

National Reimbursement Models and Alignment with Washington State Initiatives

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to the Washington Primary Care Coalition

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PURCHASING

Presentation Objectives

1. Set the context for a discussion of PCMH reimbursement models
2. Review the range of PCMH reimbursement models being utilized nationally, who is using them, and experience to date
3. Discuss the Washington Primary Care Coalition recommendations
4. Consider two additional questions:
 - a. how to motivate practices to participate
 - b. whether to use “patient-centered” as an organizing tool

Setting the Context

- All of the existing and emerging PCMH initiatives across the U.S. include payment reform as a core component.
- The Joint Principles of the AAP, ACP, and AAFP call for “payment [that] appropriately recognizes the added value provided to patients who have a PCMH”, with additional specifications.
- Most of the PCMH initiatives across the U.S. do not strictly adhere to the Joint Principles’ specifications for payment.

Setting the Context

Two cited rationales for payment reform for medical homes:

1. infrastructure support: Several have modeled the costs to a practice to deliver PCMH care and have identified the need for additional resources in the practice setting to cover costs including: increased time commitment for non-billable activities, case management/care support, HIT, and space and equipment.
2. incentive alignment: FFS payment drives how practices deliver primary care. Many believe that only changes to the payment system that motivate and support the PCMH will generate practice transformation.

Seven National PCMH Payment Models

1. FFS with discrete new codes
2. FFS with higher payment levels
3. FFS with supplemental lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment
7. 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 (+6%) 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 regions (SC, SW, NE) will probably take different approaches when they begin in early 2009

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
 - Began in 1998 with Medicaid women and children only
 - Expansion to elderly and persons with disabilities in 2008
- Connect Care Choice (RI): FFS with PMPM for enrolled chronically ill adults

PCMH Payment Models

Model #4: FFS with PMPM payment

Case example (non-Medicaid):

- Vermont Blueprint: three insurers and Medicaid pay FFS with sliding scale PMPM based on level of achievement against NCQA PPC-PCMH standards
 - Unlike most models using NCQA recognition, the payment scale is continuous rather than tiered

PCMH Payment Models

Model #5: FFS with PMPM fee and with P4P

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

Case examples:

- Emblem Health (NY): FFS, case mix-adjusted PMPM care management payment, and P4P (measures of clinical quality, efficiency and patient experience)
- THINC RHIO (NY): 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 (= NCQA PPC) and any two of the BTE Diabetes, Cardiac Care and Spine Care Link programs.
- Shared savings model: \$250/pt split between physician and purchaser/payer. Savings amount informed by BTE ROI analysis.

PCMH Payment Models

Model #7: Comprehensive Payment with P4P

- 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) will pilot starting 1/09.
- Separate small pilot in MA w/o true comprehensive payment.

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 \$.50 PMPM and \$5.50 PMPM in added spending.
- Medicare's AMA/Specialty Society Relative Value Scale Update Committee ("the RUC") has estimated \$25, \$35, and \$50 PMPM per chronically ill patient based on level of PCMH status for the forthcoming Medicare Medical Home pilot.
 - CMS plans to introduce in 2009 with some form of case mix adjustment

Estimated Practice Costs

Source	Enhancement in PMPM terms	What's included for the payment	Comments
Deloitte Center for Health Solutions	\$8.66 PMPM	PCP added annual \$100K payment for care coordination	EMR purchase cost of \$80-120K, with \$20K for installation, and then \$5K annually. Also, \$20K at risk for annual perf. bonus.
		Health coach salary plus fringe	
		Health coach tools (data collection, telephones, IT)	
		Data manager (.33 FTE with salary of \$65K and fringe)	
Rhode Island Chronic Care Sustainability Initiative (a)	\$4.78 PMPM	Case manager salary plus fringe	Assumes a three-physician practice with one NP.
		Office staff (.5 FTE with annual salary plus fringe)	
		Office space	
		Office equipment	
		Patient educational collateral materials	
Rhode Island Chronic Care Sustainability Initiative (b)	\$7.34 PMPM	All of the above, plus PCP added annual payment for alt. communication (optional)	PCP added payment is for e-mail and telephone calls, including after hours and on weekends.
Rhode Island Chronic Care Sustainability Initiative (c)	\$3.00 PMPM	Not decided as of 3-08.	The \$3.00 limit was set when one insurer stated that it would pay no more than \$3.00.

