

Transition to Alternative Payment Methods: From Patient Medical Homes to the Primary Care Payment Reform Initiative

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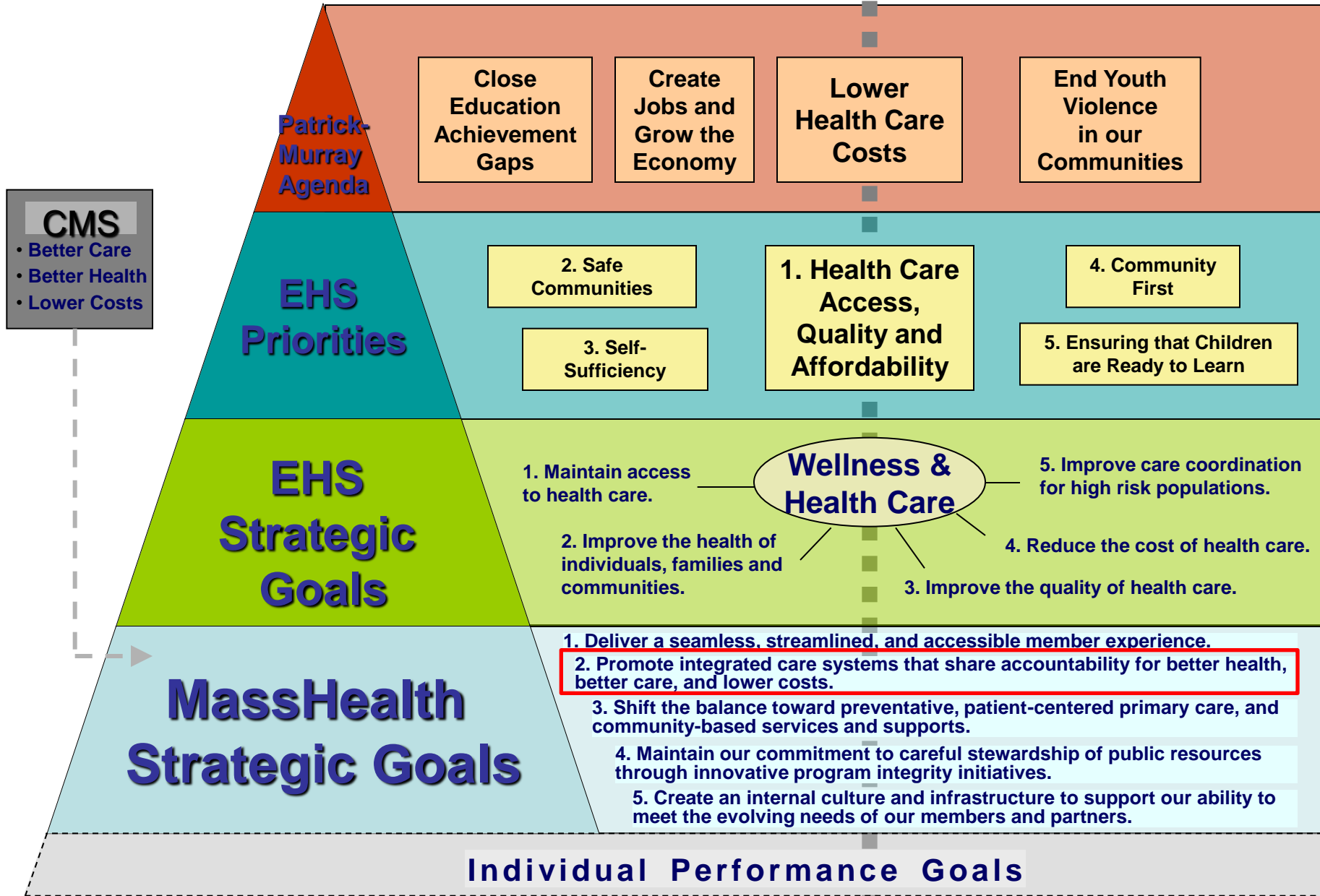


Our Mission



To improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.

