How to Buy a Medical Home? Policy Options and Practical Questions

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In this paper, we describe a range of payment options to support the PCMH, identifying their conceptual strengths and weaknesses. These include enhanced FFS payment for office visits to the PCMH; paying additional FFS for "new" PCMH services; variations of traditional FFS combined with new PCMH-oriented per patient per month capitation; and combined capitation payments for traditional primary care medical services as well as new medical home services. In discussing options for PCMH payment reform we consider issues in patient severity adjustment, performance payment, and the role of payments to community service organizations to collaborate with the PCMH. We also highlight some of the practical challenges that can complicate reimbursement reform for primary care and the PCMH. Through this discussion we identify key dimensions to provider payment reform relevant to promoting enhanced primary care through the patient centered medical home. These consist of paying for the basic medical home services, rewarding excellent performance of medical homes, incentivizing medical home connections to other community health care resources, and overcoming implementation challenges to medical home payments. Each of these overarching policy issues invokes a substantial subset of policy relevant research questions that collectively comprise a robust research agenda. We conclude that the conceptual strengths and weaknesses of available payment models for medical home functions invoke a complex array of options with varying levels of real-world feasibility. The different needs of patients and communities, and varying characteristics of practices must also be factors guiding PCMH payment reform. Indeed, it may be that different circumstances will require different payment approaches in various combinations.

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INTRODUCTION

Current demonstrations of the patient-centered medical home (PCMH) emphasize a particular payment approach featuring fee-for-service reimbursement for office visits and related services, a monthly fee for medical home activities and a performance-based component[1]. Yet, there are actually a range of payment options that should be considered. Examining the strengths and weaknesses of each raises the possibility of "mixing and matching" to improve the performance of PCMH payment reform. In a companion paper we have addressed what is presently known about the current payment approaches for primary care, particularly the reliance on payment for face-to-face office visits, and why payment reform merits such a prominent role in the patient-centered medical home (PCMH) discussion. In this paper, we will describe a range of payment options to support the PCMH, identifying their conceptual strengths and weaknesses and practical challenges, which together recommend consideration of hybrid payment models. We conclude by identifying the key research questions relevant to payment policy reforms to sustain practices to achieve the purposes of the PCMH.

SPECIFIC PCMH PAYMENT OPTIONS

Enhanced FFS Payment for Office Visits

This is administratively the most straightforward approach (see Table 1). With more payment per visit, the hope is that medical home physicians would feel less pressure to generate more visits, thereby taking more time with patients and supporting other medical home activities within the practice. This strategy assumes that physicians with enhanced revenues would cross-subsidize unreimbursed activities, raising the important researchable question about the extent to which payment generosity, rather than payment method, affects physician behavior. There is currently conflicting literature on how physicians respond to payment cuts and increases in FFS[2-8], suggesting that both the level of payment and income maximizing proclivities of individual physicians may contribute to physician responses.

To the extent that physicians have a "target income" expectation, payments above the threshold needed to support that target might well be used for cross-subsidization. However, with primary care physicians feeling professionally and financially beleaguered, a modest increase in office visits fee might simply spur on additional office visits at the expense of investing resources in desired medical home services. Payers opting for this approach would likely seek assurance (e.g. through practice certification, measuring performance, etc.) that the practices actually direct enhanced office visit payments to support medical home activities.

To adequately reward PCMH activities through increased FFS payments, additional office visit payments may also need adjustment for the complexity of the population served. FFS inherently

Table 1. Payment Models for the Patient Centered Medical Home

PCMH payment model	Advantages	Disadvantages
Enhanced FFS payment for office visits to PCMHs	● Administratively straightforward (Predominant payment method, familiar to physicians, patients, and payers) ● With more generous payments primary care clinicians may feel less like "hamsters on treadmill" and perform medical home activities	● Does not directly reward some key primary care functions (may still require practice certification and/or P4P) ● Patient complexity adjustments required to adequately reward PCMH activities (e.g. enhanced care coordination, home visits, services for limited English proficiency) ● Limits practice's flexibility about how to design the medical home
FFS payment for additional PCMH activities	● Administratively straightforward (once new service codes approved) ● Uses FFS power to incentivize performance of specific, targeted activities	● Challenges to clearly defining the desired PCMH activities for FFS payment ● Limited applicability of FFS payments to some medical home services (see above) ● Limits practice's flexibility about how to design the medical home
Standard FFS for office visits and PPPM for medical home activities (hybrid)	● Recommended by leading physician specialty societies promoting the PCMH ● Hybrid approach blends the theoretically countervailing incentives of FFS and pure capitation	● Need to certify practices eligible to receive PPPM $ ● Need to differentiate range of medical home activities to be provided by practices and paid for ● Some case mix payment adjustment required for the range of medical home activities for patients with different needs
Reduced FFS for office visits and PPPM for medical home activities (hybrid)	● Greater emphasis on the medical home functions, as more practice revenues from medical home payments ● Less reliance on office visit payments might result in ability to actually redesign practice ● Limits payers' overall financial exposure	● May replicate managed care's increased practice expectations without concomitant payment increases ● Strong primary care physician dissatisfaction with even current fee levels
Comprehensive payments combining capitation for traditional primary care medical services and new medical home services	● Creates clearer primary care clinician accountability ● Provides practice financial flexibility to redesign and to invest in personnel and technology for primary care functions ● Easy for many payers to implement	● Case mix adjustment and capitation rate-setting challenges ● Potential incentives to withhold services requires meaningful quality/access reporting and P4P ● Risk of PCMH being equated with unpopular "gate-keeping"

