

Introduction to Primary Care Payment Reform Initiative

September 12, 2012



Executive summary

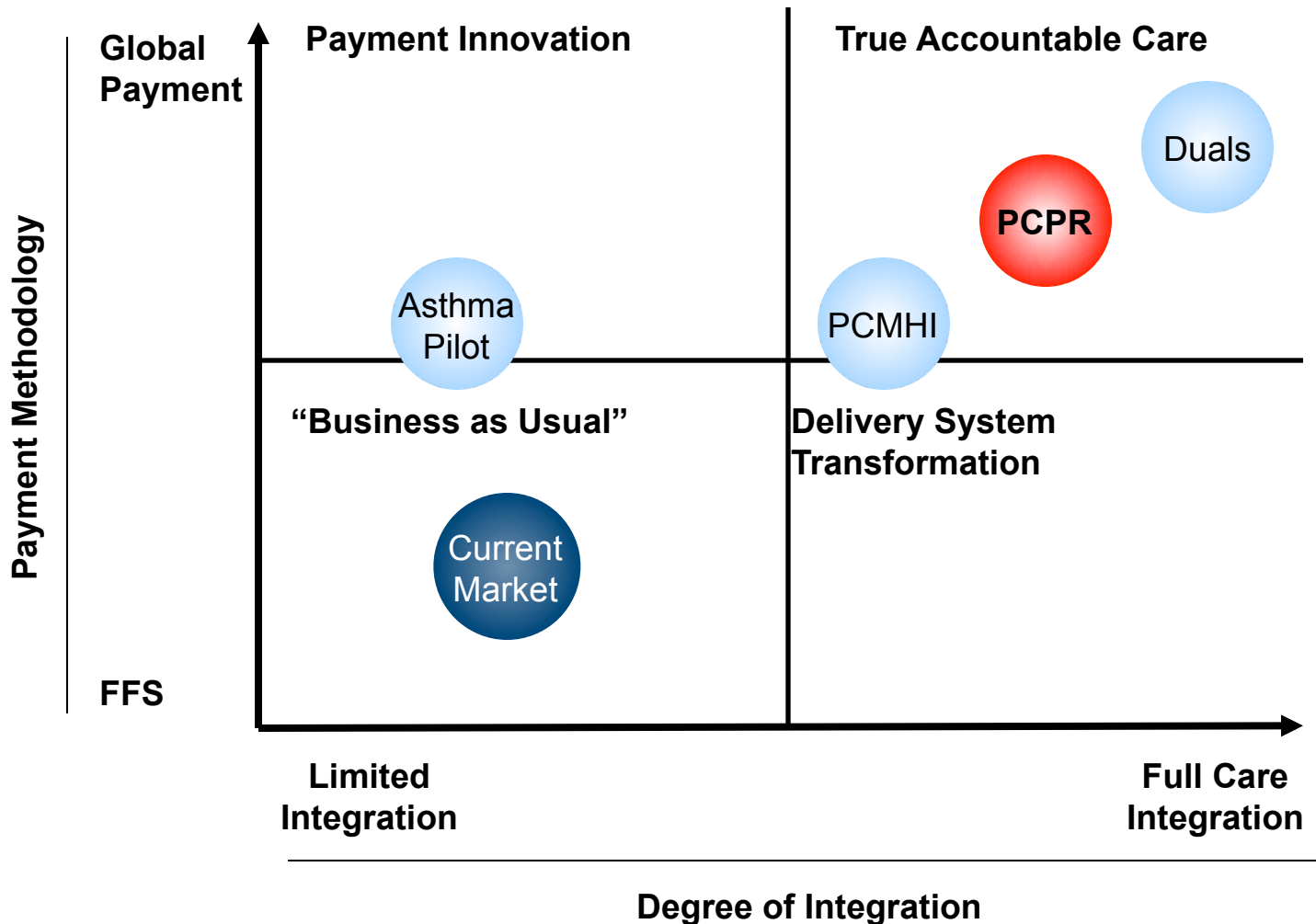
- The goal of our strategy is **improving access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health**
- We believe that **primary care is important** in improving quality and efficiency while preserving access, **through the patient 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**

Agenda

- **MassHealth strategy**
- The MassHealth Primary Care Payment Reform initiative: “Comprehensive Payment for Comprehensive Care”
 - Comprehensive Payment
 - Comprehensive Care
 - Implementation path
- Next steps

