MassHealth

Introduction to Primary Care Payment Reform Initiative

November 27th, 2012

MassHealth

Executive summary

- The goal of our strategy is **improving access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health**
- We believe 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 that supports that delivery model is a **comprehensive primary care payment combined with shared savings +/- risk arrangement and quality incentives**
- **This program would span MassHealth managed care lives across the PCC Plan and the Managed Care Organizations.** 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.
- We plan to implement on an aggressive timeframe, with an **RFP release planned in January 2013 and with 25% of member participating by July 2013, 50% of members participating by July 2014, and 80% by July 2015**

MassHealth

Proposed payment structure

A

Comprehensive Primary Care Payment

- Risk-adjusted capitated payment **for primary care services**
- Options for including outpatient 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.

MassHealth

A

Proposed payment structure: Comprehensive Primary Care Payment

What is the purpose of this payment?

- **Does not limit practices to revenue streams that are dependent on appointment volume or RVU's**

- **Gives 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

MassHealth

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

MassHealth

C Proposed payment structure: Shared Savings

	Track 1: Upside / Downside Risk	Track 2: Transitioning into downside risk	Track 3: Upside only
Targeted providers	• Large providers already taking on downside risk with other payors	• Less advanced providers interested in taking on risk, but not yet ready	• Providers that do not have the financial capability to take on risk
Non-primary care spend incentive	• Shared savings model with upside and downside risk, similar to MSSP • Risk corridors to limit provider liability	• Upside only in year 1; downside risk possibly added in year 2 • Narrower risk corridors than Track 1	• Upside only (incentive based on TME; significantly smaller than potential Track 1 upside)
Quality component	• 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)	• 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)	• Providers must pass a quality threshold to receive shared savings • Quality performance acts as a multiplier on the shared savings payment

MassHealth

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.

MassHealth

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

MassHealth

Implementation path: Member protection

We look forward to working 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

MassHealth

Next steps

- January – RFR release
- March – Applications due
- April – Applicants selected
- July – Go live