Payment Rate Brief

March 2011

Patient-Centered Primary Care COLLABORATIVE

By **Michael Bailit,** *President, Bailit Health Purchasing, LLC*

The rapid proliferation of Patient-Centered Medical Home initiatives in the United States in the past few years has been marked by experimentation and evolution in both practice transformation strategies and in payment models. One central challenge has been and continues to be how best to structure payment arrangements. Designers of Patient-Centered Medical Home initiatives have typically sought to address two objectives through payment design.

First, they seek to provide practices with financial support to address the costs that primary care practices must incur to in order to successfully operate as a Patient-Centered Medical Home (PCMH). Different conceptualizations of what it means to be a PCMH can result in a range of cost estimates, as can the size of the practice and the patient population being served. Significant variation exists in the estimates of what it costs a primary care practice to operate as a PCMH.[1]

Second, PCMH initiative designers seek to create incentives for practices to generate performance improvements in access, quality and/or efficiency. Many existing PCMH initiatives utilize a three-component payment model consisting of traditional fee-for-service payment, fixed supplemental payments administered on a per-member-per-month basis, and pay-for-performance (bonus) performance payments[2]. There is, however, variation in the application of this model. In addition, there are other substantially different models in use, including growing application of shared savings arrangements.

A survey of 26 PCMH initiatives active or with plans to implement in 2009 revealed that payments to practices ranged in dollar value from $0.50 to $9.00 per member per month.[3] This brief has been created to provide a detailed look at the payment arrangements and dollar value of a sample of 12 PCMH initiatives. The examples were selected to provide descriptions of a diverse mix of initiatives, including those involving a single commercial payer, multiple payers and a state Medicaid agency acting alone. They were also selected to provide a range of payment models, including some newer payment model designs. The information that follows will provide a reference for primary care practices and payers interested in creating new PCMH initiatives, or in refining existing ones. Except where noted, the cited examples all maintain fee-for-service payment and supplement it with additional forms of payment.

Colorado Multi-Payer, Multi-State Medical Home Pilot[4]

Developed and being evaluated in parallel with a medical home pilot of The Health Improvement Collaborative of Greater Cincinnati (described below), the Colorado payment model includes supplemental per member per month (PMPM) payments and a pay-for-performance bonus. In order to establish the value of the PMPM payments, HealthTeamWorks, the convening organization, took three things into account. First, they estimated the costs that the participating practices would incur, including EMR upgrades, hiring a care coordinator and time off to attend learning collaborative session and to work on quality improvement

NCQA Recognition Level	PMPM Payment
1	$4.00 to $5.50 PMPM
2	$6.00 to $7.00 PMPM
3	$7.25 to $8.50 PMPM

processes. Second, one health plan provided actuarial analysis of what it felt was a reasonable PMPM in order to recoup upfront costs later. Third, payment amounts used in other medical home pilots were considered. Separate estimates were developed for practice sites of 1-2 physicians and 3-5 or more physicians. Estimated PMPM ranges were established for practices for each level of NCQA recognition. Participating insurers made their own decisions regarding how much to pay practices, but all elected to pay within the estimated ranges provided to them. Medicaid is a participant but has not yet made payment so the amount of its payment is not known.

The pay-for-performance bonus model considers both quality measures (weighted 60%) and service utilization (weighted 40%), with the weighting percentages still under discussion due to challenges obtaining utilization data. The quality measures are practice-specific, focus on diabetes, cardiovascular disease and depression, and include both process and interim outcome measures. The service utilization measures are assessed for all of the practices in aggregate and include emergency department visits, hospital admissions, and generic prescription drug use. The actual dollar value of the bonus is to be determined independently by each participating payer.

