Payment for Medical Homes: The Massachusetts Approach

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March 8, 2011

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Presentation Plan

- Background on the PCMHI
- PCMHI Payment Model
  - Payment types and amounts
  - Detail on “shared savings” methodology
- Conclusions: PCMHI Payments in Massachusetts Health Reform Context

Origins of the PCMHI

- Legislative directive:
  - Chapter 305, Section 30 of Acts of 2008 required MassHealth to establish a medical home demonstration
    - Restructure payment system to support primary care practices using medical home model
    - Support practices in their transformation
    - Work with other Medicaid payers and other stakeholders
- EOHHS's vision and goal:
  - Design and implement a system to support high-performing, patient-centered primary care delivery across the Commonwealth of Massachusetts
  - Transform all primary care practices into high-performing, advanced medical homes by 2015

PCMHI Key Milestones

- June 2009: Multi-stakeholder PCMHI Council convened
- November 2009: PCMHI Council "Framework White Paper" completed
- Winter-Spring 2010: RFR drafting, including
  - Discussions with payers
  - Development of specific practice transformation expectations
  - Refinement of practice technical assistance plans
- July 2010: RFR issued
- October 27, 2010: PCMHI practice selections announced
- November – March 2011: "Pre-work" technical assistance activities underway
- April 2011: PCMHI data-sharing and payments begin

PCMHI Practices

- Through a competitive RFR process, 46 practices invited to participate
  - Includes all 14 of Massachusetts Safety Net Medical Home Initiative CHC sites, and another 15 CHC sites
- Overall, PCMHI practices vary in specialty, size, type/affiliation, geographic location, and other key characteristics
  - 19 sites have 5 or fewer FTE PCPs; 10 sites have 6-10
  - Sites located from Cape to Berkshires, with concentration in greater Boston and greater Worcester areas
  - Strong public payer representation in practice revenue mix

Participating Payers

- Major Massachusetts payers have been strong PCMHI supporters and active participants
- EOHHS expects the following payers and purchasers to participate in making PCMHI payments*

–MassHealth PCC Plan
–Health Safety Net
–Health Connector Authority
–Group Insurance Commission
–Blue Cross Blue Shield of MA
–Boston Medical Center HealthNet Plan
–CeltiCare
–Fallon Community Health Plan
–Harvard Pilgrim Health Care
–Health New England
–Neighborhood Health Plan
–Network Health
–Tufts Health Plan
–Senior Whole Health
–UniCare

*Important details about the terms of participation for payers are described in the PCMHI RFR and in contracts between participating practices and payers.

PCMHI Payment Model Overview

- PCMHI payment model has 3 main components:
  1. Payment for start-up infrastructure to support initial costs
  2. Two streams of ongoing payments for:
     - General medical home activities
     - Clinical care management
  3. Payment for shared savings and quality if practice performance results in net cost reduction *and* practices meet quality of care performance thresholds

- Year 1 payments are timed to align with certain practice requirements, including attending Learning Sessions and providing Clinical Care Management services

1. Start-up Infrastructure Payment

- Amount:
  - Year 1: Up to $15,000 per practice
  - Year 2: Up to $3,500 per practice
  - Year 3: No infrastructure payment
- Details:
  - Each participating payer will pay a portion of the total amount, based on the percentage of a practice's patients covered by that payer

2a. Medical Home Activities Payment

- Amount: $1.50 PMPM, for all 3 years
- Details:
  - Each payer determines for which patients they will make PMPM payments
    - For HMO and the state's PCCM program (the PCC Plan): all patients assigned to a primary care clinician at the site, or to the site itself
    - For PPO and the state's Health Safety Net fund: all patients attributed to the practice sites using an algorithm created by Massachusetts Health Quality Partners (MHQP)

2b. Clinical Care Management Services Payment

- Amount:
  - $.60 PMPM for each patient under age 18
  - $1.50 PMPM for each patient age 18-64
  - $6.00 PMPM for each patient age 65 & older
- Details:
  - Same attribution process as for Medical Home Activities payment

