The American College of Physicians' Roadmap for Advancing Patient-Centered Care: Detailed Legislative and Regulatory Specifications and Options

As included in "A Report from America's Internists on the State of the Nation's Health Care", January 22, 2007

1. Implement and Expand the Medicare Demonstration Project on Patient Centered Medical Homes

- No later than January 1, 2008, CMS should implement the Medicare medical home demonstration project mandated by "The Tax Relief and Health Care Act of 2006" and work with the ACP and other medical organizations on the qualifications, reimbursement structure, and performance metrics for practices that participate in the demonstration project.

- Congress should expand the demonstration from eight states to a voluntary national demonstration project and specifically require that physicians in such practices be paid under a hybrid payment structure that would include risk-adjusted prospective and bundled payments for the physician work associated with care coordination; prospective bundled payments for the systems improvements required to provide patient-centered care; a fee-for-service component for face-to-face visits, and a performance-based component for reporting on evidence-based clinical, cost, and patient satisfaction measures of patient-centered care.

2. Revise the pay-for-reporting framework created by H.R. 6408 to support a systems-based approach to advancing patient-centered care.

- Create payment incentives to support *systems based approaches to improving performance*, tied to structural measures of systems and process improvements that have been demonstrated to enable practices to provide patient-centered care.
- Such pay-for-systems improvements would apply to practices that have not been paid on a prospective basis as a qualified patient-centered medical home.
- Medicare would create payment incentives to encourage physicians to acquire specific structural enhancements and tools that are directly related to care management in the ambulatory setting, such as patient registry systems, secure email, and evidence based clinical decision support, which can be measured and reported on. (That is, paying doctors for acquiring the systems needed to become medical homes).

- The Bridges to Excellence program, for instance, uses a scoring system that provides higher payments for having a fully functional EMR system than having a very basic registry system, and a similar scoring model, with tiered payments, could be used for Medicare.
    - Tier 1 – the reporting on evidence-based standards of care; the maintenance of patient registries for the purpose of identifying and following up with at-risk patients and provision of educational resources to patients;

- Tier 2 – the use of electronic systems to maintain patient records (EHRs); the use of clinical-decision support tools; the use of electronic orders for prescriptions and lab tests (e-prescribing), the use of patient reminders; use of e-consults (communication between patient/physician or other provider) when an identifiable medical service is provided; and managing patients with multiple chronic illnesses; [Practices can qualify that utilize three or more incentives].
- Tier 3 - whether a practice's electronic systems interconnect and whether they are "interoperable" with other systems; whether it uses nationally accepted medical code sets and whether it can automatically send, receive and integrate data such as lab results and medical histories from other organizations' systems.

- Such tiered payments for systems improvements could either be in the form of a tiered "add on" to the Medicare office visit payment that would increase as the practice achieves a higher tier, or in the form of a la carte coding and payment mechanisms to allow physicians to report when they use individual elements inherent to patient-centered care, such as use of a registry and use of clinical decision support. Congress should allocate funding to pay physicians when they appropriately use and report these tools and/or direct HHS to exempt the expenditures associated with these tools from the budget neutrality requirement pertaining to payments for Medicare Part B services.

- Congress should specify that "scoring" associated with systems improvements should take into account savings that result from providing practices with the capability to deliver patient-centered services that may reduce hospital admissions and other Medicare program costs and assure a sufficient timeframe (no less than five years) to demonstrate such cost savings.

- Pay physicians on a proportionately greater (weighted) basis based on the (1) impact of the structural or clinical interventions being measured on quality and cost of care and the ability of a practice to deliver patient-centered care (2) and the amount of work and practice expenses associated with reporting on a particular set of measures. This would replace the "one size fits all" approach that pays physicians the same "performance" bonus for reporting on as few as three measures without taking account the impact or practice expenses associated with the specific measures being reported by a given physician.

3. Enact legislation that would lead to elimination of the SGR and replace it with an alternative update framework that will:

- Assure stable and predictable baseline updates for all physicians.

- Set aside funds for a separate physicians' quality improvement pool that would allocate dollars to support voluntary, physician-initiated programs that have the greatest potential impact on improving quality and reducing costs, and allow for a portion of savings in other parts of Medicare (such as reduced hospital expenses under Part A) that are attributable to programs funded out of this pool to be allocated back to the physicians' quality improvement pool. Congress should direct that priority be given to those

applications for funding under the quality pool that are most likely to improve care quality and efficiency by accelerating and supporting the ability of physicians to organize care processes to deliver patient-centered services through a medical home. Priority would also be given to programs that address regional variations in quality and cost of care.

- Consider alternative volume controls only as a "back up" should the reforms proposed to support patient-centered care, improve the RBRVS, and support "high impact" quality improvement programs not achieve a desired level of quality and efficient use of resources.

