Patient Centered Medical Homes: Overview of Models & MA Activity

Health Policy Commission
Care Delivery and Payment System Reform Committee

May 20, 2013

Agenda

- Introduction and Review
- Setting the Context: National Trends
- The PCMH Movement in Massachusetts
- Payment Models for PCMH
- State-Sponsored Delivery System Initiatives
- Presentation: Atrius
- Committee Discussion

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What is the definition of a PCMH?

Chapter 224 of the Acts of 2012

"Patient-centered medical home", a model of health care delivery designed to provide a patient with a single point of coordination for all their health care, including primary, specialty, post-acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and continuous; and (iii) delivered by a team of health care professionals to manage a patient's care, reduce fragmentation and improve patient outcomes.

Statutory responsibilities

- In consultation with MassHealth, HPC must develop and implement standards for voluntary certification of patient-centered medical homes in the Commonwealth

- Purpose is to establish best practices and encourage the adoption of innovative care delivery models that improve primary care, enhance care coordination, and reduce cost growth

- PCMH Certification Program must also develop:
  - a model payment system for payers to adopt that supports patient-centered care;
  - a directory of key existing referral systems and resources; and
  - a training program for providers to learn the best practices of the patient-centered medical home model.

Minimum certification standards

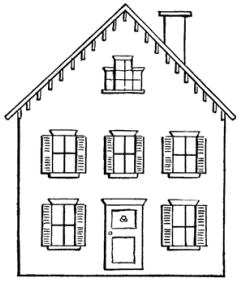
1. Enhance access to routine care, urgent care and clinical advice though means such as implementing shared appointments, open scheduling and after-hours care;

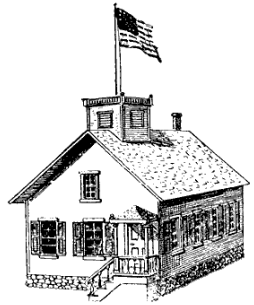
2. Enable utilization of a range of qualified health care professionals, including dedicated care coordinators, which may include, but not be limited to, nurse practitioners, physician assistants and social workers, in a manner that enables providers to practice to the fullest extent of their license;

3. Encourage shared decision-making for preference-sensitive conditions such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided that shared decision-making shall be conducted on, but not be limited to, long-term care and supports and palliative care; and

4. Ensure that patient centered medical homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions.

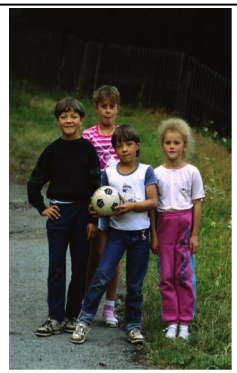
The Medical Home



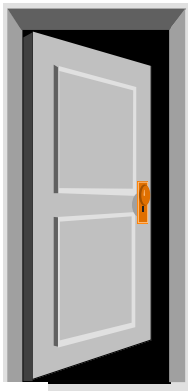


PROTECT

Quality

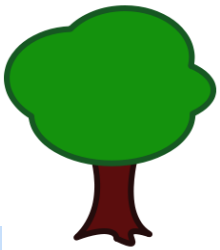


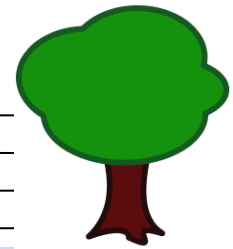
Relationship



Support

FOUNDATION





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What we see in national trends

Setting the context

- Pilots, demonstrations, and implementation of PMH models under way/planned in every state
- Most states use combination of national standards (NCQA, JC) and state-specific criteria with performance measures for certification
- The majority include payment reform as a core component
- Most state models include at least a minimal level of infrastructure support

Key PCMH Model Features

- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Data & feedback
- Practice education/facilitation
- Health Information Technology

Source: NASHP 2013

Two different options for qualification process

Option 1: Use nationally-recognized standards

- Minimize burden on providers
- Leverage investments
- Align with local partners
- Minimize resources for independent certification process
- National certification processes can be costly to practices

Option 2: Modify/redefine standards or criteria for qualification

- Focus on core standards and/or state-specific criteria
- Add minimum threshold for specific performance standards
- Develop tiered levels for basic to advanced PCMH performance
- Resource considerations involved with implementing a certification process that is truly “stand-alone”

Two philosophies to guide PCMH assessments

High bar for recognition		Low bar for recognition
▪ Advanced practices – stringent criteria	Participation	▪ Practices varied capabilities – committed to PCMH
▪ Help advanced practices	Goal	▪ Help all practices transform
▪ Prior to certification	Transformation	▪ Ongoing, incremental process
▪ Long list of capabilities – criteria	Content/ Criteria	▪ Limited number of meaningful but hard to document criteria and ongoing measurement
▪ Based on medical home score upon certification	Payment	▪ Based on performance of quality or cost/utilization measures