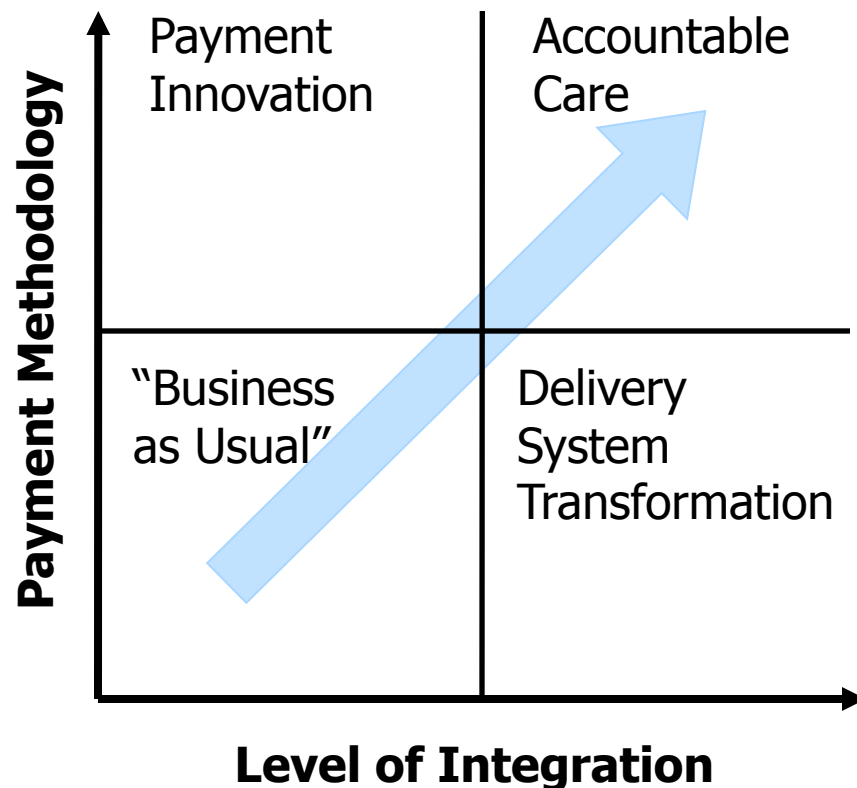
MassHealth is leveraging alternatives to fee-for-service payments to promote integrated, accountable care across initiatives

● For discussion today



These initiatives are supported by investments

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



...supported by a number of strategic investments such as

- MassHealth Delivery System Transformation Initiatives (DSTI) for Safety Net Hospitals (\$628M)
- 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

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 ED 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

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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Proposed 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.

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

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



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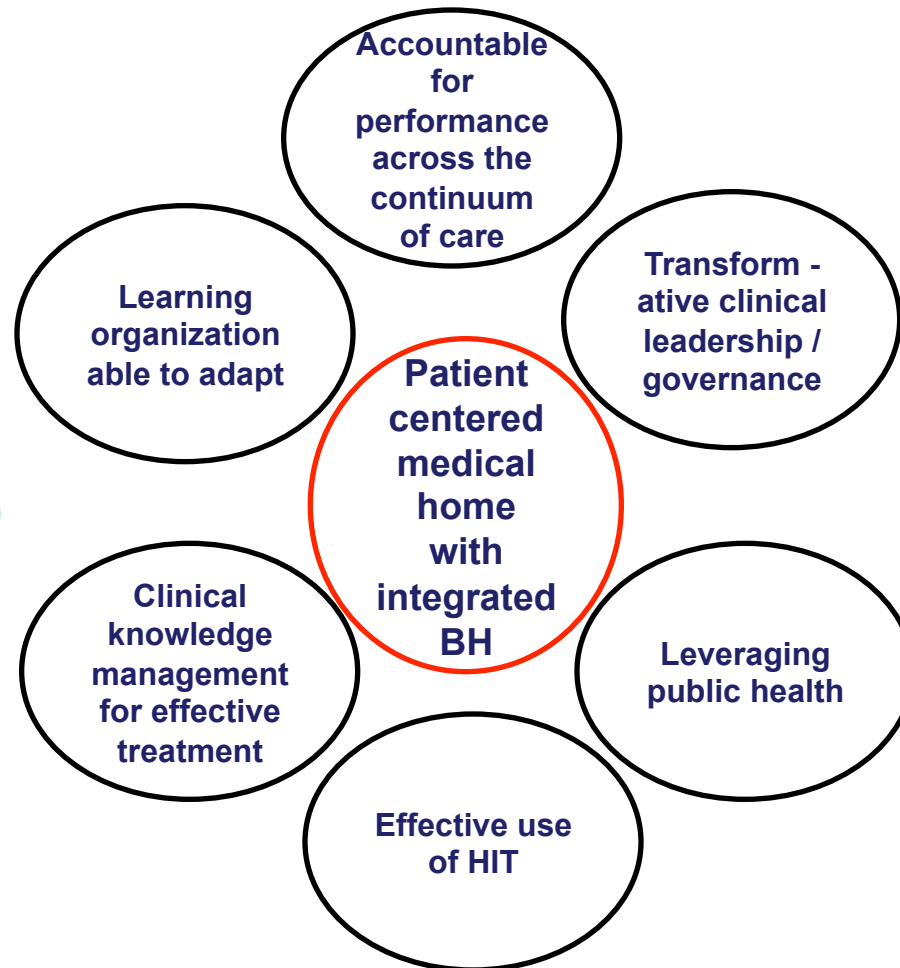
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Delivery model: Based on the PCMH foundation plus features targeted at system wide impact

