Patient-Centered Medical Homes: Medicaid Shared Savings Update

ACHI
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Arkansas has been a leader among states in full-scale healthcare system transformation. The state's transformation efforts have been successful in part because of multi-payer collaboration from both public and private sectors and alignment of financial incentives across initiatives to achieve higher quality, more patient-centered, cost-effective care. The Arkansas Health Care Payment Improvement Initiative (AHCPII) is at the core of these efforts and includes two primary strategic models for supporting these efforts: Patient-Centered Medical Homes (PCMHs) and Episodes of Care. Both models are designed to incentivize providers and reward those who meet quality and financial targets while providing better-coordinated, high-quality care. Support for Medicaid components of the state strategy includes a team of individuals at the Arkansas Department of Human Services, Hewlett-Packard, General Dynamics Health Solutions, the Arkansas Foundation for Medical Care, Qualis Health, and the Advanced Health Information Network, among others. These efforts include providing quarterly progress reports and leading, not only practice support initiatives across the state, but also monthly advisory calls with front-line physicians to shepherd the effort. For PCMH providers who achieve practice transformation and quality of care targets, the program offers a shared-savings opportunity in which practices may receive up to half of the generated savings. The 2014 outcomes from the PCMH program demonstrate a reduction in cost growth and improvements in quality outcomes, resulting in significant shared savings for some providers. This fact sheet describes Arkansas Medicaid's shared-savings methodology and 2014 results.

SHARED SAVINGS METHODOLOGY

Arkansas Medicaid has established a PCMH shared-savings model that rewards providers if they meet eligibility requirements and achieve quality and financial targets.[1] To ensure that savings are the result of real improvement and not random variation in utilization and cost, enrolled practices must maintain a minimum patient volume of 5,000 attributed Medicaid beneficiaries. This threshold was selected as the smallest actuarially approved number, with the goal of extending eligibility to as many practices as possible. In 2014, practices could meet the volume requirement independently or by joining with another practice. Of the 123 practices or groups in the PCMH program in the first year, 37 met the 5,000 Medicaid beneficiaries mark.[1]

Practice Requirements[1]

- Must have at least 5,000 attributed Medicaid beneficiaries as a shared-savings entity
- Must achieve PCMH transformation milestones and process measures
- Must meet at least two-thirds of shared-savings quality metrics
- Must meet financial targets by either beating a historical statewide benchmark trend or improving on their own historical benchmark costs

Quality and efficiency targets must be met in order to receive shared savings. Practices must meet a majority of practice support metric targets, achieve PCMH transformation milestones, and meet at least two-thirds of the shared-savings quality metrics—all designed to increase preventive care and improve chronic disease management. In 2014, the vast majority of practices met transformation milestones, and 78 percent of quality measures improved or maintained prior-year levels. These quality measures include an increase in pediatric wellness visits, hemoglobin A1c testing for diabetics, breast cancer screenings as well as improved Attention Deficit Hyperactive Disorder management and thyroid medication management.[1]

2014 SHARED-SAVINGS OUTCOMES[2]

In the first year of the program, there were 659 primary care physicians in 123 PCMH practices or groups enrolled in the PCMH program covering 295,000 Medicaid beneficiaries. Among the 123 participating practices who enrolled in January 2014, 37 practices or groups were potentially eligible for shared savings, having at least 5,000 Medicaid beneficiaries either as a stand-alone practice or by joining or pooling with one other participating practice. Among the 37 eligible practices or groups, 19 received shared savings by both meeting quality and financial targets. Shared savings amounts ranged from approximately $9,000 to $900,000, with an average shared-savings payment of approximately $278,000.[2]

Overall, the PCMH program saved the state $34 million in Medicaid costs in 2014. Per-member per-month payments to practices were factored into the overall program cost, resulting in a net-shared savings of $5.3 million paid out to qualifying practices. After only one program year, the results are indicative of the program being cost effective and sustainable beyond its first year of implementation.

Some participating practices met quality targets but not financial benchmarks, while others met financial targets but failed to achieve quality targets. In both scenarios, shared savings were not awarded to those practices. Shared-savings outcomes for the 2014 performance year—based on preliminary claims analysis and final reconciliation based on fully adjudicated claims—will be completed in the first quarter of 2016. This final reconciliation may slightly alter the final payment amounts for some practices.

