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INVESTMENTS IN MEDICAL HOME MODEL STARTING TO PAY DIVIDENDS

It has been 5 years since the AAFP adopted a policy stating that every American should have a "personal medical home." In the years since then, the Academy has championed the idea of the patient-centered medical home (PCMH) with the belief that the PCMH model improves outcomes and lowers health care costs.

Although many of you have started—and in some cases completed—the long process of transforming your practices into officially recognized medical homes, some of you have decided that the necessary time, money, and effort make it too daunting a task relative to an uncertain financial benefit. In short, you want assurances that your sizable investment will pay off.

Recent events, however, indicate that becoming a PCMH may be an investment worth making:

- Maryland's Multi-payer PCMH program has distributed about $3 million in its first payment to 54 participating primary care health professionals. Of that total, $2.1 million came from private payers, and $900,000 came from the state's Medicaid program, according to a recently published report.
- Earlier this year, 6 health plans paid $1.5 million to 236 primary care physicians from 11 practices in New York's Hudson Valley after those practices achieved PCMH recognition from the National Committee for Quality Assurance.

Skeptics could say these are isolated examples with unnamed docs. Fair enough. Let me tell you about an e-mail I recently received from former AAFP President Jim King, MD, of Selmer, Tennessee, on this very subject. He told me that his practice of 7 physicians has received $114,000 in incentive payments this year: $34,000 from CMS' Physician Quality Reporting Initiative (PQRI); $35,000 for electronic prescribing (eRx); and $45,000 in primary care incentive program payments.

King also expressed concern that PQRI and eRx incentives are beginning to decline, and primary care bonus payments are scheduled to stop after 2014. The important thing to remember, however, is that as these programs are phased out, new opportunities keep coming. When they do come along, it's important to be ready.

For example, last month, the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation announced the launch of the Comprehensive Primary Care Initiative (CPCI). CMS plans to collaborate with commercial and state health insurance plans to support primary care practices that deliver coordinated and seamless care.

The program will blend fee-for-service payments with a risk-adjusted, per-patient, per-month, care coordination fee that ranges from $8 to $40. Participating practices also will have the opportunity to share in savings resulting from the program. This payment model is what the AAFP has been advocating for some time to reward physicians for coordinating and managing patient care within the PCMH.

In response to the announcement of this plan, AAFP staff members recently met with America's Health Insurance Plans (AHIP), the national trade association that represents health insurance companies. During that meeting, AHIP representatives said that the organization intends to encourage its members to apply to participate in the CMS initiative.

The Academy also has sent letters to each of the nation's major health insurance plans, encouraging them to participate.

CMS will be responsible for recruiting 75 primary care practices in as many as 7 markets for the initial phase of the CPCI, with practices applying to participate in spring 2012. The blended payment model will be used for these practices' Medicare and Medicaid patients, as well as patients enrolled in participating private insurance plans.

The program will be limited to practices that already have achieved Level-3 NCQA recognition and have met meaningful use standards for electronic health records. These requirements reinforce the need for us to transform our practices and to be prepared to participate in such programs.

Although the first phase of this initiative will be limited in scope, CMS officials told me in a meeting recently that they are eager to rapidly and broadly expand the program once it has been shown to reduce costs and improve quality—which it almost certainly will.

Even if you live in an area that is not initially selected for the CPCI, other PCMH pilots from health plans and state Medicaid agencies are likely to use similar formats.

The bottom line is that making the changes necessary to earn PCMH recognition will result in enhanced revenue in the future. Some of you have asked the Academy to show you the money when it comes to the medical home model. The money is coming. Will you be ready to act when opportunity knocks?

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AAFP President

From the American Board of Family Medicine

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UNDERSTANDING THE "SUM OF SUBTEST TO OVERALL SCORE DISCREPANCY" ON THE MC-FP EXAMINATION

When high-stakes examinations, such as the American Board of Family Medicine's (ABFM) Maintenance of Certification-in Family Practice (MC-FP) examination are administered, candidates and diplomates are keenly interested in the accuracy of their test scores, especially when their scores are close to, but below, the pass/fail cut point. In some instances, candidates will attempt to reverse engineer their scores using the information provided on the score report in an effort to verify the "weighted sum of the subtest scores" is congruent with the overall test score. Any discrepancy might become alarming to the candidate, providing a seemingly legitimate reason to believe the overall score was inaccurate, thus prompting a phone call to the ABFM for further investigation and clarification. Historically, such a mistake in scoring has never been found; however, a statistical phenomenon that we will describe below could make it appear so. We would like to explain this phenomenon so that examinees who attempt to reverse engineer their score reports will better understand the "sum of subtest to overall score discrepancy" phenomenon.

Sum of Subtest to Overall Score Discrepancy

Sometimes when examinees attempt to reverse engineer their score reports, the weighted sum of the subtest scores will be higher than the total score. When the reverse happens we generally do not receive a phone call. For example, some candidates may find the weighted subtests add up to a scaled score of 400 when the overall scaled score was 380. Because the current minimum passing standard (MPS) is 390, candidates who experience this phenomenon may question the validity of the overall score, and ultimately the pass/fail decision. Below, we will attempt to explain (albeit briefly) this rather technical statistical phenomenon.

Diplomates typically view scores as quantities that have additive properties. For instance, in the past the ABFM presented raw scores on the score report. If one were to add the weighted raw scores of the subtests, the scores would certainly equal the raw score of the total test. Unfortunately, raw scores are not measures. Although raw scores are useful for descriptive purposes, they lack generality because they are specific to the particular test that was taken. Raw scores are counts and are deterministic and exact, but the measures they imply are probabilistic and have some degree of imprecision. The ABFM employs the Rasch model, [1] a 1-parameter Item Response Theory (IRT) measurement model, to score examinations. The Rasch model converts raw scores to linear measures and controls for the difficulty of the test version one received.

In some instances, the weighted sum of the subtests scores (as determined by the IRT scoring method) will be greater than the overall score. The primary reasons for this are twofold: first, score exchanges have asymmetric non-linearity. That is, within-person variation increases on subtest areas, making the distribution of subtest measures wider than the distribution for the overall test. This can often make mean measures appear larger. Second, there is an increase in measurement error due to the small number of items available in each subtest area. Consequently, the increase in measurement error also inflates measure variance, thus causing even more inferential instability. It is for these reasons that we report a standard error with each measure on the MC-FP score report, as it assists the examinee in understanding the stability of each particular measure. For a more detailed discussion on the topic of summing subtest measures, readers are encouraged to see Wright.[2]

Additional Insights and Recommendations to Test Takers

What does the statistical phenomenon presented above mean to persons who take the MC-FP examination? First, examinees should know that only the overall scaled score is used to determine the pass/fail decision. This score is based on one's cumulative performance on 350 items, thus the results will be both highly precise and statistically stable. Therefore, subtest scores should be viewed simply as good approximations for one's performance in a particular clinical content area,