Maryland Patient-Centered Medical Home Pilot[5]

PMPM Payment: Commercial Population			
Physician Practice Size (# of patients)	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	$4.68	$5.34	$6.01
10,000–20,000	$3.90	$4.45	$5.01
> 20,000	$3.51	$4.01	$4.51

PMPM Payment: Medicaid Population			
Physician Practice Size (# of patients)	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	$5.45	$6.22	$7.00
10,000–20,000	$4.54	$5.19	$5.84
> 20,000	$4.08	$4.67	$5.25

PMPM Payment: Medicare Population	
Physician Practice Size (# of patients)	Level of PCMH Recognition Year 1 of pilot: Level 1+ or higher Year 2 of pilot: Level 2+ or higher
< 10,000	$11.54
10,000–20,000	$9.62

To be implemented in July 2011 with approximately 60 practices, this multi-payer initiative borrows some characteristics from other models, and introduces some of its own innovations. To qualify for payments practices must achieve at least NCQA "Level 1+"[6] recognition in year 1, and at least "Level 2+" recognition each year thereafter. Payment rates are adjusted by practice size (to account for economies of scale), and by patient population group (to account for variation in patient need and corresponding savings opportunities).

In addition, the Maryland PCMH Pilot allows practices to share in any savings that they realize as a result of their medical home efforts. The percentage of savings that can be retained by the practice is linked to both reporting on quality measures, and beginning in year 2, achievement of performance thresholds relating to the measures. Should a practice meet the minimum requirements, it can retain 30% of the savings. Better performance can qualify the practice to retain 40% or 50% of the savings.

Minnesota Health Care Homes[7]

At the direction of 2008 state health reform legislation, Minnesota state government designed a payment methodology for what the state refers to as "health care homes." Health care homes are defined by the state as providing care coordination for patients who have chronic or complex medical needs. Implemented in 2010 by the state's Medicaid program and for other state-funded health programs with state-certified health care homes, the payment methodology groups patients based on their number of "major health conditions", with larger payments made for those patients with greater numbers of such conditions.

The state considered additional factors that do not necessarily predict health care resource use but were thought to increase the need for care coordination. The ability to capture in administrative data and objectively verify two such factors led to their inclusion in the methodology. As a result PMPM payments are increased 15% for each tier for patients that have: a primary language other than English, and/or a serious and persistent mental illness.

Minnesota's legislation requires commercial insurers to offer health care homes in their networks for all privately insured patients. Insurers must pay state-certified practices in "a manner consistent with" that developed by the state. Some health plans have begun to use the state's methodology.

Tier	Major Condition Groups	Minutes of Work PMPM	PMPM Payment
0	None	N/A	N/A
1	1-3	15	$ 10.14
2	4-6	30	$ 20.27
3	7-9	60	$ 40.54
4	10+	90	$ 60.81

New York: Capital District Physicians' Health Plan[8]

Capital District Physicians' Health Plan (CDPHP) has employed a payment model since 2008 that differs from those of other PCMH initiatives. Initially involving three practices, CDPHP announced an expansion in 2010 to up to 24 practices. Practices are paid for all traditional primary care services on a PMPM basis, the amount determined by looking back at two prior years of experience and then applying a customized medical home risk adjustment methodology. For its initial pilot, CDPHP pledged to keep the practices whole, meaning that risk adjustments would only increase payments for practices with higher risk patients, but not reduce them for practices with lower risk patients.

In addition, practices receive a one-time payment in the first year of $35,000 for each physician with a panel of patients. This payment is intended to address internal practice transformation costs. Beginning in year 2, practices are eligible for an annual bonus payment worth up to $50,000 per physician depending on practice performance relative to a set of quality measures and targets. The bonus payments are not risk-adjusted, but plans to risk-adjust bonus payments in the future, accounting for both clinical and socioeconomic risk.

Using CDPHP's estimate that the average physician panel size in the pilot is 1750, the PMPM value of the supplemental payments under the CDPHP pilot equates to the following (see chart at right).

In the future risk adjustments to the PMPM payments for traditional primary care services will be adjusted both upwards and downwards.

Payment Model Component	PMPM Payment
Practice transformation cost payments (year 1 only)	$1.67 PMPM
Performance bonus (beginning in year 2)	Up to $2.38 PMPM (value based on performance)
Risk-adjustment	Up to $1.67 PMPM (only for practices with above average patient panel risk profiles; amount varies by practice)

New York: EmblemHealth Medical Home High Value Network Project[9]

This single-payer initiative commenced in 2008 utilizing the three-tiered reimbursement methodology espoused by the Joint Principles of Patient-Centered Medical Home established by the AAFP, ACP, AAP and AOA.[10] EmblemHealth supplemented traditional fee-for-service payment for 38 practices with a PMPM care management payment and a potential pay-for-performance payment.

