

AMERICAN ACADEMY OF PEDIATRICS

The Medical Home for Children: Financing Principles

Prepared by the Committee on Child Health Financing
January 2012

INTRODUCTION

Major delivery and financing reforms in the public and private health insurance markets are spawning accelerated interest in an innovative model for the provision of comprehensive care for infants, children, and adolescents. Referred to as a “family- or patient-centered medical home,” this model of care incorporates expanded access and communication, improved coordination and integration of care, changes in administrative processes and quality oversight, active patient and family partnership, and linkages with community-based services. Its design and functionality is in alignment with the goals pronounced in the “Triple Aim”; mainly, improving the individual experience of care, improving the health of populations, and reducing per-capita costs of care.¹

Although the American Academy of Pediatrics (AAP) pioneered the medical home concept and has long supported the medical home model of care,² a vast majority of the medical home pilot and demonstration programs in place have focused on adults, with minimal representation from pediatricians. As a result, pediatric practices have not had the financial support of public and private payers to organize their practices to fully implement this model of care. Pediatric practices have long provided telephone and e-mail communication with patients and families, team care, extended time to manage the care of children with chronic and complex conditions, consultation and coordination with specialists and other services providers, opportunities for community engagement, and patient and family education and support.³

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Development of the medical home model requires the implementation and maintenance of new health information technology (HIT) and quality-improvement programs; particularly in response to the Health Information Technology for Economic and Clinical Health (HITECH) legislation designed to facilitate the adoption of HIT in public insurance programs. The HITECH act stipulates that, beginning in 2011, healthcare providers will be offered financial incentives for demonstrating meaningful use of electronic health records (EHR). Incentives will be offered until 2015, after which time penalties may be levied for failing to demonstrate such use. Also, compensation mechanisms for all of these services need to be addressed to enable pediatricians to provide and sustain the level of care called for in the medical home model.

The American Academy of Family Physicians, the American College of Physicians, the American Osteopathic Association, and the AAP jointly published a set of patient-centered medical home principles.⁴ These principles call for care that is overseen by a personal physician and that involves a team of health professionals at the practice level. Also recommended is care that is coordinated and integrated through information technology and registries, care that actively involves and supports children and their families, care that is guided by evidence-based and -informed medicine and supported by clinical decision-support tools, and care with expanded hours and open access. Further, the principles call for a new payment structure that promotes the value of primary care and recognizes the additional physician and non-physician staff time required to implement the medical home model, along with the infrastructure support necessary to ensure its start-up and sustainability.

The principles encompassed in this document are divided into 4 sections. The first section reviews the guiding principles for family- and patient-centered medical home payment reforms recommended by the AAP. The second section describes the elements of the implementation

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strategy called for by the National Committee for Quality Assurance (NCQA) and other organizations that have developed medical home recognition programs. The third section presents specific payment strategies to support the pediatric medical home, and the fourth section outlines a set of recommendations to improve system-wide financing of pediatric services delivered in the medical home. This is intended as a discussion piece to enable AAP members to participate and comment on the formulation of major new financing policy recommendations at the federal, state, and health plan levels.

Principles Guiding the Family- and Patient-Centered Medical Home Payment Reforms

Recommended by the AAP

1. Medical home payment reforms should benefit all children, not only those with special health needs, and should apply to all public and private payers.
2. Payments should be set at a level that provides a realistic incentive for pediatric practices to initiate and sustain practice redesign in order to provide the clinical and care coordination work⁵ associated with the medical home model.
3. Prevailing inequities in the current resource-based relative value scale (RBRVS)-based fee-for-service payment environment continue to put primary care physicians at a serious disadvantage. The RBRVS should be reassessed, taking into account the complex and comprehensive nature of cognitive work and practice expenses incurred by primary care physicians and nonprocedural-oriented medical subspecialists who offer the medical home model of care. The realities of caring for the increasing number of children with chronic diseases (eg, obesity, asthma, diabetes, mental health problems) in the primary care setting and the significant amount of time and effort required to manage their care trigger the need for public and private payers to increase the payment for cognitive

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services. A major influence on an individual's life course begins with early childhood experiences. Significant investments in ensuring and promoting the health and welfare of infants have a direct effect on ensuring their role as productive and engaged parents and workers.

