SustiNet Health Partnership

Medical Home Advisory Committee

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Patient Centered Medical Home Advisory Committee Meeting
May 5, 2010
Meeting Minutes

Committee Attendees: *Ellen Andrews, Co-chair; Tory Westbrook, Co-chair; Keith vom Eigen; Maureen Smith; Sheldon Toubman; Sandi Carbonari; Les Holcomb; Sylvia Kelly; Jim Augur; Dominique Thornton; Jody Terranova; Rick Duenas; Judith Meyers; Joanna Douglass; Bruce Gould; Ken Lalime; Drew Morten; Jennifer Jaff; Jim Cox-Chapman*

Excused: *Evelyn Barnum; Lisa Cannella; Amy Casavina Hall; Margherita Giuliano; Joseph McDonagh; Rose Stamilio; Scott Wolf; Deborah Poerio; James Stirling; Thomas Woodruff*

Ellen Andrews opened the meeting by welcoming all participants. She said that Lisa Cannella has resigned from the Committee for personal reasons. Lisa would like to be considered for participation in the future. Ellen said the Committee wishes her well at this time.

Ellen said that the last meeting was not as productive as it should have been. She said that due to the tight timeframe the Committee will need to make more progress. She has looked at the surveys that Committee members responded to, and feels that some members are not being heard, so there will be some changes. She reminded members that they all agreed to do the work involved and consider the best interests of SustiNet. From now on, discussion will be limited to members of the Committee only. Everyone will be given an opportunity to speak. No one will speak for a second time until all members have had a chance to speak once. Members will go around the room and everyone will have two minutes to speak without interruptions. Ellen asked that everyone give their full attention to the speaker. Ellen said that she and Tory Westbrook will discuss all comments after the meeting.

Today's issue for discussion is how to pay a patient centered medical home (PCMH). Ellen read from the original SustiNet law, which stated that the Committee shall recommend community based resources that enhance the medical home function, including loans on favorable terms that assist with infrastructure and the offering of

reduced price consultants who will help providers in restructuring their practices so as to function more effectively in response to changes in health insurance coverage. The Committee shall also offer recommendations for payments for medical home functions.

Ellen mentioned the PCMH and state employee program that will be offered through ProHealth and how that will be structured, and the PCMH in PCCM and Husky. Some states grade the level of payment amounts based upon which NCQA level a medical home is at. Many states are moving toward risk adjusting payments, whereas many use Medicare's more clinically based payment scale but include psychosocial risk factors, such as income levels, literacy rates, or non English-speaking patients, etc., all of which involve more case management. Some states use the patient's individual diagnosis history, for example, if a patient visited an emergency department many times in the past, there will be more resources needed in order to prevent that. Other options used include: fee for service plus a per member per month (PMPM) and flat fee, which is what PCCM does now; varying the PMPM fee depending on the NCQA level the medical home is at; other states do this and also offer a quality incentive; some states offer bumps based on outcomes; some offer a higher fee for service, only paying fees for actual patient visits; some offer shared savings, comparing expenses from the past with those in the present and paying a percentage of the savings to the practice; in some states consumers get a lower rate if they go to a medical home; and incorporation into accountable care organizations.

Ellen spoke of value based insurance design, which involves different insurance designs based on individual needs. An example of this is taking co-pays off medication to maintain blood pressure; people will be more likely to take meds if there's no co-pay. This is something for this Committee to consider, not simply for medications, but for screening procedures as well. An unidentified speaker said that Anthem has introduced programs like this in Maine on a pilot basis which is now in year two. He said that this has shown higher costs upfront, but has resulted in savings later on, showing how plan designs can work well.

Tory asked Committee members for comments. Maureen Smith asked if there will be federal contributions available on an ongoing basis. The response was inaudible. An unidentified speaker asked for clarification on utilizing rate setting procedures. Ellen's response was inaudible. An unidentified speaker commented that if the Committee wants physicians to transition to this, it's important for it to be simple and understandable. It would be a good idea to base this on a well known, well understood system such as Medicare, although Medicare reimbursement does have its flaws. The same speaker continued, saying that from the ACP's perspective, the payment system that seems to be the most widely used and easiest for physicians to understand is the fee for service payment plus the PMPM fee plus some quality incentives. Another thing to consider is that some practices don't deal with Medicare, so they may need a different kind of structure. An unidentified speaker said that pediatricians don't use Medicare, but use Medicaid, which uses rates that are a percentage of Medicare. She also said that she would like to see pediatric services not be reimbursed less for the same level of care and complexity. All of these things will be based on the transformation of practices and patients, which will