Source: Burton, R.A., Devers, K.J., and R.A. Berenson. 2012. "Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content and Operational Details." Urban Institute, CMS Office of Research, Development and Information

Two state model examples

Oregon
365 practices certified to date

- Oregon Health Authority responded to 2009 legislation
- Core attributes and standards for primary care homes
  - A detailed set of measures for primary care homes
  - Coordination across state agencies and PCMH initiatives
- Restructured primary care payment aligns with PCMH
  - Three levels (or tiers): basic to more advanced PCMH
  - Verification site visits and collaboration with providers
  - Supplemental PCMH payments from commercial payers
- Launched public-private partnership (Patient Centered Primary Care Institute) to provide assistance for practice transformation

Minnesota
214 practices certified to date

- 2008 state legislation required regulated health plans to pay for PCMH
- State designed PCMH standards and certification program
- Minnesota's multi-payer program is unique in several ways:
  - Practices required to include patients/families in QI
  - Enhanced payment: patients with >1 chronic condition
  - Payment tiered: patient complexity and supplementation factors
  - Practice must actively identify patient as qualifying member of their panel
  - Practice supports, in addition to recently launched regional public health nurse consultants to provide direct TA to providers seeking certification

Recommendations from State PCMH Models

Recommendation	How to achieve recommendation
▪ Tailor definition of “medical home” to reflect state priorities	▪ Behavioral health integration ▪ Care coordination
▪ Use payment policy to foster collaboration	▪ Care transitions ▪ Utilization
▪ Use payment policy to reward more better performing medical homes	▪ Tiered-payment models for enhanced results
▪ Help practices improve performance	▪ Measurement ▪ HIT ▪ Training
▪ Provide support for care coordination	▪ Care managers ▪ Payment
▪ Ease the evaluation burden for providers	▪ PCMHI portal ▪ APCD
▪ Base MH certification on existing models	▪ NCQA ▪ JC
▪ Align with local PCMH initiatives	▪ PCMHI ▪ PCPRI
▪ Balance desire for improved performance with cost to improve	▪ “Certify” existing PCMH practices ▪ Stimulate transformation with payment reform and innovation grants

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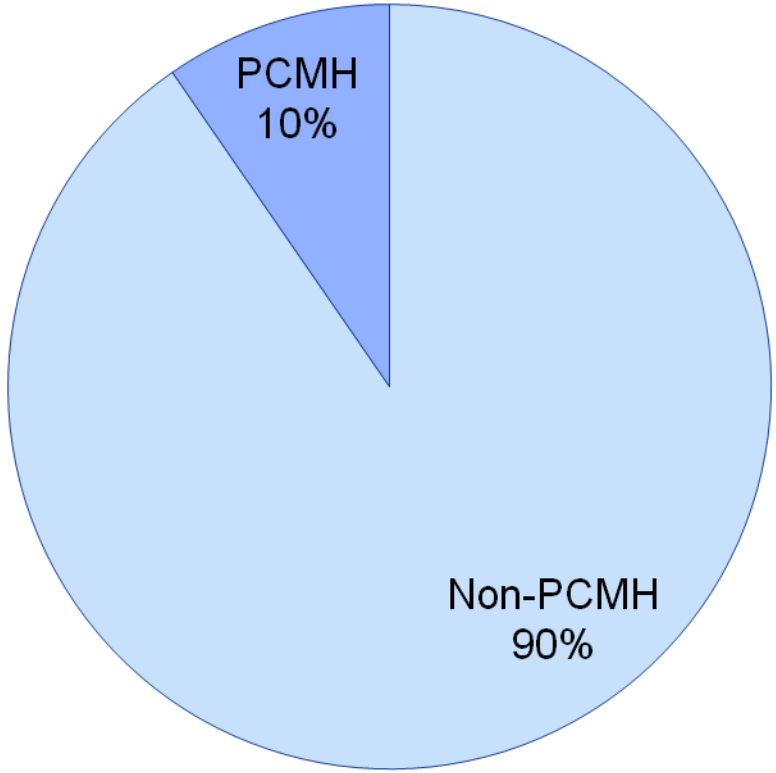
Proportion of PCMH for all Primary Care in MA