4. Essential medical home services, including care management, preventive counseling, patient and family education, telephone and e-mail communication, health information infrastructure needs, new technologies to facilitate home monitoring of patients, and access to appropriate medical subspecialty consultation, should be adequately compensated.
5. Payment must be sufficient to enable pediatric primary and medical subspecialty care practices to support the services of a comprehensive care team, which may include nurses, care coordinators, mental health professionals, social workers, psychologists, dietitians, pharmacists, and administrative professionals.
6. Financing mechanisms must be developed to allow pediatricians to be paid prospectively to acquire and maintain necessary health information technology and other practice infrastructure supports, including after-hours phone triage services, care coordinators, etc. Adoption of electronic health records and other health information technology requires initial software and hardware equipment, consultation or active and ongoing participation of on-site or readily available information technology specialists, education and training of staff, administrative upgrades (eg, new fax servers, hands-free headsets, etc), and engagement of specialists in fostering systems designed to project the health care needs of populations and children with complex conditions.

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7. Quality-improvement and performance systems should be designed by pediatricians to recognize and reward practices for achieving improvement in clinical areas of most significance to children's health. Pediatric performance measures should be developed that take into account risk adjustment methodologies that incorporates severity of illness and comorbidities and nonmedical risk factors that affect health outcomes.
8. Medical home payments should be risk-adjusted to reflect differences in the complexity of patients and their families and the severity of their conditions. Adult-driven risk-adjustment methodologies should not be used for pediatric patients. Rather, private and public payers should commit to the development, testing, and implementation of a risk-adjustment methodology designed for pediatric patients. For example, methodologies designed for adults with chronic obstructive pulmonary disease are not appropriate for use in children with cystic fibrosis. These are 2 distinctly different conditions requiring alternative approaches to risk adjustment.
9. An ongoing process for evaluating and updating payment models as well as quality performance and overall effectiveness should be built into medical home payment reforms from the outset. Quality-performance measures used to evaluate medical home improvement should be evidence-driven and based on the principles for quality measurement of the AAP.⁶

Patient-Centered Medical Home Recognition Programs

The marketplace's increased interest in the value of the medical home approach has contributed to a growth in the number of organizations developing programs designed to certify or recognize primary care practices that undergo systematic change on the basis of the principles of the medical home. The first, and often viewed as the dominant player in this area, is the

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NCQA. It has created a set of standards to measure and recognize practices that have implemented specific medical home functions. Derived from the conceptual frameworks of the chronic care model⁷ and from the Institute of Medicine report *Crossing the Quality Chasm*,⁸ this tool, titled “Patient-Centered Medical Home Recognition Program,” is organized according to 6 standards: enhance access and continuity, identify and manage patient populations, plan and manage care, provide self-care support and community resources, track and coordinate care, and measure and improve performance.⁹ Presumably, medical practices that achieve standard levels of sophistication in medical home delivery competency will then receive practice payments that are aligned with the competency scoring levels.

Although the NCQA medical home quality and payment standards are increasingly being adopted by public and private payers, they are not the only approach for evaluating the performance of a family- and patient-centered medical home and supporting opportunities to appropriately pay pediatric practices offering a medical home standard of care. Other organizations that have recognition programs include The Joint Commission (TJC), URAC (formerly the Utilization Review Accreditation Commission), and Accreditation Association for Ambulatory Health Care (AAAHC). In February 2011, the authoring organizations of the original “Joint Principles on the Patient-Centered Medical Home” published *Guidelines for Patient-Centered Medical Homes Recognition and Accreditation Programs*. The guidelines establish a set of 13 principles that should define the characteristics of these programs.¹⁰

Payment Strategies to Support the Medical Home

Payment to support medical home innovations should include up-front or start-up funding for practices that are not part of larger organized systems and that do not have the necessary infrastructure to implement the primary elements of the medical home standard. Practices will

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incur additional significant infrastructure and staffing costs associated with the development and maintenance of practice management information and electronic health record systems, expanded physician and non-physician time for care coordination, and potential financial compromise associated with the loss of income attributable to less acute care and more chronic care. There also will be a need to provide staff training to accelerate familiarity with and adoption of the model. Provision of an up-front practice payment or other investment strategies in the form of subsidies, favorable loans, grants, or other financial incentives will facilitate the upgrade of pediatric practices and enable them to participate in providing a family- and patient-centered medical home. These efforts all contribute to a strong and solid demonstration of the value these approaches deliver in reducing the overall cost of care.