2014 SHARED-SAVINGS AWARDEES[2]

1. University of Arkansas for Medical Sciences (UAMS) Regional Programs (Area Health Education Centers in Ft. Smith, Fayetteville, Springdale, Jonesboro and Texarkana) – $927,642.50
2. Mercy Clinic Northwest Arkansas (Bentonville) – $749,909.13
3. Drs. Collom and Carney Clinic (Texarkana) – $642,364.03
4. Monticello Medical Clinic PLC – $484,992.61
5. Hot Springs Pediatric Clinic – $448,847.62
6. Pillow Clinic PLC (Helena-West Helena) – $387,197.53
7. Mountain View Clinic LLC – $237,706.57
8. The Children's Clinic of Jonesboro – $236,806.58
9. John Paul Wornock (Searcy) – $234,529.38
10. Central Arkansas Pediatric Clinic (Benton) – $229,927.88
11. Medical Associates of Northwest Arkansas (Fayetteville) – $214,169.21
12. Pediatric Associates of West Memphis – $201,050.12
13. Arkansas Pediatric Clinic PLLC (Little Rock) – $66,267.51
14. Little Rock Pediatric Clinic – $65,581.17
15. Apache Drive Children's Clinic (Jonesboro) – $57,498.31
16. Regional Family Medicine (Mountain Home) – $54,950.73
17. Conway Children's Clinic – $32,572.28
18. Ozark Internal Medicine (Clinton) – $9,135.48
19. Mercy Health System of NWA (Rogers) – $8,567.56

Performance Expectations[1]

- Take responsibility for total care experience
- Provide 24/7 live-voice access to clinical advice
- Demonstrate improved chronic disease management
- Identify and develop care plans for top 10% of high-priority patients
- Coordinate care of high-priority beneficiaries, including post-hospital and transitional care across facilities and providers
- Utilize health information technology tools, including use of Electronic Health Records and incorporation of e-prescribing into practice workflows

INCREASING INCENTIVE OPPORTUNITIES

Because additional payers have joined in supporting the PCMH model, the incentives for participating in the program are increasing. Beginning in 2015, Qualified Health Plans (QHPs) operating on the insurance exchange and dual-specialized needs managed care plans are required to participate in the state PCMH program by either legislative or regulatory requirements.[3] These carriers include Arkansas Blue Cross and Blue Shield, Qualchoice, Centene/Ambetter, United Healthcare, and other carriers. Commercial carriers are already supporting PCMH practices with per-member per-month payments for care coordination and practice transformation and are required to develop their own shared-savings methodology in 2016. These increased incentives will support and reinforce changes in practice patterns and improvements in quality and efficiency of care delivery.

In addition to more payers supporting the program and offering shared savings in the future, all PCMH practices will have an opportunity to achieve shared savings beginning in 2015. While practices had to meet the 5,000 Medicaid beneficiary threshold—either as a stand-alone practice or with one other practice in 2014—the pooling options increased in 2015. For the current 2015-performance year, the opportunity to be eligible for shared savings will be extended to all PCMH practices—practices without at least 5,000 Medicaid beneficiaries as a stand-alone practice may pool with one or more practices or be placed in a statewide default pool to meet eligibility requirements. While there is no downside risk for PCMH providers, the opportunity cost of not participating in the program is becoming greater as multi-payer per-member per-month payments and shared-savings potential increase. For this reason, enrollment in the PCMH program is anticipated to increase beyond current levels and foster a rebalancing of the state's healthcare workforce toward primary care delivery and overall population health management.

REFERENCES

[1] Arkansas Medicaid. "Patient-Centered Medical Homes: Provider Manual Section II." Accessed on October 26, 2015; https://www.medicaid.state.ar.us/download/provider/provdocs/manuals/pcmh/pcmh_ii.doc.

[2] Amy Webb, Arkansas Department of Human Services Director of Communications, e-mail message to the Arkansas Center for Health Improvement on October 23, 2015.

[3] Rule 108, "Patient-Centered Medical Home Standards," effective January 1, 2015.