

PAYING FOR THE MEDICAL HOME:

Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net

Introduction

Operating as a medical home requires increased non-reimbursed activity (e.g., care team meetings, patient self-management education, care coordination, data analysis, communication with other clinicians) and care management. In order for patient-centered medical home (PCMH) practice transformations to be sustainable, there must be payment reform to incentivize high-value, first-contact, primary care, and support medical home costs that are traditionally not reimbursed (e.g., non face-to-face encounters). Together with the [“Health Reform and the Patient-Centered Medical Home: Policy Provisions and Expectations of the Patient Protection and Affordable Care Act”](#) brief, this publication provides an introduction to a series of policy briefs focusing on payment reform opportunities to support and sustain the medical home.

PCMH Payment Models: An Overview

The current method of paying for healthcare, fee-for-service (FFS), rewards volume over value. New models of payment offer opportunities for infrastructure support and incentive alignment to spur and sustain practice transformation. The goal of payment reform is to align incentives to support and promote the delivery of high-value primary and preventive services and reward improved health outcomes, while stabilizing or reducing total healthcare costs. Many payment models are available to support and sustain medical home transformation. There is no suggested hierarchy in the order of models, and in the real world, practices may be supported by a combination of models.

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The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, the SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute.



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The following 10 payment models are ways to support enhanced PCMH payment.

Figure 1: Ten Payment Models to Support Patient-Centered Medical Homes

1	<p>FFS with new codes for PCMH services Payment for non-traditionally reimbursed codes, such as T codes; new HCPCS codes were created for medical home payments effective 1-1-10 (HCPCS T1017 pays for targeted case management).</p>
2	<p>FFS with higher payment levels Enhanced rates paid to qualifying practices.</p>
3	<p>FFS with lump sum payments Periodic lump sums are paid to qualifying practices; lump sum payment often covers pre-work and/or recognition of NCQA PPC®-PCMH™ achievement.</p>
4	<p>FFS with PMPM payment PMPM fee is often referred to as a “monthly care coordination payment” and can cover care management, care coordination, and/or Rx consultations paid to PCPs or PCP networks.</p>
5	<p>FFS with PMPM payment and P4P PMPM fee is often referred to as a “monthly care coordination payment” and P4P is based on predetermined outcome or process measures.</p>
6	<p>FFS with PMPY “shared savings” payment Shared savings model which is informed by internal return-on-investment (ROI) analysis.</p>
7	<p>FFS with lump sum payments, P4P, and shared savings Practices do not need to meet any criteria for lump sum payment, but practices that meet quality metrics qualify for shared savings, roughly adjusted for patient case mix.</p>
8	<p>FFS with PMPY payment and shared savings Includes an initial lump sum infrastructure investment, FFS payment, and an evaluation of savings; the next year (or step) assesses a prospective disease management (DM) PMPY payment (billed by S code) informed by the savings evaluated from year 1 pilot, with FFS payment plus shared savings.</p>
9	<p>Comprehensive payment with P4P Risk adjusted PMPM comprehensive payment covers all primary care services; payments support investment in medical home systems to improve care, unlike traditional primary care capitation.</p>
10	<p>Grants Provider sites receive a grant to support PCMH transformation.</p>

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In an effort to understand how these 10 payment models relate, we can break them down into five different payment models: FFS with adjustments, FFS plus, shared savings, comprehensive, and grant-based payments.

FFS with Adjustments Model: FFS with discrete codes and FFS with higher payment levels comprise the “FFS with Adjustments” model. Texas Medicaid¹ demonstrates the FFS with adjustments model in their initiative to pay for traditionally non-reimbursed care management services for children (Texas Medicaid Health Steps EPSDT program).

FFS Plus Model: The second category is comprised of “FFS Plus” payments, which include FFS with lump sum payments, FFS with a PMPM payment, and FFS with a PMPM payment and P4P. EmblemHealth² and Colorado’s Multi-Payer Initiative³ are examples of the FFS with PMPM payment and P4P model (in this example, the PMPM payment incentivizes care management). This payment model is endorsed by the Patient-Centered Primary Care Collaborative (PC-PCC) and several physician professional associations.