EHS – MH Strategic Goal Alignment



Strategic Goals and Top Ten Strategic Initiatives



4 Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives

- Program Integrity Optimization



Members

1 Deliver a seamless, streamlined, and accessible member experience

- Operations and Customer Service Enhancement
- Integrated Eligibility System/ Health Insurance Exchange
- ACA Expansion

2 Promote integrated care systems that share accountability for better health, better care, and lower costs

- Duals Demonstration
- Delivery System Transformation
- **Primary Care Payment Reform**
- Health Information Exchange/Technology

3 Shift the balance toward preventative, patient-centered primary care, and community-based services and supports

- PCC/ Behavioral Health Integration
- Money Follows the Person



5 Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners

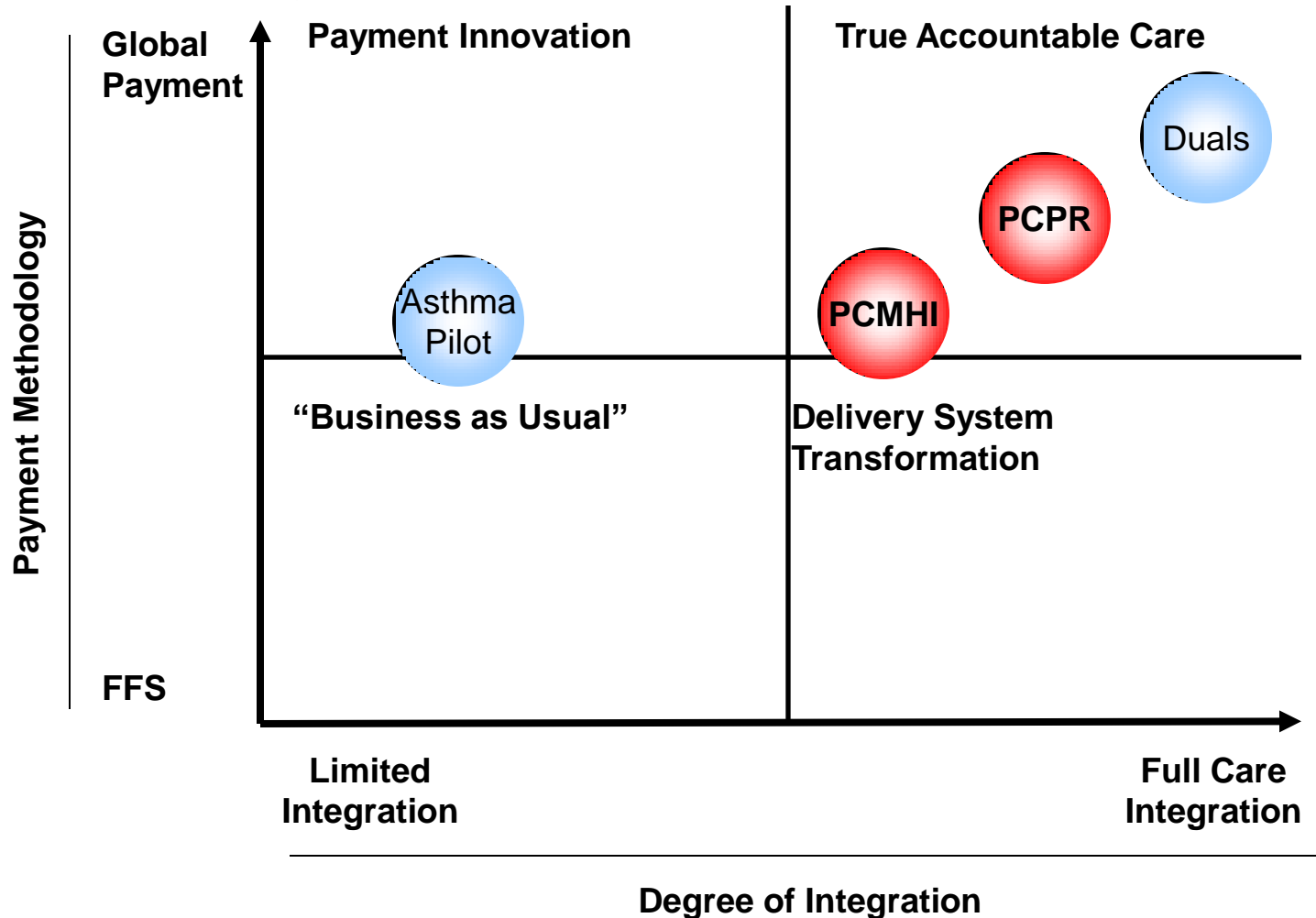
- Meet members where they are
- Focus on stewardship and fiscal responsibility
- Be data driven
- Model a team based approach