be a challenge. She also said that the Committee needs to keep in mind that certain complex medical conditions will always have a need for ER visits, and that when ER visits will not be eliminated but perhaps can be minimized. Ellen said that this effort can involve more than just one model. Additionally, she said perhaps down the road there can be a recommendation to combine the PCCM with the state employee health plan. Tory said that the Committee could look at the PMPM fee and perhaps make recommendations for changing it. An unidentified speaker said that SustiNet is attempting to do two things at the same time; one thing is to grow the critical mass of potential providers and patients and the other thing is to develop a compensation model. Small practices really can't afford to enter into a capitated model of reimbursement, but larger group practices probably can. The speaker suggested that models should allow both types of reimbursement to occur. Perhaps when a practice reaches a point where they have a critical mass of patients, they could switch from fee for service to capitated payments. The same speaker said that if in addition to this there is a medical management fee paid, it should probably be risk adjusted. Some practices have a higher risk population then others, and it seems unfair to compensate them at the same rate. Another unidentified speaker said that there should be some type of reimbursement to bring small practices up to speed, otherwise only large practices will participate. The same speaker said that patient and provider incentives work well to change behaviors. An unidentified speaker said that SustiNet is attempting to have volume-based systems change to value-based systems, and this will require an incremental approach. Successfully changing provider behavior requires leadership, tools and meaningful financial incentives. The same speaker recommended a fee for service component, and said that the PMPM component is important for infrastructure changes. The same speaker suggested that quality outcomes need to be measured, so there should be quality incentives and opportunities for providers. It is also crucial to change incentives for patients. He commented that the fee of $7.50 PMPM sounded very good to him. An unidentified speaker said that incentives need to be linked to quality and outcomes. She said it is important to figure out how to structure pediatrics into this.

An unidentified speaker said that Pitney Bowes has done a large survey of its network of providers to determine what would work. Fee for service would work; physicians are skeptical of capitation, and would prefer a portion of the risk-adjusted premium, which would equate to a PMPM care management fee. Payors and purchasers need to be part of this equation because there is a cost issue that needs to be addressed. The same speaker said that feedback he has received indicates that 25% of the total payment is a good amount, which is about $10 PMPM if using the Medicaid schedule. For the Medicare schedule, $7.50 is acceptable.

An unidentified speaker stated some things he felt were important to keep in mind. First, he said, this effort needs to keep things simple, and secondly, there needs to be a fee for service model with some enhancements. The basic premise that needs to be agreed upon is that providers will be doing more and they will need to make an investment, and at least initially this needs to be recognized. The same speaker said that he doesn't think the model that is put into place now will be the same one that will be used five years from now. There needs to be flexibility in order to engage all

willing providers and get them on the right track. Ultimately, this model will result in better outcomes and lower costs.

An unidentified speaker commented that using a utility model and collectively using the money would be a better economic and quality approach to building the infrastructure for medical home, versus just leaving it for individual practices to use as they see fit. She said it was hard to say whether $7.50 PMPM would be adequate. Another unidentified speaker said he opposes capitation, and prefers a three-part model that includes fee for service for health services, a PMPM care management fee, and possible enhancements and rewards for performance. Rick Duenas commented that certain factors must be considered for reimbursement, saying that practice location needs to be looked at in addition to NCQA levels and the fact that some doctors may not get into the NCQA system. Additionally, Rick said that practices with high numbers would do well with a PMPM fee, whereas practices with small numbers would not, so perhaps the fees could be tiered. Dominique Thornton said the best thing would be a combination of several models, adding that results incentives for physicians in addition to compliance incentives for patients should be considered. Bruce Gould emphasized the importance of providing support for practices while adapting these changes, saying that practices that deal with complex issues will need additional support. He said that getting the full array of services into place should take precedence over the payment discussion, recommending networking with national groups and efforts that are already in place. An unidentified speaker said that there should be a basic payment that is applicable to all, but the challenge is how to motivate small practices to get involved. An unidentified speaker said that it is essential to get cash flow moving in order to involve small practices. He said that there needs to be a shrinking of the fee for service over time and a moving of dollars that are coming in into an incentive model that has quality, patient satisfaction and effectiveness at the back end of a population model. The same speaker said that this probably would take a generation to achieve.