adjusts for patient acuity; the process of caring for patients with more conditions and more complicated health problems, will surely produce higher coding levels (reimbursement) and more frequent office visits, and thus increased FFS revenues. Nevertheless, patients with complex illness will often benefit as well from more non-visit-based, medical home-type activities. Indeed, some of these patients may have difficulty coming in for additional face-to-face encounters—limited physical mobility, frailty, and social vulnerability might constrain office-visits.

Other important patient characteristics might merit some adjustment of visit payments as well (e.g., cognitive impairment, health literacy, limited English proficiency)[9-12]. Further, advances in our understanding of human genetics is beginning to identify patients with additional risks of disease and treatment side effects, adding new patient management complexity not captured in current code definitions for office visits[13].

In the context of FFS coding and payment, such case-mix adjustment might be achieved through adding FFS office visit codes, with additional definitions to reflect differences in patient population served and/or physician activities required to best serve patients. A simpler, but perhaps cruder, approach would apply different multipliers for different practices to office visit fees to reflect the specific case mix and medical home activities being undertaken by the practice.

Reimburse for Additional Activities by Defining and Paying for New CPT Services

This approach is also logistically straightforward but not very efficient for paying for the PCMH. One of the desired aspects of FFS payment is the ability to incentivize performance of specific, targeted activities; indeed, sometimes FFS is used to promote specific services even under capitated payments. The challenge is to be able to crisply and clearly define the desired PCMH activities. By their very nature some key PCMH activities (e.g. those related to enhanced communication and access to the practice) may not be conducive to easy codification and FFS payment, although some others would. Examples include reimbursement to health professionals for conducting palliative care conferences with patients and families and for specific, defined professional activities to improve hospital-to-community transitions after discharges.

Some argue that many "medical home" activities have a thin evidence base and therefore should not receive specific reimbursements by function of becoming carefully defined CPT codes. But that sets up a double standard related to new physician services. Currently, the CPT editorial panel that considers new services consider whether reputable physicians see value in a proposed new services and do not require a formal test of effectiveness. Whereas many new procedural

services and tests are approved annually based on this review, very few "cognitive" services are approved, thereby leading to continued orientation of fee schedules toward procedural and technical services[14].

FFS for Office Visits and PPPM for Medical Home Activities

This approach is the most commonly recommended by the four physician specialty societies promoting the PCMH[15], as well as by the Patient-Centered Primary Care Collaborative (PCPCC)[16]. In this hybrid model the incentives of both FFS and capitation are employed to rebuild primary care into medical homes (see Table 1). While FFS reimbursement would continue at established rates for all reimbursable services in the physician fee schedule, monthly medical home payments would reward practices that demonstrate the requisite PCMH capabilities.

Under this approach there is a need to certify or otherwise determine that a practice is eligible for the add-on monthly payments, as well as a need to determine for which patients these payments should be made. These details (e.g., specific PCMH qualification criteria and attribution of patients most benefiting from medical home activities) are beyond the scope of this paper. Whatever the policies adopted, this payment model requires methods for assuring practice eligibility for the additional PPPM medical home payments as well as accountability for actual PCMH performance.

This method also requires some case-mix adjustment of the add-on amount as well as adjustment for the range of medical home services committed to by the practice. This case-mix adjustment need not be as sophisticated as would risk-adjusters for PPPM payments for actual medical services provided, since the range of medical home services would not vary based on patient acuity as much as the actual medical service requirements. In the prototype NCQA Physician Practice Connections recognition tool[17], there are three levels of recognition (each with incremental payments) based on the commitment of the practice to achieving different PCMH levels. Further, as discussed later, if medical homes are provided through virtual teams, with community-based entities complementing the more clinically-oriented activities provided directly by practices, the practice's payments would need to be adjusted accordingly.

