Patient-Centered Medical Home Work Group
Payment Approach Discussion

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Payment Principles

The Joint Principles call for “payment appropriately recognizes the added value provided to patients who have a PCMH”:

• Value of physician and non-physician staff, patient-centered care management work that falls outside of the face-to-face visit.
• Services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
• Support adoption and use of health information technology for quality improvement.
• Support provision of enhanced communication such as secure e-mail and telephone consultation.
• Recognize the value of physician work associated with remote monitoring of clinical data using HIT
• Separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, should not result in a reduction in the payments for face-to-face visits).
• Adjust for case mix differences in the patient population being treated within the practice.

Most medical home pilots do not follow precisely the specifications for payment, endorse the joint principles, but...

Most pilots have followed some sort of blended models, FFS+ a payment bundle.
What happening beneath the surface

- Practice management redesign
- Staffing change
- Clinician behavior modification program
- Patient behavior modification program
- Communications project
- Health information technology implementation

- incentive alignment support efficient and effective care: break incentives of FFS.
We are trying to achieve

• Improve clinical care process

• Increased access

• Enhance patient experience of care

• Increase clinician and staff work satisfaction

• LOWER TOTAL COSTS OF CARE
Estimated Practice Costs

• Demonstrations take different approaches ...
  – Transformation costs
  – Ongoing costs associated with being a PCMH
    • Care management by physician and nurse care coordinators
    • eVisits, telephone consults and extended hours
  – Costs for uninsured patients and patients insured by non-participating payers

• Most pilots include at least some in per member payment
  – Some include one-time transformation costs
  – Care management costs of nurse care coordinators support varies by pilot
    included in PMPM also lump payment

• Assumption change EHR acquisitions costs will be subsidized independent of pilot
  – US and Maryland have established subsidy programs for ‘meaningful’ use
  – Assume PCMH adoption will constitute “meaningful use.”
  – Disagreement on whether subsidies are adequate
# Estimated Practice Costs

<table>
<thead>
<tr>
<th>Source</th>
<th>Enhancement in PPM terms</th>
<th>What’s counted for enhanced payment</th>
<th>Comments</th>
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</table>
| Deloitte Center for Health Solutions[^1] | $8.66 PPM | PCP added annual $100K payment for care coordination  
Health coach salary plus fringe  
Health coach tools (data collection, telephones, IT)  
Data manager (.33 FTE with salary of $65K and fringe).  
Need to reduce annual system net costs by at least $150K per primary care physician to break even. For a panel of 1,000 patients who need care coordination, net costs for health services must be reduced by at least $150 per patient per month to break even. | One time EMR purchase cost of $80-120K, with $20K for installation, and then $5K annually.  
Also, $20K at risk for annual perf. bonus. |
| Rhode Island Chronic Care Sustainability Initiative | $4.78 – 7.34 PPM | Case manager salary plus fringe  
Office staff (.5 FTE with annual salary plus fringe)  
Office space (case mgr, office staff, co-located specialists)  
Office equipment (case manager, office staff, co-located specialists)  
PCP added annual payment for alt. communication (optional) | Assumes a three-physician practice with one NP. PCP added payment is for e-mail and telephone calls, including after hours and on weekends |
| Medicare Demo Guided Care Costs | Tier 1: $27.12/$80.25 and Tier 2: $35.48/$100.35 Based HCC | Full-time Guided Care Nurse: $95,900  
Half-time LPN (salary, benefits): $27,300  
Other Costs (transport, equip, Comm): $3,000  
EHR: $13,000  
Total: $139,200 | Costs Assumes achieving CMS tier 2 recognition |

# Estimated Practice Costs

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<tbody>
<tr>
<td>Richard Baron for PA SEPA Project, 9-07</td>
<td>$3.78 - $5.04 PMPM</td>
<td>PCP added annual payment for lost revenue&lt;br&gt;Nurse Practitioner (.3 FTE)&lt;br&gt;Medical assistant (.3 FTE)&lt;br&gt;Health educator (.1 FTE)&lt;br&gt;Social worker (.1 FTE)</td>
<td>EMR purchase cost of $78K.&lt;br&gt;Lost revenue due to PCP time on project management.</td>
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<tr>
<td>Allan Goroll et. al. [1]</td>
<td>$5.83-$9.38 PMPM</td>
<td>Nurse Practitioner (.5 to 1 FTE)&lt;br&gt;Data manager (.85 to 1 FTE)&lt;br&gt;Nutritionist (0 to .5 FTE)&lt;br&gt;Social worker (0 to .5 FTE)&lt;br&gt;The latter two would be excluded in smaller practices.</td>
<td>EMR and quality monitoring system: $35K annually.&lt;br&gt;Also, $35-$50K annual bonus for meeting mutually est. goals.</td>
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### Miscellaneous Notes:

- Bridges to Excellence’s new medical home program estimates annual savings of $245 savings per patient from a medical home, and has capped award payments to providers at $100,000 per year.
- United HealthCare estimates the additional reimbursement to a primary care practice for implementing a Patient-Centered Medical Home at 20% above baseline reimbursement.

Costs factors that may affect enhanced payment

1. All patients (the broader inclusion strategy broadens the base lowers the PMPM)

2. Health IT has recently started diffuse – anticipated federal rewards.

3. High possibility for federal reform – could partly solve who pays for the uninsured patients in a PCMH.
• Payment Approaches
• FFS+ PMPM with P4P – Method endorsed by ACP, PCPCC, used in CareFirst Demo
• FFS + PMPY – BTE Prometheus
• FFS + PMPM + P4P + shared savings
• Full capitation of the PCMH