

Person-Centered Care: In Today's Health Care Environment, the Business Case Is Stronger than Ever

Executive Summary

With changes in compensation for providing care to older adults, person-centered care is becoming financially advantageous for more health care organizations. Person-centered care programs improve the care and the quality of life of patients. They can also result in fewer hospitalizations and emergency room visits, shorter hospital stays, and other reductions in the utilization of medical services, leading to lower health care expenditures. While some organizations have been able to benefit from such cost reductions and realize a significant return on their investment in person-centered care, others have not. Because of compensation structures used by Medicare and other payers, the cost savings created by person-centered care may not go to the organizations implementing and paying for the care. As a result, the financial incentives for some provider organizations and health plans to adopt person-centered care have been weak. Fortunately, a number of compensation methods introduced or expanded under the *Affordable Care Act* enable health care organizations to share in the financial benefits of person-centered care. Some forms of compensation can even increase revenue to those implementing person-centered care programs. This emerging system is creating opportunities for more organizations to adopt person-centered care to both enhance the quality of life of those they serve and improve their bottom line.

This brief is based on [Person-Centered Care: The Business Case](#)¹, a report prepared for The SCAN Foundation by Victor Tabbush, Ph.D., Alexis Coulourides Kogan, Ph.D., Laura Mosqueda, M.D., and Gerald F. Kominski, Ph.D. Refer to this report for a more in-depth discussion as well as data and documentation.

What is Person-Centered Care?

Traditionally, health care has been *provider-driven*—while the patient is consulted on some matters, physicians and other medical professionals largely set clinical care goals and determine treatment. In *person-centered care* (PCC),* the person being treated is moved from the periphery of the decision-making process and placed at the center. The values and preferences of the person and their family are elicited, and they are used to shape a plan of care and to guide all aspects of medical treatment and social support in pursuit of the person's health and life goals.²

This type of care is achieved through collaboration among the person, their family or other chosen individuals, and health care providers. A team is formed, typically made up of a nurse practitioner, a social worker, and the primary care physician, with one professional designated as the lead point of contact for the person and family. The person's health status and needs are assessed, and an individualized care plan (ICP) is developed and periodically reviewed and modified. Providers consult with one another and the older person and family themselves in order to coordinate their efforts to ensure that everyone is working toward the objectives of the ICP.

PCC is appropriate for everyone, but it has the greatest impact on older adults with multiple chronic conditions and functional limitations. Their care is typically extensive and expensive (about \$40,000 a year). Also, their care is complicated with comorbidities, numerous providers, and frequent transitions of settings.

How Does PCC Enhance Quality and Reduce Costs?

For the person receiving care, PCC results in a greater sense of empowerment, a focus on wellness and quality of life, and a better care experience. There is also evidence that it improves the job satisfaction of health care providers, who enjoy connecting meaningfully with patients and working as a team. But there are some costs to setting up and operating a PCC program (e.g., training, salaries, and occasional greater utilization of primary care and other services). However, the savings in reduced medical expenditures can far exceed these operational costs.

How does this happen?

* The American Geriatrics Society has developed a national consensus definition of person-centered care. All articles can be found at <http://www.thescanfoundation.org/learn-more-about-person-centered-care>.

Summarized in Table 1, when the goals and preferences of the person and their family are taken into account, and the focus is placed on quality of life, there are often fewer undesired medical interventions and less disproportionate care. With closer coordination of providers, there are fewer unnecessary and duplicative services. Also, care is less reactive and more proactive. Community-based supports meet many needs. There are fewer visits to emergency rooms and specialists. Discharge from the hospital is better planned and monitored. All of this can lead to fewer hospitalizations, including fewer readmissions, shorter stays in the hospital or other facilities, and fewer resources needed during those stays (such as less time in intensive care).

Table 1: How Person-Centered Care Produces Health Care Cost Savings

Inputs	→	Activities	→	Short-Term Results	→	Long-Term Results
Preferences, values, and goals of person and family Team (e.g., nurse, social worker, primary care physician) Lead point of contact Community-based supports		Assessment leading to development and ongoing review and modification of an individualized care plan (ICP) Consultation and coordination among providers, ensuring that all work toward the ICP		Fewer undesired medical interventions and less disproportionate care Fewer unnecessary and duplicative services; care is more proactive		Fewer, shorter stays in hospitals and other facilities, with less care needed during those stays Fewer visits to emergency rooms and specialists

Who Benefits from Cost Savings?

