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Briefing

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State Multi-Payer Medical Home Initiatives and Medicare's Advanced Primary Care Demonstration

By Jason Buxbaum and Mary Takach

State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

In September 2009, the U.S. Secretary of Health and Human Services announced that Medicare will join selected state-based, multi-payer medical home initiatives in an Advanced Primary Care (APC) Demonstration. States have welcomed this announcement, viewing Medicare as a valuable potential strategic stakeholder. Yet they are concerned that the proposed APC criteria may be too narrow to fit many current initiatives. This *State Health Policy Briefing* builds from a December 2009 research scan and webcast that examines a broad range of state multi-payer initiatives and compares some of these criteria against the proposed APC criteria. It will inform those planning multi-payer initiatives about approaches that are now being used by leading states, as well as areas that will likely be of interest to the federal government.

NASHP does not speak on behalf of CMS. Rather, this brief builds on information provided to states by CMS and is based on our experience and research on state medical home initiatives.

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Much of the content of this brief was informed by Centers for Medicare & Medicaid Services (CMS) plans as of December 1, 2009. Criteria for participation in Medicare's Advanced Primary Care (APC) Demonstration has evolved since then, largely influenced by feedback received from states, and will be reflected in the request for proposals (RFP) expected to be released in early 2010. Readers of this paper should note that its discussion of CMS eligibility criteria or expected operational arrangements for the Medicare APC Demonstration is based on preliminary thinking that is subject to change as the solicitation for the Demonstration goes through CMS and Departmental clearance. The solicitation will articulate the definitive eligibility criteria and requirements for the Medicare APC Demonstration. With this in mind, this brief will review what we know about the Medicare APC Demonstration and will look at how a number of multi-payer medical home initiatives that have significant state support—Medicaid is a payer or purchaser, there is passed legislation or signed executive order, and/or dedicated staff is committed to support a multi-payer project—lined up against some of the proposed criteria. This brief will offer information for states and stakeholder groups planning multi-payer initiatives regarding approaches that are currently used by leading states, as well as areas that will likely be of interest to the federal government.

Introduction

Medical homes provide enhanced primary care in which care teams attend to the multi-faceted needs of patients, and provide whole person, comprehensive, ongoing, and coordinated patient-centered care. Sometimes referred to as APC, many experts say the medical home model shows great promise to improve the quality, accessibility, and value of health care in the United States.[1]

State efforts to promote APC through the provision of

medical homes often begin with Medicaid and the Children's Health Insurance Program (CHIP). In 2008, Medicaid and CHIP covered more than 42 million poor and low-income people, accounting for more than $340 billion in health care spending.[2] More than 30 states have been seeking to improve Medicaid and CHIP beneficiaries' access to high functioning medical homes.[3] Several are advancing medical homes as a core component of comprehensive health care reform, and several states are using their clout as purchasers to promote medical homes beyond the safety net through state employee health benefit plans, the private sector, and multi-payer collaboratives.

States that participate in multi-payer collaboratives report that they do so to gain provider buy-in. Providers are more likely to invest time and resources if their administrative burden is reduced because of aligned expectations among payers. In addition, public and private payers—including states with Medicaid fee for service, and purchasers (employers and states with managed care contracts)—want to spread the costs and risks of medical home investments across all those that benefit. In December 2009, a National Academy for State Health Policy (NASHP) scan found that at least 12 states are participating in multi-payer medical home initiatives: Colorado, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia.[4]

Medicare fee for service has not participated in any of these 12 multi-payer initiatives. One state official said that the absence of Medicare fee for service in multi-payer medical home efforts limits pilots to fewer providers, payers, and patients. This may be about to change. In September 2009, at the urging of five New England governors, U.S. Secretary of Health and Human Services Kathleen Sebelius announced the APC Demonstration whereby Medicare will join selected state-based, multi-payer medical home initiatives for three years. Sebelius has hailed this Demonstration as a significant step towards increased public-private alignment that will result in improved health care quality, value, and efficiency.[5]

As of January 2010, CMS has not issued the request for proposals (RFP). However, to provide anticipatory guidance for states, CMS's Office of Research, Development, and Information has outlined several key considerations that will guide state selection for the Demonstration:

- **Strong practice qualification criteria and enhanced payment:** The initiative has a formal mechanism for qualifying practices as medical homes, a method of tracking the relationship between patient and medical home provider (attribution), and a means of providing enhanced payment to the primary care site in recognition of meeting the criteria.
- **Sufficient progress, scale, and stakeholder participation:** The medical home initiative is underway, has substantial participation among other payers (including Medicaid), and has widespread support among primary care physicians.
- **Integration and alignment with other efforts:** The medical home initiative is designed to achieve integration with available community resources and is integrated with state wellness and disease prevention efforts.
- **Administrative functions are adequately performed:** Initially, CMS indicated it would rely on a state agency (or perhaps a non-profit organization) to oversee the selection and qualifications of practices, the tracking and attribution of beneficiaries, performance reporting, and the disbursement of dollars to practices and support organizations. However, CMS's current thinking is that CMS will engage its own contractor to administer beneficiary eligibility determinations, payments, and related functions. States are expected to offer prospective assurance to support budget neutrality for Medicare's participation and will be expected to provide ongoing monitoring of Medicare data for the budgetary impact throughout the three-year Demonstration.

This brief elaborates on the four considerations above and offers examples of what state multi-payer medical home projects are doing in each area. This brief was informed by a December 1, 2009, NASHP webcast entitled "Will Medicare Join State Multi-Payer Medical Home Initiatives? A Conversation with States Regarding Medicare's Proposed Advanced Primary Care Demonstration."[6] During this Commonwealth Fund-supported webcast, NASHP facilitated a discussion with a CMS official and leaders from seven states (Colorado, Maine, Maryland, Massachusetts, Minnesota, Pennsylvania, and Vermont) with multi-payer medical home initiatives. More than 300 state officials, federal officials, and other interested parties attended the webcast. This brief also draws on data from the chart "State Involvement in Multi-Payer Medical Home Initiatives"[7] and an October 2009 briefing offered to states by CMS regarding the proposed criteria.[8]

Qualification criteria and enhanced payment

According to Medicare's initial guidance to states regarding the proposed APC Demonstration requirements, state applicants must be able to show recognition and payment processes capable of supporting robust and effective medical homes.

Practice Qualification

The Medicare APC Demonstration will require all states to have a mechanism in place to "rigorously" qualify medical home practices, ensuring that they have the capacity and ability to provide APC services to their patients. Unlike the Medicare Medical Home Demonstration which requires participating sites to qualify as medical homes based on criteria established by the National Committee for Quality Assurance (NCQA),[9] the Medicare APC Demonstration plans to provide states with flexibility in how they qualify sites as long as the process is "rigorous."

Currently, there is a great degree of variation among states with respect to qualifying medical home practices. Nine states with multi-payer projects, including Colorado, Maine, New Hampshire, Rhode Island, and Vermont – have adopted the National Committee for Quality Assurance Physician Practice Connections–Patient Centered Medical Home (NCQA PPC-PCMH) tool.[10] Some experts have expressed concern, however, that the NCQA criteria overemphasizes practice characteristics that are easy to measure (e.g. medical technology use), underemphasizes characteristics that may be more difficult to measure (e.g. patient experience and care coordination), and only recognizes physician-led practices.[11] As one medical home initiative leader said, "our feeling … is that the NCQA [tool], —while it's a useful framework for recognizing certain structures in the practice—wasn't sufficient in terms of describing our full vision for transformation to a more patient-centered model of care."[12]

Given these concerns, many states have modified the NCQA criteria or developed their own recognition systems. For instance, Maine uses the NCQA criteria as an initial threshold for entry into their pilot, but has also developed ten "core expectations" for participating practices, including factors such as same-day access, behavioral-physical health integration, and commitment to waste reduction.[13] Minnesota, looking to emphasize "patient engagement and quality improvement," has a locally-developed certification process that includes demonstrating a measureable improvement in clinical quality between initial practice certification and recertification.[14] Medicare has indicated that they are willing to look beyond NCQA for practice recognition for the APC Demonstration.