Shared Saving Model: This category encompasses all models that include a shared savings component, for example FFS with PMPY shared savings payments; FFS with lump sum payment, P4P, and shared savings; and FFS with PMPY and shared savings. To illustrate, a practice could be made eligible for FFS with lump sum payment, P4P, and shared savings; in this example, the lump sum payment, offered as a forgivable loan, is only kept by the practice if it meets pre-determined

performance measures on time. In this model, practices that meet payer-specified quality metrics can qualify for 50/50 shared savings using a formula that roughly adjusts for case mix and compares expected expenditures against total practice cost. Pennsylvania has two programs using the FFS with lump sum payment, P4P, and shared savings model: the Northeast Regional Rollout of the Pennsylvania Chronic Care Initiative⁴ and Geisinger Health Plan.⁵

Comprehensive Payment Model: This model is similar to a capitation model, but includes enhanced payment to support medical home systems. The Capital District Physician Health Plan of New York⁶ is piloting this approach with risk-adjusted PMPM payments covering all primary care services with 15%–20% of annual payments based on performance and paid as a bonus.

Grant-Based Payment: The final category is grant-based payment enhancements. An example of this payment model is the Texas Medicaid Health Home Initiative for Children pilot¹, in which pilot sites receive traditional FFS plus quarterly grants over a 24 month period. Grant payments are intended to cover all medical home transformation costs and are based on an approved budget.

Figure 3 on page 4 demonstrates the feasibility of payment reform methods for different-sized organizations and helps illustrate the challenges in making payment reform appropriate and beneficial to providers.

The more integrated a health care organization is, the larger the bundle of patient care for which they can assume responsibility.⁷ In general, the assumption of risk in global or bundled payment models creates both financial opportunities and challenges. If a health center or private practice has a large enough patient population for statistical stability in cost and quality performance measures, it can succeed under the performance-based reimbursement models, including shared savings and global payment. In order to realize the financial benefits, providers must have strong leadership, good data management, strong medical home operations, and patient care management expertise for high-risk patients. When a provider group is not large enough to assume the risks associated with performance-based payment, it would need to be grouped with one or more other groups of providers for performance assessment purposes.

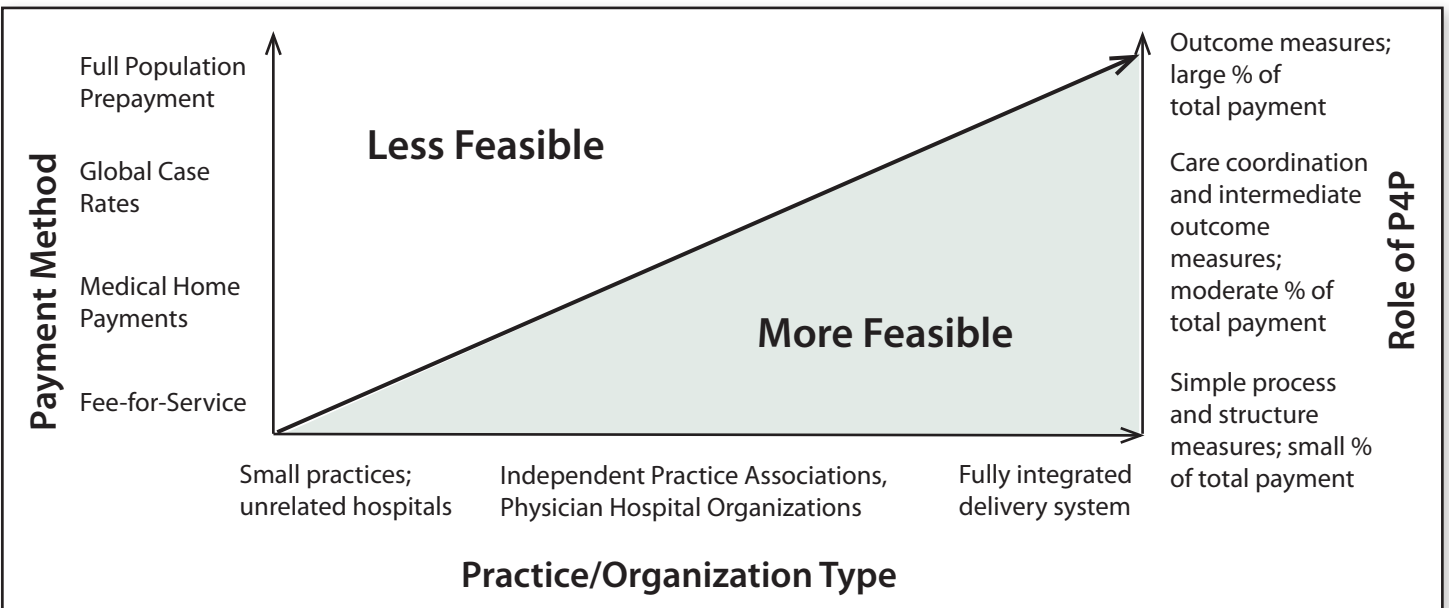
Under the health reform law, Medicare and Medicaid will both have bundled payment demonstrations in multiple states. The Medicaid demonstration will be based on bundled payments for an episode-of-care, supporting both hospital and physician services, and will be modeled in up to 8 states beginning in 2012. The Medicare pilot program will bundle payments for acute, post-acute care, and ambulatory conditions for 10 selected conditions, beginning in 2013.⁸ The infusion of federally led, global and bundled payment demonstrations may decrease the power and prevalence of FFS, both in the short term in states where the demonstrations occur, and, in the long term, at the national level.

