

Achieving Medical Home recognition

Introduction

The purpose of this paper is to explain the programs that the National Committee for Quality Assurance (NCQA) and Bridges to Excellence (BTE) have initiated to recognize physician practices as “Medical Homes.” There are numerous models for Medical Homes with varying criteria; however, this paper focuses on these two active models as they are inter-related and the BTE model is one of the few that will compensate practices that meet the program’s criteria. The paper also includes background information on the concept behind the Medical Home and additional information about other NCQA and BTE recognition programs that are integral to the process of obtaining Medical Home recognition. The basic premise of the Medical Home concept is that personalized, coordinated and comprehensive patient care managed by a personal physician will lead to improved health outcomes and lower health care costs. The purpose of this paper is not to opine on the Medical Home but to educate physicians on the concepts behind the NCQA and BTE models.

AMA Policy on the Medical Home

The AMA has adopted the “Joint Principles of the Patient-Centered Medical Home,” which include guidelines for the coordination of care to improve the patient-physician relationship, quality and safety, access to care, and the payment model for coordinated services. The AMA, through its Initiative to Transform Medical Education (ITME), is working collaboratively with other organizations to bring substantive improvements to medical education across the continuum aimed at enhancing physician and health system performance. The Patient-Centered Medical Home model provides excellent opportunities for improving both patient care and teaching programs.

Joint Principles of the Patient-Centered Medical Home

The American Medical Association (AMA) voted to adopt the “Joint Principles of the Patient-Centered Medical Home” joining the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association in endorsing these principles:

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private

community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the Medical Home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the Medical Home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a Patient-Centered Medical Home.

The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

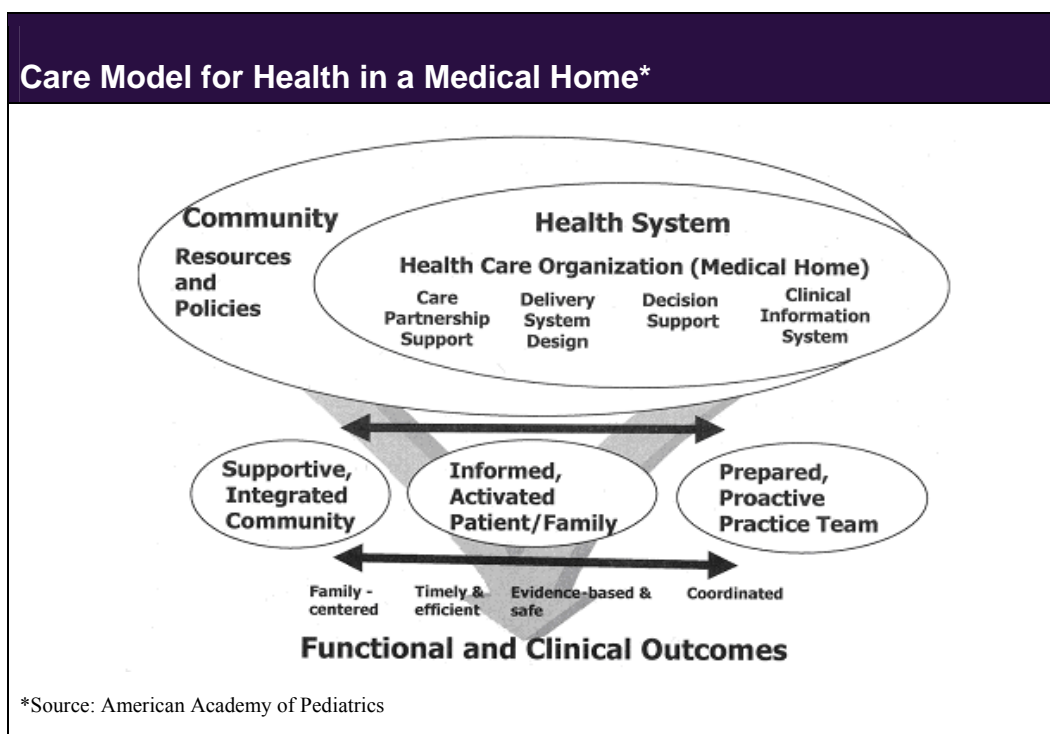
It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

There have been various Medical Home pilots, including the following:

- North Carolina's Medicaid program, Community Care of North Carolina (CCNC), demonstrates how physician-led primary care networks and Patient-Centered Medical Homes can improve health care quality and save costs. Since its inception in 1999, CCNC has grown to encompass 15 networks, 3,500 primary care physicians and 1,000 Medical Homes, which provide care for more than 750,000 Medicaid recipients. Since CCNC began, external accounting estimates that North Carolina Medicaid saved a half a billion dollars over what it would have otherwise spent. Under the program, the state pays physicians 95 percent of Medicare plus a \$3 per-member, per-month case management fee. The state also pays networks a \$3 per-member, per-month fee for care and disease management. The Patient-Centered Medical Home serves as a regular source of treatment, enabling primary care physicians to manage and coordinate patient care on an ongoing basis, which results in fewer ER visits and hospitalizations and reduces unnecessary medical costs. The North Carolina state legislature, in an attempt to capitalize on the success of the program, has mandated CCNC coverage for all of the state's aged, blind and disabled recipients, as well as, the recipients of the State Children's Health Insurance Program.