When a PCC model makes hospital stays less frequent and shorter, avoids emergency room visits, and otherwise reduces medical utilization, costs are cut. But who receives the savings? The organization that has invested in the PCC program may not be the recipient. This is a key element in determining whether there is a business case for PCC in a particular situation.

For example, take a hospital that operates a PCC model that reduces the average length of stay for the older adults who participate. Medicare pays the hospital a certain amount for a hospitalization based on the person's diagnosis, regardless of length of stay. The hospital bears utilization risk if the person stays longer than average, the hospital absorbs the costs; if they stay fewer days, the hospital reaps the savings. Thus, when the PCC program shortens stays, the hospital receives the same compensation but has lower costs and it realizes a return on its investment in PCC.

But suppose the hospital's PCC program also reduces future visits to the emergency room. Medicare reimburses the hospital for each emergency department visit. So in this case, there will be cost savings to the health care system at large, but the hospital will actually receive less compensation because it will provide fewer services. Similarly, if a medical group sets up a PCC program and reduces utilization, the savings accrue for those organizations at risk for the care, but this may not be the medical group.

Essentially, if a health care organization bears risk for a certain type of medical utilization — that is, if the organization receives the same compensation whether utilization is high or low, as it would, for example, under a capitation system — the organization can benefit from reducing utilization by means of PCC. On the other hand, if the organization does not bear utilization risk — if it receives more compensation for more utilization, as under traditional fee-for-service approaches — it can cut health care costs by means of PCC, but it will not see any financial gains itself. It has little if any financial incentive to set up a program.

New Medicare Compensation Methods Create New Opportunities for PCC

Fortunately, the sectoral shift in compensation is creating new opportunities for health care organizations to share in the cost savings brought about by PCC. Under the *Patient Protection and Affordable Care Act (ACA)*, Medicare — the primary payer of care for the older adults who are the focus of PCC — is moving away from traditional fee-for-service systems and toward rewarding providers and health plans for *value*—better outcomes at a lower cost. As a result, more organizations will find that there is a strong business case for implementing PCC.

Below are some Medicare payment methods that are tied to value and outcomes:

- Accountable care organizations (ACOs) are groups of physicians, hospitals, and other providers who come together voluntarily to give coordinated, high-quality care to Medicare beneficiaries. Several million people are now served by ACOs, and the great majority of ACOs participate in the Medicare Shared Savings Program, which enables organizations that reduce medical costs to receive a portion of the money saved by Medicare. ACOs can be organized so that all participating providers share in these savings.
- The ACA created several initiatives aimed at reducing inappropriate hospital admissions, including the Hospital Readmission Reduction Program (HRRP). HRRP compares the

performance of hospitals and provides penalties for those deemed to have excessive readmissions for five medical conditions. PCC programs can be effective at helping hospitals reduce readmissions and avoid these penalties.

- Under the Bundled Payments for Care Improvement (BPCI) Initiative, providers enter into payment arrangements with Medicare that include financial and performance accountability for episodes of care. Hospitals participating in BPCI have a strong incentive to adopt PCC.

PCC Can Also Increase Revenue

So far, the focus has been on the reduction in medical utilization and costs that PCC can produce. This is the main financial benefit PCC offers but in some cases, PCC can also increase revenue to health care organizations.

- Based on assessments of an individual as part of a PCC program, their condition may be reclassified or a secondary condition may be identified, and their categorization under the Hierarchical Condition Categories (HCC) system on which Medicare payment is based may change. Such reclassification can result in an increase in the monthly capitation amount paid to a Medicare Advantage plan by Medicare or to a health delivery system by a private-sector health plan.
- A health system may receive \$42.90 per member per month (PMPM) from Medicare for chronic disease management, which can include a PCC program.
- A few health plans pay providers (such as a medical group) an incremental per member rate for PCC, in recognition of the cost savings it produces.

In addition, Medicare has been increasing its compensation to providers based on value (quality of care per dollars spent).

