary care, home health, skilled nursing, and assisted living.

As one of the primary sources of care in their local delivery system, rural and critical access hospitals may be in a position to take the lead in developing the PCMH initiative. In some communities, such as those with very few or even no primary care providers, these hospitals can be the only providers in a position to lead such an initiative. However, these hospitals typically serve more vulnerable populations and receive lower reimbursement for their services, so they often

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<th>Hospital Type</th>
<th>Unique Roles and Opportunities</th>
<th>Key Considerations for Securing Support and Participation</th>
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| Rural/Critical Access  | Already provide a greater share of non-traditional outpatient services, including primary care, home health, skilled nursing, and assisted living  
May be in a position to take the lead in the development of a PCMH initiative given role as the primary source of care in local delivery system | May require a greater level of financial support from stakeholders to invest in the new technology, facility upgrades, and care coordination necessary to implement the PCMH model due to lower reimbursement |
| Large/Urban            | May be in a position to create economies of scale for smaller practices by reallocating or hiring staff or investing in technology                                                                                               | Market conditions may influence willingness to participate in initiative with competitors; alternatively, participation may create competitive advantage for those that choose to participate |
| Academic               | Opportunity to train the next generation of providers on interdisciplinary teams and the PCMH model                                                                                                                               | Providers’ competing priorities of clinical care, research, and teaching make it more challenging to find time to implement and sustain a PCMH model |
| Non-Profit/Community   | Required by the ACA to conduct a community needs assessment and adopt an implementation strategy to address those needs every three years                                                                                      | Supporting PCMH model can help mission-driven hospitals provide whole-person care and meet the medical and psychosocial needs of the community |

Table 1: Overview of Unique Roles and Key Considerations by Hospital Type
lack resources necessary to invest in new technology or upgrade their facilities. In order to successfully implement a rural PCMH initiative, payers, policymakers, and grantmakers may need to provide greater financial support to these small hospitals.

Similarly, as discussed earlier, academic medical centers may find themselves with unique opportunities and concerns compared to non-teaching hospitals. The Ohio General Assembly capitalized on this opportunity by creating a PCMH education advisory group tasked with working with medical and nursing schools in the state to develop curricula to prepare graduates to work within the PCMH model. However, while teaching hospitals have an opportunity to train the next generation of providers on working within interdisciplinary teams and the PCMH model, competing priorities of providing clinical care, research, and teaching make it more challenging to find time and resources to implement and sustain these models.

The Growth of Accountable Care Models

The rapid growth of ACOs is an important consideration for PCMH initiatives. PCMH and ACOs are complementary models. ACOs provide enhanced connections between primary care providers and specialists, hospitals, and other community providers, and PCMH provides a strong primary care base for the ACO. As the models evolve, policymakers and stakeholders may find themselves building PCMH into an existing ACO program or leveraging their PCMH initiative to launch ACOs, as opposed to starting an entirely new program.

Although hospitals drove the initial growth of the model from 2011-2012, physician groups have since taken over as the most common sponsor of ACOs. Both types of ACOs have the ability to break down silos and align incentives to better coordinate care across providers. To date, however, ACOs have tended to prioritize improving care within the system of the sponsoring entity (i.e., the physician group or hospital) as opposed to increasing coordination across the continuum of care.

If an ACO—either hospital- or physician-led—can achieve success without working with their partners in the larger medical neighborhood, there is a reduced incentive to better coordinate and integrate care. However, ACOs may achieve even greater success when hospitals and physician groups work together. Many experts believe that a strong primary care base is key to an ACO’s success, and physician groups benefit from strong hospital partnerships when their patients require emergency services or inpatient admission. Stakeholders have opportunities to structure ACO contracts to incentivize coordination, such as dedicating payments for enhanced primary care services and aligning physician performance measurement with the tenets of PCMH. For example, Illinois’ Accountable Care Entities will be measured on their members’ access to primary care providers, well-care visits, and screenings. Program leaders may also wish to encourage hospitals and physicians to develop shared governance models for ACOs to better identify and overcome barriers to working across the continuum of care.

Potential Legal Concerns

As hospitals formalize relationships with non-employed primary care providers in a PCMH initiative, stakeholders must ensure the initiative abides by federal and state consumer protection laws. The two sets of laws that have the greatest potential to affect a PCMH arrangement are anti-kickback and self-referral laws:

- **Anti-kickback laws**, most notably the federal anti-kickback statute, prohibit providers from paying or receiving anything of value to induce or reward referrals.
- **Self-referral laws**, including the oft-cited Stark Law, prohibit providers from referring patients to entities with which they or a family member have a financial relationship.