- The Tax Relief and Health Care Act of 2006 mandates the creation of a Medicare Medical Home Demonstration Project, which is scheduled to begin in 2010. The Centers for Medicare and Medicaid Services have announced the acceptance of the proposed description of services to be included within Medical Homes, as well as the monthly payment, developed based on recommendations of the AMA/Specialty Society RVS Update Committee (RUC). The RUC's Medical Home recommendations are available at www.ama-assn.org/go/medicalhome.
- Aetna and Partners in Care, Corp. have announced a pilot Patient-Centered Medical Home program, which will provide primary care physicians with reimbursement for the extra services they provide to coordinate the care of their patients.
- CIGNA and Dartmouth-Hitchcock have launched a Patient-Centered Medical Home pilot program that focuses on approximately 19,000 CIGNA members who access their health care from 391 Dartmouth-Hitchcock primary care physicians. The participating physicians will receive reimbursement for providing medical services and enhanced services, such as care management. Additionally, these physicians will be rewarded through a “pay for performance” structure for improving quality and decreasing health care costs.
- IBM and UnitedHealthcare have established a Medical Home initiative. The pilot will test the Medical Home model on small physician practices in Arizona. The consulting unit for the pilot, run by the American Academy of Family Physicians, will assist physicians with implementing practice re-design tools to improve care coordination, such as patient registries. A participating physician will receive a quarterly management fee and may be eligible for bonuses that could increase a physician’s overall revenue as much as 30 percent.



Background on NCQA and BTE

BTE is an employer-based, not-for-profit organization that incentivizes physicians to adopt better care processes in order to improve patient outcomes and decrease health care costs. NCQA is an accrediting organization that seeks to recognize health insurers, health care institutions, physicians and other health care providers for providing and measuring quality health care services. BTE uses the NCQA recognition programs as the eligibility criteria for physicians participating in many of BTE’s incentive programs, although BTE has other

programs that rely on organizations other than the NCQA. Before one can understand the NCQA and BTE Medical Home programs, it is first necessary to understand these recognition and incentive programs.

NCQA and BTE physician programs

Using evidence-based standards of care, physicians have the opportunity to structure their practices in a manner that can lead to certification in NCQA's physician recognition programs.

The NCQA programs include the following:

- Back Pain Recognition Program
- Diabetes Physician Recognition Program
- Heart/Stroke Recognition Program
- Physician Practice Connections

Once physicians receive certification in one of the NCQA physician recognition programs, they can qualify for BTE's corresponding incentive payment program. They are then eligible to receive incentive payments when they see a patient who is employed by one of the employers that fund these BTE programs. These incentive programs include the following:

- Spine Care Link
- Diabetes Care Link
- Cardiac Care Link
- Physician Office Link

It should be noted that other programs, such as the Hypertensive Care Link, rely on methods of performance assessment other than the NCQA's recognition programs and can be used to achieve BTE recognition.

The BTE incentive programs mirror the NCQA physician recognition programs (e.g., once physicians achieve certification in the Back Pain Recognition Program, they are eligible for BTE's Spine Care Link incentive program). The BTE programs each have three levels of program incentives that correspond to the three levels of NCQA's recognition programs. The following section of this paper provides a synopsis of the BTE physician incentive programs. Visit www.ama-assn.org/go/pfp to view a more comprehensive description of the programs in the AMA document, "Bridges to Excellence overview."

BTE physician incentive programs

Spine Care Link offers bonuses to physicians for improving the quality of care for patients with sub-acute or chronic back pain. Eligible physicians must demonstrate that they provide high levels of spine care by passing NCQA's Back Pain Recognition Program. This program requires physicians to submit data on 16 evidence-based criteria to NCQA. Physicians who demonstrate top performance in spine care can earn up to \$50 per year for each spine care patient covered by a BTE-participating employer and may become eligible for fee schedule updates.

Diabetes Care Link offers primary care physicians and endocrinologists the opportunity to earn bonuses for providing care to diabetic patients. Physicians qualify for participation in Diabetes Care Link by achieving certification in the Diabetes Physician Recognition Program, developed by the American Diabetes Association and NCQA. In order to receive Diabetes Physician Recognition Program certification, physicians' diabetic patients must meet certain outcome measures. Electronic data submission on eligible patients is required for Diabetes Physician Recognition Program certification. Physicians participating in Diabetes Care Link receive a year-end bonus of as much as \$100 for each diabetic patient covered by a BTE-participating employer.