- The share of Medicare payments to hospitals that depends on performance under the HRRP, the Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program is rising, projected to be 6 percent by 2017.
- Medicare Advantage plans are given quality scores based on a composite Five-Star Quality Rating System, and since 2012 they have been given incentive payments for high scores.

Is There Evidence for Cost Savings from PCC?

The trend toward greater accountability and risk-sharing for utilization, as well as rewards for value is creating a new environment in which more and more organizations can realize significant financial gains by adopting PCC. PCC programs can, in theory: reduce hospital admissions, readmissions, and emergency room visits; shorten hospital stays; and otherwise reduce utilization and costs. But is there actual evidence that they do so? The answer is yes.

Table 2 below describes four selected PCC programs. They each target older adults with multiple chronic conditions and functional limitations, and they each bear full or significant risk for medical utilization (for full data and sources, see [Person-Centered Care: The Business Case](#)).

Table 2: Financial Benefits of Selected Person-Centered Care Programs

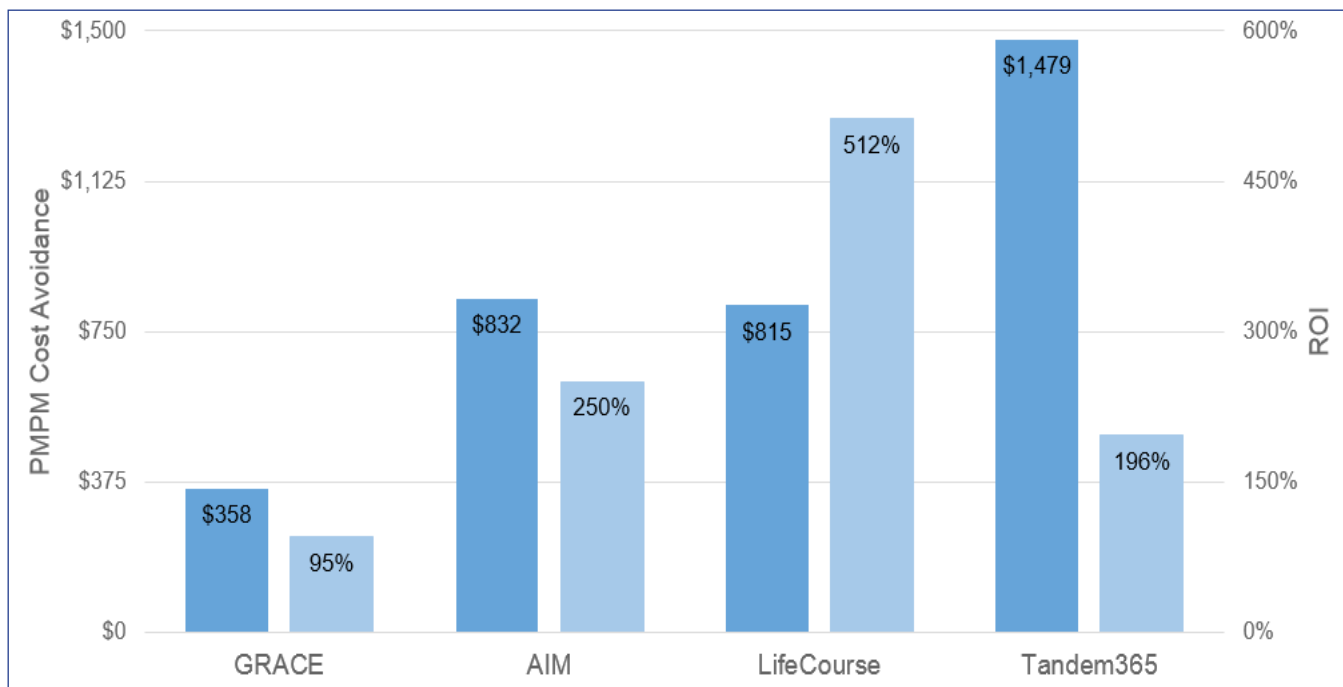
Person-Centered Care Program	Financial Benefits
<p>Geriatric Resources for Assessment and Care of Elders (GRACE)³</p> <p><i>Targeted</i> older adults with multiple chronic conditions and functional limitation. <i>Implemented</i> in various settings, including Indiana University Health Medicare Advantage, Veterans Administration Healthcare System (Indianapolis), and HealthCare Partners (Southern California).</p>	<p><i>Reductions</i> in hospital admissions, readmissions, and Emergency Department (ED) visits.</p> <p><i>Increase</i> in capitation amount from payer.</p>
<p>Sutter Health Advanced Illness Management (AIM) Program⁴</p> <p><i>Targeted</i> individuals with advanced illness in the last 12-18 months of life with indicators of active decline. <i>Implemented</i> within integrated health system in Northern California.</p>	<p><i>Reductions</i> in hospitalizations, ICU days, and ED visits.</p>
<p>Allina Health LifeCourse Program⁴</p> <p><i>Targeted</i> individuals estimated to have 2-3 years to live, many of whom do not believe they are ready for palliative care. <i>Implemented</i> in Minnesota integrated health system operating as a Pioneer ACO.</p>	<p><i>Reductions</i> in inpatient days and skilled nursing facility expenses.</p>
<p>Priority Health Tandem³⁶⁵⁵</p> <p><i>Targeted</i> advanced and chronically ill patients who find traditional ambulatory care impractical. <i>Implemented</i> as a Michigan Medicare Advantage Program within an integrated health system.</p>	<p><i>Reductions</i> in hospital stays, ED visits, specialty care, and skilled nursing facility expenses.</p>

