Designing a Medical Home for Medicare Beneficiaries

Linda M. Magno
Director, Medicare Demonstrations

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Medical Home Demonstration

- Tax Relief and Health Care Act of 2006 (sec. 204)
- "... to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations"
- 3 years, up to 8 states (including urban, rural, underserved areas)

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Personal Physician

- Board certified
  - First point of contact
  - Continuous care
- Ongoing support, oversight, guidance to implement plan of care
- Staff & resources to manage comprehensive & coordinated care

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Practice Responsibilities

- Target beneficiaries for participation
- Provide safe, secure technology to promote access to personal health information
- Develop health assessment tool
- Provide training for personnel involved in coordination of care
- Provide medical home services

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Medical Home Services

- Oversee development & implementation of plan of care
- Use evidence-based medicine & decision-support tools
- Use health information technology to monitor & track health status of patients, provide patient access to services
- Encourage patient self-management
- Non-visit-based access & care

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Payment

- Fee-for-service for covered services
- Care management fee to personal physicians
- Incentive payment for medical home practice
  - Share of savings attributable to medical home
  - Shared savings reduced by care management fees

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Design Issues

- Medical home definition
- Practice eligibility
- Beneficiary eligibility
- Care management fee
- Technical assistane

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Definition of Medical Home

- What are the minimum requirements to ensure practices have capacity to act as “quarterback” for health care team caring for participating beneficiaries?
- Should we recognize multiple levels of medical home practices? What should differentiate them?

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Tier 1 Requirements

- 16 core requirements such as:
  - Access standards & measurement of performance on such standards
  - Development & use of integrated care plan
  - Pre-visit planning
  - Coordination & follow-up of referrals
  - Provision of patient education & support
  - Performance measurement

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Tier 2 Requirements

- All Tier 1 requirements *plus*
- Additional requirements, including:
  - Electronic health record
  - Coordination across range of settings
  - Broader range of performance measurement & reporting
  - Automated reminders
  - Interactive Web-based access to health information

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Practice Eligibility

- Located in selected geographic area
- Application to CMS
- Qualification based on CMS version of the NCQA PPC-PCMH tool
  - Same basic framework
  - Scoring consistent with CMS's demonstration
- Not all physicians in the practice need participate

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Beneficiary Eligibility

- Medicare fee-for-service Parts A & B
- One or more chronic conditions
- Agreement between physician and patient

- Excludes ESRD beneficiaries, hospice patients and nursing home residents

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Care Management Fee

- Monthly fee for each medical home Medicare patient
  - Adjusted for complexity of patient
- Valuation set by AMA's Relative Value Scale Update Committee (RUC)
- Designed to cover inter-visit activities
  - "Work" = staffing mix, level of effort
  - Practice expenses

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What Is the Care Management Fee?

Per Member Per Month Payments			
Medical Home Tier	**Patients with HCC Score <1.6**	**Patients with HCC Score ≥1.6**	**Blended Rate**
1	$27.12	$80.25	$40.40
2	$35.48	$100.35	$51.70

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Technical Assistance

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- Awarded to the Lipitz Center for Integrated Health Care at Johns Hopkins University
- PI: Charles E. Boult, MD, MPH, MBA

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Operational Issues

- Site selection & announcement
- Practice recruitment & selection
  - ~50 practices or 250 physicians per site
  - ~400,000 beneficiaries
- Monitoring & measurement of medical homes' performance

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Implementation

- Approval of demonstration
- Physician recruitment
- Practice qualification
- Notification of practices
- Patient recruitment/enrollment
- Demonstration begins

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Evaluation

- Measure vs. comparison population
- Value added
  - Clinical quality
  - Physician perspective
  - Beneficiary perspective
- Savings to Medicare
- Lessons learned

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Expansion

- Medicare Improvements for Patients and Providers Act of 2008 (passed July 2008)
- Expansion may occur if the project is expected to:
  - Improve the quality of patient care without increasing spending, *or*
  - Reduce spending without reducing the quality of patient care

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For More Information

- www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage

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