Capitation and Shared Savings Models for the Medical Home

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Presentation Overview

1. Trace the evolution of PCMH payment models
2. Explain the underlying concepts for capitation and shared savings models
3. Review examples of such models in use today in PCMH programs

Evolution of PCMH Payment

- Early models focused on supplemental payments to support:
  - practice infrastructure investment
  - time spent on historically non-compensated services
  - higher operating costs
- These models typically involved PMPM payments linked to status level of PCMH recognition.
- There were a few early programs that supplied supplemental payments through reimbursement of new procedure codes.
- Most payment models were focused on paying for structure (capacity) – and not performance.

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Evolution of PCMH Payment (continued)

- While early payment models did not reward performance, a number of medical home pioneers anticipated the need and desirability of moving in this direction.
- AAFP/ACP/AAP/AOA PCMH Joint Principles (2007) excerpt *"The payment structure should be based on the following framework:*
  - *Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.*
  - *Allow for additional payments for achieving measurable and continuous quality improvements."*

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Evolution of PCMH Payment (continued)

- Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission Incentive Alignment Principles (2007)
  - "Align incentives with the delivery of efficient, good chronic care, as defined by evidence-based care standards, and as measured in terms of structure, process and outcome."

Linking Performance and Payment

- Early payment models rewarded practice for “medical homeness” – which may or may not have improved quality and saved money.
- Several stakeholders wanted this to change:
  - Health plans and employers: wanted to pay for value, not infrastructure
  - Primary care practices: wanted to get off the pay-for-volume treadmill
- Some models incorporated pay-for-performance, but many sought more fundamental payment change.

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Linking Performance and Payment: PCMH Assumption of Performance Risk

- Three fundamental models:
  - Shared Savings: provider can share in financial rewards for constraining spending to less than it would have been *while* assuring quality
  - Primary Care Capitation: provider receives a fixed sum to provide PCMH services to a defined population of patients
  - Shared Risk: provider can share in financial rewards for constraining spending to less than it would have been *while* assuring quality – but must also share in the excess costs if spending is not constrained
- Shared Savings and Primary Care Capitation are sometimes used together.

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Shared Savings Model Description

1. Defines expected spending for the attributed population
2. Assesses performance relative to projection or control group
3. Distributes savings after consideration of quality performance relative to a predefined set of quality measures and criteria related to acceptable (and/or excellent performance) and/or improvement.
4. No savings distribution if quality level is unacceptable.
5. No penalty to practice if costs exceed budget: payer bears risk.
6. *Challenge*: large population required for cost measurement statistical certainty

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Case Study: Pennsylvania Chronic Care Initiative

- Shared savings since 2009; current design since 2012
- Insurers calculate results using common methodology
- Practices grouped to address small number problem
- Comparison of cost trend to book-of-business per business line (commercial, Medicaid, Medicare Adv.)
- Savings net of PMPM supplemental payments
- Risk-adjustment and high-cost outlier adjustment
- Adjustment for benefit carveouts
- “Gate and Ladder” approach to savings distribution if net savings achieved based on % of earned points
- Maximum eligible savings increases annually over three years: 40%/45%/50%

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Case Study: Pennsylvania Chronic Care Initiative

- A Practice shall be awarded one point for achieving either of the following:
  - attaining the NCQA HEDIS national 50th percentile rate for commercial “All Lines of Business”, Medicaid HMO and Medicare Advantage/Medicare
    - the 50th percentile calculated on a practice-specific basis by calculating a weighted average, using attributed patient count data to account for patient mix (i.e., Medicaid vs. commercial vs. Medicare Advantage), or
  - demonstrating a statistically significant improvement in the practice rate compared to the prior measurement year.

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Case Study: Pennsylvania Chronic Care Initiative

- A Practice shall be awarded two points for attaining the NCQA HEDIS national 75th percentile rate.
- A Practice shall be awarded three points for attaining the NCQA HEDIS national 90th percentile rate.

% of eligible points	% of earned savings
25%	20%
35%	25%
45%	30%
55%	35%
65%	40%

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Case Study:
Pennsylvania Chronic Care Initiative

1. PEDIATRICS
Prevention
1a. Weight Assessment for Nutrition and Physical Activity for Children/Adolescents (Year 1)
1b. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Years 2 and 3)
2. Childhood Immunization Status
3. Immunizations for Adolescents
4. Adolescent Well-Visit
Management of Chronic Conditions
5. Use of Appropriate Medications for People With Asthma
Clinical Care Management (to be risk-adjusted by payer)
6. All-cause 30-day readmission rate
7. ED Level 1 and Level 2 visit per 1000 (CPT Codes 99281 and 98282)

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Case Study:
Maryland Patient-Centered Medical Home Pilot

- Implemented in 2011.
- The percentage of savings that can be retained by the practice is linked to both reporting on quality measures, and achievement of performance thresholds relating to the measures.
- If a practice meets the minimum requirements, it can retain 30% of the savings. Better performance can qualify the practice to retain 40% or 50% of the savings.
- Practices must show improvements in the quality measures and reductions in ER visits and patient hospital days per 1,000 patients to maximize payments.