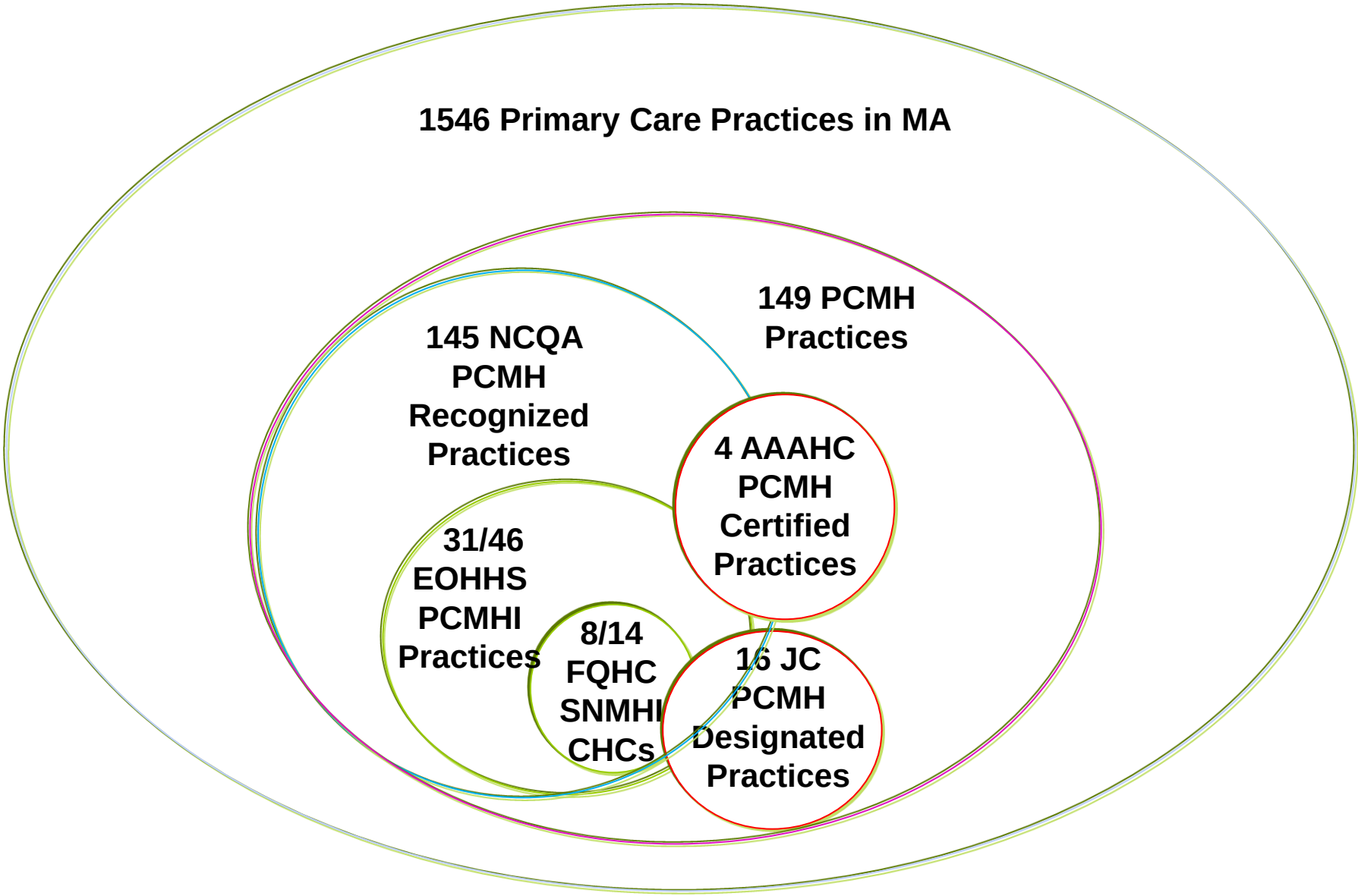
Breakdown of primary care practices
100% = 1,546 practices



Note: Of 1,546 practices , 788 solo PCPs, 214 two PCPs, and 588 with ≥3 PCPs

Source: MHQP

Massachusetts medical home movement



PCMH recognition and certification in MA

	Organizations	Providers	Practices			
			Total	Level 1	Level 2	Level 3
NCQA	63	1,242	145	22	10	113
PPC (2008)	*33*	*645*	*96*	*20*	*0*	*76*
PCMH (2011)	*30*	*597*	*49*	*2*	*10*	*37*
JC	3*	75	16**	N/A	N/A	N/A
AAAHC	4***	80	4	N/A	N/A	N/A
Total**	**67**	**1,301**	**149**	**N/A**	**N/A**	**N/A**

* Two practices (Lynn Community Health Center & Harbor Health Services) accredited by NCQA and JC
** One practice (Harvard University Health Services) accredited by NCQA and AAAHC
*** Lynn Community Health Center operates 8 school based clinical programs
**** Totals reflect unduplicated count from each column

Source: List of accredited organizations, providers and practices from NCQA, JC and AAAHC, May 2013