Agenda

- **MassHealth Strategy and Background**
- The MassHealth Primary Care Payment Reform initiative: “Comprehensive Payment for Comprehensive Care”
 - Comprehensive Payment
 - Delivery Model for Comprehensive Care
 - Implementation path
- Next steps

MassHealth has multiple programs to move towards integrated, accountable care to reform our payment and delivery system while providing affordable, quality care

● For discussion today



Primary Care Payment Reform is a high priority for MassHealth in this transition to accountable care

Tackling Primary Care payment methodology is essential to attaining accountable care

Primary Care Physicians can help reduce unnecessary utilization and improve quality

- Regular use of primary care physician is associated with improved satisfaction, better compliance, fewer emergency department visits and hospitalizations
- Geographic areas with more PCPs have lower rates of hospitalizations for diabetes, pneumonia and hypertension.
- Increase of 1 PCP per 10,000 population results in a 68 per 100,000 population absolute decrease in all-cause mortality.

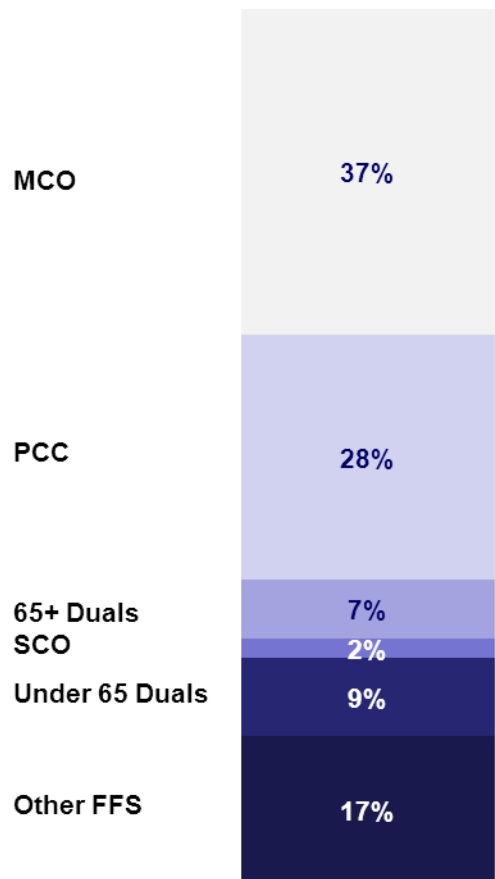
However, Fee for Service reimbursement does not optimally support PCPs taking on this role

- FFS compensation mechanism perpetuates a dysfunctional system that rewards quantity over quality
- PCPs increasingly frustrated by a system that encourages delivering complex care in short 15 minute visit
- Fewer medical students are choosing primary care as their careers.
- Older PCPs are retiring earlier than specialists

Overview of MassHealth Coverage Vehicles

MassHealth enrollment by plan
Percent of MassHealth enrollment

100% = 1.3 million members



Managed Care Organizations:

- Boston Health Net
- Cambridge Health Alliance
- Fallon Community Health Plan
- Neighborhood Health Plan
- Health New England

Primary Care Clinician Plan: MassHealth-administered managed care plan

Dual Eligibles:

- Eligible for Medicare coverage due to age
- Eligible for Medicare coverage due to disability or other reasons
- Most in FFS
- Seniors are eligible for SCO & PACE

Other FFS:

- Patients being assigned to an MCO
- Beneficiaries with third party coverage
- Members with access to limited benefits

