Paying the Bill

The medical home may sound like primary care nirvana, but the bottom line is whether or not physicians can afford to take on all the front-loaded costs—possibly $50,000 per doctor or more—to change their practices to this model. The good news is that payers and insurers are taking note and testing solutions they hope will pay off for everyone.

Chapter in Brief:

- *The most common medical home reimbursement structure can be viewed as a pyramid: fee-for-service is the base, the middle layer is a care coordination fee to cover services not covered now, and the top layer is some form of pay-for-performance.*
- *Models are already being tested that reward physicians for showing measurable improvements in areas like diabetes or effective communication. Participating practices have to meet NCQA standards.*
- *Some say fee-for-service needs to be eliminated entirely in favor of a system that compensates primary care physicians for comprehensive care delivered through a medical home model.*

Trumping any other debate over the medical home is the question of payment. The basic problem is that the cost of changing to a medical home model is front-loaded, with big outlays for electronic records and other technology; salaries for case managers, health educators, and other physician-extenders; and payments to consultants to help the practice change the way it operates. But the benefits of fewer specialist and emer-

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gency visits, less hospitalization, and better disease control could be years away. Who's ready to make the leap?

That level of risk is unfamiliar territory for most physicians. Unlike other businesses and professions, physicians haven't had to routinely assume large upfront costs to get an eventual return on their investment. While some well-organized practices can change to the new model and find profits better than ever, most physicians are, understandably, reluctant or unable to pay out of their own pockets without some guarantee of an immediate and sizable jump in income.

"If you're going to give patients better access and give clinicians better infrastructure and time to spend building those rela-

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tionships, you need to pay them differently," says Ms. Abrams of the Commonwealth Fund. Healthcare financing must shift from emphasizing volume to rewarding the quality of the interaction, the care taken with the medical history, the time spent explaining and reconciling medications, and the selection of the proper specialist.

Medical home reimbursement is a classic chicken-egg problem, says Dr. Keckley of the Deloitte Center for Health Solutions. "There's a honeymoon around the idea, but when the payers and the provider organizations sit down to negotiate, the conversations can end really abruptly. The physicians say, 'Pay me more and I promise we'll get better results,' while the payer wants to tie part of the payment to that promise," he says.

Still, physicians can't be expected to underwrite the costs of this huge change. Many practices operate on a shoestring and don't have extra capital. And in today's credit environment, borrowing is neither attractive nor, in some cases, feasible.

"There has to be a model of payment that's reasonable and isn't just break-even," says ACP's Dr. Barr. "It has to include shared savings or some other form of incentive. It doesn't all

have to come up front, but you have to make sure you're not creating a higher cost structure for physicians" without supplying a significant reward.

While Dr. Mambu, who runs a three-physician primary care practice in Lower Gwynedd, Pa., could afford to spend $50,000 per physician on an EMR system for his medical home, he knows that's not possible for everyone. "Primary care doctors are so strapped that they can barely keep their heads above water, so to ask them to take this on without any surety of compensation isn't going to happen," he says. "The first 2 percent of us look at it as an investment, but the other 98 percent are watching to see if we survive."

Payers Back Medical Homes

The reason those backing the medical home idea expect it to be more than just another short-lived quality improvement fad is that payers are on board and apparently willing to back that support with money.

"Blue Cross Blue Shield supports the concept 110 percent," says Sally Bleeks, RN, managing director of the office of clinical affairs for the Blue Cross Blue Shield Association. "We hope it will lead to better outcomes, better patient satisfaction, and also decreased cost," she says. Twenty-nine out of 39 Blue Cross Blue Shield plans have some form of medical home pilot test in progress; most of them began just this year.

The board of directors of America's Health Insurance Plans (AHIP), a consortium of more than 1,300 insurers, issued a statement in June 2008 strongly supporting the concept of the medical home and, significantly, the concept of paying the costs to coordinate that care. (See the full statement at *http://www.ahip.org/content/default.aspx?bc=31|44|23691*.)

"There's widespread agreement from stakeholders across the board that the current payment structure is not providing the right incentives in our healthcare system," says AHIP spokesman Robert Zirkelbach. "We need a system that rewards quality and value. With costs increasing as fast as they have been, there is a

growing momentum to look at the payment system and see if we have the right incentives in place."

How Pyramid Reimbursement Works

The most common form of medical home reimbursement being used in current pilot tests can be portrayed as a pyramid. The largest component, at the base, is the usual fee-for-service. The middle layer is a care coordination fee to cover the services that aren't covered now: providing patient education; hiring a care manager to keep track of routine tests and screenings; installing an EMR system; and using phone, e-mail, or text messaging to communicate with patients. No one knows quite how big that care coordination fee ought to be. The pilot tests in progress are paying anywhere from $3 to $100 per patient per month. (See "One State Experiment: Medical Homes for All PCPs," p. 59, and "Humana: Testing a Three-Tiered Pay Program," p. 61.)

