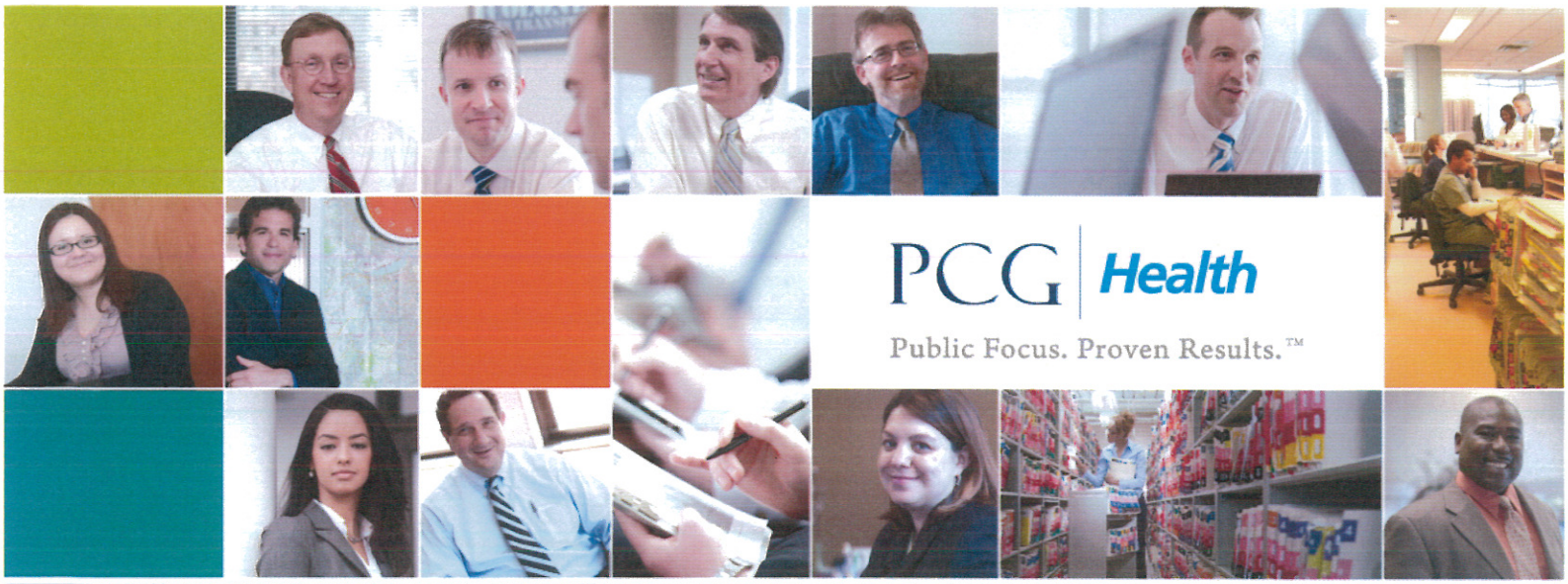
Alaska Department of Health and Social Services

Infrastructure Payment Memo

September 2012



I. Introduction

This memo examines Alaska DHSS's need to define how and what the Patient Centered Medical Home (PCMH) initiative will be funded. The memo provides an inventory of peer program experiences and how they funded the "start-up infrastructure" cost. PCG then provides observations, recommendations, and next steps. This memo is meant to provide context and experiences for DHSS staff to consider when defining how the PCMH will fund the pilot. Upon feedback from DHSS, PCG will develop a final budget methodology for the PCMH grant process and prescribed set amounts of infrastructure payments based on participation in the pilot.

II. Peer Program Infrastructure Payments

An environmental scan of peer program PCMH infrastructure payments to adopt a Medical Home initiative reveals multiple methods. In most cases fees are being covered through prospective payments or infrastructure grants. However, how they are being covered varies. In many of the projects, a prospective "care coordination" fee paid upon achievement of PCMH recognition is expected to cover the cost of recognition. This means that the practice will pay for the recognition and training up front, but will then be reimbursed upon implementation, once they achieve that recognition. This is usually paid through a PMPM fee. Other projects are asking the payers to provide a separate up-front infrastructure payment prior to PCMH recognition. This includes the recognition fee in addition to other items, such as technology and staff. Still others are paying the recognition fee up-front for the participating practices through a means other than the payers, such as by a grant or another participating stakeholder. The section that follows summarizes 4 PCMH pilots operating in New York, North Carolina, and Pennsylvania.