The PCMHI and PCPR programs are a cornerstone in the accountable care strategy

- EOHHS began the **multi-payor Patient Centered Medical Home Demonstration** in April 2011 to test payment and delivery system transformation. PCMHI combined a payment model of **infrastructure support and shared savings** with a robust technical assistance program.
- With the **benefit of experience from the PCMHI Demonstration, MassHealth is developing the Primary Care Payment Reform (PCPR) Initiative**. This is the **alternative payment methodology** that will enable MassHealth to meet the benchmarks laid out in Ch. 224 for enrolling members in alternative payment methodologies
- Both PCMHI and PCPR are based on the belief that that **primary care is important** in improving quality and efficiency while preserving access, **through the patient centered medical home** with integrated behavioral health services
- The payment mechanism in PCPR **comprehensive primary care payment combined with shared savings +/- risk arrangement and quality incentives**
- Both PCMHI and PCPR **span the PCC Plan and the MCO's**. As in PCMHI, we propose to launch a procurement for PCCs to participate in the program and MCOs will participate in a similar payment structure with these organizations.

Background on PCMHI

- This 46 practice, multi-payer demonstration project covers over 100,000 members enrolled in both the PCC Plan and MCO plans
- Practices receive infrastructure payments, a per-member per-month payment for medical home activities, and upside-only shared savings
- PCMHI practices will be able to transition into PCPR

Lessons learned from PCMH

- Cooperation between the PCC Plan and MCOs is critical to keeping the administrative burden for practices to a manageable level
- Practice transformation is challenging and requires time and investment, especially on behavioral health integration
- Retaining strong ties to FFS incentives can hamper the process of practice transformation

Bodenheimer T, Grumbach K, Berenson RA. "A lifeline for primary care." *N Engl J Med*. 2009;360(26):2693–6.

Hauer KE, et al. "Factors associated with medical students' career choices regarding internal medicine." *Jama*. 2008;300(10):1154–64.

Lipner RS, et al. "Who is maintaining certification in internal medicine—and why? A national survey 10 years after initial certification." *Ann Intern Med*. 2006;144(1):29–36.

Bitton A, Martin C, Landon BE. "A Nationwide Survey of Patient Centered Medical Home Demonstration Projects." *J Gen Intern Med*. 2010. Jun;25(6):584-92

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PCPR will have a three-pronged payment structure

A



Comprehensive Primary Care Payment

- Risk-adjusted capitated payment for **primary care services**
- May include some behavioral health services

B



Quality Incentive Payment

- Annual incentive for quality performance, based on primary care performance

C



Shared savings payment

- Primary care providers share in savings on **non primary care spend**, including hospital and specialist services

The payment structure will not change billing for non-primary care services (specialists, hospital); PCP's will not be responsible for paying claims for these services. However, we are evaluating complementary alternative payment methodologies to hospitals and specialists for acute services.

Alternative payment systems in MA all include cost and quality accountability

	MSSP	Pioneer	AQC	PCMHI
Description	Medicare program, allows providers to form ACOs to share savings	CMMI program, aimed at integrated organizations	BCBS program for providers for HMO patients	Multipayor initiative with primary care sites in the state
Cost accountability	Upside only, or shared risk contracts	Shared risk contracts, optional transitions to pop. payments	Upside only and shared risk contracts	Upside only shared savings model
Quality accountability	Earning potential tied performance on 33 measures	Earning potential tied performance on 33 measures	Bonus based on performance on 32 ambulatory measures and 32 hospital measures	Mastery of 12 PCMH competencies and NCQA accreditation.

A

Proposed payment structure: Comprehensive Primary Care Payment

What is the purpose of this capitated payment?

- **Does not limit practices to revenue streams that are dependent on appointment volume or rate value units (RVUs).**
- **Allows practices the flexibility to provide care as the patient needs it**, without depending on fee-for-service billing codes. This may support expanding the care team, offering phone and email consultations, allowing group appointments, targeting appointment length to patient complexity, etc.
- **Allows a range** of primary care practice types and sizes to participate
- **Provides financial support for behavioral health integration** by including some outpatient behavioral health services in the CPCP
- **Ensures support and access for high-risk members through risk adjustment** based on age, sex, diagnoses, social status, comorbid conditions

B Proposed payment structure: Quality incentive payment

- Similar to pay-for-performance programs, **participants will win some percentage bonus to the base payment** based on quality performance
- **We will use a set of metrics that are common across other programs**, including programs deployed by other payors or used for other quality measurement purposes

