

Payment Reform: A Review of Existing Models

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PURCHASING

Why Reform Payment?

Why change payment? Two commonly cited rationales:

1. infrastructure support: Some have modeled the costs to a practice to operate a medical home and have found that it requires additional resources in the practice setting, including physician and other care team member time on traditionally non-billable activities, care management, HIT, and space and equipment.
2. incentive alignment: Many believe that only changes to the payment system that motivate and support efficient and effective care and counter the fee-for-service “gerbil wheel” incentive will generate practice transformation.

Approaches to Reforming Payment

1. Fee-for-Service (FFS) with discrete new codes
2. FFS with higher payment levels
3. FFS with lump sum payments
4. FFS with PMPM fee
5. FFS with PMPM fee and with P4P
6. FFS with PMPY payment
7. FFS with lump sum payments, P4P and shared savings
8. FFS with PMPY payment and shared savings
9. Comprehensive payment with P4P

Approaches to Reforming Payment

Approach #1: FFS with new codes for PCMH

Case examples:

- BCBSMI: pays T-Codes for practice-based care management (and also delegated DM fees)
- Horizon BCBS of NJ: pays for traditionally non-reimbursed care management services
- Texas Medicaid: pays for traditionally non-reimbursed care management services for children
- Note: A new ICD-9 S-code was created for medical home payments effective 1-1-10.

Approaches to Reforming Payment

Approach #2: FFS with higher payment levels

Case examples:

- BCBSVT: pays enhanced rates (6%) to qualifying practices for office-based E&M, consultations, preventive medicine, and counseling codes
- BCBSMI: pays 10% higher E&M code rates to 1200 qualifying practices
 - BCBSMI and OK Medicaid use their own criteria and process for practice designation and not NCQA

Approaches to Reforming Payment

Approach #3: FFS with lump sum payments

Case example:

- PA Chronic Care Initiative (SE, SC and SW Regions): ten participating insurers pay periodic lump sum payments to qualifying practices per clinician FTE
- Lump sum payment for a) start-up costs (time spent at learning collaborative, NCQA fees, costs of registry prep and EMR report development) and b) in recognition of documented level of NCQA PPC-PCMH achievement

Approaches to Reforming Payment

Approach #4: FFS with PMPM payment

Case examples (both Medicaid-specific):

- Community Care of NC: FFS with PMPM payment to PCPs and another PMPM payment to regional PCP networks for care management and pharmaceutical consultation
- Connect Care Choice (RI): FFS with PMPM for enrolled chronically ill adults

Approaches to Reforming Payment

Approach #4: FFS with PMPM payment

Case examples (non-Medicaid-specific):

- Vermont: three insurers and state Medicaid pay FFS with sliding scale PMPM based on level of achievement against NCQA PPC-PCMH standards
- Rhode Island: three insurers and state Medicaid make PMPM payment with requirement of NCQA recognition
- Both VT and RI separately provide additional funding for care managers integrated in some fashion with the primary care site, or provide the practice the actual care managers

Approaches to Reforming Payment

Approach #5: FFS with PMPM fee and with P4P

- The model endorsed by the PCPCC.
- PMPM fee referred to as a “monthly care coordination payment.”

Case example:

- EmblemHealth and Colorado Multi-Payer Initiative: FFS, PMPM care management payment, and P4P
- THINC RHIO: FFS with enhanced PMPM payment for PCMH structural measures (NCQA Level 2) and for performance on 10 HEDIS measures

Approaches to Reforming Payment

Approach #6: FFS with PMPY “shared savings” payment

- This is the Bridges to Excellence medical home model.
- Practices must be Level 2 certified for BTE’s Physician Office Link *and* any two of Diabetes, Cardiac Care and Spine Care Link programs.
- Shared savings model: \$250/pt split between physician and purchaser/payer, informed by BTE ROI analysis

Approaches to Reforming Payment

Approach #7: FFS with lump sum payment, P4P and shared savings

- Unlike other FFS models, practices need not meet any criteria to receive the lump sum payments (viewed as a “forgivable loan”)
- Practices that meet quality metrics can qualify for shared savings (50/50)
- Formula roughly adjusts for case mix

Case example:

- Geisinger Health Plan (PA) – GHP assigns its own salaried care managers to the practices
- PA Chronic Care Initiative Northeast Regional Rollout design is similar, but not identical to that of GHP.

Approaches to Reforming Payment

Approach #8: FFS with PMPY payment & shared savings

- Initially, \$20K per practice infrastructure investment, FFS and then evaluation of savings
- Later, prospective DM PMPY payment (bill an S code) informed by savings findings from Year 1 pilot, FFS, plus shared savings
- Move to PMPY payment at practice request – so no need to wait 18 months for payment.

Case example:

- Blue Cross Blue Shield of North Dakota - Found savings of \$500 PMPY
- Blue Cross Blue Shield of W. NY was reportedly pursuing

Approaches to Reforming Payment

Approach #9: Comprehensive Payment

- This is a risk-adjusted PMPM comprehensive payment covering all primary care services
- Unlike traditional primary care capitation, the payments support an investment in medical home systems to improve care
- 15-20% of annual payments are performance-based and paid as a bonus

Case example:

- Capital District Health Plan (NY) pilot