PCMH Practices Participating in Medicare ACOs

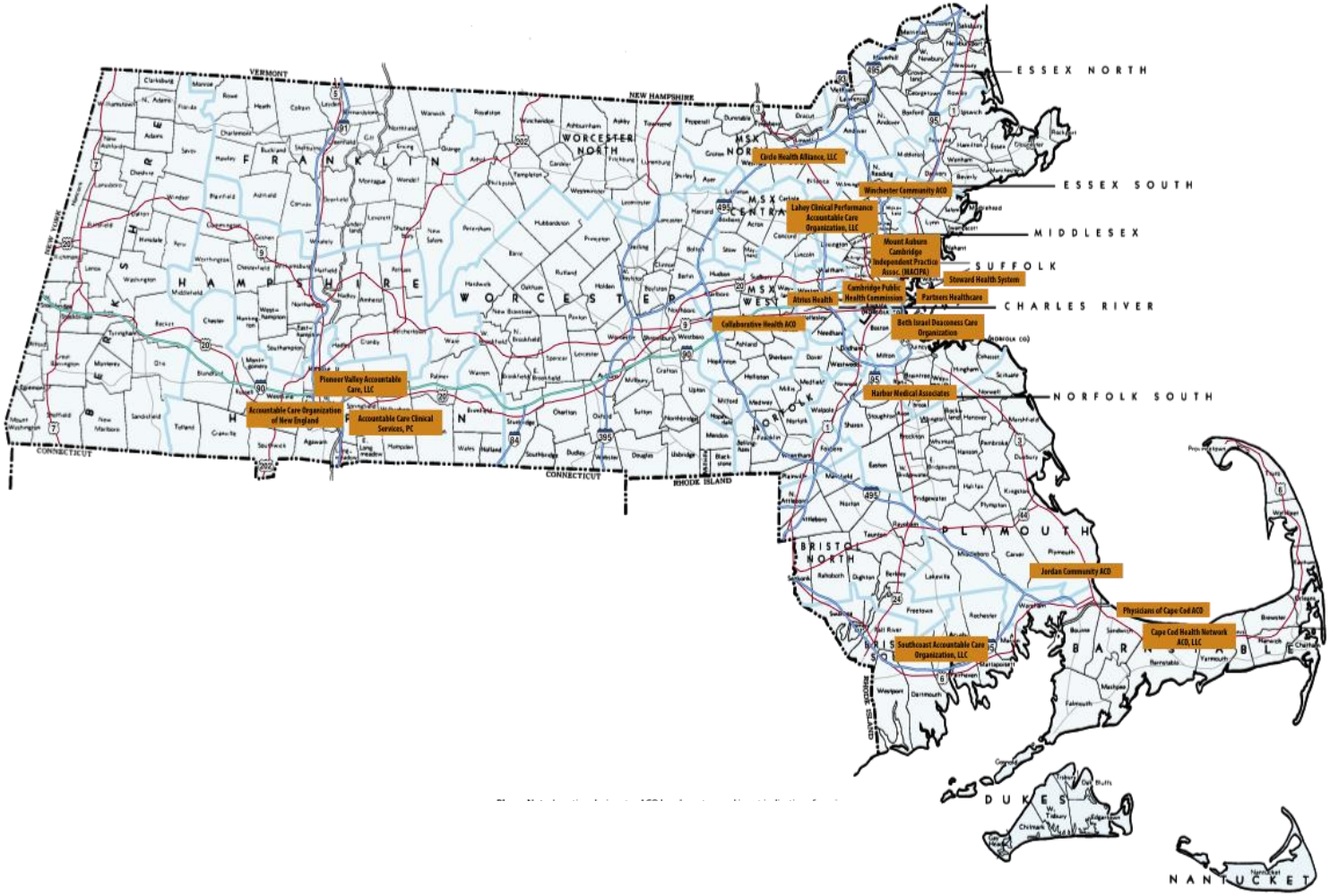
Participation rate

100% = 149 PCMH accredited practices in MA

Note: 149 represents unduplicated count of practices accredited by NCQA, JC and AAAHC