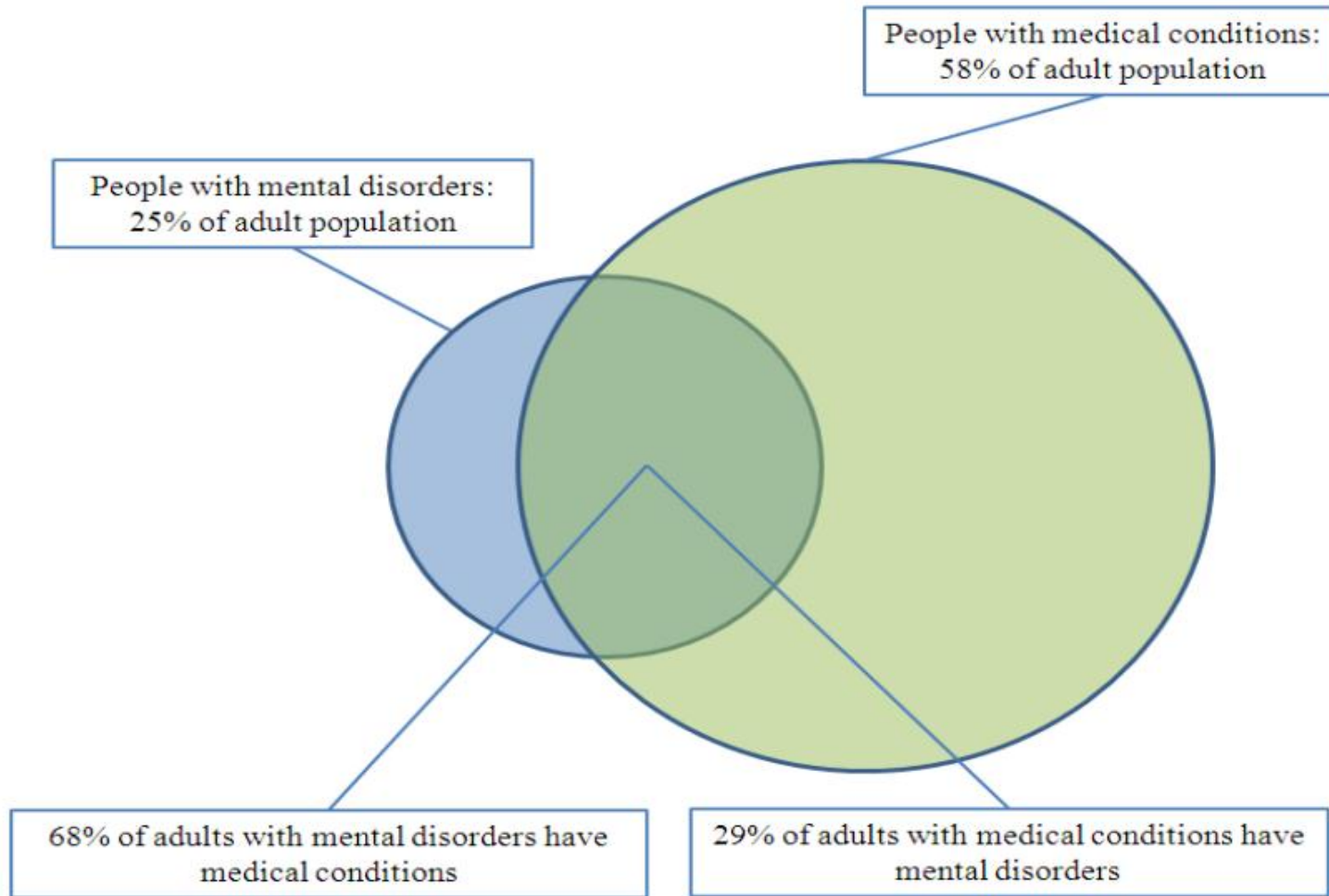
C Proposed payment structure: Shared Savings

