Enhanced PCMH Payment Models and Mechanisms

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The Safety Net Medical Home Initiative

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Presentation Agenda

1. The rationale for Medical Home payment reform
2. PCMH payment models in use across the U.S.
3. The business case for safety net PCMH transformation
4. The likely impact of payment reform on community health centers

Why Reform Payment?

Why change payment? Two commonly cited rationales:

1. infrastructure support: Some 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 physician 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 fee-for-service "gerbil wheel" incentive will generate practice transformation.

Approaches to Reforming Payment

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. FFS with PMPY payment and shared savings
9. Comprehensive payment with P4P
10. Grants

Approaches to Reforming Payment

Approach #1: FFS with new codes for PCMH

Case examples:

- BCBSMI: pays T-Codes for practice-based care management (and also delegated DM fees)
- Horizon BCBS of NJ: pays for traditionally non-reimbursed care management services
- Texas Medicaid: pays for traditionally non-reimbursed care management services for children
- Note: A new ICD-9 S-code was created for medical home payments effective 1-1-10.

Approaches to Reforming Payment

Approach #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: pays 10% higher E&M code rates to 1200 qualifying practices
  - BCBSMI and OK Medicaid use their own criteria and process for practice designation, and not those of NCQA

Approaches to Reforming Payment

Approach #3: FFS with lump sum payments

Case example:

- PA Chronic Care Initiative (SE, SC and SW Regions): ten participating insurers pay periodic lump sum payments to qualifying practices per clinician FTE
- Lump sum payment for a) start-up costs (time spent at learning collaborative, NCQA fees, costs of registry prep and EMR report development) and b) in recognition of documented level of NCQA PPC-PCMH achievement

Approaches to Reforming Payment

Approach #4: FFS with PMPM payment

Case examples (all Medicaid-specific):

- Community Care of NC: FFS with PMPM payment to PCPs and another PMPM payment to regional PCP networks for care management and Rx consultation
- Minnesota Health Care Programs (proposed): FFS with PMPM payments to state-certified Health Care Homes for "care coordination services." Payment levels tiered (4) and only for enrollees with one or more major conditions (proposed to CMS). Adjustments for SPMI and primary language other than English.
- Connect Care Choice (RI): FFS with PMPM for enrolled chronically ill adults

Approaches to Reforming Payment

Approach #4: FFS with PMPM payment

Case examples (non-Medicaid-specific):

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

Approaches to Reforming Payment

Approach #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 examples:

- EmblemHealth and Colorado Multi-Payer Initiative: FFS, PMPM care management payment, and P4P
- THINC RHIO: FFS with enhanced PMPM payment for PCMH structural measures (NCQA Level 2) and for performance on 10 HEDIS measures

Approaches to Reforming Payment

Approach #6: FFS with PMPY "shared savings" 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

Approaches to Reforming Payment

Approach #7: FFS with lump sum payment and shared savings

- Unlike other FFS models, practices need not meet any criteria to receive the lump sum payments (viewed as a “forgivable loan”)
- Practices that meet quality metrics can qualify for shared savings (50/50)
- Formula roughly adjusts for case mix

Case examples:

- Geisinger Health Plan (PA) – GHP assigns its own salaried care managers to the practices
- PA Chronic Care Initiative Northeast Regional Rollout design is similar, but not identical to that of GHP.

Approaches to Reforming Payment

Approach #8: FFS with PMPY payment & shared savings

- Initially, $20K per practice infrastructure investment, FFS and then evaluation of savings
- Later, prospective DM PMPY payment (bill an S code) informed by savings findings from Year 1 pilot, FFS, plus shared savings
- Moved to PMPY payment at practice request – so no need to wait 18 months for payment.

Case examples:

- Blue Cross Blue Shield of North Dakota - Found savings of $500 PMPY. Split 50/50. Recently went statewide.
- Blue Cross Blue Shield of W. NY was reportedly pursuing

Approaches to Reforming Payment

- Other shared savings examples include:
  - BCBS of Alabama (in development)
  - BCBS of Michigan
  - Care 1st (DC and Maryland)
  - Massachusetts PCMH Initiative (public and private multi-payer)

Approaches to Reforming Payment

Approach #9: Comprehensive Payment

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

Case example:

- Capital District Physicians Health Plan (NY) pilot – began 5/08; expanding from 3 to 24 practices in 10/10

Approaches to Reforming Payment

Approach #10: Grants

- Provider sites receive a grant to support transformation to a PCMH.
- Can be accompanied with practice transformation support.

Case examples:

- Texas Medicaid: practices will submit grant proposals to the state in 2010 for child PCMH pilots
- Harvard Pilgrim Health Care (MA): providing grants to selected practice sites

Approaches to Reforming Payment: In Summation

- Many different approaches – we don't know which work better or worse yet – but we are learning
- *Timing* of payment initiation is another key design consideration that should not be taken lightly
- Payment models vary based on:
  - focus and objectives of individual PCMH initiatives
  - payer and provider preferences
  - administrative capabilities
  - other special concerns (e.g., billing back to ASO accounts)
- Payments should address PCMH requirements and related costs <u>and</u> should align with objectives for participating practice performance

The value proposition for safety net PCMH transformation

So why do it?

1. Higher quality of care for patients
    - Chronic Care Model studies (over 100)
        - "interventions that contain one or more elements of the CCM improve clinical outcomes and processes for patients with chronic illness"
    - Results of early PCMH pilots
        - Colorado Medicaid: 72% of children in the PCMH practices had well-child visits, compared with 27% of controls
        - North Carolina Medicaid: 93% of asthmatics received appropriate maintenance medications and diabetes quality measured improved by 15%

The value proposition for safety net PCMH transformation

2. Increased clinician work life satisfaction
   - Pennsylvania physician participating in the state's multi-payer medical home initiative:

     "The experience has been validating, transformational, inspirational, humbling and amazingly gratifying. I feel liberated as a primary care doc."

The value proposition for safety net PCMH transformation

3. Increased financial support for primary care

- Most current payment models pay between $3PMPM and $12PMPM, depending upon the patient population.
- Additional payment is used for:
  - Adding non-physician members to the primary care team, including nurse clinical care managers, health educators, nutritionists, community health workers and data analysts.
  - Investing in space and equipment for new staff.
  - Increasing clinician compensation.

The value proposition for safety net PCMH transformation

4. Fee-for-service payment is going away – and payment will be more performance-based
   - Federal health reform will provide significant additional funding to CHCs. However, federal health reform will also put "booster rockets" on existing early efforts to move the delivery system towards ACOs and global payment.
   - Primary care practices (including CHCs) are the bedrock of an ACO, but they have to operate as a PCMH in order to be successful.
   - Safety net providers need to excel as PCMHs to succeed in a new payment environment.

The likely impact of payment reform on community health centers

- Could vary by state – some states may feel they are already paying enhanced rates for medical home infrastructure.
- If performance doesn't improve, increased payment will be fleeting.
- There is an opportunity for CHCs to use their strength as PCMHs as a base for ACO development and/or relationships.