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Case Study:
Maryland Patient-Centered Medical Home Pilot

- State calculates results using common methodology and the state's All-Payer Claims Database
- Comparison of cost trend to statewide book-of-business trend of non-pilot practices per business line (commercial, Medicaid, Medicare Adv.)
- Savings net of PMPM supplemental payments
- High-cost outlier adjustment
- Adjustment for patients who are born or due during the year, claims for accidents & poisonings, and pharmacy
- Range of eligible savings from 30% to 50% with "gate and ladder" methodology based on thresholds met.

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Case Study:
Maryland Patient-Centered Medical Home Pilot

Measure Title	Reported by Pediatric Practices	Reported by Adult Practices
Asthma Assessment	YES	YES
Appropriate Testing for Children with Pharyngitis	YES	
Core: Hypertension: Blood Pressure Measurement		YES
Controlling High Blood Pressure		YES
Alternate Core: Weight Assessment and Counseling for Children and Adolescents	YES	
Core: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment		YES
Core: Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention		YES
Colorectal Cancer Screening		YES
Use of Appropriate Medications for Asthma	YES	
Alternate Core: Childhood immunization Status	YES	
Alternate Core: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old		YES
Pneumonia Vaccination Status for Older Adults		YES
Asthma Pharmacologic Therapy	YES	YES
Diabetes: HbA1c Poor Control		YES
Diabetes: Blood Pressure Management		YES
Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD		YES
Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control		YES
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		YES
Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment		YES
Core: Adult Weight Screening and Follow-Up		YES
Diabetes: HbA1c Control (<8%)		YES

Case Study:
Maryland Patient-Centered Medical Home Pilot

	Measures generated from the state's All-Payer Claims Data Base	Analyzed for Pediatric Practices	Analyzed for Adult Practices
Year 3	3-percentage point reduction from the baseline in the 30-day readmission rate (members of participating Carriers only)	n/a	YES
	3-percentage point reduction from the baseline in the Ambulatory Care Sensitive Condition (ACSC) hospitalization rate (members of participating Carriers only)	n/a	YES
	3-percentage point increase from the baseline in total primary care Practice visits (members of participating Carriers only)	YES	YES
	4% decrease from the baseline in emergency room visits per 1000 (members of participating Carriers only)	YES	YES

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Case Study:
Maryland Patient-Centered Medical Home Pilot

	Quality Measures Reporting			Utilization Measures		
Year 3						
50% share of savings	Meet thresholds for the 5 measures	Meet thresholds for the 18 measures	Meet thresholds for the 20 measures	Meet thresholds on 2 measures	Meet thresholds on 3 of 3 measures	Meet thresholds on 3 of 3 measures
40% share of savings	Meet thresholds for 4 measures	Meet thresholds for 15 measures	Meet thresholds for 16 measures	Meet thresholds on 1 of 2 measures	Meet thresholds on 2 of 3 measures	Meet thresholds on 2 of 3 measures
30% share of savings	Meet thresholds on 3 measures	Meet thresholds on 12 measures	Meet thresholds on 12 measures	n/a	Meet thresholds on 2 of 3 measures	Meet thresholds on 2 of 3 mea

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Primary Care Capitation Model Description

1. Determines cost of delivering PCMH services to a defined population. Typically takes historical costs and adjusts up to support historically non-reimbursed services.
2. Does not directly account for the costs of services delivered by other providers.
3. May, however, be accompanied by a P4P program or a shared savings program.

Case study:
Capital District Physicians' Health Plan

- Initial pilot was in 2008.
- Primary care capitation: amount determined by looking back at two prior years of experience and then applying a customized medical home risk adjustment methodology. Reimburses at 20% higher than previous fee-for-service for eligible practices
- Infrastructure support: practices receive $20,000 each to support transformation efforts over a 12 month period. Additionally, consulting support for meaningful use and interoperability of clinical data. Health Plan resources (nurse case manager, behavioral health and pharmacists) embedded in practice.
- P4P: Currently funded on a risk adjusted basis at $5.32 pmpm based on Triple Aim outcomes.

Case study: Massachusetts Medicaid Primary Care Payment Reform (PCPR) (*new in 2013*)

- Comprehensive Primary Care Payment
  - Risk-adjusted capitated payment for primary care services
  - Include three options for levels of behavioral health services
- Quality Incentive Payment
  - Annual incentive for quality performance, based on primary care performance
- Shared Savings Payment
  - Share in savings on non-primary care spend, including hospital and specialist services
  - Options for shared risk terms too

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Shared Risk Model Description

- Comparable design to shared savings, except for potential provider liability if spending exceeds budget target.
- Downside risk exposure is capped to protect the PCMH from assuming *insurance risk* (vs. *performance risk*).
- Potential upside gains for the provider are often greater than if shared savings design only.
- Generally speaking, practice organizations needed to be large (or in an IPA) to have the infrastructure to manage downside risk, and to have a sufficient patient population to be protected against statistical random variation.
- Most PCMHs with shared risk are considered to be ACOs.

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Summary

- PCMH payment methodologies in the U.S. are moving towards an emphasis on rewarding value.
- To be successful it will be important to remove the FFS volume incentive.
- As with everything else having to do with PCMH transformation and optimal performance, we are still learning.

For follow-up questions…

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