Enhanced Payment

CMS has indicated they will only consider joining multi-payer state medical home initiatives if the recognized primary care sites are also receiving additional reimbursement. The additional payment is a key feature of the medical home model, since much of the work involved in running a medical home occurs outside of a standard office visit and thus is not reimbursed under current payment systems. A NASHP survey of state medical home activity shows that states are using or planning to use a range of payment methods to reimburse practices for the added value of medical homes. CMS has indicated that it would consider a variety of payment methods, provided there is consistency across all payers in each initiative.[15]

Providing a separate per member per month (PMPM) payment in addition to fee for service is the most common method of payment among the multi-payer states scanned in NASHP's survey; most of these initiatives use some type of PMPM reimbursement.[16] Vermont's Blueprint, for instance, pays practices a PMPM payment of up to $2.39 that varies depending on the practice's NCQA practice score; Colorado's PMPM fee increases with each of the three NCQA tiers.[17] Minnesota's PMPM payment rates are stratified to recognize the complexity of caring for chronically ill patients. In addition to medical complexity, Minnesota is also considering adding two supplemental aspects to a complexity adjustment formula, including caring for a non-English speaking patient or one who has a mental health illness.

Pennsylvania's payers are taking different approaches in different regions. In Southeast Pennsylvania, for instance, one portion of the payment to medical home practices –approximately $21,000 per practice – is paid to account for the registry licensing fee, support for data entry to registry, cost of the NCQA survey and application fee, and lost revenue time to attend learning collaboratives. Each payer pays its share of the $21,000 payment in proportion to the share of the practice's revenue that comes from the payer. For instance, if payments from Independence Blue Cross were to represent 20 percent of a given practice's revenue, Independence Blue Cross would pay 20 percent of the supplemental lump sum. According to

a Pennsylvania state official, if Medicare fee for service were a payer, their share of the lump sum payment would be approximately 30-50 percent.

Shared savings and "pay for performance" are two additional payment methods that are frequently used to complement another reimbursement strategy, such as PMPM or lump sum payment. Shared savings entails sharing the savings from predicted but averted acute care with primary care providers (PCPs). Pay for performance rewards providers for meeting certain pre-determined performance criteria, such as decreased hospitalizations for ambulatory care sensitive conditions. Several states, including Colorado, Maryland, Massachusetts, and West Virginia are planning to use shared savings or pay for performance. Modeling after a successful program implemented by Geisinger for practices that are not Geisinger-owned but work with the health plan, Pennsylvania has implemented a shared savings arrangement in the Northeast region.[18]

Attribution of Beneficiaries to Providers

CMS has indicated that the Medicare APC Demonstration will require states to demonstrate a clear methodology for tracking the ongoing relationship between patient and PCP. CMS has indicated beneficiary flexibility in selecting and changing primary care clinicians as a core principle they want to maintain. Therefore, a "lock-in" system, where patients are prohibited from changing or choosing their own provider, will most likely not qualify for Medicare participation.

The Joint Principles of the Patient-Centered Medical Home, developed by four primary care physician associations, stipulate that in a medical home, "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care." There has been no indication to date from CMS that medical homes must be physician-led, leaving open the possibility of Medicare participation in initiatives that allow nurse practitioners or other non-physician providers to lead medical homes, such as Pennsylvania's initiative.

Enhanced payment for medical homes typically requires some formal process by which payers, insurers, and providers can identify a given provider's patient population. This process is often referred to as the attribution of a patient to a PCP. CMS has indicated that the Medicare APC Demonstration will require states to demonstrate a clear methodology for tracking the ongoing relationship between patient and PCP. To this end, states are employing a variety of attribution models:

- "an enrollment model, where the beneficiary… is providing a designation of one of the participating practices," and
- a "claims analysis [method] to identify [which] beneficiaries belong with which practices."[19]

Maryland is an example of a state that plans to use the enrollment model of attribution for members of health maintenance organizations (HMOs). With respect to claims analysis methodology, state multi-payer medical home initiatives are taking different approaches. Maryland (for preferred provider organization (PPO) members) and Maine plan to attribute patients to the practice where they have received most of their evaluation and management care, while Rhode Island plans to attribute patients to providers on the basis of last visit to a PCMH site within the past two years.

Sufficient progress, scale, and stakeholder participation

CMS has indicated that they will only consider medical home initiatives that are underway, beyond the planning phase, and enjoy widespread support from public and private payers.

Sufficient Progress

For a multi-payer medical home initiative to qualify for Medicare participation under the APC Demonstration, the initiative must be "established." What exactly will be considered "established" is unclear at this time, but CMS has indicated that certain milestones should have been met, including planning and analysis, and financing decisions.

Some state initiatives have been underway for a year or more and are operating on impressive scales. For example, over one million Pennsylvanians now have medical homes through the state's multi-payer medical home initiative, receiving care from more than 750 providers. Many states are using the "pilot, refine, expand" model to generate momentum, and have started with considerably smaller efforts. Rhode Island's medical home initiative, for instance, has enrolled 5 practices, 28 physicians, and covers 28,000

patients. The initiative plans to double these numbers during 2010.

