

Patient Centered Medical Home Work Group

Payment and Performance
Measurement: Issues In Identifying

An Approach

June 19, 2009

Draft

Starting Assumptions

Market and political realities will necessitate action on delivery system reform before evidence is available to determine the optimal course of action.

Adopting PCMH in the context of no more healthcare resources and an economic downturn. PCMH's will require considerable up-front capital investments. Ongoing costs will require infusions of money.

Demonstrations point to payment reform that rewards primary care work beyond face-to-face visits or procedures, typically adding a bundled care management fee of some kind and some form of pay-for-performance bonus.

These are common themes, but significant differences exist in payment model specifics or level of development.

Agenda

- Challenges of arriving at payment formula
- Arriving at recommendation for payments to a PCMH
- Alternatives for measuring performance of a PCMH
- Plans for reaching consensus

Possible short term savings from PCMH adoption

- Decreased redundancies
- Decreased medical errors
- Decreased emergency department visits and hospitalizations for ambulatory care sensitive conditions
- Decreased rehospitalizations for patients recently discharged, and prevention of costly complications

Focusing on short-term gains is tempting, but in the end may prove foolhardy, but are demonstrable.

BTE studies estimated substantial savings

Management of Diabetes (focusing on ABC)

- Maintaining HbA1c at or below 7% saves \$279 a year in health costs per patient.
- Keeping a diabetic's LDL below 100 saves \$369 per year and keeping the blood pressure below 130/80 saves \$494.
- Keeping all measures at target saves \$1,059 per patient per year.
- Avoiding dialysis by controlling diabetes can save \$44,206 per year.
- Preventing one MI saves \$36,256.

Cardiac Care Management estimated savings of \$540 per patient

- Blood pressure control < 140/90 mm Hg
- Completion of Lipid Profile
- LDL control < 100 mg/dl`
- Use of aspirin or other antithrombotic
- Notation of smoking status cessation advice or treatment

Source: "Diabetes Care Analysis –Savings Estimates" Bridges to Excellence, December 5, 2005

http://www.bridgestoexcellence.org/Documents/DCL_analysis1207051.pdf, Cardiac Care Analysis –Savings Estimates, Dec. 29, 2003,

<http://www.bridgestoexcellence.org/Documents/CCL%20Analysis%20by%20Towers.pdf>

Potential Cost Factors in PCMH Adoption

Features w/direct cost impacts:

- PCMH Recognition
- Open access scheduling
- On-line appointments
- EMR
- Medical protocol software
- Web-based info
- Group visits
- E-consults
- Care management
- Team approach to treatment
- Population management
- Performance/ Outcomes analysis



Practice Financial Implications???

- Training costs
- Service volume
- RVU per service
- MD time per service
- Clinical staff time per service
- Office expense
- Administrative staff
- Malpractice premiums
- Organization Chaos

Some effects of provider payment

Payment Mode	Core Incentive	Organizational Effect	Consumer Shopping Effect
Fee For Service	Increase volume	Favors fragmentation	Can only shop for individual services
Capitation	Decrease volume	Favors consolidation	Can only shop for “systems”
Episode	Decrease volume w/in episode, increase volume of episodes	Favors some consolidation..at the disease/procedure level	Can shop for “care packages” – relevant price transparency

Payment Approaches in Existing Pilots

FFS + Care Management Fee

- Per-patient per month/practice/year
- Fee-for-service including reimbursement for telephone & Evisits
- Care management fees linked to PCMH levels
- Most pilots have not implemented an adjustment for performance or case-mix.
- Covers care coordination of mid-level health providers .

Fully Capitated Payment

- PMPM linked to PCMH capabilities
- May not be permitted in PPOs (MIA seeking clarification)
- Better opportunity to align incentives
- Negative connotations among Maryland practices

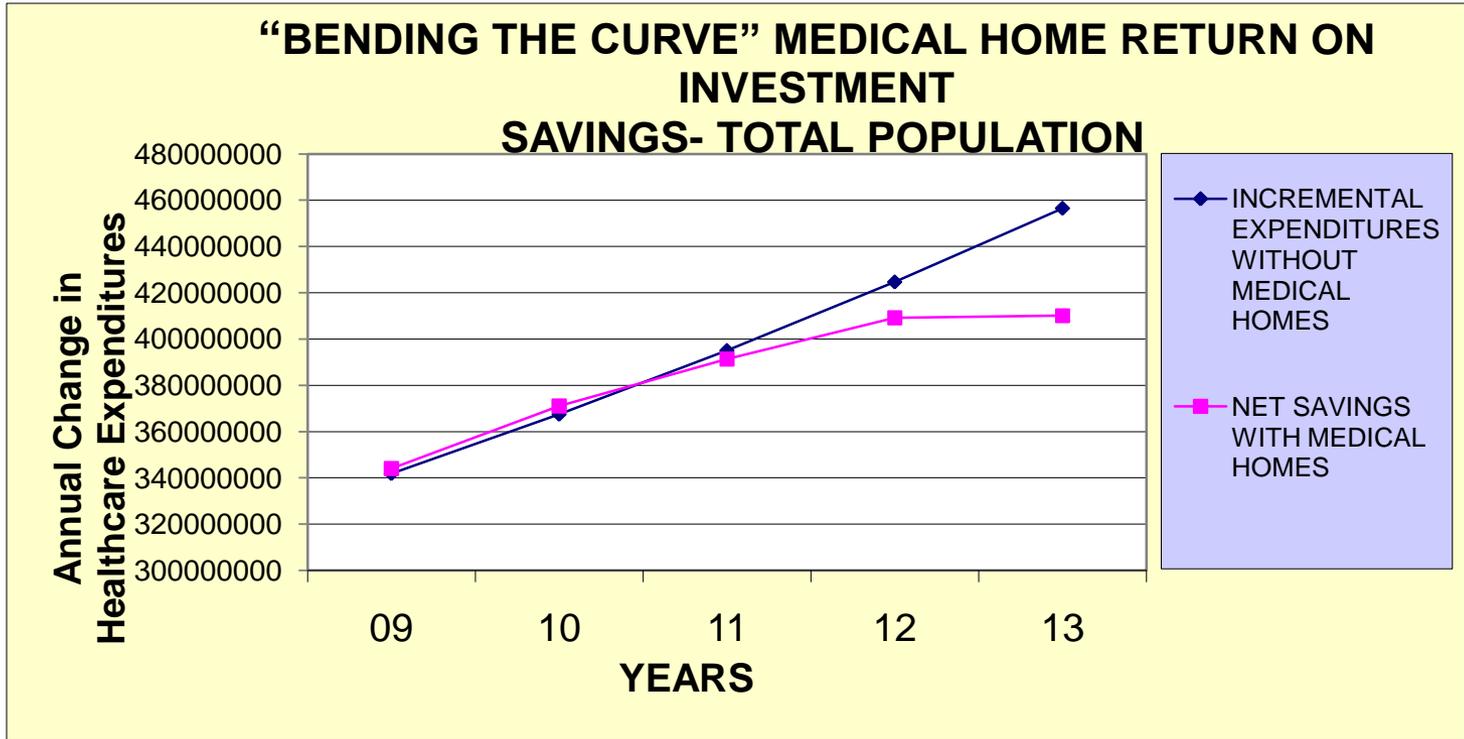
Episode-Based Payments -- still in its infancy.