Adirondack Medical Home Pilot (AMHP)

The Adirondack Medical Home Pilot (AMHP) has brought together payors across the NY region to participate in the Medical Home initiative. The pilot term is over a five-year period from 2010 to 2014. Currently, the AMHP has completed a Readiness Assessment & Work Plan (January 2010), an E-Prescribing initiative (July 2010), and NCQA Recognition project (February 2011). The initial development investment for the initiative was broken down as follows:

- Project Development - ($500,000) Health Resources and Services Administration (HRSA) grant
- Regional Pod Capacities – ($3,000,000) MSSNY grant funds
- Electronic Connectivity – ($7,000,000) HEAL 10 grant funds
- Matching Commitments – ($8,000,000) Providers

Southeast Pennsylvania (SEPA) Chronic Care Management Reimbursement and Cost Reduction Commission (CCM)

In May 2007 the Chronic Care Management Reimbursement and Cost Reduction Commission (CCM) was established in Pennsylvania. The goal of the commission was to reduce the cost of chronic care conditions through a medical home model. The SEPA CCM was established through six payer organizations that agreed to support the initiative. The SEPA collaborative provides supplemental compensation defined by the terms of the participation agreement drafted by the Governor's Office of Health Care Reform. In addition to traditional service reimbursement from insurers and any ongoing pay-for-performance program administered by the individual insurer, the practices received the following from the SEPA collaborative; 1) "Infrastructure" payments in Year 1 to cover the cost of time away at the learning collaborative sessions, miscellaneous administrative expenses such as those related to registry implementation, and the costs of the NCQA application and submission fee, and 2) Supplemental payments based on level of NCQA recognition. Annualized payments were based on provider full-time equivalents, prorated by carrier and based on each carrier's proportional contribution to the practice's overall revenue. The payments are detailed in Table below[i].

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Table 1. Southeast Pennsylvania (SEPA) Rollout Practice Payments*

Year 1 Infrastructure†	Total
NCQA Survey Tool (one per practice)	$80
Registry Assistance (.25 FTE per practice)	$8,000
NCQA Application Fee (for clinician champion only)	$360
Recognition of Clinician Champion Participation in Learning Collaborative Sessions (7 days)‡	$11,655
	$20,095

NCQA PPC-PCMH Recognition§† Per FTE Physician or NP‖	Practice Size: 1 FTE MD/NP	Practice Size: 2–4 FTE MD/NP	Practice Size: 5–9 FTE MD/NP	Practice Size: 10–20 FTE MD/NP
Level 1 Recognition	$40,000	$36,000	$32,000	$28,000
Level 2 Recognition	$60,000	$54,000	$48,000	$42,000
Level 3 Recognition	$95,000	$85,500	$76,000	$66,500

* NCQA, National Committee for Quality Assurance; FTE, full-time equivalent; PPC-PCMH, Physician Practice Connections Patient-Centered Medical Home; NP, nurse practitioner; MD, physician.

† Prorated by carrier and based on each carrier's proportional contribution to the practice's overall revenue. On average, 70% of practice revenue was paid by one of the six participating payers (that is, on average, practices received 70% of these funds). This 70% average includes the seven pediatric practices that focused on pediatric asthma in the SEPA rollout. The pediatric practices generally had higher covered revenues than the practices focused initially on diabetes, which care for large Medicare populations. Traditional Medicare was not one of the participating payers.

‡ Paid following each quarterly learning session in Year 1, pending attendance at the learning session by the clinical champion. The other Year 1 infrastructure payments were included in the first quarterly payment.

§ Paid annually but prorated for recognition obtained after May each year. Fifteen of the 25 practices did not obtain NCQA PPC-PCMH recognition until the end of Year 1 (April 2008–May 2009) and thus received little or no recognition payments in Year 1. No practice obtained NCQA PPC-PCMH before September 2008.

‖ Recognition payments were based on FTE clinicians in each practice, excluding residents in residency practices. Mid-level providers (NPs, physician assistants) were not included in the FTE clinician count in physician practices. FTE NPs were counted for the nurse-managed community health centers.