Cost avoidance PMPM represents the reduction in medical expenses. Return on investment (ROI) is defined as the difference between cost avoidance and PCC program cost (net benefit), divided by the program cost.

The Business Case for PCC: A Representative Case Study

Figure 1 shows how selected (or examples of) PCC programs can deliver significant financial returns. How can other organizations estimate the returns they might obtain if they implemented a program? The SCAN Foundation has supported development of an ROI calculator; data on program costs and benefits are inputted, and the ROI is automatically calculated. The user can estimate what ROI on PCC would be under both realistic and conservative conditions.

Figure 1: Cost Avoidance and ROI of Selected Person-Centered Care Programs



Source: *Person-Centered Care: The Business Case*

When realistic data (based on the populations served and on reported outcomes of PCC programs) are inputted into the calculator, the output is impressive; utilization costs fall from a baseline of about \$42,000 to about \$25,000, per person per year. With the costs of implementing the program considered, this savings translates into an ROI of 370 percent (see Table 3).

Table 3: Results of Representative Simulations of Person-Centered Care

	PMPM Cost Avoidance	ROI
Base Case	\$1,411	370%
Conservative (Pessimistic) Case	\$642	78%

This return of 370 percent is generated for an organization that bears full risk for medical utilization and is predicated on these assumptions:

- The cost of the PCC program is \$300 PMPM.
- Hospital admissions and readmissions fall by one-third as a result of PCC.
- Visits to the emergency room and days in a skilled nursing facility fall by 20 percent.
- Both the average length of a hospital stay and the cost per day are reduced by 10 percent.
- The number of outpatient visits remains constant.

These results demonstrated by the ROI calculator under these hypothesized but realistic assumptions are in line with those reported for the programs described above (see [Person-Centered Care: The Business Case](#) for references and sources for the assumptions and data).

Of course, some may suggest that the assumptions used for this base case are simply forecasts and be overly optimistic. However, if the calculator is used again to simulate a more conservative (pessimistic) scenario, the results are still favorable. Specifically, when each of the above assumptions is adjusted by 20 percent (increasing or decreasing the variable according to which direction will cause a negative impact on ROI), the tool calculates cost avoidance of \$642 and an ROI of 78 percent.

Will PCC Benefit Your Organization?

The potential for obtaining a positive ROI from a well-implemented PCC program will of course vary greatly from one organization to another. It will depend on the population served, the compensation structure, the activities and costs of the PCC program envisioned, and other factors (for a detailed and data-based discussion of factors and considerations, see [Person-Centered Care: The Business Case](#)). Yet in general, for organizations that serve a substantial number of older adults with multiple chronic conditions and functional limitations, and that bear at least some risk for the medical utilization of these people, the business case is strong and the current Medicare payment methods are making it stronger. Leaders of such organizations would be advised to take a close look at the new opportunities to enhance quality and cut costs that person-centered care offers in today's value-driven environment.

Acknowledgements

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