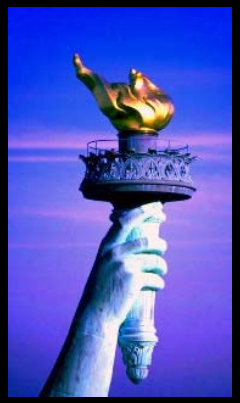


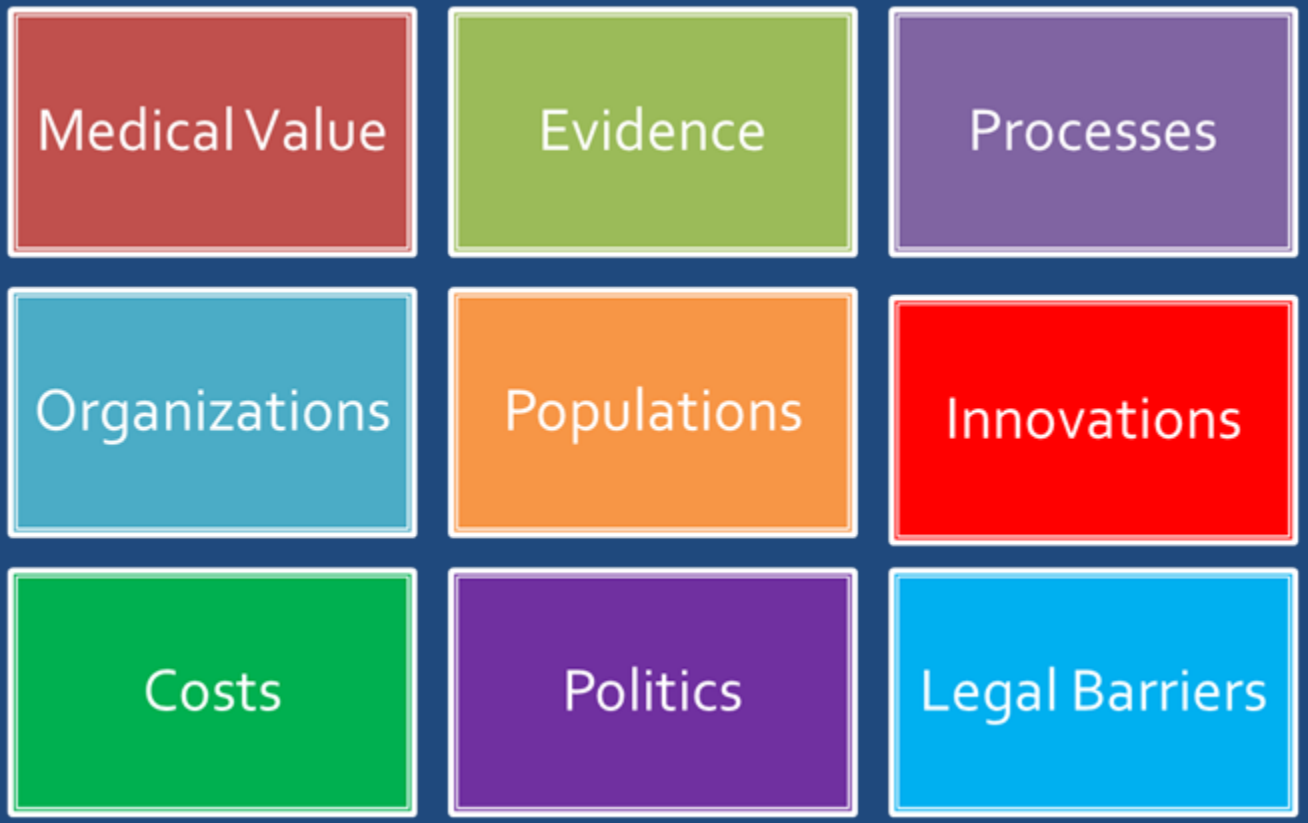
Nandan Kenkeremath, JD

Payment Models and Incentives for Patient-Centered Medical Homes

Agenda

- Definitions, Framework, Relationships
- 2007 Joint Principles on Patient Centered Medical Homes
- Payment Task Force Report

Certain Factors in Payment Reform



Some Issue Areas for Today's Discussion

Conference ACO Definition

- **What is an ACO?**
  ACOs are provider collaborations that support the integration of groups of physicians, hospitals, and other providers in different ways around the opportunity to receive additional payments by achieving continually advancing patient-focused quality targets and demonstrating real reductions in overall spending growth for their defined patient population.