The actual value of the care management payment is determined based on a) the practice's "medical homeness" score as assessed using the NCQA PPC-PCMH recognition standards and EmblemHealth supplementary questions (e.g., use of an EHR), and b) the level of care management need of the practice's population. The value of the pay-for-performance payment depends on the practice's performance relative to a set of performance measures assessing practice quality, efficiency, and patient experience with the practice. Quality is measured using HEDIS process and outcome measures, with an emphasis on management of chronic conditions. Efficiency is measured based on savings relative to a control group. Patient experience is measures using the CAHPS Clinical and Group Survey.

Payment Model Component	PMPM Payment
Care management payments	Up to $2.50 PMPM
Pay-for-performance payments	Up to $2.50 PMPM

North Carolina: Community Care of North Carolina[11]

In 1998 North Carolina implemented a statewide medical home-based program for women and children served by the Medicaid program. Using as a base a fee-for-service payment system that pays primary care practices at 95% of the Medicare fee schedule, North Carolina added two additional streams of payment. The first was a PMPM payment to the practice for implementing a medical home, reporting data to the state, and addressing state-defined quality improvement topics. The second supplemental stream of payment flowed to 13 regional networks that were created by primary care practices in response to state requirement that the practices do so. The payments to the regional networks were intended to support local care management activities performed by nurse care managers and pharmaceutical consultation performed by clinical pharmacists.

Population	PMPM Payment: Practice	PMPM Payment: Network
Women and children	$2.50	$3.00
Aged, blind and disabled	$5.00	$8.00

Beginning in State Fiscal Year 2008, North Carolina began expanding its program, initially on a pilot basis, to the elderly and persons with disabilities, and developed separate rates for that combined population.

Ohio: The Health Improvement Collaborative of Greater Cincinnati[12]

The medical home pilot in Cincinnati involves 11 practices and three leading commercial insurers that have independently negotiated supplemental PMPM payments linked to NCQA participation. Practices received payment from the start of the pilot at the NCQA Level 1 payment level, based on the assumption that all practices would at least achieve Level 1 recognition (and they have).

While there are not common payment rates across the payers, the effort's organizer believes that the payments are approximately as follows:

Participating payers with pay-for-performance programs are continuing them as independent initiatives not specific to the medical home pilot.

NCQA Recognition Level	PMPM Payment
1	$2.50 to $3.00 PMPM
2	$4.00 PMPM
3	$5.00 to $6.00 PMPM

Oklahoma SoonerCare Choice[13]

Oklahoma Medicaid converted its managed care program, SoonerCare Choice, to a statewide medical home model in January 2009. Previously the state had paid participating practices on a capitated basis for those services for which they were directly responsible.

To implement the redesigned SoonerCare Choice, the state paid some providers a one-time payment to support transition from the state's prior capitation payment model to the new medical home model that supplements fee-for-service payment with supplemental PMPM care coordination payments and pay-for-performance payments.

The care coordination payments are tiered to reflect level of medical home recognition, and the population served by the practice. The PCMH recognition process is state-administered using a set of standards and an application developed by the state.

Practice Population	Level of PCMH Recognition		
	Tier 1	Tier 2	Tier 3
Children Only	$3.03	$4.65	$6.19
Children & Adults	$3.78	$5.64	$7.50
Adults Only	$4.47	$6.53	$8.69

Additional payments available to Tier 1 medical homes include the following (see chart, top right).

Practice Capability	PMPM Payment
practice accepts electronic communication from the state in lieu of written notice	$0.05
practice provides 24 hours-a-day/ 7 days-a- week voice-to-voice telephone coverage with immediate availability of an on-call medical professional	$0.50

Oklahoma also makes available a "pay-for-excellence" program named "SoonerExcell." Incentive payments are made based on performance relative to measurement of provision of the 4th DTaP (diphtheria, tetanus, and pertussis) vaccine, breast cancer screening, cervical cancer screening, emergency department utilization, EPSDT (pediatric preventive) services, the generic drug prescription rate, and making visits to inpatients.