3. Shared Savings and Quality Payment

- Amount:
  - To be determined based on a methodology to be tested in the coming months (see following slides)
- Overview:
  - Practice will share with the payers in cost savings if grouping of like practices has generated cost savings relative to a control group of primary care practices, after subtracting other medical home payments; and
  - The practice meets quality of care performance thresholds

Shared Savings Payment Details (Draft)

- Data source: The Division of Health Care Finance and Policy (DHCFP) will perform calculations of gross savings using the Division's All-Payer Claims Database
- Gross savings: Will be determined by calculating the multi-payer paid Allowed Amount claim cost experience of all participating payers' patients attributed to the practice site
  - Separate claim cost calculations will be performed for commercial and Medicaid patient populations

Shared Savings Payment Details (Draft)

- Minimum patient volume:
  - To provide some statistical confidence in savings calculations, a minimum patient volume is necessary
    - For Medicaid and CommCare, 5,000 attributed patients
    - For commercial, 10,000 attributed patients
  - Practices with fewer attributed patients will be grouped for purposes of analyzing savings
- Assigning savings to payers: Savings for a specific population (e.g. commercial) will be prorated across the participating payers based on the payer's share of attributed patients

Shared Savings Payment Details (Draft)

- Net savings: Will be calculated by subtracting the value of PMPM payments made to the practice during the year
  - If there are no net savings, the practice site or practice grouping will receive no shared savings payment for the relevant patient population
- Risk margin: First 5% of any identified net savings will accrue to the payers in order to protect against the award of payments for savings resulting from random variation
- Practice-eligible savings: For any net savings beyond the first 5%, the practices will be eligible for 30% (Year 1), 40% (Year 2) and 50% (Year 3) savings

Shared Savings Payment Details (Draft)

- "Quality gates": Whether a practice receives a share of savings, and the % of savings it receives, will be depend on its performance relative to certain quality measures
  - One set of measures for pediatric practices
  - One set for family medicine and internal medicine practices
- Requirement: Practices' rates for the given measurement year will be averaged to create a composite. That composite must either:
  - exceed the weighted NCQA national 50th percentiles for the most recent year in which NCQA has reported data for the measure; OR
  - be a 5% improvement in the practice's composite rate compared to prior year

Quality Gate Measures: Pediatrics

Measure	Data Source
a. Well-child Visits (<15 months)	All-Payer Claims Database
b. Well-child Visits (3-6 years)	All-Payer Claims Database
c. Adolescent Well-child Visits	All-Payer Claims Database
d. Asthma Medication Mgt (ages 5-17)	All-Payer Claims Database

Quality Gate Measures: IM and Family Practice

Measure	Data Source
a. Diabetes: LDL Control < 100	Practice Patient Registry
b. Diabetes: HbA1c Poor Control > 9.0	Practice Patient Registry
c. Diabetes: Blood Pressure < 140/80	Practice Patient Registry
d. Asthma Med. Mgt (ages 18-56)	All-Payer Claims Database
e. Anti-Depressant Medication Management – Cont. Phase	All-Payer Claims Database
f. Breast Cancer Screening	All-Payer Claims Database
g. Colorectal Cancer Screening	All-Payer Claims Database
h. Appropriate Use of Antibiotics for Acute Bronchitis	All-Payer Claims Database

Shared Savings Payment Details (Draft)

- Calculating performance relative to the quality gate: The 50th percentile will be calculated on a practice site-specific/practice grouping basis with a weighted average
  - using attributed patient count data to account for patient mix (i.e., Medicaid and commercial),
  - using NCQA national 50th percentile rates for commercial “All Lines of Business” and Medicaid HMO

PCMHI in Health Reform Context

- The PCMHI payment method aligns with broader state payment reform goals
  - Shared savings component reflects interest in finding appropriate balance between volume-based payment methods and pure capitation
- Ultimately, primary care practices functioning as PCMHs can form the foundation of accountable care organizations
  - Primary care practices and frequently-used specialties, working together, can further improve the quality and efficiency of care
  - PCMHs can support a focus on prevention, chronic care management, reducing unnecessary hospitalizations, use of community-based resources, and improving care transitions

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