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Figure 2: Attributes of 10 PCMH Payment Models

	Public Sector or Safety Net Demo in Place	Feasible for Small Practice Size	Includes Upfront Payment	Financial Support for Traditionally Non-Billable Services	Typically Requires PCMH Recognition or Certification	Emphasizes Value Over Volume	Simplifies Payment
1. FFS with new codes	✓	✓					
2. FFS with higher payment levels	✓	✓			✓		
3. FFS with lump sum payments	✓	✓	✓	✓	✓		
4. FFS with PMPM payment	✓	✓	✓	✓	✓		✓
5. FFS with PMPM payment and 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	✓	✓	✓	✓			

Figure 3: Relationship Between Payment Methods and Organizational Models



Adapted From: Shih A, Davis K, Schoenbaum S, Gauthier A, Nuzum R, McCarthy D. Organizing the U.S. Health Care Delivery System for High Performance. The Commonwealth Fund. 2008.

What Should Community Health Centers Do to Prepare for Transformed Payment?

Community Health Centers (CHCs) must prepare to operate in a system that is not FFS. CHCs can and should actively participate in the national dialogue on payment reform. To prepare for the future of primary care payment, we recommend CHCs and other safety net providers:

- 1. Implement the PCMH model** and seek recognition for medical home achievement (NCQA PPC®-PCMH™, state recognition, etc.). Like private practices, most CHCs will need to engage in significant practice redesign before achieving the high-performing, patient-centered, medical home status required by most enhanced payment programs.
- 2. Participate in discussions on payment redesign.** Many state-based medical home initiatives involve multiple payer and provider representatives. These multi-stakeholder groups often develop payment design through a collaborative process. CHCs should make their voices heard in these discussions, as they can sometimes come to be dominated and directed by payers. CHCs should also make their need for enhanced payment known. While some will argue that CHCs receive higher payments than independent physicians, these payments are typically for costs other than those required of a medical home.
- 3. Prepare for performance-based payment.** While most early medical home initiatives provide supplemental payments, there is a strong trend towards performance-based payments. Under these arrangements, there is either a) a sizable P4P component linked to quality and/or efficiency measures, or b) a shared savings arrangement, under which eligibility for sharing any savings, or the extent of sharing, is contingent on performance on quality and, sometimes, efficiency measures.

The models described in this paper span the breadth of enhanced medical home funding provisions. As the healthcare landscape continues to change, some of these models will be tested on a larger scale and other models may be developed. The Safety Net Medical Home Initiative will provide updates on payment reform and other policy initiatives pertinent to medical home transformation in the safety net. For updates and additional information, refer to: www.qhmedicalhome.org/safety-net



What should CHCs do?

1. Implement the PCMH model.
2. Participate in payment design activities where possible.
3. Prepare for performance-based payment.

Glossary

ACOs

Accountable Care Organizations (ACOs) will be comprised of providers who voluntarily meet specified criteria, including reporting quality measures. ACOs will share in or fully retain the cost-savings they achieve for Medicare and Medicaid programs depending on the adopted payment model. ACOs are expected to manage the full continuum of patient care and are held accountable for overall costs and quality of care for a defined population. ACOs may be comprised of a variety of networks, from large integrated delivery systems to physician-led hospital groups, multispecialty practice groups, group physician practices or health center networks. ACOs may receive bundled or global payments for services, or contract on a shared savings basis.