Cardiac Care Link is offered to primary care physicians, cardiologists and neurologists for providing care to cardiac and stroke patients. Physicians qualify for participation in Cardiac Care Link by obtaining certification in the Heart Stroke Recognition Program, developed by the NCQA, the American Heart Association and the American Stroke Association. In order to receive Heart Stroke Recognition Program certification, a physician's patients with cardiovascular disease or stroke must meet certain outcome and process measure objectives. Qualified physicians are eligible for an annual bonus of as much as \$160 for each cardiac or stroke patient covered by a BTE-participating employer.

Physician Office Link offers bonuses to physicians for implementing the use of information technology and care coordination processes in their office practices. Physicians who receive a passing score on NCQA's Physician Practice Connections (PPC) program are eligible to receive a bonus from the Physician Office Link program for each patient covered by a BTE-participating employer. There are nine Physician Practice Connections modules: 1) access and communication; 2) patient tracking and registry functions; 3) care management; 4) self management support; 5) electronic prescribing; 6) test tracking; 7) referral tracking; 8) performance reporting and improvement and 9) interoperability. Qualified physicians can receive per-patient-per-year bonuses of as much as \$15 for level one to \$50 for level three. Physicians that have adopted an EMR system, certified by the Certification Commission for Health Information Technology, can also qualify for level two of the Physician Office Link, without having to complete the NCQA's PPC program.

Through December 2008, employers participating in BTE's programs have distributed about \$15 million in rewards to physicians across the country. In addition to these amounts, many health insurers have been paying incentives directly to physicians as part of their network arrangements.

The Medical Home programs

NCQA Medical Home

The NCQA's Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH) program recognizes primary care practices that function as Patient-Centered Medical Homes. The PPC-PCMH program is based on, but independent of, the Physician Practice Connection module of the NCQA's physician recognition programs. These two programs are similar in that they both have three different levels of recognition based on the physician's overall evaluation scores. However, the PPC-PCMH program requires more "must-pass" elements, contains different weighting systems and requires more advanced electronic communications standards than the Physician Practice Connections program. At this time, we are unaware of any additional or increased physician payments associated with NCQA's recognition or Medical Home (PPC-PCMH) programs. However, this could change as health insurers, employers and the government (all of which are seeking to pilot the Medical Home concept) may consider incentivizing physicians who achieve this recognition.

BTE Medical Home

BTE bases participation in its Medical Home program on a physician's status in the four BTE incentive programs. The physician must first achieve either level 2 or 3 in BTE's Physician Office Link program. Next, the physician is required to achieve level 2 or 3 in two of the other BTE incentive programs: Spine Care Link, Diabetes Care Link, Cardiac Care Link, Hypertensive Care Link, COPD Care Link, CHF Care Link and Asthma Care Link. When physicians meet these requirements, they are designated as a Medical Home by BTE and are eligible for additional compensation. Bonus payments for the BTE Medical Home recognition can be as much as \$150 per patient annually in addition to bonus payments already received for recognition in the BTE-component incentive programs that are used to designate the Medical Home.

BTE has recently been engaged by Capitol District Physicians' Health Plan (CDPHP), a plan in the Albany, New York area, to measure the quality of care in selected physician practices participating in a Medical Home pilot. The rewards are significant (up to \$50,000 per physician), but dependent on a comprehensive set of

quality measures that spans the gamut of all the BTE programs. This pilot is a variation on the Medical Home formula that BTE laid out; however, BTE views the CDPHP model as a very positive improvement and intends to expand that model with others.

Costs for physician participation

There are no direct physician costs associated with participation in the BTE incentive programs; however, physicians incur substantial fees to participate in the NCQA programs. The fee to gain recognition in NCQA programs is approximately \$450 per physician per program for up to six physicians in a practice. For practices with more than six physicians, the fee is capped at a total of \$2700 for the first 100 physicians. Additional fees are required to obtain survey tool licenses and to achieve higher levels of recognition within a program. Physicians who participate in the BTE programs through avenues other than the NCQA usually have lower or no costs associated with their participation.

Conclusions

The Medical Home as a building block for our health care system is a concept that is capturing the attention of leaders and experts throughout the medical community. There is little doubt that coordinated care equates to more efficient and higher quality care; yet, there is no unanimity on exactly what constitutes a Medical Home or how the Medical Home should be integrated into our health care system.

This paper examines the programs that NCQA and BTE created in order to identify examples of the Medical Home. Both NCQA and BTE use other existing programs to identify competency or excellence in specific endeavors of medical practice to serve as the foundation for the cumulative recognition of a Medical Home. It seems somewhat counterintuitive to use a system that recognizes relatively isolated and specialized endeavors to identify a Medical Home, which is ideally designed to succeed because of the magnified strength of the sum of its parts rather than areas of individualized or specialized success. Still, both the NCQA and BTE initiatives represent concrete programs that try to identify efforts to achieve the concept of the Medical Home, and the BTE program has even succeeded in devising a methodology to compensate physicians for these efforts. These programs warrant monitoring as they may serve as partial models for future Medical Homes or similar projects.

Questions or concerns about practice management issues?

AMA members and their practice staff can e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call (800) 621-8335 and ask for the AMA Practice Management Center.
- Fax information to (312) 464-5541.
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site.

The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.