Reduced FFS for Office Visits and PPPM for Medical Home Activities

This approach would permit a greater proportion of the practice's revenues to come from the monthly medical home payments and less from office visits. A possible virtue of this approach is that it would permit adoption of the hybrid payment approach, while reducing the FFS incentives for churning via visit-oriented billing, thereby directing relatively more payment (and attention) to PCMH activities (see Table 1). Joseph Newhouse has most prominently proposed combining capitation with FFS to try to balance incentives to avoid either overuse or stinting on services[18]. Others have suggested that a hybrid payment approach would pay partly based on panel size through capitation (perhaps 20% to 40% of budgeted funds) and partly on actual patient care encounters (perhaps 60-80% of budgeted funds)[19]. The virtues of a mixed capitation and FFS payment model are not merely theoretical; that approach is the dominant model in some other countries, notably Denmark[20].

Additionally, some payers concerned about the potential lack of return on investing in medical homes might choose this kind of approach to restrain their financial exposure until the concept has been proved. That is, marginal incentives for the practice would be altered, but the total payout for primary care physicians can be constrained through reduced FFS visit reimbursements.

The concern, of course, is that payers would provide a set of new expectations on practices without providing the requisite payments to support performance to meet those expectations. Clearly, there are a variety of visit payment reductions and offsetting medical home payment enhancements that could be combined to balance the goals of promoting excellent PCMHs, while preserving budgetary discipline.

Pay-for-performance could be added to this hybrid payment model to further reward medical home behavior and to potentially offset reductions in office visit fees. Nevertheless, as suggested, the greater implementation challenge may arise from primary care physician dissatisfaction with current fee schedule levels, and anticipated reluctance of practices to accept reduced visit payments in an environment of multiple payers and payment schedules.

Comprehensive Payments Combining Capitation for Traditional Primary Care Medical Services and New Medical Home Services

The logic and potential pitfalls in this approach have been described and largely follow those of capitation generically (see Table 1) [21, 22]. As we argue in the companion paper, a major determinant of physician behavior under capitation payment might be the relative generosity of the capitation payment, and not simply the intrinsic capitation incentives. In recommending what a comprehensive payment to support medical homes, Goroll and colleagues emphasize the need for robust risk adjustment, substantial supplemental PPPM payments to support multidisciplinary team-based medical home activities, and pay for performance— for quality, patient experience, and, health care spending. For some payers, this approach might be administratively simplest; if a payer is able to administer capitation correctly it could also administer a higher capitation level to include the cost of medical home activities. Despite these advantages, PCMH capitation payments incur the risk that the public might equate this enhanced primary care with 1990s-style "gate-keeping"

PERFORMANCE MEASUREMENT, P4P AND THE MEDICAL HOME

Measurement of performance may play a special role in PCMH payment reform because of the need to determine which practices deserve additional payments for performing medical home activities. The prevailing approach to identifying medical homes currently requires a certification of practices that have medical home capabilities, possibly at different levels[17]. This approach assumes that practices that demonstrate their medical home capabilities will apply them appropriately and therefore merit medical home payments in support of these additional activities.

An alternative—or perhaps complementary—approach would rely on performance measurement to provide financial

rewards or to determine eligibility to receive extra medical home payments; here the focus would be on demonstration of medical home performance, not on certifying capacity to perform. But such an approach relies on availability of a broad and relevant measurement set; reliability, validity and immunity from "gaming" of the measures; and administrative feasibility for practices and payers.

Well developed measures related mostly to primary and secondary prevention are available[23] and in use in many medical home demonstrations[1]. These could be part of a measure set for the medical home, and P4P priorities among available measures might be established. In addition, tools such as Clinician & Group Consumer Assessment of Healthcare Providers Survey (CG-CAHPs) can be used with primary care patients and present the opportunity for use both in public reporting and P4P related to patient experience. A core aspect of the patient-centered medical home is, not surprisingly, patient-centeredness, a quality perhaps best assessed through the views of patients, rather than a sterile assessment of a practice's theoretical capability to be patient-centered, as in the current NCQA recognition standards.

Measures and P4P for utilization and cost management should be an essential part of the PCMH payment approach. Indeed, risk-adjusted, risk pool analysis might be able to permit specific rewards and penalties for medical home physicians to promote the cost-savings potential of medical homes; primary care currently receives 6-8% of total health care spending, but arguably could affect spending in the other 92–94% of the system if the practices took responsibility for patients' overall care—and were rewarded financially for doing so with gainsharing on savings generated[22]. Initially, especially for small medical home practices, it might be simpler for P4P to reward focus on major "cost drivers," such as avoidable emergency room visits and hospitalizations for ambulatory care sensitive conditions, such as congestive heart failure, which typically fall within the purview of the primary care practice. These parameters would be more clinically transparent, could provide actionable information for medical home clinicians, and might be administratively more straightforward.