To make sure that the services billed under the fee-for-service component are the right ones, the top of the proposed pyramid is some kind of pay-for-performance, or gain-sharing, so that as the overall cost of care goes down, doctors will share part of the savings. "We want to pay for delivering better care rather than for doing more things," Ms. Bleeks says. Some medical home pilots already include the tip of the pyramid; others will incorporate it only after initial experience shows whether the model actually saves any money.

Primary Care Shortchanged

Bridges to Excellence (BTE), a pay-for-performance program backed directly by employers rather than by insurers, has been trying since 2002 to improve reimbursement for primary care. It's putting up real money—five- or six-figure sums for some medical practices—for measurable improvements in areas like diabetes and cardiac care, or for effective use of information technology. It recently added the medical home to the list of activities and practices for which it will pay.

For the medical home program, BTE will compensate physicians $125 per year per covered patient (i.e., a patient employed by one of the BTE participating employers) up to a maximum of

One State Experiment: Medical Homes for All PCPs

Blue Cross Blue Shield of North Dakota, the state's biggest insurer, is sponsoring a medical home pilot project that includes almost all the state's primary care physicians. In January it began providing an annual payment of $100 per patient, over and above any visit fees or other charges, to physicians who act as a medical home for any patient with diabetes, hypertension, or heart disease.

In return, physicians agree to upload their patients' data to a central database so that all caregivers can access it; to adhere to standard practice guidelines for treating the targeted diseases; and to take extra steps to make sure their patients get other basic preventive services like mammograms, pap smears, immunizations, and colonoscopies.

Because Blue Cross Blue Shield covers about 85 percent of the commercially insured North Dakota population, or about 275,000 people, it almost has to spearhead any medical home efforts in the state, says Jon Rice, MD, senior vice president and chief medical officer. He estimates that 780 physicians will participate. The pilot program is made easier because most North Dakota physicians practice in one of several large multispecialty group practices.

The care management fee structure is experimental for now as Blue Cross Blue Shield gathers information about the costs of chronic disease care from program participants. "We may be able to start making more intelligent decisions about how to pay for [medical homes], maybe as some kind of risk-adjusted capitated payment," Dr. Rice says. For now, the care management payment is limited to the 40,000 to 50,000 North Dakotans who have one of the targeted chronic diseases, but a risk-adjusted payment could allow Blue Cross Blue Shield to pay the management fee for all patients.

So far the pilot program doesn't include specific performance targets, but Dr. Rice hopes to set some within two years, and perhaps tie them to additional payments.

$100,000 per year. That money is a bonus, over and above whatever patients' insurers are paying. To participate, practices have to achieve NCQA recognition (see Chapter 2) at Level 2 or 3 in two condition-specific programs (diabetes, cardiac care, or spine care) plus Level 2 or 3 recognition for use of information systems (called Physician Office Link by BTE and Physician Practice Connections by NCQA). Achieving NCQA's new Patient-Centered Medical Home recognition will also do the job.

Why now? BTE employers who either self-insure or purchase commercial insurance for their employees are interested in reducing their costs, especially for chronic disease care, says François DeBrantes, BTE's CEO. He says primary care has suffered from the RBRVS, which Medicare and other insurers use to calculate reimbursement for medical services. The process of setting the values, conducted through a committee under the auspices of the AMA, has been dominated by specialists, Mr. DeBrantes says, which has kept payment for primary care functions relatively low. As a result, 70 percent of the employers' healthcare dollar is consumed in potentially avoidable complications, because primary care physicians can't spend more time per visit or to coordinate care, he says.

One Idea: Reward Comprehensive Care

Not everyone sees the virtue in maintaining fee-for-service reimbursement in a new payment system, claiming that the current system is a big part of the problem.

Some want to ditch fee-for-service payment for primary care entirely and replace it with a system that specifically rewards the care that the medical home provides. One of these advocates is

Recommended BTE Rewards by Program

Program Level	Physician Office Link	Diabetes Care Link	Cardiac Care Link	Spine Care Link
3	$50 per patient per year			
2	$30 per patient per year	$200* per diabetic patient per year	$200* per cardiac patient per year	$50 per back pain patient per year
1	$15 per patient per year	$100* per diabetic patient per year	$100* per cardiac patient per year	$0 per back pain patient per year

**The per-patient rewards for DCL and CCL are $80/%160 respectively when in combination with POL rewards.*

Source: Bridges to Excellence, April 2009.

Humana: Testing a Three-tiered Pay Program

As part of its test of a medical home reimbursement system, the Louisville, Ky., insurer Humana is trying a three-tier plan. After fee-for-service, the next largest component would be a care management fee, currently pegged at $3 to $5 per patient per month. The third tier, some form of gain-sharing or pay-for-performance, isn't in play in this particular test while the company sorts out the other two tiers.

Humana began its medical home pilot project in May 2008 with 11 physicians and 800 patients in Atlanta. The insurer pegged those patients with the chronic conditions that cost it the most: diabetes, hyperlipidemia, and hypertension. The pilot practice, Wellstar, had just implemented an electronic medical record system a few months before the medical home project began.