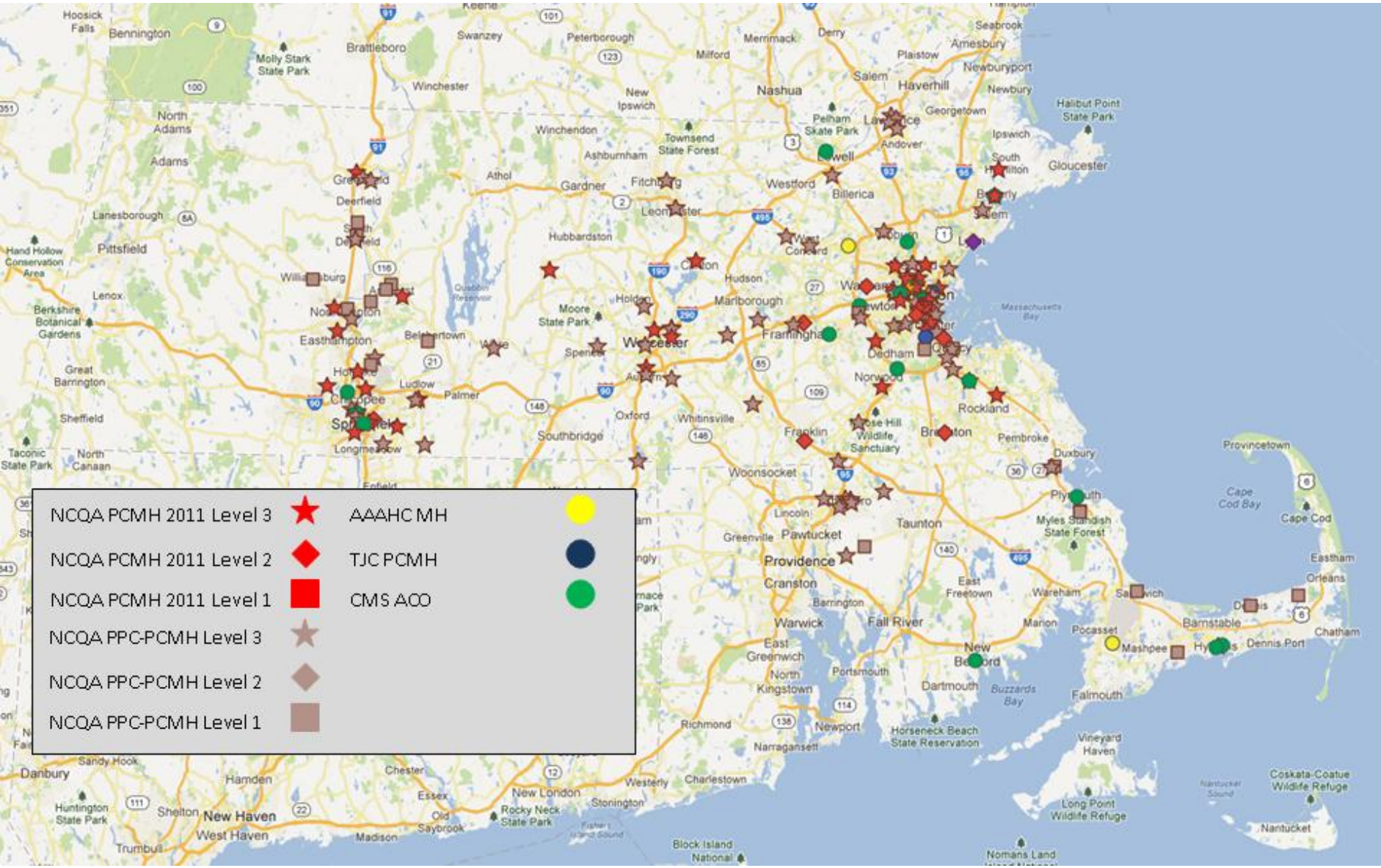
Source: NCQA, JC, AAAHC

Massachusetts accountable care organizations as designated by CMS



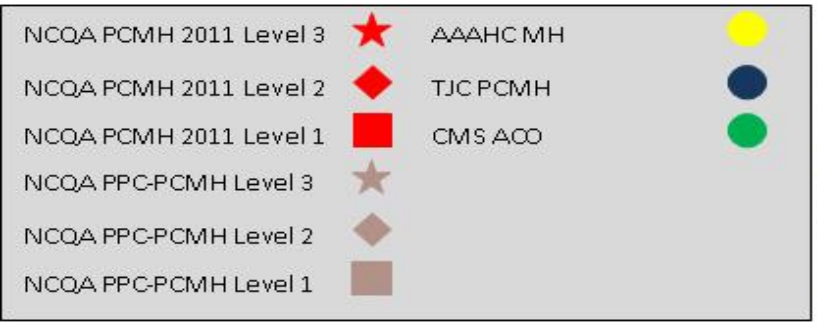
Source: Massachusetts Medical Society, Physician Practice Resource Center, updated from CMS in Jan 2013