According to NASHP, five states considering mechanisms -- capitation, global fees, risk adjustment (LA, MN, NH, OR, WA).

Performance 'Bonus' payments as an 'add-on' will work with any model.

Vermont Blueprint for Health – PCMH Pilots

Estimated Financial Impact



	2009	2010	2011	2012	2013
Percentage of Vermont population participating	6.7%	9.8%	13.0%	20.0%	40.0%
Participating population	42,179	61,880	82,332	127,045	254,852
# Community Care Teams	2	3	4	6	13

Source: Watkins Laura, "Vermont Blueprint for Health Integrated Pilot Programs", presentation to PCPCC Jan. 20, 2009

Constraints on Reimbursement – Budget Neutrality and PayGO

Carriers can be tempted to target budget neutrality in setting payment rates because of lack of data on costs of PCMH services, fiscal pressures, purchaser resistance but...

- Equally rare data on potential savings
- Each PCMH service has a different cost and potential savings
- Payments must be sufficient to ensure physician participation
- “Zero-sum” initiatives will generate more opposition from providers not getting PCMH payments
- Early “deficits” may smooth the way toward longer lasting corrections of fee-for-service distortions and broader payment reform
- May be reasonable for mature programs with refined understanding of effective features of PCMH to target budget neutrality

Approaches to arriving at payments

- Estimate potential savings from PCMH (ED services, hospitalizations, redundant testing)
 - Offset by increased desirable spending (preventive services, primary care)
- Look at actual costs for providing the services at ‘reasonably efficient’ practices.
 - A major challenge is cost management systems at most small practices are crude
- Pure guesswork, but can place upper bound on payments
- Pay-as-you-go approach of payment through shared savings only
 - Requires extensive data gathering
 - Generally will create recruitment challenges
- Private sector models assume very low PMPMs, but include entire patient panel.
- Medicare PMPMs are risk adjusted and are limited to the chronically ill Medicare population.

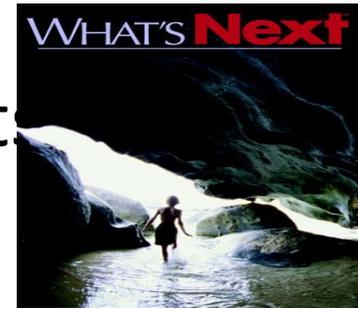
Why not budget neutrality... Key research questions are not answered

- Do practices that conform to PCMH criteria deliver:
 - better quality of care?
 - better patient experiences?
 - lower total cost?
 - improved physician and staff satisfaction?
- What does it take to turn practices into PCMHs:
 - what size of practice?
 - payer mix?
- Is there a business case for the PCMH:
 - for payers and purchasers?
 - For providers?
- What are the standard set of data collection instruments?
- What are the core outcome measures?

Challenges for practices

- Start-up costs for acquiring PCMH capabilities are highly variable.
- Percentage of patients in a PCMH's panel covered by PCMH payments.
- Can a practice recover investment costs and operating costs for a time-limited pilot?
 - MD and US govt stimulus HIT financing is a plus
- Lack of risk adjustment could pose problems for practices with sicker or older patient populations.
 - Reimbursement structure should not discourage practices that are treating patients that would be well served in a PCMH.
- Issue of what's in the package? Will it cover costs?
 - Care coordination/management PMPM fees in multi-payer demos have varied from **Up to** \$3-\$9 PMPM.
 - CMS pilot posits different PMPM structure – limited to chronically ill

Approach to moving forward on payment



- Convene a subgroup of payers and others to discuss options for payments.
 - Mixed model – FFS/PMPM/reward structure
 - Fully capitated model
 - Evidence-based case rates (BTE, MASSPRO, Mass HQIO, some payers)
- Critical that payers participate in this subgroup
- Report back to the Workgroup in about a month
 - Appraise the evidence and compare results