It might be particularly desirable to attach substantial P4P and public reporting elements to the comprehensive payment approach to counteract countervailing incentives to either skimp on care or to accept PCMH payments without altering care patterns. Not only should state-of-the-art risk adjustment improve the fairness of payments to the medical home practices receiving the combined medical services and medical home monthly payments, but it should also permit much sounder analysis of spending in downstream risk pools than were characteristic of the application of primary care capitation derived from managed care plan payment models of the late 1980s and 90 s [24].

LOWERING THE COSTS OF THE MEDICAL HOME THROUGH COMMUNITY RESOURCES

State-based and Medicare demonstration models that strive to accomplish PCMH goals but organized differently have also shown success in coordinating care and controlling costs. One is Community Care of North Carolina (CCNC), which is an extension of the statewide primary care case management program for Medicaid beneficiaries[25]. This approach constitutes more of a "virtual" medical home rather than a specific primary care practice or group of practices that qualify for entry. Here, individual primary care providers choose to enroll in a larger network and agree to serve as patients' physician care managers—and help patients obtain access to more specialized care coordination services. In return, North Carolina's Medicaid program agrees to pay these health care providers a modest monthly fee in addition to the usual fee-for-service—among other things to assure that they are available around the clock as part of a primary care commitment to access for Medicaid beneficiaries and to avoid unnecessary emergency room visits. Just as with fully embedded PCMH services, the value of a virtual medical home with shared responsibility between the practice and the community component remains to be established[26].

In addition to paying a modest bonus to the primary care providers, management fees in this program are used to hire local case managers and pay for other resources necessary to support beneficiaries' care. The program targets high-cost areas such as chronic diseases, pharmaceutical use, and emergency department utilization. Accountability is achieved at various levels through chart audits, practice profiles, care management reports on high-risk and high-cost patients, scorecards, and the monitoring of progress against benchmarks.

Health Quality Partners (HQP) provides an example of a similar type of community-based organization that has successfully partnered with primary care practices and hospitals to address the medical and social/behavioral needs of Medicare beneficiaries with multiple chronic conditions[27]. A not-for-profit 501(c)3 healthcare quality improvement organization that describes itself as "a community-based health care extension service," HQP provides nurse care management, including geriatric assessments and in-home interventions, self-management skill building, individual one-on-one sessions for high-risk patients, and group programs, such as weight management and fall prevention.

HQP was one of the three organizations participating in the Medicare Care Coordination Demonstration (MCCD) that achieved savings, which HQP achieved by contributing efforts to achieve substantial reductions in hospitalizations. The MCCD payment model was to negotiate specific monthly per capita payments in relation to the activities the organizations committed to performing.

For purposes of this discussion, the important point is that PCMH activities can be promoted through shared coordination by separate organizations–independent practices and a community care network. In North Carolina Medicaid and the Medicare demonstration, there are separate payment streams. An alternative would be to make payments to the medical practice and have the medical practice subcontract for arranged, external services to complement what is performed by the practice. This approach would likely be more difficult logistically but would offer the potential of greater physician involvement, literally "ownership" of the care coordination enterprise.

CHANGING PHYSICIAN PAYMENT POLICY: THEORY AND PRACTICE

There are a variety of general issues that must be considered in determining the policy relevance of any proposed reform of

provider payment. The proposed payment reform must be able to withstand legal challenges to its compliance with existing law and regulation, and be practicable within the constraints of diverse employer contracts for employment-based insurance.

Second, it must not expose the overall program of provider payments to significant risks that the perceived integrity of the payment system will be jeopardized, e.g., by so rewarding undesirable provider behaviors that this "gaming" will offset the theoretical advantages of the proposed reform. In this regard, even hybrid payment models, especially those mixing FFS and capitation, while theoretically providing needed balance to unidirectional incentives to overuse or underuse, might cause physicians to separately (and perversely) respond to each of the incentives. For example, a practice reimbursed at existing FFS levels for visits and prepaid a monthly per patient payment for medical home activities might continue to churn office visits, yet give short shrift to the desired medical home services, thereby producing the worst of both worlds.