4. Require that CMS develop and implement additional changes in Medicare payment methodologies to support patient-centered primary and principal care for (a) practices that qualify as patient-centered medical homes and (b) practices that are not fully qualified as PC-MHs but are able to provide defined services, supported by systems improvements, associated with patient-centered care.

- Physicians in practices that qualify as a patient-centered medical home would be given the option (based on standards to be established in statute) of participating in a national demonstration project, as described earlier under recommendation 1, Implementing and Expanding the Medicare Medical Home Demonstration Project. Physicians in such practices would receive a bundled, prospective care coordination fee for providing the key attributes required of the patient-centered medical home and having the necessary tools to deliver it, with reporting on quality measures built into the system. Such practices would also qualify for the bonus payments under the Medicare pay-for-reporting program. The legislation to expand the demonstration project would describe the benefit—what is meant by patient-centered care, the qualification process, and the new payment structure.

- For physicians who are not practicing in a qualified patient-centered medical home, Medicare should be directed to pay separately for the following CPT/HCPCS codes that involve coordinating patient care for which Medicare currently does not make separate payment.
    - Physician supervision of nurse-provided patient self-management education
    - Physician review of data stored and transmitted electronically, e.g. data from remote monitoring devices
    - Care plan oversight of patient outside the home health, hospice, and nursing facility setting—this is reported through CPT 99340, which is described in item #3, "Create a specific, new alternative and optional patient centered medical home benefit…"
    - Anticoagulant therapy management
    - New physician team conference codes
    - New telephone service codes (scheduled to appear in CPT in 2008)

- Direct HHS to develop or select a coding mechanism to allow physicians to report when they use individual elements inherent to patient-centered care—such as use of a registry

and use of clinical decision support—and make separate payment for these services. The coding mechanism to report use of these tools could take the form of a "modifier" that is appended to the code describing the specific service or procedure that the physician furnished to the patient. This approach is described further in item #1, "Modify the pay-for-reporting program enacted by the 109th Congress," Recommendation 2.

- Create an add-on payment to the Medicare office visit fee when supported by electronic health records that has the functionalities required to provide patient-centered medical care and to report on quality measures. As described under Recommendation 2, modify the pay-for-reporting program enacted by the 109th Congress, Congress could direct that HHS implement a tiered payment structure that would increase the add-on payment to the office visit for achieving higher levels of systems improvement.

6. Congress and CMS could expand federal waiver authority to allow states to obtain waivers to redesign Medicaid, S-CHIP, and Medicare and to expand access to the uninsured with changes that will allow enrollees to have direct access to services through patient-centered medical homes.

- Provide language on the S-CHIP re-authorization bill that would allow and encourage states to structure the benefit for qualified children so that they-- and in states that offer optional "buy in" coverage to their family members, their parents'--access to patient-centered medical home services with an appropriate payment structure to qualified physicians and incentives for S-CHIP recipients to receive care through the medical home; *AND*

- Enact legislation that allows states to seek Medicaid and Medicare waivers to also include specific language to seek waiver proposals for organizing services around the patient-centered medical home as its foundation, similar to what Louisiana has proposed and has been proposed by the Medicaid Commission.

- Specifically, the Medicaid Commission has recommended the following:

    - States should place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without needing to seek a waiver or any other form of federal approval.

    - At the same time, it is incumbent on states to ensure an adequate network of providers to fulfill the goals of moving all categories of beneficiaries into a medical home. The Commission defines a medical home as a source of primary health care that provides accessible, comprehensive, coordinated care. Care should be delivered or directed by well-trained physicians who provide primary care services and who manage and facilitate essentially all aspects of care. The primary health care provider should be made known to the beneficiary (and

family, where appropriate) and should be able to develop a partnership of mutual responsibility and trust with the beneficiary.[1]

7. Enact legislation to provide dedicated funds to support the ability of states to implement programs to expand health insurance coverage and drive systems improvements, such as was proposed in the bipartisan Health Partnership Act introduced in the 109th Congress. Legislation to grant such authority should include specific language to encourage states to submit applications for federal funding that would include access to patient-centered medical homes and the required changes in reimbursement policies to support PC-MHs.

8. Enact legislation that results in all Americans having access to affordable coverage by a defined date through a mix of public and private financing options, as proposed in the bipartisan Health Coverage, Accessibility, Responsibility, and Equity Act proposed in the 109th Congress. The bill includes: creation of an optional income-eligibility standard for Medicaid to replace categorical eligibility; improvements in the S-CHIP program, insurance market reforms, development of a core benefits package, and tax credits to enable low-income persons to buy into the Federal Employee Health Benefits Program.

[1] Medicaid Commission. Final Report and Recommendations. December 31, 2006. Accessed at http://www.aspe.hhs.gov/medicaid/122906rpt.pdf