	Track 1: Upside / Downside Risk	Track 2: Transitioning into downside risk	Track 3: Upside only
Targeted providers	<ul style="list-style-type: none"> • Large providers already taking on downside risk with other payors 	<ul style="list-style-type: none"> • Less advanced providers interested in taking on risk, but not yet ready 	<ul style="list-style-type: none"> • Providers that do not have the financial capability to take on risk
Non-primary care spend incentive	<ul style="list-style-type: none"> • Shared savings model with upside and downside risk, similar to MSSP • Risk corridors to limit provider liability 	<ul style="list-style-type: none"> • Upside only in year 1; downside risk possibly added in year 2 • Narrower risk corridors than Track 1 	<ul style="list-style-type: none"> • Upside only (incentive based on TME; significantly smaller than potential Track 1 upside)
Quality component	<ul style="list-style-type: none"> • Providers must pass a quality threshold to receive shared savings • Quality performance acts as a multiplier, up and downside (i.e., higher quality performance improves savings bonus and reduces liability if there are losses) 	<ul style="list-style-type: none"> • Providers must pass a quality threshold to receive shared savings • Quality performance acts as a multiplier, up and downside (i.e., higher quality performance improves savings bonus and reduces liability if there are losses) 	<ul style="list-style-type: none"> • Providers must pass a quality threshold to receive shared savings • Quality performance acts as a multiplier on the shared savings payment

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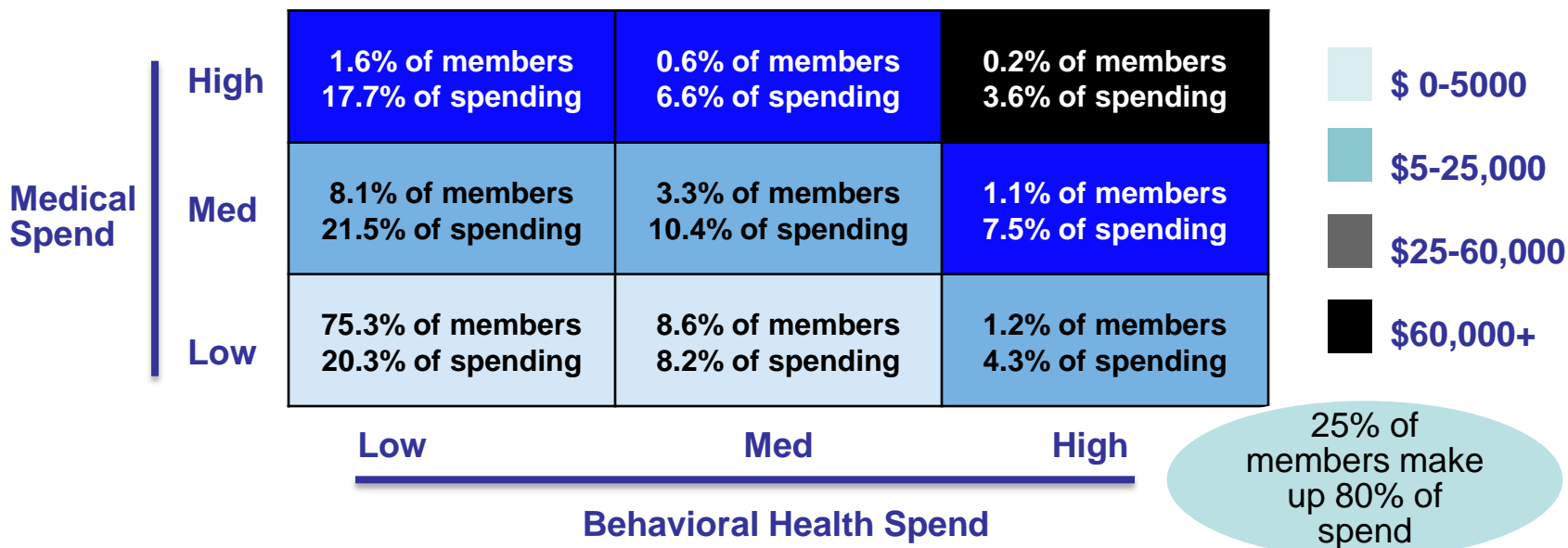
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Why are we focused on the integration of primary care and behavioral health?