Other multi-payer initiatives are still in the planning stages, but are making steady progress. For instance, Massachusetts is taking a broad approach to engaging stakeholders as they plan for a 2010 project launch. The Secretary of the Executive Office of Health and Human Services has regularly convened a Patient-Centered Medical Home Initiative Council composed of high-level representatives of the major private payers; Medicaid's contracted health plans; Medicaid's primary care case management (PCCM) plan; and representatives of consumers, providers, and others. Under the preliminary criteria outlined in the initial announcement for the APC Demonstration, it is unclear if Massachusetts would qualify. Depending on the definition of "established", the number of states that would be eligible to participate could vary significantly. If "established" means providers have been enrolled and payments are being disbursed, only six state multi-payer initiatives would qualify (as of November 2009).[20] An additional six states may be able to qualify for the Demonstration depending on CMS's definition of "sufficient" progress.

Substantial Support Among Payers and Providers

Medicare has indicated that a medical home initiative must have "substantial participation" by Medicaid *and* private payers. A Medicaid-only initiative would be ineligible for Medicare participation, as would an initiative that does not have Medicaid as a participating payer. Of the six multi-payer medical home initiatives in operation as of November 2009, all six include commercial payers. For instance New York is working with 8 separate payers and Pennsylvania is working with 16. Many of these initiatives include purchasers such as state employee benefit plans (e.g. Colorado, Minnesota, and West Virginia), while others have partnered with Medicare Advantage plans (e.g. Pennsylvania and Rhode Island).

Substantial support among PCPs will also be a requirement for Medicare participation. CMS has not defined "substantial" in detail; however, there have been indications that a state may be able to fulfill this criterion through the endorsement of state medical societies.

Convening a broad array of stakeholders—including payers, providers, provider associations, mental health agencies, etc.—is an essential component of a multi-payer medical home initiative to help create and sustain momentum and share valuable knowledge and resources. Pennsylvania and Vermont are examples of states that have played lead roles in bringing broad stakeholder groups together. CMS, however, has indicated that the state need not serve as the lead convener (although the initiative must be conducted under state authority). In several states, non-profit organizations perform this role: in Colorado, the Colorado Clinical Guidelines Collaborative has assumed this function, while in Maine, the Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition have partnered to organize the medical home pilot.

Integration and Alignment with Other Efforts

CMS has indicated that they will only participate in state multi-payer medical home initiatives that are integrated and aligned with community resources and existing public health programs. The implications for these criteria, including how broadly or narrowly these criteria will be defined, will not be known until the request for proposals is released by CMS. We offer examples of states that are currently working to support and align medical home initiatives with other efforts.

Integration with Community Resources

Given that patients frequently require social support and other non-medical services not traditionally provided by doctors, effective care coordination across systems is a hallmark of APC. As such, Vermont's Blueprint makes use of community health teams (CHTs) that include nurse coordinators, social workers, dieticians, community health workers, and others. Living in the communities they serve, CHTs offer patients counseling, self-management coaching, linkages to non-medical resources (e.g. food stamps), and links to other services. CHTs, which are shared among practices, also work closely with hospital discharge planners and public health specialists. Each CHT is funded jointly by all payers, and offers services at no cost to patients and providers.[21]

Other states have taken different approaches with respect to linking practices with community resources. Minnesota's initiative, for instance, has included the establishment of these linkages as a requirement for practice recognition.

Integration with State Disease Prevention and Wellness Efforts

Another proposed APC Demonstration criterion requires state multi-payer medical home initiatives to be integrated with other wellness and disease prevention efforts. Some states are making integration with public health efforts a condition of practice recognition. For instance, one of the Maine multi-payer medical home initiative's core expectations is that practices are linked with the local Healthy Maine Partnership (HMP). HMPs are community health coalitions that focus on environmental and policy change to promote healthy lifestyles, and help to connect residents to preventive services such as tobacco cessation assistance, anti-obesity coaching, asthma support, and a variety of other wellness programs.

Administrative capacity

Any successful medical home initiative requires the successful undertaking of a variety of administrative functions. Originally, Medicare indicated that the state would act as the administrative agent for Medicare, paying providers for services rendered to Medicare beneficiaries. According to a CMS official, however, CMS is very likely to perform functions related to verification of beneficiary eligibility and payment instead of delegating these functions to the states.