While these laws are necessary to protect consumers from improper business relationships, the penalties associated with these statutes and their corresponding regulations can deter providers from participating in legitimate
collaboration and communication central to the PCMH model. Federal and state law provides a number of exemptions and safe harbors that allow hospitals and other PCMH stakeholders to pursue the model while also protecting consumers. For example, payment arrangements for PCMH services from the hospital to the provider (or vice versa) can fall under the personal services exception, provided the parties enter into a written contract that clearly stipulates the legitimate business purposes of the arrangement and uses fair-market rates determined in advance.\textsuperscript{68,69,70} Stakeholders may also wish to explore development of a new entity, such as \textit{Primary Care Institute}, in which the hospital and physicians partner to form and co-manage a new and distinct legal entity.\textsuperscript{71}

The second major legal consideration for hospitals and providers is patient privacy, notably the protections afforded under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule\textsuperscript{72} and federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations (better known as 42 CFR Part 2).\textsuperscript{73} If not already in place, hospitals and providers will need to sign business associate and data use agreements to share protected health information for care coordination purposes. Program leaders will also need to develop a method to obtain patient consent for sharing the information. The New York State Department of Health developed a single consent form that covers all patient information protected under state and federal law and may serve as a resource for other states and programs.\textsuperscript{74}

**Opening a Dialogue Between Hospitals and Community Providers**

As described earlier, hospitals and primary care providers do not always effectively communicate with one another. However, clear and open communication between hospitals and community primary care providers is integral for truly coordinated care. State policymakers and program leaders are well positioned to facilitate and strengthen these relationships.

PCMH initiatives—especially multi-payer initiatives—are developed with strong multi-stakeholder engagement.\textsuperscript{75} Ensuring that hospitals have a seat at the table is an important first step in connecting hospital leadership with engaged providers and assures program leaders can address any concerns raised by hospitals during program design.

In Colorado’s multi-payer HealthTeamWorks PCMH initiative, program leaders established a PCMH-Hospital committee charged with improving communication and coordination between hospitals and PCMH practices.\textsuperscript{76} Parties drafted a hospital-physician compact that enumerated the components of care transitions and catalogued the mutual care management agreements between physicians, hospitals, and skilled nursing facilities.\textsuperscript{77,78} Three key takeaways from the HealthTeamWorks experience include:

- Secure buy-in at the executive level, but engage additional hospital staff during planning—particularly quality improvement staff;
- Engage and secure buy-in at the corporate level when hospitals are part of a larger corporation; and
- Frame conversation from the patients’ perspective—the committee loses effectiveness if parties use it as an opportunity to defend their turf.\textsuperscript{79,80}

To the last point, conveners can directly engage patients by including them in the initiative’s governance structure, developing a patient advisory group, or inviting consumer representatives to participate in planning meetings. Initiatives in which FQHCs participate have an opportunity to draw from the consumers that sit on the FQHCs’ boards.
Providing New Payment for New (or Unfunded) Services

As discussed in the Roles for Hospitals section, hospitals may be uniquely suited to provide shared services for small, independent providers that cannot afford care coordination and management staff. In order for this arrangement to be sustainable, however, the hospital must be appropriately reimbursed to cover the direct and indirect costs of providing these services; in other words, the new services should be at least cost-neutral to the hospital. As providers move toward more accountable models of care, policymakers and payers will likely place greater emphasis on risk-based payments such as bundled global or episode-based payments. However, some hospitals and provider groups may not be ready to take on risk-based payments.

While shared savings arrangements can be used as an intermediate payment option, there are limitations—most notably the lack of up-front or pay-as-you-go reimbursement to cover new costs. Additionally, without supplementary payments made in addition to shared savings, the hospital’s financial incentives end after the savings have been realized. Pay-for-performance methodologies based on utilization metrics may be more appealing to hospitals than traditional shared savings. Hospitals that lower utilization would receive enhanced funding to offset revenue loss, and hospitals that did not would not lose the revenue in the first place—although this removes part of the incentive for hospitals to actually lower utilization.

Most states have used direct care management fees to pay for care coordination services. Whether these fees are paid for an entire population (e.g., PMPM payment) or only for patients who receive their services (e.g., fee-for-service or case rate payments), hospitals have an opportunity to replace lost emergency and inpatient revenue through rate negotiation.

Including Hospital and Specialty Participation Requirements

There may be a clearer role for hospital participation if program requirements include specific standards and expectations for hospitals, specialists, and other PCMH-neighbors. In 2013, the Joint Commission launched a PCMH certification option for hospital-based ambulatory clinics. That same year, NCQA launched their Patient-Centered Specialty Practice Recognition standards, which extended medical home concepts to specialists, including outpatient specialty clinics owned and operated by hospitals. The Patient-Centered Specialty Practice Recognition standards build off NCQA’s PCMH recognition standards by measuring the specialty practice’s ability to manage and coordinate care with primary care providers and other specialty providers, provide enhanced access and communication, and track and coordinate referrals. While these programs are still in their early stages, program leaders that choose to adopt national practice standards may want to consider including these sets in their participation requirements as well.

Summary

Hospitals are key partners in the medical neighborhood and have important roles to play in PCMH initiatives. First, hospitals may be in a position to either directly provide enhanced primary care services through their owned-and-operated outpatient clinics and/or provide shared wrap-around services for smaller independent providers. Second, hospitals can also use their influence to educate and engage patients, train providers, and survey community needs. Lastly, hospitals can use their significant market power as an employer to influence the marketplace to promote and grow PMCH.

Although there are unique considerations for different types of hospitals—as well as potential legal considerations to keep in mind—state policymakers, payers, and other stakeholders can utilize key strategies to engage hospitals and secure their support. These strategies include making the business case for participation, opening a dialogue between the hospital and community providers, implementing sustainable payment reforms, and including hospital and specialty participation requirements. Collaborative partnerships between hospitals and community providers will increase coordination and integration across the continuum of care, and will also lead the way to create and strengthen accountable care models.
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