Patient-Centered Medical Homes

ACHI
Arkansas Center for Health Improvement

January 2015

Arkansas has been a leader among states in full-scale health care 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 multiple initiatives to achieve higher quality, more patient-centered, cost-effective care. The Health Care Independence Act of 2013, which expanded coverage to low-income Arkansans by offering them premium assistance to purchase coverage through the health insurance marketplace, reinforced this principle of aligning financial incentives across multiple initiatives. It did so by including a provision requiring marketplace insurers to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII), including support for the patient-centered medical home (PCMH) model. The Arkansas Insurance Department (AID) developed a rule to implement the requirement for insurers to offer PCMH support, although several of the state's insurers were voluntarily participating in PCMH efforts across the state. This fact sheet describes the Arkansas PCMH model adopted by the AHCPII participants and the insurer participation requirements in the AID rule.

PCMH CHARACTERISTICS

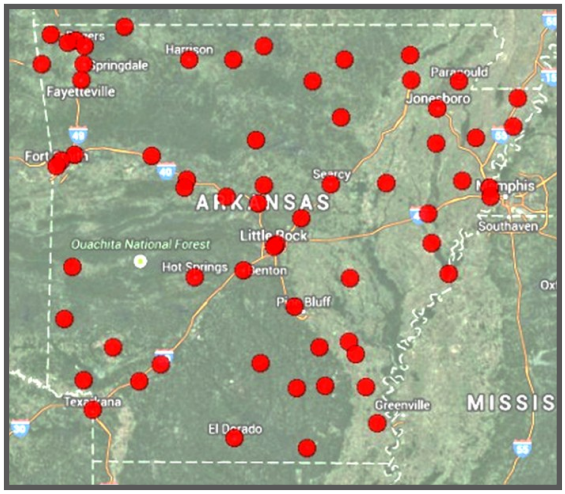
- **Goal**: Help patients stay healthy, increase the quality of care received, and reduce costs
- **Not a physical location:** Care teams take responsibility for overall health of patients
- **Team-based:** Team of health professionals led by a physician to care for the whole person, including individuals with complex needs
- **Primary care providers:** Physicians, advanced practice registered nurses, and physician assistants can each manage a panel of patients in a PCMH
- **Proactive care**: Identifies and treats at-risk persons before they become sick
- **Future success:** Relies on statewide multi-payer participation, ongoing innovation, and achievement of set transformation milestones

INSURER REQUIREMENTS[1]

1. Adopt the Arkansas PCMH model defined by the multi-payer AHCPII and implemented by Arkansas Medicaid in 2014
2. Recognize PCMH practices in good standing with the Arkansas Medicaid PCMH program
3. Offer participating practices a minimum avg. of $5 per-member per-month payment for care coordination and transformation expenses
4. Provide performance reports in a pre-specified standardized format and share statistics in the form of analyzed claims data
5. Develop a shared savings model for practices to achieve a per issuer enrollee cost of care that is below a set benchmark

[1] *Act 1498*

PARTICIPATING PCMH PRACTICES



193 total practices:

- 142 practices participating through Medicaid, covering about 82% of all eligible Medicaid beneficiaries
  **AID rule requires insurers to offer support only to these practices*
- 63 Comprehensive Primary Care Initiative (CPC) practices, a Medicare-led effort with Medicaid and private payer participants in Arkansas
- 12 practices participate in both programs

● = cities in which there are PCMH practices

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

1401 W Capitol Avenue, Suite 300 ● Little Rock, Arkansas 72201 ● (501) 526-2244 ● www.achi.net

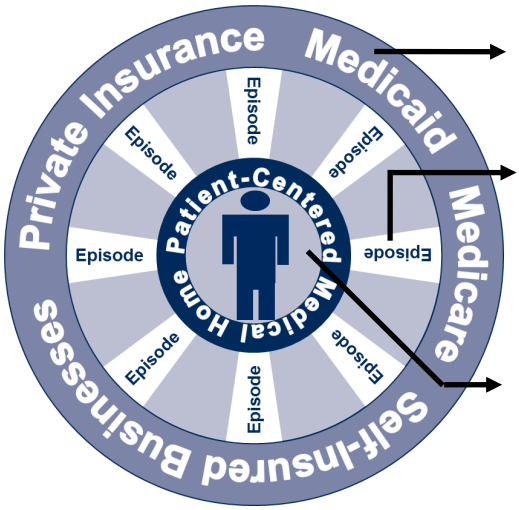
ARKANSAS PAYMENT IMPROVEMENT MODEL DESIGN

Key attributes:

- Evidence-informed preventive care and improved wellness
- Coordinated integrated care across multidisciplinary provider teams
- Referrals to high-value providers (e.g. specialists)

Incentives:

- Monthly financial support for care coordination and transformation expenses
- Upside-only shared savings model



Multi-payers: Responsibility for entire experience of patient panel with incentives to control cost and improve quality

Episodes: All care associated with treatment for a specific medical condition with a defined start and end point

Patient-Centered Medical Home: Improve quality and coordination for the patient while reducing variation in cost and quality of care across providers for similar services

SHARED SAVINGS MODEL

1 Practices must **perform on quality metrics**

- Meet 2/3 of targets for metrics
- Remain in good standing for practice support payments

2 Payer calculates **average yearly cost per member** for each shared savings entity

- Pre-set "medium" and "high" cost levels
- Benchmark costs based on historical costs projected forward

3* PCMH **can earn shared savings payments in 1 of 2 ways -** receive greater of the two

1. Beating a system-wide medium cost threshold
2. Beating its own benchmark cost

***Earning shared savings eligibility:**

Eligibility requires a minimum of 5,000 Medicaid patients who have been attributed for at least six months. Since few individual practices have sufficient numbers of patients to reach this threshold, Arkansas Medicaid allows two practices or multiple providers with the same tax identification number to pool their patients to achieve the 5,000 patient minimum as long as the pooled practices are accountable for their combined quality metrics and attributes of a medical home. In 2015, a statewide default pool will provide another means of practice entry into shared savings.

TRANSFORMATION MILESTONES

- Identify team lead(s) for care coordination
- Identify the top 10% of high-priority patients
- Assess operations of practice & opportunities to improve
- Develop & record strategies to implement care coordination & practice transformation
- Identify & reduce medical neighborhood barriers to coordinated care at the practice level
- Make available 24/7 access to care
- Track same-day appointment requests