Achieving medical home recognition using the NCQA PPC-PCMH tool www.ncqa.org positions your practice for improved payment under developing pilots and policies. These changes are occurring in real time along with other medical home-related reforms. Using this "Building Your Medical Home" toolkit to assess practice level of "medical homeness", to build necessary improvements, and to be equipped to show your "portfolio" of quality care processes and structures will help you to *advocate* and *negotiate* with health plans and state Medicaid programs for these enhanced payments.

Advocacy refers to influencing policies and practices on behalf of an issue vital to your practice (e.g. being included in a pilot and/or getting paid for providing excellent, comprehensive primary care). ***Negotiation*** is a critical activity and involves using your skills to craft payment outcomes for your practice that will mutually satisfy your patients, fellow providers, and payers.

Pediatric Councils

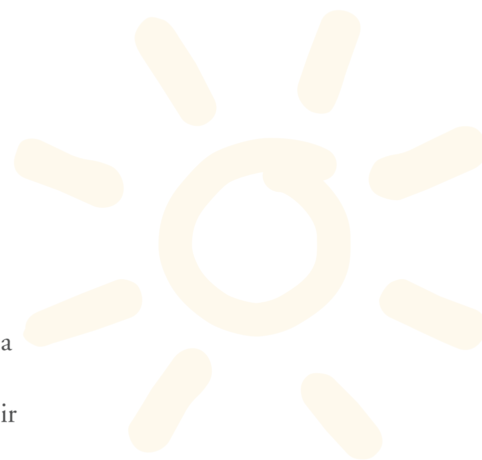
Appropriate reimbursement for medical home continues to be an issue for pediatricians. Public and private payors may not be fully aware of the impact of plan design on pediatric services, especially on access to appropriate, quality care and reimbursement. In order to address these concerns, several American Academy of Pediatrics (AAP) Chapters have developed Pediatric Councils. Pediatric Councils serve as forums for pediatricians to address their concerns with payers about covered services, plan policies, and administrative procedures, which impact access, quality, efficiency of treatment and reimbursement. There are currently 41 Pediatric Councils, for more information log-in to the AAP Member Center and go to: http://www.aap.org/moc/reimburse/pedcouncil/default.htm Contact your local Chapter Pediatric Council to leverage your individual advocacy and negotiation initiatives.

Medical Home payment reform includes a "hybrid" approach, blending four strands of enhanced reimbursement:

- A prospective per member per month payment (PMPM)
- Traditional fee-for-service payments (FFS)
- Payment for infrastructure changes
- Payment for quality or performance

Per member per month payments (PMPM)

PMPM rates range from about \$3-\$4/per member per month to higher prospective payments (e.g. \$15-\$25 PMPM when developed as part of a pilot or special contract to provide comprehensive care for patients with more complex conditions). This enhanced PMPM payment is necessary to fund the time-consuming, but critically important care coordination activities for children and youth with special health care needs, as well as other medical home practice activities.



A standard level of practice performance is required as a prerequisite for participation in a public or private payer pilot or medical home initiative. Standards are set at a plan, regional or state level. Both private health plans and state Medicaid programs choose their medical home practice eligibility criteria; many are using the NCQA PPC-Patient Centered Medical Home Standards www.ncqa.org

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Fee for Service (FFS) Payment

FFS refers to the traditional, continuing, but *insufficient* method by which most clinicians are paid. Fee for service takes into account the nature, amount, place and type of service provided. Face to face encounters typically make up the currency of fee for service; however there are new developments related to payment codes for key medical home activities. These promising changes relate to the patient and family-centered medical home and include frequently provided: a) non face-to-face care b) team care, and c) appropriate practice utilization of already existing fee for service codes. You will need to *advocate/negotiate* to achieve payment for the codes listed below. Also, you can refer to the AAP Medical Home Coding tip sheet www.medicalhomeinfo.org/how/payment_and_finance/

PHYSICIAN **FACE-TO-FACE CARE**		**Codes**
Preventive Medicine Counseling	Existing	99401-99404
Behavior Change Intervention: Smoking and Tobacco Cessation	New 2008	99406-99407
Behavior Change Intervention: Alcohol or Substance Abuse Screening	New 2008	99408-99409
***PHYSICIAN NON*-FACE-TO-FACE CARE**		**Codes/reference link**
Telephone E/M Patient Care	New 2008	99441-99443
Online E/M Patient Care	New 2008	99444
Team Conference Codes	New 2008	99367
Prolonged Services – No Longer Add On Code	Revised 2010	99358-99359
Care Plan Oversight: Patient in Home, Domiciliary or Rest Home (not under care of home health agency)	New 2006	99339-99340
TEAM – *NON PHYSICIAN* CARE		**Codes**
Telephone Assessment and Management Patient Care	New 2008	98966-98968
Online Patient Care	New 2008	98969
Patient Education for Self-Management	New 2006	98960-98962
Nurse Visit, Medical Nutrition, Health Behavioral Visit	Existing	99211

Infrastructure Payment: To provide a medical home at the highest functioning, at times practice redesign and practice innovations are needed. When working with public and private payors, it may be appropriate to advocate and negotiate payment for some of the infrastructure changes needed in the practice such as EMR development and support and data collection activities.