Feds Set to Test Medical Home Payment Models

Models to be chosen based on ability to improve service coordination, quality, and efficiency.

BY SHERRY BOSCHERT

EXPERT ANALYSIS FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF PEDIATRICS

SAN FRANCISCO – Beginning in January 2011, federal agencies will identify and test various models of paying for health services in a patient-centered medical home.

The Centers for Medicaid and Medicare Services (CMS) is charged by the 2010 Affordable Care Act to test innovative payment and service delivery models to reduce program spending while promoting quality care.

The health care reform act specifies that models of care be chosen based on their ability to improve the coordination, quality, and efficiency of services, Dr. Xavier Sevilla said at the meeting.

The patient-centered medical home is one of the models to be tested, and the challenge lies in figuring out payment methods that will enable physician practices to provide comprehensive primary care that is accessible, continuous, family centered, coordinated with other caregivers, compassionate, and culturally effective, he said.

"I don't think we're going to see the private payers move until CMS does," added Dr. Sevilla, chief of pediatrics for Manatee County Rural Health Services, Bradenton, Fla.

He serves as the Academy's representative to the National Committee for Quality Assurance Advisory Panel on the Physician Practice Connections Patient-Centered Medical Home.

Today, however, the most common "resolution kit" available to physicians trying to resolve payment issues for the different kinds of work they do in patient-centered medical homes is a homemade sign with a circle around the words "Bang head here," he joked.

Current payment systems encourage quantity over quality and reward procedures over evaluation and management of patients, he said. Payments are made only for services administered by clinicians and cover only services performed in the office setting when the patient is present, which ignores care coordination and nonoffice communications with patients, such as via e-mail.

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DR. SEVILLA

The ideal payment system would incentivize care coordination and improving the quality of care. It would support the transformation of practices from individual care to population-based care, from physician-provided care to team-based care, and from episodic care to continuous care, Dr. Sevilla said.

He described several payment proposals that could be tested in the demonstration programs, some of which already are underway in pilot projects.

One model retains existing fee-for-service contracts and adds a per-member-per-month case-management fee and pay-for-performance reimbursements using nationally validated quality measures of process and outcome. A Colorado-based pilot is testing this model in a Multistate Patient Centered Medical Home program.

This model could improve office efficiency and access, depending on the pay-for-performance measures, Dr. Sevilla said. The management fee supports non–office communications and non–physician care, and allows the practice team to concentrate on the whole practice population.

Fundamental practice changes are unlikely unless the management fee and payments for performance are large enough, he added. The management fee could allow small practices to join together to share costs.

This payment model could be relatively easy to implement, because it simply adds to the existing payment system.

Another model also would keep the fee-for-service system but develop new CPT codes for medical home activities that currently are not reimbursed. These may include phone and e-mail consultations, after-hours services, phone calls with specialists, and more.

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Currently, Blue Cross and Blue Shield of Michigan pays for practice-based care management, and Horizon Blue Cross and Blue Shield of New Jersey pays for phone calls to patients and specialists.

This model does not incentivize improving the quality of care or population-based care, however, and the new CPT codes would need to include tasks performed by non–physicians to support a team approach.

Many of the CPT codes needed for patient-centered medical homes exist, but are not recognized by most payers, including CMS.

Adding more codes to the 8,000-code CPT system would increase complexity, and costs may not decrease if the codes are over-used, Dr. Sevilla said.

A third payment model would provide monthly comprehensive payments based on yearly per-patient risk-adjusted calculations of per-patient–per-month reimbursements. In addition, practices would receive up to 25% risk-adjusted bonuses for achieving goals in quality, cost, and patient experience.

"To make this work, we'd need a validated actuarial model that predicts a patient's need for primary care and that provides a relative risk based on demographics and billing diagnoses," he said.

The guaranteed monthly payment would cover the multidisciplinary team, technological infrastructure, and non–face-to-face communications.

"This would require a major culture change by payors and physicians," Dr. Sevilla noted. Payors would need to make up-front investments and change their basis for payment.

The Capital District Physicians Health Plan in Albany, N.Y., is trying this payment model, he added.

While demonstration projects test the various practice and payment models, physicians can help move the medical system toward patient-centered medical homes by advocating for payment methods that support the medical home, and participating in one of the demonstrations of new payment methods, Dr. Sevilla said.

"Familiarize yourself with opportunities to participate in payment demonstration projects" and use what you learn when negotiating contracts with payers, he suggested. "I think this is really coming to a practice near you pretty soon."

Dr. Sevilla said he had no relevant conflicts of interest. ■

House Passes Short-Term SGR Fix, But Long-Term Solution Still MIA

BY ALICIA AULT

The House of Representatives voted Nov. 29 to approve a 1-month extension of current Medicare physician fee schedule.

If signed by President Obama, which is expected, physicians will avoid a 23% reduction in fees mandated by Medicare's Sustainable Growth Rate (SGR) and slated to go into effect Dec. 1.

However, unless Congress takes additional action before the Christmas recess, physicians face a 25% cut in fees Jan. 1.

The House vote follows the Senate's Nov. 18 approval of a 1-month extension contained in the Physician Payment and Therapy Relief Act of 2010. That bill was introduced in the Senate by Finance Committee Chairman Max Baucus (D-Mont.) and ranking minority member Chuck Grassley (R-Iowa).

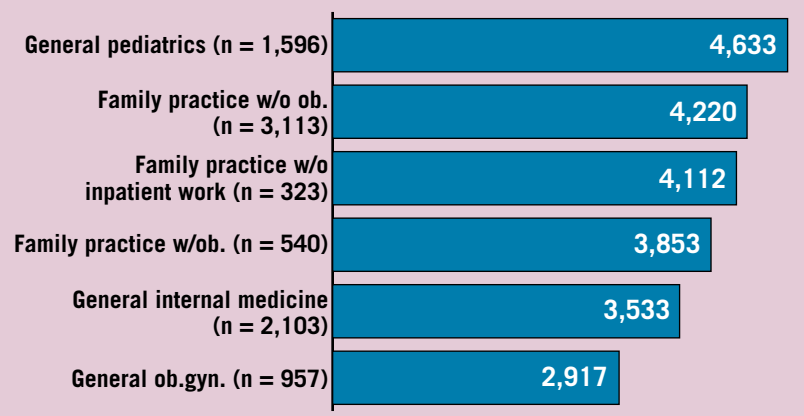
The estimated cost for the 1-month extension is $1 billion.

The Senate legislation pays for that by using savings from a new Centers for Medicare and Medicaid Services policy that reduces Medicare payments for multiple therapy services provided to patients in 1 day. Therapists would not be squeezed, however; the proposal would also shrink the called-for reduction from 25% to 20%, according to Sen. Baucus and Sen. Grassley.

In a statement, American Medical Association President Cecil B. Wilson said that the short-term delay "helps ensure that physicians can continue to care for seniors for the next month." But he added "the AMA urges Congress to build on the bipartisan action that delayed this year's cut and act in December to stop the cut for 1 year so that Congress has time to work on a long-term solution." ■

DATA WATCH

Ambulatory Encounters Were Similar Among Family Medicine Work Settings in 2009



Note: Based on a 2009 survey of physicians in group practice.
Source: Medical Group Management Association

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