Some states, such as Pennsylvania, already perform certain functions of the administrative entity, including coordinating payments from payers to practices. Sometimes, these roles are delegated to various stakeholders. In Colorado, the Colorado Clinical Guidelines Collaborative handles many administrative functions, but not attribution and provider payment—payers independently administer these functions using a common methodology. Massachusetts plans to implement a similar decentralized system for attribution and payment.

Budget Neutrality

CMS has indicated that state applicants must be able to show evidence that supports projection of budget neutrality. (Budget neutrality will not be required for other payers.) Medical home programs in Minnesota and Maryland have budget neutrality expectations for all payers. States applying for the APC Demonstration must ensure that their multi-payer programs are capable of analyzing and monitoring Medicare data throughout the three-year Demonstration and can assure Medicare budget neutrality. States cited concerns about the Medicare budget neutrality requirement including:

- Cannot expect "budget miracles" in the first phases of implementation: many states agree that a focus on shared savings is a better way to generate cost savings in a short period of time. Maryland, Massachusetts, and Pennsylvania are several states that use or plan to use this approach.
- Medicare claims data for states has been historically slow to come by, and it would be impossible to hold providers responsible for budget neutrality without timely data. CMS is planning to release Medicare data with the RFP solicitation so states can be accurate in estimating budget neutrality.

More considerations

There are additional program aspects that Medicare will consider in determining whether to join a state's multi-payer initiative, including the development of a problem definition and evaluation plans.

Problem Definition

CMS has indicated that interested applicants will need to ensure that their demonstrations address and meet the unique needs of the problems faced by the Medicare population—primarily an elderly population—which are often different than Medicaid and commercially insured populations. For instance, Vermont is exploring ways to connect their Program of All-Inclusive Care for the Elderly (PACE)[22] to their health information technology infrastructure in order to smooth transitions between care settings such as hospitals, homes, and long-term care facilities.

Evaluation

CMS is required by federal law to conduct its own evaluation, but states will be expected to evaluate their own initiatives as well—additional information will be provided at the release of the RFP. All 12 state multi-payer medical home pilots are currently conducting or planning to conduct comprehensive evaluations.

Conclusion

Medicare's APC Demonstration offers the possibility of enabling more state multi-payer medical home initiatives to achieve "critical mass," whereby momentum accelerates and more providers and payers join these projects. But how stringent or narrow the proposal criteria are defined could significantly affect the number of states that may be eligible to participate. For

instance, CMS has indicated that it will join an "existing" initiative but, depending on how this is defined, could leave out from consideration states that are nearing the completion of their pilot plans but have not yet begun implementation (such as Massachusetts, Maryland, New York, West Virginia). In addition, expectations that states can promise Medicare budget neutrality over three years may be an unrealistic requirement.

There are many ways that states are defining the medical home, testing different payment models, integrating with community resources, aligning with public health efforts, and performing necessary administrative functions. States in multi-payer collaboratives have worked with stakeholders to make careful and deliberate choices among these options. As a result, state multi-payer medical home initiatives show great diversity – and Medicare's choices about where to draw the line among these options will greatly effect how many and which states will be able to participate in the APC Demonstrations. Of course, the addition of Medicare to the multi-payer table as a stakeholder will also likely result in adjustments to existing and planned multi-payer initiatives to accommodate and reflect the unique needs of Medicare beneficiaries and the requirements of the APC Demonstration. But there should be no question that the addition of Medicare at the table is an opportunity for select states and for the rest of the nation to see if the provision of APC through an all-payer medical home model can bend the cost curve while improving patient care and outcomes. The implications of these lessons could have profound effect on our health care delivery system.

Endnotes

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15 Competing payers may be concerned about running afoul of federal anti-trust statutes as they try to harmonize medical home enhanced payment methodology with one another. In some states, the state action doctrine – under which states can convene private payers and others to further a "clearly articulated state policy" while shielding them from certain anti-trust regulations – has been essential in facilitating coordination and consistency across payers.

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Portland, Maine Office:
10 Free Street, 2nd Floor, Portland, ME 04101
Phone: [207] 874-6524

Washington, D.C. Office:
1233 20th Street NW, Suite 303, Washington, D.C. 20036
Phone: [202] 903-0101