Getting the Payment Models Right

The National Medical Home Summit

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Current Financial Model for Primary Care is Based on the Face-to-Face Office Visit

“Hamsters on a treadmill”

“Tyranny of the urgent”

Time in office visit mostly unchanged (marginally greater) but the work of what needs doing has exploded

Reliance on OVs may not well serve either physicians or patients
Inherent Limitations in FFS to Support the Medical Home

Relatively high transaction costs compared to value of the direct costs for many PCMH services -- inefficient

Program integrity concerns (although also in OV up-coding that may be taking place to make up for payment shortfalls)

Potential for moral hazard-related volume growth associated with some of these services, e.g. emails and phone calls
Capitation, the Main Alternative, Was Executed Poorly in the Past

Crude, inadequate risk adjustment

Actuarially flawed conversion from FFS spending to PMPM rates (ignored greater expectations of PCCMs to manage more care)

Depending on how structured, there are perverse incentives, e.g., low threshold for referring out

Concerns about conflict of interest – but now better able to measure under-service so could possibly assuage this concern
Is Salary Relevant Here?

Not readily applicable to network model delivery systems, as third party payers are not employer who can easily adopt salary

Very commonly used by intermediary organizations, e.g., multispecialty group practices, although often with performance incentives

Very different views – and mixed record -- on whether “incentive neutrality” represented by salary is desirable or not
Reporting/P4P can only be complements -- but may be important complements -- to a basic payment approach.

Reporting/P4P provide a theoretical alternative to heavy reliance on “certification” of PCMHs – especially if they can focus on outcomes.

What is an episode of a chronic condition? An oxymoron. Also, chronic conditions tend to cluster, so should have episode clusters – but then, why not go straight to PPPM?
The Logic of Hybrid Payment Approaches

To balance incentives – to simulate incentive neutrality
E.g., FFS for visits with PPPM for medical home activities
BUT – a response could be to churn visits and not do much of the PCMH activities, i.e., game each incentive separately rather than balance the incentives
Experiences in Pilots and Demos

Most, but not all, commercial insurance/multi-payer PCMH demos and the would-be Medicare demo are using the PCPCC recommended approach – standard FFS with a monthly add-on for PCMH services, with or without some P4P bonuses.
State Payment Approaches in Medicaid PCMHs (from NASHP, June, 2009)

- Providing PPPM and/or lump sum payments in addition to standard FFS
- Enhancing fees for certain visits (e.g. well child visits)
- Modifying managed care purchasing process through contracts with providers
- Pay-for-performance and shared savings
Five Specific Payment Options (not mutually exclusive)

- Enhanced FFS payments for office visits
- Reimburse for new CPT services
- Regular FFS for OV's and smaller PPPM for medical home activities
- Reduced FFS for OV's and larger PPPM for medical home activities
- Comprehensive payment for medical services and medical home activities
Enhanced Payments for Office Visits or Subset of Services

FFS on steroids
Administratively easy for current FFS payers
Provides more time for physicians to engage with patients – consistent with “concierge” practices and “ideal medical practices”

Is more physician time and attention the core of what the PCMH is designed to accomplish?

Is it a leap of faith to assume that physicians will take their extra reimbursements from OVs to actually perform PCMH activities – so need an ability to “certify” practices and/or verify performance.
Clinicians do respond to FFS incentives – “if you pay for it, they will do it”

But many of the desired PCMH activities can’t be crisply defined, which is what you need for coding to work well (see problems with E&M codes requiring “documentation guidelines”)

And many are “small ticket,” highly repetitive activities so subject to practical problems described earlier

There are some opportunities – codes for work associated with patient transitions, palliative care conferences, group education
Regular FFS for OVs and Small, Add-on PPPM for Medical Home Activities

The prevailing models in most demos, with or without P4P/shared savings

Could be effective, especially if able to recognize the right practices and verify PCMH activities are done

But maintains the dominance of FFS payment and incentives – the centrality of face-to-face

Seems most compatible with multidisciplinary team approach to PCMH
Reduced FFS for OVs and Relatively Larger PPPM for Medical Home Activities

Attempts to reduce the centrality of visits while recognizing their continued role
Can possibly achieve a better FFS/PPPM balance
Permits payers to support PCMH in “budget neutral” way – which is why some primary care physicians might resist
Lots of change all at once (but less than going to full comprehensive payment approach)
Comprehensive Payment for Medical Services and Medical Home Activities

The unsavory legacy of capitation is sufficient for giving all of this a new name.

But the reality – pros and cons – are not much different, but our implementation tools are better than in the past.

Design issues are crucial to PCMH response, e.g., at-risk for referrals or not?

 Probably works best if embedded in a larger organization -- see Massachusetts’ “global payment”
An Additional Payment Variation

The North Carolina and Vermont medical home model – a complementary “community care network”

Additional PPPM split between the practice and community-based complement to function as a virtual team – is this a split-level, medical home?