Third, the costs to the payer for administrating the reform must be acceptable; ideally the administrative costs for the reformed payment option would be lower than for the provider payment system it replaces. Theoretically elegant payment reform approaches can be rendered infeasible by real world operational issues for payers, like claims processing software programming problems or challenges introduced by missing data. For example, some payers have difficulty supporting FFS combined with new monthly medical home fees–and therefore have opted to enhance office visits code payments, despite the theoretical incentive problems created. Similarly, assigning a payment-relevant "severity code" to each plan enrollee, as suggested earlier, might prove technically difficult or impose unacceptable administrative costs.

The issue of attribution is relevant–and difficult— as well, as plans on an ongoing basis–at least monthly–would have to maintain an accurate roster of subscriber/beneficiary-PCMH matches to determine which practices qualify for additional payments. In addition, payers would need a reliable and relatively inexpensive way to qualify practices for additional payments and/or apply a fairly robust set of performance measures to guide payment decisions, with all of the complications of establishing and maintaining valid and reliable measures.

In addition to these administrative and financial challenges for payers, the administrative costs to the medical practice for participating in the reform must be reasonable. Some of the preferred payment approaches described above would include administrative costs that go beyond the already substantial, standard administrative functions for billing and collecting, now to include medical home services[28]. The process of qualifying as a medical home and of contributing data for severity adjustments or pay-for-performance would be important considerations, both in net revenue for the practice and for perceived relevance to enhancing patient care.

Thus, there are several major payment policy issues that must be resolved to translate the theoretical advantages of medical home payment reform into real world benefits in primary care practices. These include fundamental questions identified above regarding how to best pay practices for basic medical home services, as well as questions about how to best to reward practices for superior performance as medical homes. There are also policy challenges inherent to promoting optimal medical home connections to other community health care resources. Finally, payers must overcome various implementation challenges to medical home payment policy. As revealed through discussions and feedback at the recent conference "Patient Centered Medical Home: Setting a Policy Relevant Research Agenda," each of these overarching policy issues invokes a substantial subset of policy relevant research questions. These collectively comprise a robust policy research agenda relevant to "buying a medical home." (see Table 2).

CONCLUSIONS

Visit-oriented, fee-for-service payment has never provided optimal incentives for primary care services. With the rising prevalence of chronic conditions and new modes of chronic care intervention, the increasing opportunities to proactively head off complications rather than responding when they occur, and new tools for communication and care coordination, there is a compelling rationale for payment reform to support primary care practices functioning as patient-centered medical homes. Past research on physician payment offers only general insights confirming the potential problems with standard fee-for-service, capitation, and salaried payment approaches.

The conceptual strengths and weaknesses of available payment models for medical home functions invoke a complex array of options with varying levels of real-world feasibility. The different needs of patients and communities, and varying characteristics of practices must also be factors guiding PCMH

Table 2. PCMH Payment Policy Research Questions

1 Paying for the medical home
a What is the experience with alternative physician payment/ incentives approaches for the medical home?
b What are the best ways to reward essential primary care services (eg 24/7 access, comprehensive care)?
c What are best mechanisms to severity adjusting payment to best meet patient needs?
d Should PCMH payments be provided for all patients in a practice or be reserved for the chronically ill?
2 Rewarding Medical Home Performance
a How should reporting and P4P be integrated with other elements of payment to promote adoption and reward desired performance?
b Should overall costs of care (beyond PCMH services) for applicable patient population be incorporated into payment incentives? Downstream utilization?
3 Paying to Connect Medical Homes to other Healthcare Resources
a What core elements of PCMH services should the practice be paid to provide, and what could be effectively provided through other community resources?
b What incentives will facilitate collaboration across distinct entities?
c What payment options will facilitate coordination of specialists, hospitals, and other specialized entities with PCMH?
4 Implementation challenges to Medical Home Payment
a How do the answers to the preceding questions vary based on physician characteristics, practice size, existing infrastructure, historical affiliations, and community characteristics?
b What barriers exist to payers implementing otherwise desirable payment reforms? What are the policy solutions to these barriers?
c What are advantages and disadvantages to individual payers setting their own payment policies for PCMH versus approaches that promote local multiple or all-payer medical home payments?
d What should be the mechanism for attributing or assigning patients to a PCMH? Prospectively, concurrently, or retrospectively? Voluntary or mandatory? Lock-in, soft lock-in, no lock-in?

payment reform. Indeed, it may be that different circumstances will require different payment approaches. Accordingly a substantive array of key research questions emerges relevant to payment policy to support medical homes. The PCMH demonstrations, which have adopted varying payment approaches and payment amounts, offer an opportunity to start to answer many of the outstanding research questions. Formal quantitative and qualitative evaluations of the impact of the various payment approaches would contribute importantly to furthering the medical home concept.

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