Payment Reform and the Medical Home

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Motivation for Current Wave of Payment Reforms

- (Almost) no one is happy with current payment system
- Providers find it administratively complex and often at odds with best clinical practice
- Payers see pervasive quality problems coupled with declining affordability (i.e., spending growth exceeds income growth)
- Patients face access problems, particularly in primary care

Baby Steps in Payment Reform: Pay for Performance

- Following IOM Crossing the Quality Chasm in 2001, new interest in pay for performance
- Inventories of programs across all types of payers document[1] nearly 150 pay-for-performance programs
- In a national survey, 52% of HMOs (covering 81%[2] of enrollees) report using pay for performance

1. The Leapfrog Group and MedVantage, 2007.
2. Rosenthal MB, et al. Pay-for-Performance in Commercial HMOs. New England Journal of Medicine, November 2, 2006.

Empirical Evidence on Impact of Pay for Performance

- Rigorous (controlled) studies of pay-for-performance in health care are few
- Overall findings are mixed: many null results in terms of targeted measures even for large dollar amounts
- Recent findings from Medicare demo, National Health Service GP Contract, IHA suggest modest quality improvements in many but not all measures and some "gaming"

What Most Experts Have Concluded about P4P in Health Care

- Small bonuses for performance on top of fee for service is a little like moving deck chairs on the Titanic; holistic reform is needed
- Pay for performance – on either quality or cost-related targets -- is the wrong model for cost control
- Broader payment reforms are needed (but not sufficient)

Current Landscape of Payment Reform

- Incremental reforms
  - Pay for performance: process and outcome measures of quality, efficiency
  - Non-payment for preventable complications, adverse events
- Episode-based payment concepts
  - PROMETHEUS™ Payment
  - Geisinger's ProvenCare™
  - Medicare bundled payment demonstration
- Shared savings
  - CMS Physician Group Practice demo
  - Alabama Medicaid
- Where does the medical home fit?
  - Primary care capitation or management fee (per member per month)
  - Pay for performance
  - Continued fee for service

Common Themes in Current Proposals

- More prospective payment
- Mixed payment (FFS, capitation, P4P)
- Quality is integral – minimum standards, incentives
- Targeted risk sharing (not full delegation): implicit or explicit parsing of controllable vs. uncontrollable variation
- Structural guidelines/prerequisites (co-development of chicken and egg)

Medical Home as Payment Reform Promises:

- Attenuation of fee for service incentives – slowing down the hamster wheel
- Incentives/support for investment in infrastructure and human resources (e.g., non-physician clinical staff)
- Incentives to improve quality, reduce costs as embodied in pay for performance – possibly aligned with QI efforts

Hoped for Effects of the Paying to Support Medical Homes

- Primary care physicians will find the reimbursement environment less toxic and the workforce crisis will abate
- IT adoption will finally reach the steep part of the curve
- Patients will have improved access
- Chronically ill and high risk patients will receive care that prevents acute events and hospitalization, readmission, ED use
- Net cost savings…world peace…

How Could the Medical Home Payment Model be Strengthened?

- Payment incentives better aligned with payer hopes for outcomes: incentives for cost savings are virtually nil in most arrangements but payers still put this as #1 objective
- Linkages with specialists, hospitals, other parts of the continuum
- Benefit design that supports prospective accountability, makes patients partners in the same objectives

Payment Incentives that are not Present in Most Medical Homes

- Most pay for performance remains targeted at quality improvement for chronic illness and primary prevention
- To the extent that quality saves money there are implicit incentives for cost savings in most medical homes
- In most cases there are no (explicit or implicit) incentives to reduce spending by:
  - seeking out and using more efficient specialists and other downstream providers;
  - eliminating overuse and misuse;
  - substituting lower-cost interactions (email, group visits, phone) for traditional office visits
- It may be that focusing first on basic structures of the medical home and care management for chronically ill patients makes sense; but phasing in explicit incentives for cost savings (with value) may be necessary

No Medical Home is an Island

- Reforming primary care payment alone cannot fix problems that reside largely in specialty care and play out in care transitions
- At the very least there is a risk of creating conflicts reminiscent of the "gatekeeping" era
- Payers could:
  - Reform specialist and hospital payment at the same time!
  - Allow specialists to bill for consults to medical homes
  - Provide medical homes with information about how various specialists perform on quality measures, including over use of highly profitable tests and procedures
  - Support shared accountability through pay for performance: e.g., reward both the medical home and it's primary hospital for reductions in readmissions

Disconnect between Payment/Care Delivery Model and Patients

- Implementation of medical home pilots has been challenged by the problem of identifying which patients belong to a practice
- Without prospective accountability, ability to manage patients effectively is hindered
- Trick is to avoid making the medical home a dreaded gatekeeper and make it a trusted partner instead
  - Voluntary patient commitment
  - Positive incentives – reduced copayments for identifying medical home; shared performance incentives for quality

Concluding Thoughts

- While the structural model and process elements of the medical home have been around for decades, a payment model to support it has emerged as part of broader reform efforts
- Elements of the payment model – mixed payment, targeted incentives, emphasis on capabilities as a prerequisite for participation – are mirrored in other prominent reforms
- The medical home could fit into a larger payment reform; alignment of other providers and patients will be critical to ensuring that primary care is not the tail trying to wag the dog