

# American Academy of Pediatrics

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## THE MEDICAL HOME FOR CHILDREN: FINANCING PRINCIPLES

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American Academy of Pediatrics Committee on Child Health Financing

### Introduction

Major delivery and financing reforms are needed in public and private health insurance to support a new model for the provision of comprehensive care for infants, children, and adolescents. Referred to as a “Family- or Patient-Centered Medical Home,” this evolving 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 involvement, and linkages with community-based services.

Although the American Academy of Pediatrics (AAP) pioneered the medical home concept and has long supported the medical home model of care,<sup>1</sup> 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 provide 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, and patient and family education and support. These efforts also require the implementation and maintenance of new health information technology and quality improvement programs. Compensation mechanisms for all of these services need to be addressed to enable pediatric practices 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, and the American Osteopathic Association, and the AAP jointly published a set of patient-centered medical home principles.<sup>2</sup> These principles call for care that is coordinated 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 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 nonphysician staff time required to implement the medical home model, along with the infrastructure support necessary to ensure its start-up and sustainability.

This set of principles is organized 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 strategy called for by the National Committee for Quality Assurance (NCQA) and endorsed by the AAP. The third section presents specific payment strategies to support the pediatric medical home, and the fourth section describes specific system-wide financing recommendations. 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 apply to all children, not only those with special health needs, and to all public and private payers.
2. Payments should be at levels that represent an incentive for pediatric primary and specialty practices to initiate and sustain practice redesign and provide the clinical and care coordination work<sup>3</sup> associated with the medical home model.
3. Cognitive services should be assigned an even greater value through the resource-based relative value scale (RBRVS), taking into account the complex and comprehensive nature of cognitive work and practice expenses provided by primary care physicians who offer the medical home model of care.
4. Essential medical home services, including care management, preventive counseling, patient and family education, telephone and e-mail communication, and specialty consultation, should be adequately compensated.
5. Payment must be sufficient to enable pediatric primary and specialty care practices to support the services of a care team, which

may include additional support from nurses, mental health professionals, dietitians, and administrative professionals.

6. Pediatric practices should be paid prospectively to acquire and maintain needed health information technology and other practice infrastructure supports, including after-hours phone triage services. Adoption of electronic health records and other health information technology requires initial software and hardware, consultation or active participation of on-site information technology specialists, education and training of staff, administrative upgrades, and population and diagnosis-based planning.
7. Quality improvement and performance systems should be identified and rewarded on an ongoing basis.
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.
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.<sup>4</sup>

#### NCQA Physician Practice Connections and Patient-Centered Medical Home

The NCQA, with endorsement from the AAP and other medical organizations and payers, has adopted 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 model<sup>5</sup> and from the Institute of Medicine report *Crossing the Quality Chasm*,<sup>6</sup> this tool, titled “Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH),” is organized according to 9 standards: access and communication, patient tracking and registry functions, care management, patient self-management, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications.<sup>7</sup> One can receive 100 points for perfect performance on the 9 standards. Three levels of recognition are included: level 1 totaling 25-49 points, level 2 totaling 50–74 points, and level 3 totaling 75-100 points. Payment amounts would be aligned with scoring levels. Although the NCQA medical home quality and payment standards are increasingly being adopted by public and private payers, they should not be the only approach for evaluating and reimbursing practices offering a medical home standard of care.

### Payment Strategies to Support the Medical Home

Payment to support medical home innovations should include up-front start-up funding for practices that are not part of larger organized systems and that do not have the necessary infrastructure to implement the medical home standards of the NCQA. Practices will 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 nonphysician time for care coordination, and marked changes associated with the loss of income attributable to less acute care and more chronic care. There also will be a need to provide training to accelerate familiarity and adoption of the model. Provision of an up-front structural practice payment or other investment strategies in the form of subsidies, favorable loans, grants, or other financial incentives will enable pediatric practices to participate in providing a family- and patient-centered medical home.

The medical home payment method should have 3 fee structures:

1. A *contact- or visit-based fee* component that recognizes and values evaluative/cognitive services and also preventive counseling, telephone and e-mail communication, consultation, and team care, as defined by *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and paid on a fee-for-service or capitated basis.
2. A *care management fee* to cover physician and nonphysician clinical and administrative staff work linked to the delivery of medical home services and paid as a per-member per-month fee, with adjustments based on the complexity of the patient mix.
3. A *performance or pay-for-performance fee* for evidence-based process, structure, or outcome measures and paid as a bonus, either on a per-member per-month basis or as a fee schedule increase.

Importantly, as of 2008, most medical home services can now be reported with CPT codes that reflect physician and nonphysician 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 a necessary but not sufficient source of funding for the medical home. Other sources of payment will be needed to supplement the costs of implementing the medical home model and to ensure its financial and organizational success. Continued efforts to obtain fair payment for medical home services will be essential.

### Recommendations

The AAP calls for a partnership among private and public payers, employers, clinicians, and families and patients to ensure that medical homes for the pediatric population are implemented in a way that ensures quality, financial sustainability, and equity among 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. The payment structure 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, expanded care management responsibilities, after-hours accessibility, new quality-improvement activities, and up-front investments and support for infrastructure.
3. Congress should enact legislation to establish a Medicaid Payment Advisory Committee that could work with the Secretary of the Department of Health and Human Services to implement and evaluate large-scale Medicaid medical home pilot projects for children. It should also support an all-payer pilot project of the medical home model for infants, children, and adolescents.
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 require state Medicaid agencies to recognize and incentivize essential medical home services.

### Conclusion

The AAP believes that the family- and patient-centered medical home will achieve 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. Implementing these payment reforms is critically important for pediatric practices to offer a comprehensive medical home for all children in the United States.

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<sup>1</sup> American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110(1):184-186

<sup>2</sup> American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. *Joint Principles of the Patient-Centered*

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*Medical Home*. Elk Grove Village, IL: American Academy of Pediatrics; 2007. Available at: <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>. Accessed December 10, 2008

<sup>3</sup> American Academy of Pediatrics, Council on Children With Disabilities. Care coordination in the medical home: integrating health and related systems of care for children with special health care needs. *Pediatrics*. 2005;116(5):1238-1244

<sup>4</sup> American Academy of Pediatrics, Steering Committee on Quality Improvement and Management and Committee on Practice and Ambulatory Medicine. Principles for the development and use of quality measures. *Pediatrics*. 2008;121(2):411-418

<sup>5</sup> Wagner EH. Chronic disease management: what will it take to improve care for chronic illness. *Effective Clinical Practice*. 1998;1:2-4

<sup>6</sup> Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington, DC: National Academies Press; 2001

<sup>7</sup> National Committee for Quality Assurance. *Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH)*. Washington, DC: National Committee for Quality Assurance; 2008