Conference ACO Definition (2)

- The ACO model is highly flexible and can be organized in a number of ways - ranging from fully integrated delivery systems to networked models within which physicians in small office practices can work effectively together to improve quality, coordinate care and reduce costs.
- They can also feature different payment incentives ranging from "one-sided" shared savings within a fee-for-service environment, to a range of limited or substantial capitation arrangements with quality bonuses.

Joint Principles on Patient Centered Medical Homes 2007

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Payment Framework Portion of Joint Principles

- ***Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:***

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

Payment Framework Portion of Joint Principles (2)

- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;

Payment Framework Portion of Joint Principles (3)

- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

Payment Framework Portion of Joint Principles (4)

- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements

Payment Reform to Support High-Performing Practice

Report of the PCPCC Payment Reform Task Force

JULY 2010

PCPCC Payment Reform Task Force Models Reviewed

- Fee for Service
- Management Fee
- Pay for Performance
- Prometheus Evidence-Informed Case Rate Models
- Risk Adjusted Comprehensive Payment and Bonus Model
- Risk Adjusted Global Payment in ACO

Fee for Service

- **Fee-for-service** is a standard business model where services are unbundled and paid for separately. In the health insurance fee-for-service occurs when health care providers receive a fee for each service such as an office visit, test, procedure, or other health care service.[1].

Pay for Performance

- **Pay for performance** is an emerging movement in health insurance (initially in Britain and United States). Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services

Evidence-Informed Case Rates

- Under this system, providers are paid a single, risk-adjusted payment across inpatient and outpatient settings to care for a patient diagnosed with a specific condition. Working with experts in the health care field, the authors selected 10 conditions for ECR development, examining issues like diagnosis, services covered by the ECR, and criteria for successful completion of care.

Diagnosis-Related Group

- **Diagnosis-related group** (**DRG**) is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, have been used in the US since 1983 to determine how much Medicare pays the hospital.

Risk Adjusted Comprehensive /Global Payments

- A yearly per-patient risk-adjusted comprehensive payment paid monthly for all physician and team services.
- Risk adjusted payments for integrated delivery system that commit to manage the care of a population

Recommendations on Promoting PCMH Payment Reform

- Many different payment reform models for the PCMH should be piloted and evaluated.
- PCMH payment piloting efforts in a primary care practice should include as many payers and patients as possible because the PCMH is intended for all patients.

Recommendations on Promoting PCMH Payment Reform

- Medicare and Medicaid should participate in multi-payer piloting efforts to help promote the payment reform effort through public-private partnerships.
- Fast-track piloting should be undertaken rather than demonstrations.

Payment Reform Task Force Guiding Principles (short versions)

- Payment reform is essential to the establishment and sustained operation of the PCMH.
- No one payment system is universally best for the PCMH. Take into account the local patient population, practice environment and culture, financial needs, and commitment to change.

Payment Reform Task Force Guiding Principles (short versions)(2)

- A blended strategy to payment reform can help minimize the shortcomings associated with any single method approach.
- Pay-for-performance and bundled or global approaches to payment should be risk adjusted

Payment Reform Task Force Guiding Principles (short versions)(3)

- Pay-for-performance should, to the extent possible, be based on evidence and focused on outcomes.
- A portion of shared savings and bonus payments should be folded into the base payment over time to avoid reductions in total pay.

Payment Reform Task Force Guiding Principles (short versions)(4)

- PCMH sustainability is proportional to the penetration of payment reform in the practice.
- A substantial majority of the practice population needs to be covered by the payment reform for the PCMH to be sustained, often necessitating multi-payer participation.

Payment Reform Task Force Guiding Principles (short versions)(5)

- Payment reform should correct existing imbalances and distortions in physician payment and take into account value created by primary care.
- Payment reform should improve the practice environment and enhance the professional satisfaction and attractiveness of a career in primary care.

Payment Reform Task Force Guiding Principles (short versions)(6)

- Payment reform should encourage patient-centered, coordinated care by all providers, not just those inside the PCMH.
- Payment reform models and proposals should be widely piloted, systematically evaluated, and, for those shown to be effective, rapidly promulgated.