Estimated Practice Costs

Source	Enhancement in PMPM terms	What's included	Comments
Richard Baron for PA SE Regional Rollout, 9-07	\$3.78 - \$5.04 PMPM	PCP added annual payment for lost revenue	EMR purchase cost of \$78K. Lost revenue due to PCP time on project management.
		Nurse Practitioner (.3 FTE)	
		Medical assistant (.3 FTE)	
		Health educator (.1 FTE)	
		Social worker (.1 FTE)	
Allan Goroll et. al	\$5.83-\$9.38 PMPM	Nurse Practitioner (.5 to 1 FTE)	EMR and quality monitoring system: \$35K annually. Also, \$35-\$50K annual bonus for meeting mutually est. goals.
		Data manager (.85 to 1 FTE)	
		Nutritionist (0 to .5 FTE)	
		Social worker (0 to .5 FTE) (Latter two would be excluded in smaller practices.)	

Miscellaneous Notes:

- United HealthCare estimated the additional reimbursement to a primary care practice for implementing a Patient-Centered Medical Home at 20% above baseline reimbursement.

Examples of Other CCM/PCMH Programs

Source	Enhancement PMPM	What's required	Comments
Community Care of North Carolina	\$5.50 PMPM	<ul style="list-style-type: none"> ▪The payment is <u>not</u> based on an assessment of practice costs. Requirements include: <ol style="list-style-type: none"> 1.Create a medical home. 2.Give data to the state. 3.Address four quality improvement program areas: disease management; high-risk and high cost patients; pharmacy management; and emergency department utilization. 4.Use local network funds to support local case and disease management activities and staff for putting resources into the community (e.g., initially case managers, then clinical pharmacists). 	\$2.50 is paid to the PCP, while \$3.00 goes to the network.
Blue Cross Blue Shield of Michigan (prior approach)	\$0.17 PMPM	<ul style="list-style-type: none"> ▪The payment is not based on an assessment of practice costs. ▪The payment is made to local physician organizations or networks and is used to purchase shared resources. 	"A meaningful amount was estimated to be \$3000 per physician, under the assumption that...this would be enough catalyze commitment, leadership and change. Our experience to date has proved this calculus to be correct." BCBSMI will move to a fee schedule enhancement in 2009.

Examples of Other CCM/PCMH Programs

Source	Enhancement in PMPM terms	What's required	Comments
Blue Cross Blue Shield of Vermont	6% fee enhancement	The payment is not based on an assessment of practice costs. BCBSVT expects the following in return: <ol style="list-style-type: none"> 1. Patient registry and reminder system. 2. Use of evidence-based clinical guidelines. 3. Evidence that the practice team is "prepared" for the patient visit – <i>"Care Plan"</i>. 4. On-site nurse educators or easy access to nurse educators. 5. Patient access to self-management tools. 6. Tracking and reporting of outcomes. 7. Patient satisfaction survey/measures. 8. Evidence of office staff training on the scheduling and coding implications of chronic disease management. 	"We weren't necessarily aiming to offset the costs and we didn't have an anticipated ROI." "We landed on 6% as a starting point. Our anticipated ceiling is 12%."
Health Disparities Collaboratives of the Health Resources and Services Administration (HRSA)	\$0 However, health centers routinely experienced financial losses.	<ul style="list-style-type: none"> ▪ Participation in collaboratives to improve the care of patients with diabetes, asthma, or cardiovascular disease 	There were significant improvements in the measures of prevention and screening. There was no improvement, however, in any of the intermediate outcomes assessed.

Sources of Funding

- A tough issue. Because ROI is uncertain, most payers are “taking a flyer” based on research supporting the model. Approaches taken to date:
 - Reallocation of budgeted physician P4P funds
 - Reallocation of budgeted fee increase
 - Reallocation of DM/care management funding
 - New expenditure
- Idea discussed for the future:
 - Rebalancing of the physician fee schedule – reducing specialist fees to fund increase for primary care

Summary of Discussion of National Models

- There are a few different payment models that have emerged so far.
- Even within those that have emerged so far there is variation.
- We don't know what works best yet, so don't feel bound by what others have elected to do.

The Washington Primary Care Coalition Recommendations

- “the definition of a medical home remains a topic of nationwide debate” (p.1)
 - Absolutely, and there is a great tug of war about what to include and what to emphasize. The value proposition will be based on what you decide here. Agreement on a detailed operational definition is necessary before proceeding. The current definition (p.9) is too heavy on principles.
- “This proposal assumes that most payors will participate in implementing the recommendations...” (p.2)
 - Practices can’t be transformed without a necessary level of support, and that will require the insurers who represent the majority of a practice’s revenue to participate.