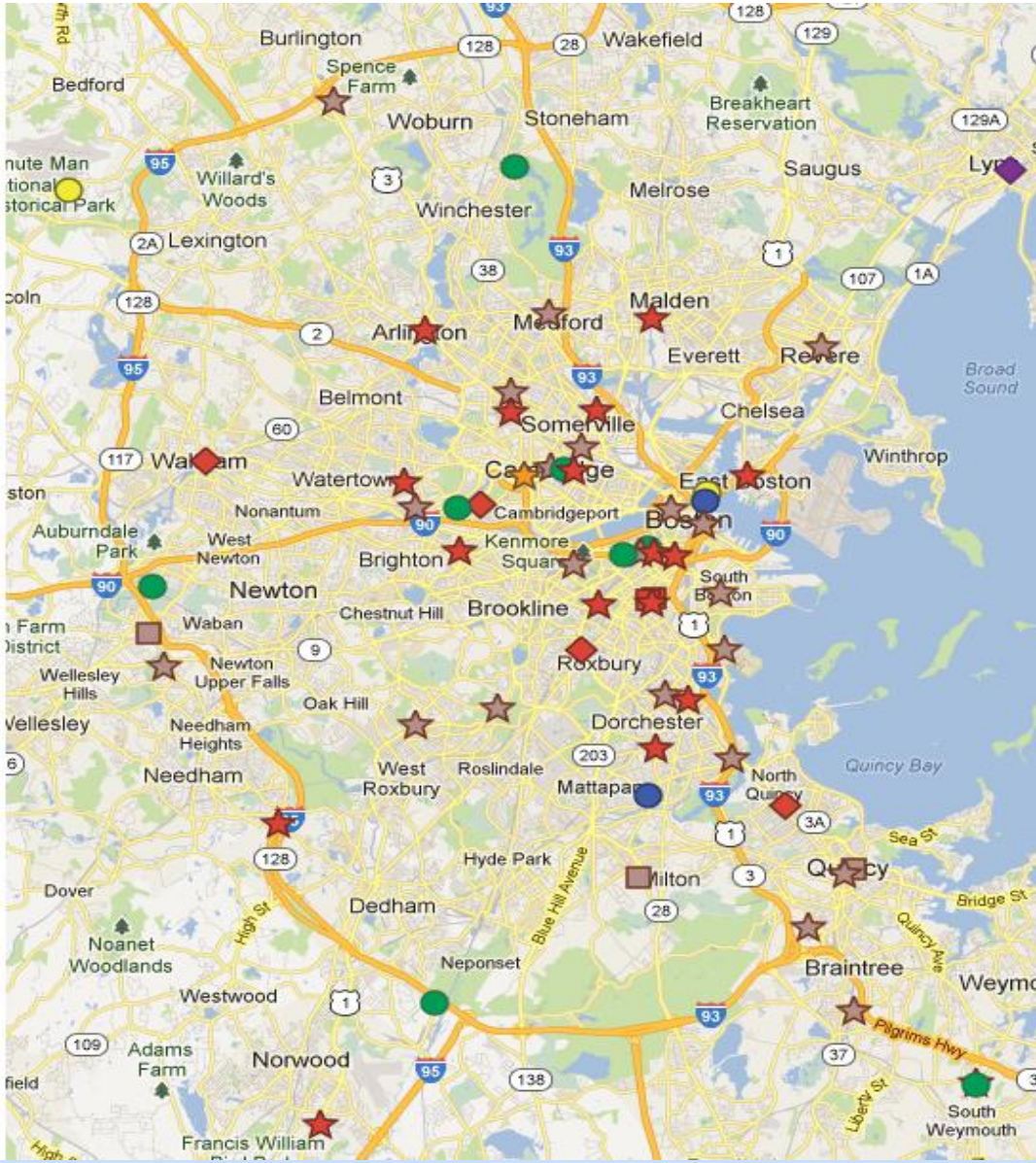
Massachusetts – Medical Homes and ACOs



Source: Primary address of PCMH accredited practice sites and CMS ACOs in MA

Greater Boston Metro – Medical Homes and ACOs





Source: Primary address of PCMH accredited practice sites and CMS ACOs in Greater Boston, MA

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Payment models for PCMH

- Multiple approaches in use nationally
- Payment models may include all patients enrolled in a medical home or limit payment to high cost populations
- Early models focused on infrastructure development such as data systems
- Later models have sought more fundamental transformation of incentives for specific transformation-level functions (e.g. enhanced payment for care management)

State PCMH payment models (1/2)

- FFS with Adjustments Models
  - FFS with discrete codes (care management codes)
  - FFS with enhanced rates to “qualified” practices
- FFS Plus Models (including P4P)
  - FFS with lump sum payments
  - FFS with a PMPM payment
  - FFS with PMPM payment and P4P
- Shared Savings Model
  - PMPM, lump sum payment and/or P4P
- Comprehensive Payment Model
  - Similar to capitation model, but includes enhanced payment to support medical home systems
- Grants
  - Provider sites receive grants to support PCMH transformation

State PCMH payment models (2/2)

- 19 states have payment models with **PMPM care management fee**
- Some states adapting initiatives for **most costly populations**
  - MN adjusts care management fee to number of chronic conditions
  - MS includes community mental health centers
- AL, MI and MN deploy **shared teams to smaller practices**
- Many states **link payments with performance results**
  - RI includes targets for utilization, patient satisfaction and quality measures
- Some states launched **multi-payer initiatives with shared savings**
  - PA calculates shared savings on key outcomes and utilization measures

Source: Takach, M. 2012. About Half of the States are Implementing Patient-Centered Medical Homes for their Medicaid Populations. Health Affairs. 31(11): 2432-40.