Integrating **behavioral health** and enhancing **primary care** will drive quality and efficiency for most complex and high cost members

Spending on members by medical and behavioral health costs in the PCC Plan

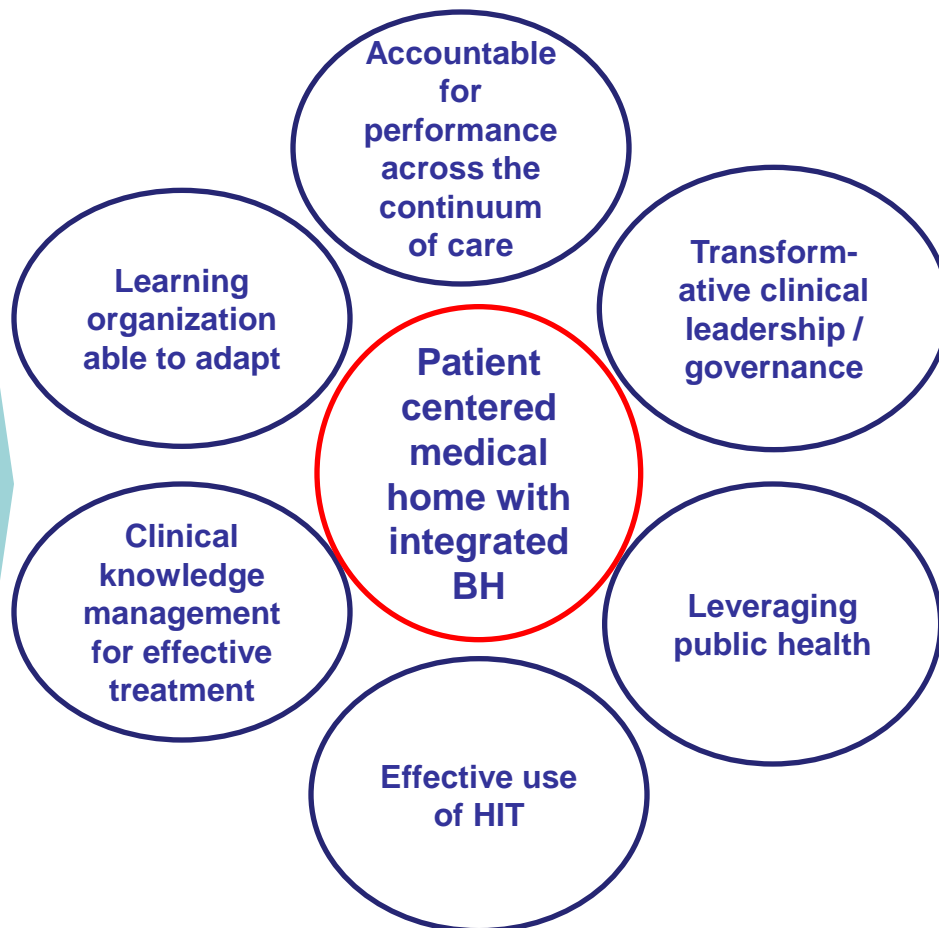


Delivery model: Based on the PCMHI foundation plus features targeted at system wide impact

PCMHI Foundation:

12 capabilities: Patient centeredness, multidisciplinary team, registry use, care coordination and managed, enhanced access, etc.

Integrated behavioral health: behavioral health includes mental health care, unhealthy substance use diagnosis and treatment, and support to alter unhealthy lifestyles



System wide impact:

- Patient centered outcomes
- Improved care coordination and patient experience
- Clinical integration and evidence based case
- Patient activation and increase health literacy
- Efficient and cost effective care
- Population health improvement

Delivery model: Primary care or behavioral health sites may be primary care home

- The Medical Home may be either the primary care practice site or the behavioral health site
- Practices may integrate behavioral health and primary care utilizing the following approaches:
 - Non- Co-located but Coordinated- Behavioral services by referral at separate location with formalized information exchange
 - Co-Located -By referral with formalized information exchange at medical home location
 - Fully Integrated- Part of the “Medical Home” team and based at the location. Primary care and behavioral health providers work side by side as part of the health care team.