Pennsylvania Chronic Care Initiative[14]

Implemented through phased regional rollouts across the state, this multi-payer initiative has employed four different payment models across regions, involving 170 practices. It will be implementing a fifth payment model in 2011. The newest model reflects the experience gained since the initial implementation in 2008 and is based on the model used in the Northeast region. In the Northeast all payments are made to the practices, with practice support payments commencing in month 1, and care management payments beginning in month 4. NCQA "Level 1+"[15] recognition is required by month 18.

Whereas Minnesota risk-adjusts payments based on number of major condition groups, Pennsylvania plans to begin to do so in 2011 based on patient age, with hopes to adopt a more clinically-based adjustment system in the future.

Payment Model Component	PMPM Payment
Practice support payments	$1.50 PMPM
Care management payments	$0.60 PMPM (ages 0-17) $1.50 PMPM (ages 18-64) $5.00 PMPM (ages 65-74) $7.00 PMPM (ages 75+)
Shared savings	Value based on performance

In addition, the Pennsylvania Chronic Care Initiative in 2011 will allow practices to share in any net savings that they realize as a result of their medical home efforts. While the 2011 design is still being finalized, the existing shared savings model used in the Northeast region allows the practice to retain between 41% and 50% of savings (net of practice support and care management payments) based on performance relative to 14 performance indicators. In order to begin a transition to a primarily performance-based payment model, Pennsylvania will implement annual 15% reductions in the value of practice support and care management payments beginning in 2012 as the new shared savings terms are implemented in three regions.

Rhode Island Chronic Care Sustainability Initiative[16]

One of the first multi-payer PCMH initiatives in the country, this effort has used a two-part supplemental payment system since 2008, adding PMPM payments to the practices and reimbursement of practice costs (salary and benefits) for a nurse care manager.

Payment Model Component	PMPM Payment
Practice support payments	$3.00 PMPM
Nurse care manager payments	$1.16 PMPM (varies by practice)

Thirteen practice sites are currently participating. For six practice sites owned by a hospital, the hospital is reimbursed by the participating payers for the services of a nurse care manager who is based in the practices and sees patients of all insurers.

Vermont Blueprint for Health[17]

Since 2008 Vermont's multi-payer PCMH initiative has paid participating practices on a sliding scale based on the number of NCQA PPC-PCMH recognition points earned (as scored by the University of Vermont Child Health Improvement Program and validated by NCQA), up to a maximum of $2.39 per member per month. In addition, each of the five participating payers (including Medicare, beginning in 2011) equally shares the $350,000 cost associated with funding each Community Health Team. A Community Health Team is comprised of approximately five full-time equivalent staff, potentially including one or more of each of the following: nurse coordinator, social worker, dietician, community health workers, Medicaid care coordinator, and a state health department public health prevention specialist. The team serves a population of 20,000 in support of the PCMH practices in a given community. The payers make their Community Health Team payments to the lead administrative entity in each Hospital Services Area (often but not always a hospital), which directly hires staff or funds others to do so.

NCQA Points	PMPM Payment	NCQA Points	PMPM Payment
0	$0.00	55	$1.68
5	$0.00	60	$1.76
10	$0.00	65	$1.84
15	$0.00	70	$1.92
20	$0.00	75	$2.00
25	$1.20	80	$2.07
30	$1.28	85	$2.15
35	$1.36	90	$2.23
40	$1.44	95	$2.31
45	$1.52	100	$2.39
50	$1.60		

Practices earning 25 to 45 points must also meet five of the 10 NCQA PPC-PCMH "must pass elements" in order to qualify for payment, while those practices earning 50 or more points must meet all 10 of the "must pass" elements to qualify for payment. Vermont believes that its current payment model represents a first step and is looking at broader payment reforms. Fourteen practices participated in 2010.