Massachusetts alternative payment systems

	Description	Cost accountability	Quality accountability
MSSP	▪ Medicare Program, allows providers to form ACOs to share savings	▪ Upside only, or shared risk contracts	▪ Earning potential tied to performance on 33 measures
Pioneer	▪ ECMMI program, aimed at integrated organizations	▪ Shared risk contracts, optional transitions to pop. payments	▪ Earning potential tied to performance on 33 measures
AQC	▪ BCBS program for providers HMO patients	▪ Upside only and shared risk contracts	▪ Bonus based on performance on 32 ambulatory and 32 hospital measures
Coordinated Care Model	▪ THP program for HMO patients includes ACO care coordination support/analytics and product design at ACO level	▪ Shared risk around managing TME	▪ Incentives for ambulatory and hospital quality measures
PCMHI	▪ EOHHS multi-payer initiative with selected primary care practices	▪ Upside only shared savings model	▪ Mastery of 12 PCMH competencies and NCQA recognition, performance on quality measures
PCPRI	▪ EOHHS APM methodology for primary care providers	▪ Shared savings/risk payment model	▪ Quality incentives on selected measures for P4R in year 1, and P4Q in years 2 and 3

Source: EOHHS; HPC analysis

PCMH payment model considerations

- No one payment system is universally best for PCMH
- Blended strategy can minimize shortcomings of any single approach
- Risk-adjustment should incorporate biomedical and psychosocial factors
- P4P should be based on evidence, focused on outcomes and complemented by process measures, especially in early implementation
- PCMH sustainability is proportional to the penetration of payment reform in the practice and its ability to fund PCMH services

Multi-payer model necessary to demonstrate the real effects of PCMH

Source: Patient-Centered Primary Care Collaborative Payment Reform Task Force, Oct 26, 2010

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Strategic initiatives supporting public-sector delivery system integration

- MassHealth Delivery System Transformation Initiatives (DSTI) for Safety Net Hospitals ($628M)
- State Innovation Model Grant – CMS ($44M)
- MassHealth Health Information Technology Incentive Payments to Hospitals & PCPs ($600M)
- All Payer Claims Database
- Health Information Exchange
- ACA Enhanced Payments for Primary Care providers
- Mass in Motion grants to promote community-wide wellness
- Group Insurance Commission 2013 Procurement promoting Integrated Risk-Bearing Organizations

Source: EOHHS; HPC analysis

MassHealth PCMH models as of May 2013 (1/2)

	PCMHI	PCPRI	SNMHI
Sponsor/ Payers	▪ EOHHS (MassHealth & Medicaid MCOs) • Commercial payers	▪ EOHHS/SIM Grant ▪ (MassHealth & Medicaid MCOs)	▪ Commonwealth ▪ Qualis ▪ MacColl ▪ Mass League ▪ EOHHS ▪ (MassHealth & Medicaid MCOs)
Timeframe	▪ Apr 2011 – Apr 2014	▪ Oct 2013 – Oct 2016	▪ Apr 2009 – Apr 2013
Participation	▪ 46 primary care practices, including: – 14 SNMHI CHCs – 15 other CHCs)	Number of participants TBD Targeting primary care clinicians ▪ 25% participation in first year ▪ 50% by Jul 2014 ▪ 80% by Jul 2015	▪ 14 CHCs (included in PCMHI practices)
Goal	▪ NCQA “Level 1 Plus” by Apr 2014 – including specified levels of performance for following criteria: – Standard 3C - 75% – Standard 3D - 100% – Standard 4B - 50%	Aiming for NCQA PCMH Level 1 recognition of participating practices within 24 months (for those not already recognized upon enrollment)	▪ NCQA PCMH Level 1 by Apr 2013

Source: EOHHS; HPC analysis

MassHealth PCMH models as of May 2013 (2/2)