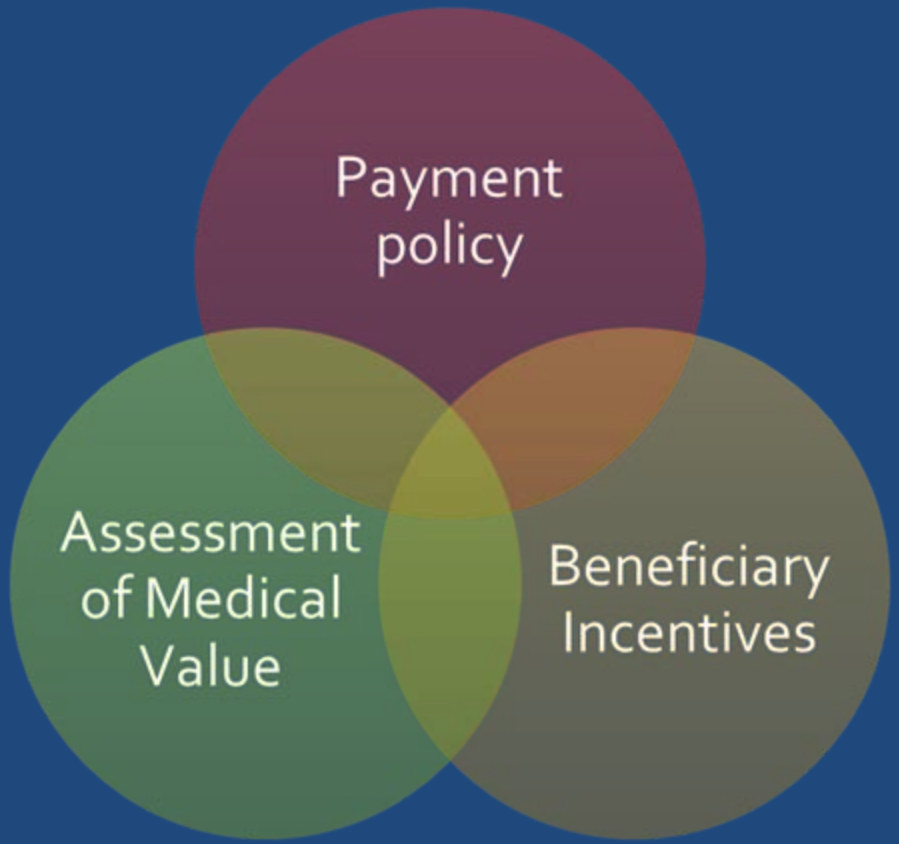
Payment Reform Task Force Guiding Principles (short versions)(7)

- Administrative practicality is desirable, if not essential (although the transition may require considerable effort).
- Payment models that achieve validation through piloting should be offered to practices by all payers.