An unidentified speaker said that all patients in an NCQA practice will need to receive these services, not just SustiNet patients, which will require a total transformation of the practice. An unidentified speaker said that she feels that multiple models may be necessary, and that some of the resources required to support the medical home may need to be community based, so there may be different payment structures needed. And unidentified speaker said that a capitated plan doesn't allow him to do what he needs to do, which is to provide care to patients. Whatever payment schedule is agreed upon must be centered on the patient physician relationship. Tory reiterated the importance of incentivizing patients to be compliant in order to reduce emergency room visits and keep costs down. He also said he could see this taking on a shifting fee schedule, so that as the years go by and NCQA levels go up there will be more pay-for-performance. He also said that the electronic health record would assist greatly in sharing community services by preventing smaller practices from duplicating what's already in place. Tory also said he thought concrete recommendations with specific data would be better received by the Legislature than just concepts. An unidentified speaker said that there's an important difference between preventive measures and pay for performance,

especially when looking at chronic diseases. She said that the baseline is a healthy patient, and for many people that baseline will never be a reality. The same speaker said it is important to draw a strong distinction between preventive and pay for performance. An unidentified speaker suggested that funding be in place for two to three years, allowing practices to become medical homes. If medical home status has not been achieved in three years, the funding would be reduced. Another approach would be to provide incentives for practices to become medical homes, similarly to how federal funding will reimburse expenses for electronic health records. This type of funding would reimburse practices after they have achieved medical home status. There also could be penalties of reduced Medicare payments for practices not adopting medical home measures.

An unidentified speaker said that in order for SustiNet to succeed, there will need to be an analysis to determine the proper payments for the various populations SustiNet will serve. The same speaker expressed concern about penalties being used. Additionally, he said that the primary care workforce in CT is dwindling, so area this needs to be examined. Maureen recommended a combination of reimbursement methodology that includes fee for service, PMPM, and incentives for performance for pay. She continued, saying there should be multiple models that share basic characteristics that this Committee identifies and endorses. She said there should be some type of penalty if goals are not achieved over a reasonable amount of time. An unidentified speaker said that rather than using penalties, providers who aren't compliant with SustiNet requirements for PCMH should simply not be recognized as SustiNet medical homes. An unidentified speaker voiced the opinion that any primary care physician who has a role in SustiNet should become a medical home. If physicians are allowed to opt out of this, then it will appear that PCMH is not core to SustiNet, although it should be. Ellen said that SustiNet can't afford to lose any Medicaid providers, although many providers will find it difficult to reach NCQA standards.

Bruce said that there needs to be an entry level to PCMH, beginning with fee for service and then evolving to a more global rate. One can assume that after a patient has been part of a practice for a while, eventually that patient's care will become easier. This is not true of all patients, but of most patients. An unidentified speaker recommended risk enhancement for a patient who has two or more chronic conditions, giving the physician more incentives to take on more difficult patients. An unidentified speaker said that in addition to NCQA, the Joint Commission is in the process of putting together certification for PCMH, so this Committee will need to keep this in mind while drafting standards. An unidentified speaker said that regarding high risk populations, global compensation can risk-adjust based on diagnosis. The same speaker said that solo practices can't collaborate easily with other practitioners for the risk of committing antitrust issues. The Government waives antitrust concerns for practices that go on risk together. Ellen said this Committee doesn't need to tackle this area. An unidentified speaker said that perhaps this Committee should set up a general principle that the medical home will adapt and integrate with the eventual formation of an accountable care organization.

An unidentified speaker said that shared savings have been mentioned as a component of the payment system and t is hat this requires further discussion, as it's complicated. The speaker said that quality incentives are very limited in terms of the specific diseases they look at and how they are measured. He said that this Committee needs to look at specific populations to determine what values should be encouraged in the system, and structure incentives that go along with this. An unidentified speaker said that many patients with chronic diseases feel as if they are being pushed away, so it's important to look at the sick end of the population and not just at those who are healthy. She suggested putting an emphasis on the patient's perspective when making recommendations, and said she would see whether she could present relevant patient data in a future meeting.

An unidentified speaker said that regarding shared savings, primary care physicians don't want to be accountable for the health insurance risk of their patients. They want to be accountable for things they can control, and they want to be able to share any actions that result in overall savings for an episode of care or population. He suggested a reward for taking care of a population that's more cost effective than other comparable populations or that beats the trend that's going on elsewhere in the state. (Inaudible comments.) An unidentified speaker said that at the individual physician level, shared savings is very difficult, saying that physicians typically don't know the cost of care. Perhaps informing physicians of costs of care is something SustiNet can do. Another speaker said that not only are expensive procedures ordered frequently, but they're also being duplicated. There also need to be incentives for other providers to communicate with referring providers, as this is often overlooked. Another speaker suggested that patients could also be made aware of costs.

Meeting was adjourned.

Next meeting will be May 10 at 10:00 am in LOB room 1C.