The medical home payment method should have 3 fee structures¹¹:

1. *Encounter-based fee* component that recognizes and values evaluative/cognitive services, preventive counseling, telephone and e-mail communication, collaborative consultation, and team care, as defined by *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes. These items should be paid as fee-for-service or integrated into enhanced capitation payments.
2. A standardized community-based *care coordination fee*, which recognizes the work of clinical and administrative staff members who provide medical home services. Payment for these services should be as a per-member, per-month fee, with adjustments based on the complexity of the patient panel and the annual change in the regional cost of living (COL) index.
3. A *performance (pay-for-performance fee)* or *quality improvement fee* earned for evidence-based or evidence-informed process, structure, or outcome measures. Payment

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should be earned as a bonus on the basis of achieving predetermined goals and paid on a per-member, per-month basis.

Shared savings should also be explored, given their role in incentivizing care coordination and team-based care.

Importantly, most medical home services can now be reported with CPT codes that reflect physician and non-physician work. However, payment policies by public and private payers to support these codes continue to be an ongoing challenge. Overall, the fee-for-service system is proving to be an inadequate mechanism for funding to support the core elements of the family-centered medical home. Other sources of payment will be needed to supplement the costs of implementing the medical home model and ensuring its financial and organizational success. Fair and adequate payment for medical home services will be essential.

RECOMMENDATIONS

The AAP calls for a partnership among private and public payers, employers, physicians, and families and patients to ensure that medical homes for the pediatric population are implemented in a way that ensures and sustains quality, financial success, and equity among all payers.

1. New payment and delivery reforms should be based on the medical home principles adopted jointly by the AAP, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association.
2. All private and public payers should adopt a comprehensive set of payment reforms to support the family- and patient-centered medical home for children. This includes investments in research to study the risks and benefits of using bundled payment mechanisms and capitated strategies to pay for pediatric care. The payment structure

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- should encompass recognition of relevant CPT and HCPCS codes based on their relative value units (RVUs); the complexity of the patient panel of the physician or practice, including the implementation of a sound and reliable pediatric risk-adjustment mechanism; expanded care management responsibilities; after-hours accessibility; new quality-improvement activities; and up-front investments and support for infrastructure.
3. The federal Center for Medicare and Medicaid Innovation should commit resources to develop, test, and implement comprehensive pediatric-specific delivery systems with specific attention to payment methodologies, including Accountable Care Organizations (ACOs), physician provider groups aligned with and without hospitals, etc.
 4. The Centers for Medicare and Medicaid Services (CMS) should update the RBRVS to take into account the value of the complex and comprehensive nature of cognitive care and practice expenses associated with the medical home model of care, provide health information technology support, and create incentives for continuous quality improvement.
 5. CMS should direct state Medicaid programs to recognize and incentivize essential medical home services. Strong consideration should be given to value-based payment systems that reward quality medical outcomes and reductions in cost of care.

CONCLUSION

The AAP believes that the family- and patient-centered medical home model is an essential component of a health care delivery system that will contribute marked improvements in access and continuity, family-centered and culturally competent care, integration and coordination of care, quality of care, family and patient satisfaction, and cost-effectiveness. To optimize the value outcomes of the US health care system with respect to child health, it is

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critical to design and implement strategies that will integrate the family- and patient-centered medical home model as the foundation of the reformed health care delivery system. Primary care physicians are absolutely essential in achieving the goal of health care cost reduction coupled with enhanced medical outcomes. Implementing these payment reforms is critically important for pediatricians to offer a comprehensive medical home for all children in the United States.

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