

MEDICAL HOME DEMONSTRATION

Fact Sheet

January 9, 2009

Background

- Section 204 of the Tax Relief and Health Care Act of 2006 requires the Secretary to establish a demonstration "...to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high need populations..."
- 3-year demonstration providing reimbursement in the form of a care management fee to physician practices for the services of a "personal physician." The legislation directs CMS to use the relative values scale update committee (RUC) process to establish the care management fee codes for care management fees.
- "High need" patients include those with prolonged or chronic illnesses that require regular medical monitoring, advising, or treatment.

Demonstration Design

- Mathematica Policy Research (MPR), under a contract with CMS, prepared option papers pertaining to defining a medical home and patient eligibility, among other topics.
- We have shared these papers with the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Osteopathic Association, the American Medical Association, The American Geriatrics Society, and others. Their comments indicated a general agreement with the options presented in the papers.
- The option papers were used to develop a draft demonstration design paper which has now been posted to the Medical Home Demonstration web page on the CMS web site.
- The Medicare Medical Home Demonstration design was presented in a Special Open Door Forum on October 28, 2008.

Physician Eligibility

- Physician practices
 - Includes family practice, internal medicine, geriatrics, general practice, specialty and sub-specialty practices (except where specifically excluded).
 - Excluded specialties and subspecialties include radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, chiropractic, psychiatry, and surgery.

Definition of Medical Home

- Two-tier medical home model with increasing levels of capability
 - Achieving medical home status at either of the tiers represents an expectation that the practice has the capability and the intention to provide a certain level of care management and coordination services to patients in the demonstration.
 - Six general domains and up to 28 specific core capabilities.
- Tier I or “typical” medical home must have 17 basic medical home capabilities, such as:
 - Uses health assessment plan
 - Uses integrated care plan
 - Tracks tests and provider follow-up
 - Reviews all medications
 - Tracks referrals
- Tier II or “enhanced” medical home must meet Tier I requirements plus 4 additional capabilities (electronic medical record, coordination of care including follow-up of inpatient and outpatient care, Measures of Performance, and Reporting to Physicians).
- Practices will qualify for medical home status on the basis of documentation submitted using the Physicians Practice Connections Patient-Centered Medical Home, CMS version (developed and owned by NCQA), modified as necessary for the Medicare demonstration.
 - NCQA has licensed the instrument to CMS without cost for use in the demonstration, including instructions for submission.
 - The completed instrument can be submitted electronically or on paper.
- Practices that qualify for Tier I may later move up to Tier II by submitting documentation of their additional qualifications.

Patient Eligibility

- Coverage eligibility
 - Medicare Part A & B, fee-for-service
 - Medicare as primary coverage
- Disease eligibility
 - Eligible beneficiaries must have at least one qualifying chronic disease
- Other eligibility
 - Patients who enter nursing home while participating in demonstration (as long as the patient continues to receive primary care services from the medical home)
 - Patients who “recover” from a qualifying chronic condition while participating in medical home

- Exclusions
 - Enrolled in a Medicare Advantage Plan
 - Current hospice patients
 - Current nursing home patients
 - Participating in other Medicare demonstrations
 - Treatment for End Stage Renal Disease (ESRD)

Monthly Medical Home Fees

- Valuation of a monthly care management fee for medical home services by the Relative Value Scale Update Committee (RUC)
 - RUC has provided CMS with its recommendations for the Relative Value Units (RVUs) for the care management fee.

MEDICAL HOME DEMONSTRATION PER PATIENT PER MONTH PAYMENT RATES, OVERALL AND BY PATIENT HCC SCORE

Medical Home Tier	Per Member Per Month Payments	Patients with HCC Score <1.6	Patients with HCC Score ≥ 1.6
Tier 1	\$40.40	\$27.12	\$80.25
Tier 2	\$51.70	\$35.48	\$100.35

- Fees are adjusted using the Hierarchal Condition Code (HCC) scores to reflect severity and burden to the physician.
- HCC scores ≤ 1.6 represent beneficiaries who are less ill and require less physician effort to manage. Those with scores ≥ 1.6 are considered more ill and require more physician effort to manage the patient.

Site Selection Criteria

- Section 204 of the Tax Relief and Health Care Act of 2006 specifies that the Medical Home Demonstration will be conducted in no more than 8 states or portions of states. Locations are to include urban, rural and underserved areas.
- CMS anticipates soliciting 50 practices in each of 8 sites for a total of 400 practices.
- CMS will choose sites that will provide good geographic distribution across the country
- CMS will choose sites that do not have other CMS demonstration projects in which contamination of comparison groups could occur.
- Sites must have a sufficiently large Medicare fee-for-service population with both Part A and Part B coverage and not enrolled in Medicare Advantage.

- Sites must provide a sufficient physician-based practice pool from which to recruit 400 practices.
- CMS expects to include 2,000 physicians from all practices participating in the demonstration.
- CMS would prefer sites that are high Medicare cost areas because there is greater potential for better care management of chronically ill beneficiaries to produce savings.
- CMS would prefer sites that have private payer Medical Home demonstrations occurring as it is expected to help in recruiting physician practices.

Site Selection

We expect to announce site selection immediately following approval to conduct the demonstration. We anticipate the demonstration will be implemented in all or parts of 8 States.

Implementation Schedule

- CMS has contracted with Thomson/Reuters (Healthcare) Inc. to assist in implementing the recruitment, application, qualification, and patient enrollment activities.
- CMS will begin soliciting practices to participate in the demonstration immediately following approval to conduct the demonstration.
- Applications from interested practices will be accepted for at least a 3-month period.
- Eligible practices will be notified to submit their qualification (recognition) survey and documentation and be evaluated as Medical Homes between by NCQA following the application period. Applicants will be notified of their evaluation status immediately following the Medical Home qualification review.
- Practices can begin enrolling qualified beneficiaries and submit Acceptance/Agreement forms immediately upon being qualified as a Medical Home.
- Payment of the monthly Medical Home fee to qualified practices is expected to begin January 2010 and continue through December 2012.

Payment Process

- CMS has contracted with Palmetto Government Benefits Administrator (Palmetto GBA) to make monthly payments for each eligible beneficiary who as been enrolled in the Demonstration by the practice and for whom they have agreed to provide their Medical Home care. This payment is made automatically each month in addition to those

payments made for any covered Medicare services the beneficiary receives during that time.

- Palmetto GBA will verify beneficiary eligibility each month prior to making payments. Beneficiaries who choose not to participate, or become ineligible due to changes in coverage or death will be deleted from their Medical Home's patient roster. Adjustments will be made for all monthly payments made to practices while the beneficiary was not eligible.