The Washington Primary Care Coalition Recommendations

- “...envision the current medical home environment as what could be described as a continuum of “medical homeness” (p.2)
 - Yes, all practices do not start in the same place. How to account for this in your practice transformation strategy will not be easy, however.
 - Need to determine how to assess comparative levels of “medical homeness”, and whether support should vary based on findings.

The Washington Primary Care Coalition Recommendations

- “...in the short term, the fee-for-service system would remain intact for most primary care providers. On top of that payment, primary care practices would receive financial incentive payments to begin the process of collecting and analyzing patient report data... to understand how patients experience care ” (p.3)
 - Interesting idea, but I’m not sure about the presumed low cost, how informed the practice will be by the data, and whether this information will generate behavior change. Seems approach may also be a little *too* patient-centered.

The Washington Primary Care Coalition Recommendations

- “Financial incentives would be used to motivate providers to use patient report data to change their practices.” (p.3)
 - This addresses one of the shortcomings I identified, but would require an evaluative mechanism and relies upon practices to correctly select and effectively implement the right transformation strategies.
- “The size of the payments for the collection and use of patient report data will need to be sufficient to offset the competing productivity pressures of present primary care.” (p.5)
 - Perhaps not if completion of this step holds promise for supplemental payments at the next stage.

The Washington Primary Care Coalition Recommendations

- “The medical home incentives must be structured to encourage primary care practices to reach out and use consultants, participate in collaboratives, and engage in regional quality improvement efforts.” (p.5)
 - It might be better to provide directed instruction than to leave practices on their own.
 - Why not require collaborative participation as a qualifying activity to receive future payment enhancements?
- “It may be that other funding sources are also needed to help provide technical assistance to practices that are struggling to adopt medical homes.” (p.5)
 - Yes. CO, NC and PA use practice coaches.

The Washington Primary Care Coalition Recommendations

- Option A: DRGs (FFS) & Case Management Fees. “In addition, new payment categories should be added to allow for reimbursement for provider activities in support of medical homes and may not be covered under case management.” (p.5-6)
 - Make sure you know what is expected for the case management fees. It is important to link these payments to qualifications or performance. This is a key issue.
 - If using case management and new payment codes, you will need to avoid duplicate payment scenario.

The Washington Primary Care Coalition Recommendations

- Option B: APGs and Risk Factor Adjustments.
“...quality bonuses linked to appropriate reduction in hospitalizations based on ambulatory sensitive conditions could be added.” (p.6)
 - Yes. Purchasers and payers need to see an ROI for this to be sustainable.
- Option C: Base Payment and Incentives for Quality.
Same as Option A or B, but “Additional payments would be made available to reach certain quality targets, be they disease-based...or preventative..” (p.6)
 - Agree.

The Washington Primary Care Coalition Recommendations

- Option D: Capitation and Risk Factor Adjustments.
“Capitation payments should be adjusted upward to compensate, incentivize and reward practices as they adopt increasing levels of sophistication.” (p.6)
- “As providers become more skilled in coordination of patient care, holding the practice at some financial risk for care provided outside the practice would represent a high level of medical home achievement. (p.6)
 - Capitation makes more sense when it is not primary care-focused. It should be part of a more comprehensive medical home payment strategy that is not linked to the medical home.

The Washington Primary Care Coalition Recommendations

- “The critical point is that we doubt that a “one size fits all” approach can successfully work.” (p.7)
 - Agreed, but customization will be quite difficult.
- “Piloting may prove to be the optimal way to ease into change in a measured way that provides a level of comfort and an opportunity to fine tune as we learn.” (p.8)
 - This is the approach being taken nationally, although some pilots are of a much larger scale than others.

Considering Two Additional Questions

1. How to motivate practices to participate
 - Practices choose to participate for either or both of the following reasons:
 - They seek a better way to operate their practice and deliver care. Many have heard of the PCMH and are intrigued by it. These are the “early adopters.”
 - They seek a means to obtain additional revenue for their practice.
 - If starting with a pilot, involvement of the primary care associations and of primary care practices in the planning process should yield sufficient numbers of interested practices.

Considering Two Additional Questions

1. How to use “patient-centered” as an organizing tool
 - It is unclear whether the concept of “patient-centeredness” resonates sufficiently with physicians to use it as an organizing tool.
 - Also, note that the PCMH is a collection of concepts, of which patient-centeredness is one.

Making Your Decision

- How to decide which model?
 - Other efforts across the country typically seem to be decided based on a) what are others doing, and b) the particular individuals involved in the design process and their values and philosophies.
- Resource for Information on Models
 - “The Patient-Centered Medical Home – A Purchaser Guide”
 - Available at www.pcpcc.net