Bundled Payments

Bundled payments occur at the chronic care condition or episode of care level. They make a single payment for all services related to a treatment or condition, potentially spanning multiple providers in multiple settings and may be adjusted for case severity. Providers assume financial risk for the cost of services associated with a particular condition or treatment as well as costs associated with preventable complications, but not for the occurrence of the medical conditions (insurance risk). Bundled payment supports coordination of care by sharing payment for treatment/ condition across multiple providers in multiple settings. Financial risk is mitigated by reinsurance or other ways to limit or cap risk. Bundled payments are seen as the middle ground between fee for service and global payment for all services.

Global Payment

Global payments, or capitation, bundle the payment at the patient level and are fixed dollar payments for the care received during a time period (month, year). Partial global payments cover primary care and/or specialty services. Full global payments cover primary, specialty, hospital, and other covered services. Global payments place providers at some risk for the occurrence of medical conditions (insurance risk) as well as management of occurring conditions (clinical risk). Providers are protected from the total insurance risk by risk adjustment of payments, reinsurance and other models which limit or cap risk. Global payments are designed to contain costs, encourage integration and coordination and reduce unnecessary services. Global payments may include added incentives for improving the quality of care. Global payment systems can be administratively complex for providers and require additional infrastructure to help manage financial risk. The risk and administrative burden in global payment potentially excludes small provider groups or solo practitioners.

Shared Savings

Shared savings arrangements are similar to global payment arrangements, except that the provider entity bears no risk for financial losses should expenditures exceed what was budgeted or targeted. Also, rather than have the provider entity retain all of the savings that it might generate through its efforts, those savings are shared with the payer. The extent to which savings are shared is often dependent upon performance on metrics that can assess access, patient experience, clinical quality and/or efficiency. Finally, shared savings arrangements are more likely than global payment arrangements to exclude some services (e.g., mental health).

Resources

The following are websites and journal articles that provide more information about payment models and the Patient-Centered Medical Home.

American College of Physicians. A System in Need of Change: restructuring payment policies to support patient-centered care. [click here](#). Published 2006. Accessed August, 2010.

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Patient-Centered Primary Care Collaborative. Patient-centered medical home: building evidence and momentum. [click here](#). Published 2009. Accessed July, 2010

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Terms

ACO: Accountable care organization

FFS: Fee-for-service

P4P: Pay for performance

PMPM: Per member per month payment

PMPY: Per member per year payment

PPACA: Patient Protection and Affordable Care Act

PPS: Prospective payment system, a reimbursement mechanism where providers are paid a flat rate per case

PQRI: Physician Quality Reporting Initiative

References

¹Texas Medical Home Initiative. Patient-centered medical home: building evidence and momentum. Patient-Centered Primary Care Collaborative. [click here](#). Published 2009. Accessed July, 2010

²Emblemhealth Medical Home High Value Network Project. Patient-centered medical home: building evidence and momentum. Patient-Centered Primary Care Collaborative. [click here](#). Published 2009. Accessed July, 2010

³Colorado's Multi-payer Initiative. Patient-centered medical home: building evidence and momentum. Patient-Centered Primary Care Collaborative. [click here](#). Published 2009. Accessed July, 2010.

⁴Pennsylvania Chronic Care Initiative. Patient-centered medical home: building evidence and momentum. Patient-Centered Primary Care Collaborative. [click here](#). Published 2009. Accessed July, 2010.

⁵McCarthy D, Mueller K, Wrenn J. Geisinger Health System: achieving the potential of system integration through innovation, leadership, measurement, and incentives. The Commonwealth Fund. [click here](#). Published June, 2009. Accessed July, 2010.

⁶CDPHP Patient Centered Medical Home Pilot. Patient-centered medical home: building evidence and momentum. Patient-Centered Primary Care Collaborative. [click here](#). Published 2009. Accessed July, 2010

⁷Guterman S, Drake H. Developing Innovative Payment Approaches: finding the path to high performance. The Commonwealth Fund. [click here](#). Published June, 2010. Accessed June, 2010.

⁸Health Reform Bills Side by Side (3/18/10 Draft). National Association of State Medicaid Directors. [click here](#). Published March, 2010. Accessed July, 2010.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.



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Recommended Citation

Safety Net Medical Home Initiative. Bailit M, Phillips K, Long A. Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net. Seattle, WA: Bailit Health Purchasing and Qualis Health, October 2010.