Patient-Centered Medical Home Work Group
Issues Requiring Recommendations

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DRAFT

Underlying objectives of PCMH

- Improve clinical care process
- Increased access
- Enhance patient experience of care
- Increase clinician and staff work satisfaction
- LOWER TOTAL COSTS OF CARE

Options for Reimbursing Practices Continuing Maryland's Tradition for Innovation in Payment Design

The Joint Principles call for payment that 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
- 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.

The moving parts of a PCMH Pilot

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

✓ Align incentives to support efficient and effective care and break incentives of FFS.

Other factors to consider

- Significant upfront costs will likely to be shouldered by payers, i.e., transformation.
- Create an expectation that savings are expected.
- Purchaser fatigue – carriers have a difficult time selling new initiatives to weary employers unless savings are promised.
- PCMH pilot (CareFirst's) already using the standard PCMH payment model.
- Council less likely to be enthusiastic about a 'me too model'.
- If savings don't result, carriers will have a difficult time selling to self-funded employers

Approaches

- FFS+ PMPM with P4P – Method endorsed by ACP, PCPCC, used in CareFirst Pilot.
- FFS + Per member per condition with a budget constraint Prometheus model endorsed by Bridges to Excellence (BTE)
- FFS + PMPM + shared savings. Shared savings has been used in some P4P pilots.
- Full capitation of the PCMH – Approach breaks the FFS incentives

Advantages/Disadvantages

- FFS+ PMPM with P4P – Already being tested in numerous pilots including CF.
- FFS + Payment per member per condition with a budget – large administrative overhead for payers. Budgets have not been created for many chronic conditions.
- FFS + PMPM + shared savings. Practices may absorb some risk, even if losses are mitigated. Practices that do reduce 'costs' may / may not be penalized.
- Full capitation of the PCMH – Offers opportunities to break FFS cycle. Negative connotations to providers.

What would a shared saving model look like?

Practices in PCMHs will earn a bonus payments, if the practice generates savings. Practices that do not generate savings, get no cost or quality bonus.

Steps in a simple Shared Savings Model (Assuming practice competes against itself)

1. Calculate the base year per capita expenditures for the practice.
2. Establish the Target= Adjusted Base Year Per Capita Expenditures × (1 + Expected Growth Rate)
3. Savings = (Target*FTE Patients - Performance Year Per Capita Expenditures) × FTE Patients.

Decisions

1. What is the base? All spending or spending for which practice is directly accountable.
2. Distribution of savings between practice and carrier. Usually majority of savings awarded to practices – 75% goes to practice and 25% goes to carrier
3. Should you hold back some savings for achieving quality measures – of 75% going to practice 2/3 of these savings awarded? Remaining 1/3 awarded to practice if they also meet quality measures. Practices loses 1/3 if they don't meet quality standards
4. Withholds -- should carrier withhold some current savings because practice may generate losses in future?
5. Models break down with small practices, how to adjust random variation can be great.

Preference of the Subgroup

Phase 1 of the pilot -- FFS+ PMPM (care management) + Performance reward.

Phase 2 of the Pilot – transition period blended payment.

Phase 3 FFS + PMPM+ shared savings

Options for Measuring Quality

Quality Measurement

Workgroup has not worked on issue.

Many pilots use a combination of…

- NQF recognized clinical and process quality
  - More emphasis on chronic conditions
  - Admission for Ambulatory Sensitive Conditions
- Cost Efficiency Measures
- Patient Experience/Satisfaction – CAHPS (AHRQ tuning survey for use by Pilots)
- Provider Experience/Satisfaction

Several pilots are using integrated quality

- Inst for Healthcare Improvement TripleAim
- Clinical Microsystems at Dartmouth

Possible Timeline and Costs Factors to Consider

Proposed PCMH Timeline

Step	Activity	Start	Time in months
1	DHMH applies for Medicaid participation	Nov-09	2
2	Grant for Evaluation Funding Submitted	Nov-09	1
3	Commitment from private payers to participate	Dec-09	2
4	Council action on the demonstration	Dec-09	1
5	Medical Home Advisory Panel Formalized from the PCMH Work Group	Jan-10	60
6	Award of implementation contractor by Medical Home Advisory Panel	Feb-10	2
7	Planning for Symposium on PCMH (Using Grant Funds) outreach to and recruitment of eligible practices begins	Feb-10	2
8	PCMH Symposium held to raise awareness	Mar-10	1
9	Practices apply for participation	Mar-10	2
10	Implementation contractor evaluates applicants' qualifications	Jun-10	2
11	Implementation contractor notifies applicants about whether they are qualified	Jul-10	2
12	Technical assistance from Implementation Contractor begins	Aug-10	6
13	Qualified practices enroll eligible patients using commonly approved attribution rules	Sep-10	3
14	Practices begin medical home service delivery. Payers begin medical home payments using enhanced FFS + PMPM	Jan-11	12
15	Transition to shared savings	Jan-12	24
16	Practices shift to a shared savings model	Jan-13	12
17	Final Reports recommendations and Council decision to go forward	Dec-13	

Costs Centers and Sources of Funding

Cost Center	Possible Providers of These Services	Funding Source
PCMH Advisory Panel	Various Stakeholder Donated time	No Cost to Pilot
Outreach Awareness & Symposium	TransforMED, ACP, Academy Health	SCI other grants
Pilot Design Services	MPR, Ballit Associates, CHC, RTI, Lewin	Grant funds and state revenue
Implementation Coordinator	Lipitz Center for Integrated Health Care, JHU, MGMA, TransforMED, Delmarva, RTI	Public , Private Payers, Large Health Care Institutions
Publicity	AAP, ACP & AAFP State supplied	Grant and State Funds
PCMH PMPM costs	n/a	Payers financed in relation to market share
Pilot Evaluation	Harvard, Rand, U Conn	Grants funds Commonwealth, AHRQ,RWJ