Washington State Multi-Payer Medical Home Reimbursement Pilot[18]

A new multi-payer medical home initiative will be implemented in Washington State in spring 2011. Washington's model will employ supplemental payments to practices as well as make available a 50% shared savings opportunity. Shared savings are linked to performance on quality measures and reductions in emergency department and inpatient hospital utilization. If a practice fails to meet a minimum target for utilization reductions, it will be obligated to repay the participating payers an amount calculated as the weighted standardized payment level times the number of ER visits and hospitalizations by which it fell short of its practice-specific targets, up to a maximum of 50% of the total amount of supplemental payments it received through the pilot.

The payment mechanism for the supplemental payments will vary. Because not all participating payers are able to administer PMPM payments, the payers will use a mix of payment mechanisms, including PMPM payments, making payments through the traditional fee-for-service claims system (e.g., using G-codes) and periodic (e.g., semiannual) lump sum payments.

Payment Model Component	PMPM Payment
Practice support payments	$2.50 PMPM (Year 1) $2.00 PMPM (Years 2 and 3)
Shared savings	Value based on performance

Endnotes

1. Goroll AH et. al. "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care", *Journal of General Internal Medicine,* Volume 22 Number 3, 410-415, January 9, 2007; "The Medical Home: Disruptive Innovation for a New Primary Care Model", Deloitte Center for Health Solutions, 2008, AMA/Specialty Society Relative Value Scale Update Committee (RUC) Medicare Medical Home Demonstration Project Recommendations, April 28, 2008, and Zuckerman S et. al. "Incremental Cost Estimates for the Patient-Centered Medical Home", The Commonwealth Fund. October 2009.
2. Bitton A, Martin C and Landon BE. "A Nationwide Survey of Patient Centered Medical Home Demonstration Projects", *J Gen Intern Med* 25(6):584–92, 2010.
3. ibid.
4. Personal communication with Marjie Harbrecht, HealthTeamWorks, 12-8-10, 12-15-10 and 1-23-11.
5. "Appendix B: Payment Methodology", contract appendix, Maryland Health Care Commission, October 1, 2010.
6. Defined as NCQA PPC-PCMH Level 1 recognition requirements, plus required mastery of additional NCQA recognition sub-elements.
7. "Health Care Homes: Minnesota Health Care Programs (MHCP) Fee-for-Service Care Coordination Rate Methodology", Minnesota Department of Human Services, March 3, 2010 and personal communication with Jeff Schiff, Minnesota Department of Human Services, 12-1-10.
8. Personal communication with Allan Goroll, 11-24-10.
9. Rollow W. "EmblemHealth Medical Home High Value Network Project", PCPCC presentation, 12-2-08.
10. Joint Principles of the Patient Centered Medical Home, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, March 2007.
11. Hewson DL. "Building a Medical Home": The Case for Medical Homes and Community Networks, presentation to the Pennsylvania Chronic Care Commission, March 18, 2009.
12. Personal communication with Robert Graham, Health Improvement Collaborative of Greater Cincinnati, 12-1-10.
13. See www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165, accessed 11-22-10.
14. "Multi-payer Advanced Primary Care Practice Demonstration: Application For the Commonwealth of Pennsylvania", Pennsylvania Governor's Office of Health Care Reform, August 13, 2010 and Participation Agreement For Participation in the Northeast Pennsylvania Rollout of the Pennsylvania Chronic Care Initiative, December 15, 2009.
15. Similar to the approach used in Maryland, but with the requirement for mastery of a different set of NCQA recognition sub-elements.
16. Personal communication with Jennifer Bowdoin, University of Massachusetts School of Public Health, 11-3-10 and 11-22-10.
17. Vermont Blueprint for Health Implementation Manual, Department of Vermont Health Access, November 17, 2010 and personal communication with Craig Jones, Vermont Department of Health, 11-23-10.
18. "Recommendations on Pilot Design for Final Action", Richard Onizuka memo to the Washington State Multi-Payer Medical Home Reimbursement Pilot Participant Group, 5-21-10, and personal communication with Steve Lewis, Washington Health Care Authority, 11-29-10.

Patient-Centered Primary Care COLLABORATIVE

Patient-Centered Primary Care Collaborative

The Homer Building • 601 Thirteenth Street, N.W. • Suite 400 • Washington, D.C. 20005

Phone: (202) 724-3331 • Fax: (202) 393-6148 • www.pcpcc.net