What will constitute success? Marcia James, process manager in physician strategies at Humana, says that she expects to see improvements in measures such as hemoglobin A1c levels and blood pressure in the short term, and fewer emergency department visits and inpatient days down the line. And she will also be looking at basic metrics such as both patient and physician satisfaction.

"Once all the processes are in place, it makes the practice easier and more enjoyable for physicians and their staff, just because you know what's going on with patients and you feel more in control of their care," Ms. James says. "I don't know why a practice wouldn't want to do this."

Allan Goroll, MD, professor of medicine at Harvard Medical School and co-founder of Massachusetts General Hospital's primary care residency program as well as chair of the Massachusetts Coalition for Primary Care Reform.

He blames the current payment system for the recent erosion in the quantity and quality of medical graduates choosing primary care. "They've been shunning the field for almost ten years, and the work life is the number one reason," he says.

Dr. Goroll's goal is to compensate primary care physicians on the same level as specialists and to stop the system from rewarding volume alone. He opposes the pyramid reimbursement model because it's still primarily fee-for-service and thus relies on volume to a degree. "You see the nuttiness of volume when you see primary care practices and Wal-Mart fighting over who gets to

Trying Out a Radical Change in Payment

The Capital District Physicians' Health Plan (CDPHP), an insurer in Albany, N.Y., is carrying on perhaps the most radical experiment in compensation for the medical home among three practices that include 15 physicians and five midlevel practitioners. For the next two years, it's trying out the payment scheme proposed by Allan Goroll, MD, of Harvard: a combination of a flat annual fee and bonuses based on quality of care.

Payments are based on the number of patients that call the practice their medical home, and each patient pool is risk-adjusted to come up with an appropriate base compensation for the physician or practice. And CDPHP is willing to stick its financial neck out to make sure the pilot works as well as it possibly can: Even though the insurer covers only 40 percent of the patients in the participating practices, it's pretending to cover all of them for the purpose of the test. That is, it will make sure physicians receive enough extra income to account for the per-patient management fee for all their patients, even though more than half of them are covered by other insurers.

Here's how it works. If Physician A's patients, as a group, need 1.5 times as much care as Physician B's patients, then Physician A would get a payment 1.5 times larger than Physician B. (Since CDPHP can only risk-adjust its own patients, it will assume that the rest of the practice's patients share the same risk characteristics as the 40 percent that it does know about.)

In terms of actual money flow, the change won't be immediately obvious because of the need to dovetail it with the existing system; but participating physicians should notice a big difference in their bottom line by the end of the first year. Physicians will keep billing all their payers on their

treat a runny nose," he says. "We should pay comprehensively for comprehensive care."

He proposes a comprehensive annual payment based on the size of the physician's patient panel risk-adjusted so that physicians with sicker patients get paid more. The payment would be enough to support the care team that's the basis of medical home care, and also the necessary information technology infrastructure. Dr. Goroll envisions that the base payment would be at least 40 percent more than what most primary care practices are now making on a fee-for-service basis.

The second part is a bonus of up to 25 percent of the base payment for achieving quality goals, outcomes standards that have

usual fee-for-service basis; but because of the changes in practice stemming from the medical home, it's possible that they may bill for fewer services than before. CDPHP's risk-adjusted payments are designed to make up whatever difference there might be in the practice's fee-for-service income so that physicians will not lose anything by participating in the test.

Beyond that, CDHP is prepared to boost their revenues by as much as $85,000 per physician per year. The first $35,000 is automatic and is supposed to pay for the extra effort involved in medical home services, such as open access, phone and e-mail contacts, health education, and management of chronic illness. The other $50,000 will be paid out based on whether the physicians hit certain quality targets, such as whether patients receive the care needed under standard guidelines, whether they're happy with their doctor, and how well the doctor communicates.

The degree to which physicians qualify for that extra $50,000 will be the main measure of success, says Bruce Nash, MD, CDPHP's senior vice president and chief medical officer. "If patient satisfaction and good outcomes are there, we're happy to pay," he says.

The additional payments should move participating physicians' income into the $200,000 range, enough to start making primary care a more attractive profession, Dr. Nash says. If the test is successful, fee-for-service billing would eventually be replaced by a combination of a risk-adjusted annual fee and performance bonuses. Some services, like immunizations, are likely to remain fee-for-service. All three practices already have electronic medical records, and they've been working with consultants from TransforMED to make other changes.

been validated by national groups, patient satisfaction measures, and cost and efficiency targets. The bonus is risk adjusted, too, so that there's a proportionally bigger reward for improving the health status of a patient who was very sick to begin with.

Tests, procedures, specialty care, hospital expenses, and medications would still be paid by fee-for-service, at least until some complementary scheme could be devised.

Will it work? Dr. Goroll's ideas are getting their first real-world test with one payer and three primary care practices in Albany, N.Y. (See "Trying Out a Radical Change in Payment," p. 62.)