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Implementation path: Providing non-financial support

- **Supporting practice transformation**

- Learning collaboratives
- EHR support / optimization through REC
- Medicaid incentive payments
- Last mile strategy to ensure connection to Health Information Exchange

- **Timely, accurate data** – we plan to build on the Patient Centered Medical Home Initiative reporting by providing access to notification of hospital admissions / ED visits, pharmacy data, and broader claims data

Implementation path: Member protection

MassHealth is working closely with stakeholders to ensure robust member protections

Key elements:

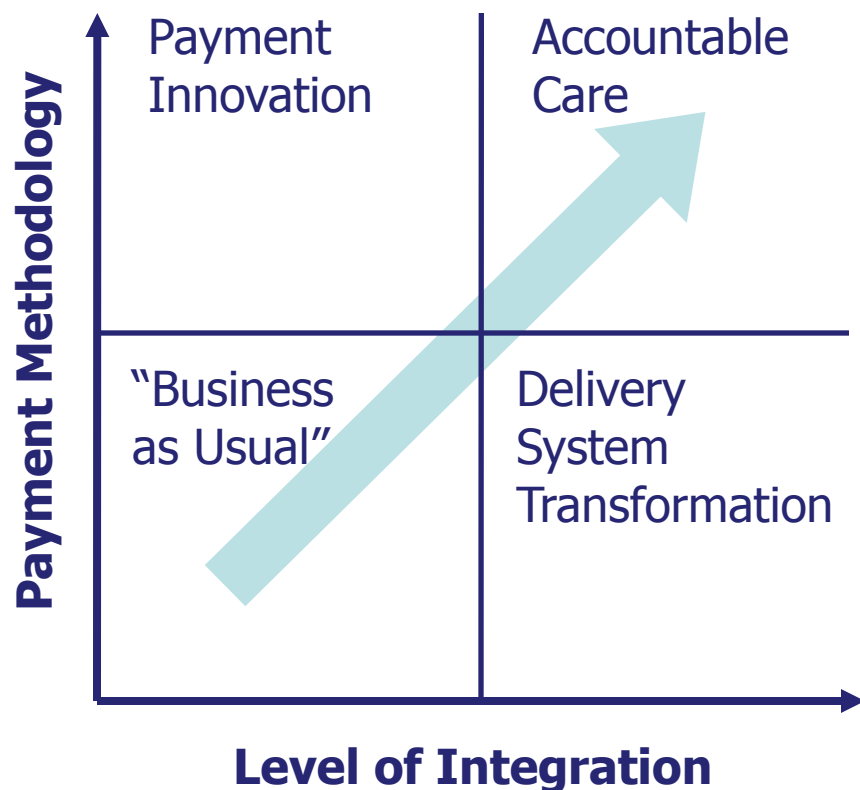
- **Choice of PCC:** Members remain free to switch primary care providers at any time
- **Patient experience impacts opportunity for quality incentive payments:** Patient experience survey data will serve as a key quality domain for quality incentive and shared savings payments
- **Notification requirements:** Providers will be required to notify their patients of their participation in the program and the potential impact on patients, including any changes in practice operations that will affect patients

Implementation path: Procurement structure

- We will establish a **3 year procurement for providers in the Primary Care Clinician Plan** to receive a **comprehensive primary care payment (CPCP)**
- We are working with Medicaid **MCO's to also pay primary care providers in this partial capitation and shared savings/risk framework**
- Eligible providers will be Primary Care Clinicians that commit to a form of integrated behavioral health services, meet minimum enrollee thresholds, and demonstrate the ability to accept capitated payments and improve coordination, quality, and efficiency
- This procurement **may be selective**
- We plan to have **25% of members (PCC + MCO) participating by July 2013, 50% of members participating by July 2014, and 80% by July 2015**

Supporting investments will facilitate MassHealth providers' transition to accountable care

MassHealth's vision is to move toward truly Accountable Care...



...supported by a number of strategic investments

- MassHealth Delivery System Transformation Initiatives (DSTI) for Safety Net Hospitals (\$628M)
- Infrastructure & Capacity Building Grants
- Distressed Hospital Fund (\$135M from 2013-2016 administered by the HPC)
- MassHealth Health Information Technology Incentive Payments to Hospitals & PCPs (\$600M)
- All Payer Claims Database
- Health Information Exchange
- ACA Enhanced Payments for Primary Care providers

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Next steps

- **January – PCPR RFR release**
- **March – Applications due**
- **April – Applicants selected through a MassHealth selection committee**
- **July – Targeted Go Live Date for participants to begin receiving payment under the PCPR payment methodology**