Issue Brief #2 – Financing new services and activities

The Innovation Plan proposes a wide array of primary care related services and activities without specifying a funding mechanism. Such services and activities are described in the context of the practices that adopt the Advanced Medical Home model, but it is also envisioned that they would be adopted by other primary care centered groups and systems.

Unfunded services include those provided by members of future, more diverse care teams such as pharmacists, nutritionists, patient navigators, and health coaches. Some of these services are among those provided by community health workers, others could be provided by licensed or certified health professionals. This category also includes diabetes prevention, asthma home environment assessments, and falls prevention services, which some practices could access through Prevention Service Centers.

There are also a variety of activities for which no funding mechanism is identified. These include telemedicine activities such as MD/consumer e-visits or MD to MD e-consults[1], non-billable interactions with patients through secure e-mail or by phone, or time spent by physicians who are case conferencing on high risk patients or supervising the activities of the care team.

For the test grant, it is essential that we describe how financing for these services will occur, whether funded by providers, fully insured health plans, self-funded employers, grants, or the state.

Care Coordination

Care coordination is not on the above list because there are mechanisms in place that many payers use to support practice-based care coordination. Many health plans and Medicaid provide advance payments (or enhanced payments) to providers that meet their requirements so that the provider has the funds to hire and provide the services of a care coordinator. Advance payments are typically monthly (PMPM) or quarterly payments (PMPQ) paid for each member attributed to a practice. If these providers are enrolled in a shared savings program, health plans may net out these advance payments before sharing any savings. Such costs may also be passed on to employers.

Some larger providers elect to pay for care coordination services "out of pocket" given the administrative burden associated with receiving and tracking advance payments. This option is only within the reach of larger, better capitalized health systems. It is not an option easily undertaken by small to mid-size practices or even many Independent Practice Associations (IPAs). In addition, some health plans would also like to avoid the administrative burden of managing advance payments. Medicare does not provide advance payments in most of its ACO arrangements including those in Connecticut. Medicare does provide advance payments in its Comprehensive Primary Care initiative because this initiative focuses on geographic groups of independent practices that are unaffiliated with larger systems.

Note that not all of Connecticut's commercial payers have committed to advance payments, nor has Medicare.

[1] E-mail consultation may be part of the services delivered today within several health plans.

Employers report that the services of care coordinators, pharmacists, nutritionists, patient navigators, and health coaches are all supposed to be services that are available through payment of a care management fee by the employer to the health plan or to a specialized third party vendor. To the extent that this is the case, there should be funds available for the health plan to pass through to qualified providers to assume these responsibilities. It such cases, it also may not be appropriate to net such expenses out of the shared savings.

Options

How can we establish a multi-payer funding strategy for supporting, over time, the expansion of teams and activities that are consistent with the core elements of our AMH model? It is important that we articulate a strategy for our test grant if, e.g., the participation of community health workers is going to be credible and sustainable.

In the next meeting of the Steering Committee on March 24th, we would like to solicit ideas that we can further explore in preparation for our meeting on April 24th.

For example:

a) Align payers around a standard advanced payment model. Adjust the advanced payment amounts for providers that demonstrate readiness to undertake new services or changes in practice. Focus on certain core capabilities each year (e.g., e-consult, health coach, or pharmacist to do medication therapy management). Offer Learning Collaboratives that focus specifically on these value-added capabilities.

b) Modification of a) above. Payers provide the adjusted advance payments for a time-limited period, e.g., one year or 18 months, with the understanding that shared savings payments will ultimately replace advance payments. Under this scenario, if the new services or activities do not generate sustainable value (i.e., savings), the advance payment enhancement would cease and so would the new service or activity.

c) Variation on a) and b). Allocate test grant funds as a source for the advance payment enhancement for a time-limited period, e.g., one year or 18 months. Con – reduces funds available for core practice transformation and HIT activities.

d) Convert unfunded services and activities to fee-for-service for those providers that are in a shared savings payment arrangement. Accountability for total cost will lead such providers to carefully target these new services and activities in a way that adds value. Con – promise of shared savings may not be enough to motivate providers to limit the services to those who will benefit, i.e., where the evidence supports better quality and outcomes. Difficult to discontinue.

e) Other?