	PCMHI	PCPRI	SNMHI
PCMH status	▪ 4/46 practices NCQA Level 2 ▪ 29/46 practices NCQA Level 3	▪ Participants required to achieve NCQA Level 1 by Oct 2015 and additional criteria of behavioral health integration and medical home transformation	▪ 2/14 FQHCs NCQA Level 2 ▪ 6/14 FQHCs NCQA Level 3
Technical assistance	▪ Learning collaboratives ▪ Webinars ▪ Medical Home facilitators ▪ Data collection and analysis ▪ On-line community	▪ Learning collaboratives ▪ Pre-qualified vendors for practice TA ▪ HIT support via REC/HIEW ▪ Access to aggregated reports ▪ And raw data claims	▪ Same as PCMHI with additional webinars
Quality focus	▪ Chronic conditions – Diabetes – Pediatric asthma ▪ Behavioral health integration (toolkit for providers) ▪ Clinical care management of highest risk patients	▪ Adult prevention and screening ▪ Behavioral health (adult and pediatric) ▪ Pediatric health ▪ Adult chronic conditions ▪ Women's health	▪ Same as PCMHI
Payment	▪ Start-up infrastructure payments ▪ PMPM for MH activities and CM ▪ Shared savings	▪ Comprehensive primary care payment combined with shared savings +/- risk arrangement, and quality incentives	▪ SNMHI practices part of PCMHI, considered Technical Assistance Plus practices receiving advanced payment

Source: EOHHS; HPC analysis

MassHealth PCMH models – measurement (1/2)

	PCMHI/SNMHI	PCPRI
Adult prevention and screening	▪ Adult weight screening & follow up ▪ Tobacco use assessment and tobacco cessation intervention	▪ Adult weight screening & follow up ▪ Tobacco use assessment and tobacco cessation intervention ▪ Chlamydia screening ▪ Cervical cancer screening ▪ Mammography screening
Adult chronic/ complex conditions	▪ Diabetes composite ▪ Hypertension: Controlling high blood pressure ▪ Self Management goals	▪ Diabetes composite ▪ Hypertension: Controlling high blood pressure
Pediatric health	▪ Asthma medication ▪ Asthma Action plans ▪ BMI assessment and counseling ▪ Adolescent immunization ▪ Childhood immunizations status/multiple vaccines	▪ Asthma medication ▪ BMI assessment and counseling ▪ Adolescent immunization ▪ Developmental screening in first 3years ▪ Well child visits: <15 months, 3-6 yrs, adolescent ▪ Childhood immunizations

Source: EOHHS; HPC analysis

MassHealth PCMH models – measurement (2/2)

	PCMHI/SNMHI	PCPRI
Behavioral health	▪ Depression screening ▪ Initiation and engagement of alcohol/drug dependence treatment ▪ Depression with f/u PHQ-9 Score ▪ ADHD medication management for children	▪ Depression screening ▪ Initiation and engagement of alcohol/drug dependence treatment ▪ Follow-up after hospitalization for mental illness ▪ ADHD medication management for children
Care management / coordination	▪ CCM follow up after hospitalizations, ED visit ▪ CCM care planning for highest risk patients	▪ CAHPS ▪ Medication reconciliation
Access	▪ CAHPS ▪ Continuity of primary provider	▪ CAHPS ▪ ED Visits (ASC)

Source: EOHHS; HPC analysis

Integration of Behavioral Health, Mental Health & Substance Use Disorder - PCMH

- Behavioral Health not emphasized in PCMH models
  - Limited focus on behavioral health in national standards
  - Pending state and federal regulations
- Some significant challenges
  - Access to behavioral health providers
  - Reimbursement for time/resources for mental health
- Potential area of focus for state/HPC
  - Current area of focus for MassHealth
  - Behavioral Health Integration Toolkit (PCMHI, PCPRI)
  - Inclusion of behavioral health for disease management
  - Integration of care management services for PCMH
  - Roadmap for implementation and performance assessment

Next steps & considerations for “certifying” medical homes

- Identify core standards and criteria for HPC certification program
- Consider performance thresholds for HPC integration priorities
- Develop eligibility and pathway for certification
- Explore payment model systems and recommendations
- Design framework for HPC care delivery and innovation programs
- Define collaboration opportunities with PCPR and SIM
- Recommend approach and timeline for HPC PCMH certification

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Sources

- Accreditation Association for Ambulatory Health Care, PCMH Practices: https://eweb.aaahc.org/eweb/dynamicpage.aspx?site=aaahc_site&webcode=find_orgs
- Burton, R.A., Devers, K.J., and R.A. Berenson. 2012. "Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content and Operational Details." Urban Institute, CMS Office of Research, Development and Information.
- Joint Commission PCMH Designated Practices: http://www.jointcommission.org/accreditation/pchi.aspx
- Massachusetts Medical Society: http://www.massmed.org/
- Massachusetts Health Quality Partners: http://www.mhqp.org
- National Academy for State Health Policy: http://www.nashp.org/
- NCQA PCMH Recognized Practices: http://recognition.ncqa.org
- Takach, M. 2012. "About Half of the States are Implementing Patient-Centered Medical Homes for their Medicaid Populations." Health Affairs. 31(11): 2432-40.

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