

Medical Home Payment Models

February 13, 2009

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Commission on Health Care Payment

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What is the Medical Home Model?

- Origins: use of a central medical record to support children with special health care needs (AAP, 1967)
- Currently: transformation of primary care to a more efficient and effective model of health care delivery
 - “**Joint Principles**” (2007): developed by the ACP, AAP, AAFP and AOA in response to a request by large national employers
 - **NCQA**: recognition program for the “Patient-Centered Medical Home” (PCMH)

Why the Medical Home?

1. Primary care-oriented health systems generate lower cost, higher quality, fewer disparities (Starfield).
2. The Chronic Care Model – the chassis for much of the NCQA standards – has been heavily evaluated and found to improve quality. There has been fewer evaluations of cost and utilization impact, but most findings have been positive (Wagner, RAND).
3. Primary care supply is declining nationwide and shortages will extend without change.
 - 2% of graduating medical students pursuing Internal Medicine intend to become primary care providers (*JAMA*, 2008)

Eight Distinguishing Characteristics

- Personal physician (clinician)
- Team-based care
- Proactive planned visits instead reactive, episodic care
- Tracking patients and their needed care using special software (patient registry)
- Support for self-management of chronic conditions (e.g., asthma, diabetes, heart disease)
- Patient involvement in decision making
- Coordinated care across all settings
- Enhanced access (e.g., secure e-mail)

Setting the Context: National Trends

- There are medical home implementations, pilots and demonstrations under way or being planned in just about every state, including Massachusetts.
- All of these existing and emerging medical initiatives include payment reform as a core component.
- The Joint Principles call for “payment [that] appropriately recognizes the added value provided to patients who have a PCMH”, with additional specifications.
- Most of the medical home initiatives across the U.S. do not strictly adhere to the Joint Principles’ specifications for payment.

Setting the Context: Why Payment Reform as Part of the Medical Home?

Two cited rationales for payment reform:

1. infrastructure support: Several have modeled the costs to a practice to operate a medical home and have found that it requires additional resources in the practice setting, including PCP and other care team member time on traditionally non-billable activities, care management, HIT, and space and equipment.
2. incentive alignment: Many believe that only changes to the payment system that motivate and support efficient and effective care and counter the FFS “gerbil wheel” incentive will generate practice transformation.

Eight PCMH Payment Models

1. Fee-for-Service (FFS) with discrete new codes
2. FFS with higher payment levels
3. FFS with lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment
7. FFS with lump sum payments, P4P and shared savings
8. Comprehensive payment with P4P

PCMH Payment Models

Model #1: FFS with new codes for PCMH

Case examples:

- BCBSMI: pays T-Codes for practice-based care management
- Horizon BCBS of NJ: pays for traditionally non-reimbursed care management services

PCMH Payment Models

Model #2: FFS with higher payment levels

Case examples:

- BCBSVT: pays enhanced rates to qualifying practices for office-based E&M, consultations, preventive medicine, and counseling codes
- BCBSMI: plans to pay 10% higher E&M code rates to qualifying practices beginning mid-2009

PCMH Payment Models

Model #3: FFS with lump sum payments

Case example:

- PA Chronic Care Initiative (SE Region): six participating insurers pay periodic lump sum payments to qualifying practices per clinician FTE based on documented level of NCQA PPC-PCMH achievement – insurers include three Medicaid MCOs
 - Other PA Regional Rollouts (SC, SW, NE) haven taken different approaches

PCMH Payment Models

Model #4: FFS with PMPM payment

Case examples (both Medicaid):

- Community Care of NC: FFS with PMPM payment to PCP and another PMPM payment to regional PCP networks for care management and pharmaceutical consultation
- Connect Care Choice (RI): FFS with PMPM for enrolled chronically ill adults

PCMH Payment Models

Model #4: FFS with PMPM payment

Case examples (non-Medicaid):

- Vermont Blueprint: three insurers and state Medicaid pay FFS with sliding scale PMPM based on level of achievement against NCQA PPC-PCMH standards
- Rhode Island: PMPM payment with requirement of NCQA recognition
- Both VT and RI separately provide additional funding for care managers integrated with the primary care site, or provide the actual care managers

PCMH Payment Models

Model #5: FFS with PMPM fee and with P4P

- The model endorsed by the PCPCC.
- PMPM fee referred to as a “monthly care coordination payment”.

Case example:

- Emblem Health: FFS, PMPM care management payment, and P4P
- THINC RHIO: FFS with enhanced PMPM payment for PCMH structural measures and for performance on 10 HEDIS measures

PCMH Payment Models

Model #6: FFS with PMPY payment

- This is the Bridges to Excellence medical home model.
- Practices must be Level 2 certified for BTE's Physician Office Link and any two of Diabetes, Cardiac Care and Spine Care Link programs.
- Shared savings model: \$250/pt split between physician and purchaser/payer, informed by BTE ROI analysis

PCMH Payment Models

Model #7: FFS with lump sum payment, P4P and shared savings

- Unlike other FFS models, practices need not meet any criteria to receive the lump sum payments.
- Practices that meet quality metrics can qualify for shared savings (50/50)
- Formula adjusts for case mix

Case example:

- Geisinger Health Plan (PA)

PCMH Payment Models

Model #8: Comprehensive Payment

- This is a risk-adjusted PMPM comprehensive payment covering all primary care services.
- Unlike traditional primary care capitation, the payments would support an investment in medical home systems to improve care.
- 15-20% of annual payments would be performance-based and paid as a bonus.

Case examples:

- Capital District Health Plan (NY) pilot started 1/09.
- MA Coalition for Primary Care Reform planning effort.

Payment Amounts

- Supplemental payments reflect both estimates of what the medical home might cost, and the availability of funds.
- Most current models typically range between \$2.50 PMPM and \$5.50 PMPM in added spending, with a few higher.

Medicare Medical Home Demonstration

- CMS is planning a medical home demonstration to begin 1/10.
- CMS plans to pay supplemental payments to NCQA-recognized practices using two tiers (NCQA modified Tier 2 and 3).
- CMS inflated recommended AMA/Specialty Society Relative Value Scale Update Committee (“the RUC”) payment rates.
- The rates are made for patients with a broad set of conditions (85% of Medicare beneficiaries), risk-adjusted by Hierarchical Condition Category score (considers eligibility information and prior treatment of particular conditions).
- Amounts: Tier 1: \$27.12/\$80.25 and Tier 2: \$35.48/\$100.35. Presumes 5% savings. Rates need to be OK’d by OMB.
- Beneficiaries need to sign agreement for the practice to receive a payment.
- Specialists can serve as medical homes.

Possible Paths for Massachusetts

1. Sponsor multi-payer demonstrations across the Commonwealth with participation of all major insurers and MassHealth, and of a diverse range of primary care practices.
 - Rationale: The model is attractive, but its value has not yet been sufficiently demonstrated as a means to reduce costs.
2. Implement medical home statewide with all primary care practices in a phase-in process.
 1. Rationale: It is clear that the system needs to be rebalanced to better emphasize, support and reward primary care, and the existing evidence is adequate to support the investment.

Summary

- There are a few different payment models that have emerged so far.
- The models make a prospective investment with the assumption that savings will result.
- We don't know what works best yet.