New York Hudson Valley P4P/Medical Home Project

The New York Hudson Valley P4P/Medical Home Project provided an opportunity to receive up to $3M in payments through a NYSDOH P4P grant and matching Taconic Health Information Network and Community (THINC) RHIO payment. The THINC facilitates EHR implementation in offices practices of the Hudson Valley that interface with regional HIE. They use standardized measures to provide performance incentives from multiple payers. Financial incentives for private practice physicians who reach Level II of NCQA's PPC-PCMH standards are provided. The funding from THINC supplements physician EMR subscription fees to cover basic EMR costs (e.g., software, maintenance, implementation, training, etc.). The maximum bonus amount for the total pool of participating physicians was $3 million dollars. Incentive payments include two components; 1) process and outcomes measures derived from aggregated administrative data received from all health plans participating in the project (20%) and, 2) structural component determined by achieving Level 2 Medical Home recognition using the NCQA PPC-PCMH assessment tool (80%).

Community Care of North Carolina (CCNC)

The Community Care of North Carolina (CCNC) initiative helps patients link to a primary care medical homes in 1,500 PCP's available to 1.2 million individuals in all 100 North Carolina counties. The PCP's receive PMPM payments and additional resources to better manage populations. This includes local community partners (health systems, hospitals, health departments, DSS, LMEs, community organizations and service providers) engaged in network governance and collaborative initiatives. Payer and providers/networks identify opportunities and priority initiatives, pilot initiatives and spread best practices. CCNC pays a $3 PMPM and has been established since 2007. It is unclear if start-up costs were paid separately or baked into future PMPM payments.

III. Alaska PCMH Infrastructure Observations

Alaska DHSS must decide how to get the best value for the limited dollars available for the PCMH pilot. The state has indicated that up to $50,000 will be available for approximately 10 applicants. This funding will go to support a variety of activities including but not limited to training, service expansion, clinical time, electronic health records/information systems, and certification costs. Below is some detail on each of these items identified:

- Provider Training/Clinical Time Away from Patients – The cost of training will be dictated by the intensity and frequency. Pennsylvania's SEPA collaborative referenced a fee of $11,655 per 7 day training session with the Learning Collaborative Sessions. This accounted for the time lost of clinical leaders participating in PCMH training. Alaska

must define what training module the Alaska providers will be attending, how they will implement, when they will attend, and how they will document the results.

- New Services (not currently covered by Medicaid) – This is a policy issue that the Medicaid agency must grapple with. This will require benefit design and budget authority to add "new" services. Alaska will need to identify the expected utilization effects of adding services and cost out the impact.
- Electronic Health Records (EHR)/Information Systems (IS) Investment – Funding practice level EHR/IS improvements with no central strategy would create a disparate system of EHR/IS resources with little coordination. Alaska should develop a comprehensive strategy for utilizing health information and data analytics to support the PCMH initiatives. The Adirondack Medical Home Pilot (AMHP), Community Care of North Carolina, and New York Hudson Valley P4P/Medical Home Project all made significant investment in a centralized data strategy to support their PCMH initiatives and Alaska should consider the same.
- Certification Reward– Pennsylvania's SEPA collaborative practices were awarded over $8,000 each for NCQA certification support for year one infrastructure payments. A similar certification support payment should be made to the selected Alaska providers.

IV. Next Steps

Alaska DHSS should focus the available funding to a select group of providers for training and certification. A more comprehensive EHR strategy should be adopted that becomes the backbone of a successful PCMH project. Additional commitment and funding from payors is critical to the success of the pilot. Every successful PCMH initiative has identified significant support from both government and private payors. The addition of new services is a terrific policy goal to the extent that more funding becomes available, but it is an unlikely first step in designing and developing a successful medical home pilot in Alaska. The items below provide action items for each recommendation provided.

- Define the actual cost of provider training in Alaska. The published reasonable cost equivalents (RCEs) and Bureau of Labor Statistics data can help us develop a reasonable estimate of compensation for "time" spent training.
- Identify the cost of certification for potential PCMH grant recipients.
- Outline a strategy and funding sources to support an Electronic Health Record/Information System investments that support PCMH programs. Alaska can learn from experiences of pilots in NY, NC, and PA.
- Discuss future service additions that support improved prevention, wellness, and overall health improvement.

[i] Gabbay, Robert, Michael H. Bailit, David T. Mauger, Edward H. Wagner, and Linda Siminerio. "Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model." *The Joint Commission Journal on Quality and Patient Safety*. N.p., June 2011. Web. 19 Sept. 2012.