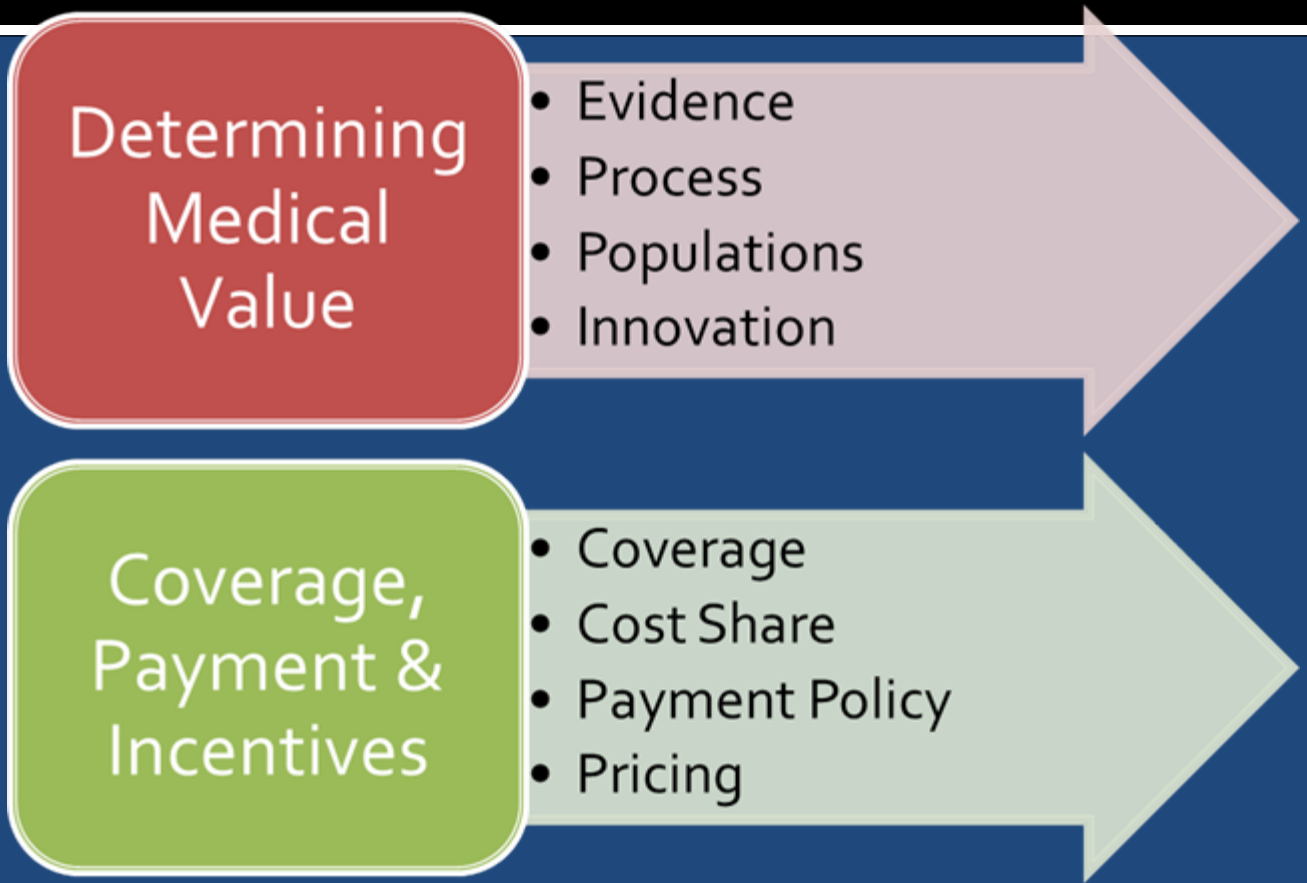
Additional Insights

Tying some Thoughts Together

Some Areas Connected to Payment Reform



Framework of Policy



Assessing Medical Value

- Evidence
- Scientific Understanding
- Framework and Assumptions
- Uncertainty
- Populations
- Variables
- Innovation
- Comparisons
- Costs
- Processes
- Organizations
- Protocols
- Translation

Areas Assessment of Medical Value Can Influence

Certain Influences on Decision-making in Practices

Value Based Insurance Design
Aligning Incentives and Systems (PCPCC 2010)

- Value Based Insurance Design(VBID) is an employer-driven benefit design strategy to optimize use of higher-value health care services and reduce use of lower-value services.
- VBID is a demand-side initiative that focuses on patient incentives to enhance use of medical services of proven value.

Certain Mechanisms for VBID

	Waive or reduce copayments or coinsurance for:
Design by Service	select drugs or services, such as statins or cholesterol tests, no matter which patients use them.
Design by condition	specific clinical conditions with which patients have been diagnosed
Design by severity	members with a particular condition who are believed to be at high risk for excessive health care costs in the near future.
Design by disease management participation	high-risk members who actively participate in a disease management programs

Employer considerations for PCMH-related benefits in VBID

- **Co-pay reductions for:**
- Medical home visits
- Specialist consults when referred by PCMH
- Ambulatory services when referred by PCMH
- Contributions to HRA/HSA for PCMH provider selection
- **Compliance with recommended care:**
- Tiered employee benefit contributions
- HRA/HSA contributions

Legal Issues in Broader Group Arrangements

- Antitrust
- Stark and Anti-kickback
- Medical Loss Ratio
- Privacy Rules
- Medical Liability
- Multi-payer
- Clinical Aggregation

Some Areas for Cost Reduction

- Uncoordinated Care
- Unnecessary Care
- Administrative
- Fraud and Abuse
- Obesity/Overweight
- Smoking
- Non-adherence
- Defensive Medicine
- Medical Errors
- Practice Variation
- Enhanced use of HIT
- Comparative Effectiveness
- Allocation of Functions to Lowest Cost Provider
- Payment Incentives
- Patient Incentives

General Thoughts

- We have tens of trillions in unfunded obligations in health care and substantially rising costs; our creditors will force the cost issues before our politicians.
- PCMH movement starts with practice transformation model and asks how payment reform can reward, incentivize, and not penalize the elements of that practice transformation.

General Thoughts (2)

- Post-diagnosis, preventative services, practice transformation, and general practice support may need different approaches
- We need a matrix explaining how the assessment and application of medical value and appropriateness will be made
- The full tool kit includes beneficiary incentives as well as payment policy changes

General Thoughts (3)

- The medical loss ratio rule, antitrust, and stark, privacy provisions, and certain other restrictions in health care reform may pose problems for certain payment reforms and incentive models
- We may want to study how different models would have effected payments based on historical data

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