PCMH 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

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

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**

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We will continue to engage stakeholders

- August – October
 - First open meeting; Release RFI
 - Refine financial model
 - Series of topic specific open meetings:
 - quality metrics
 - integration of primary care and behavioral health
 - IT infrastructure and data sharing
 - member protections
 - shared savings / risk model
 - Comprehensive Primary Payment model
 - Eligibility criteria
- November – January
 - Continue to engage stakeholder community
 - Draft and release RFP

Implementation path: Go live by 2013

Key dates:

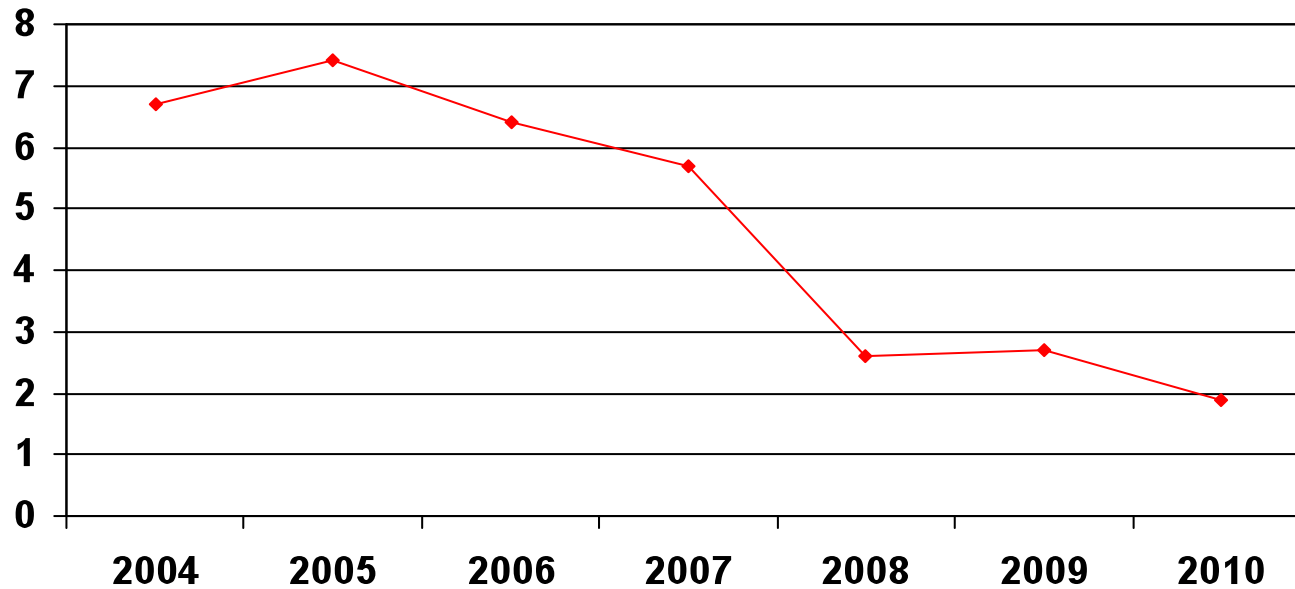
- **October 2012 – Complete making major design choices; begin drafting RFP**
- **January 2013 – Release RFP**
- **March 2013 – Select applicants**
- **May 2013 – Go live**

Appendix

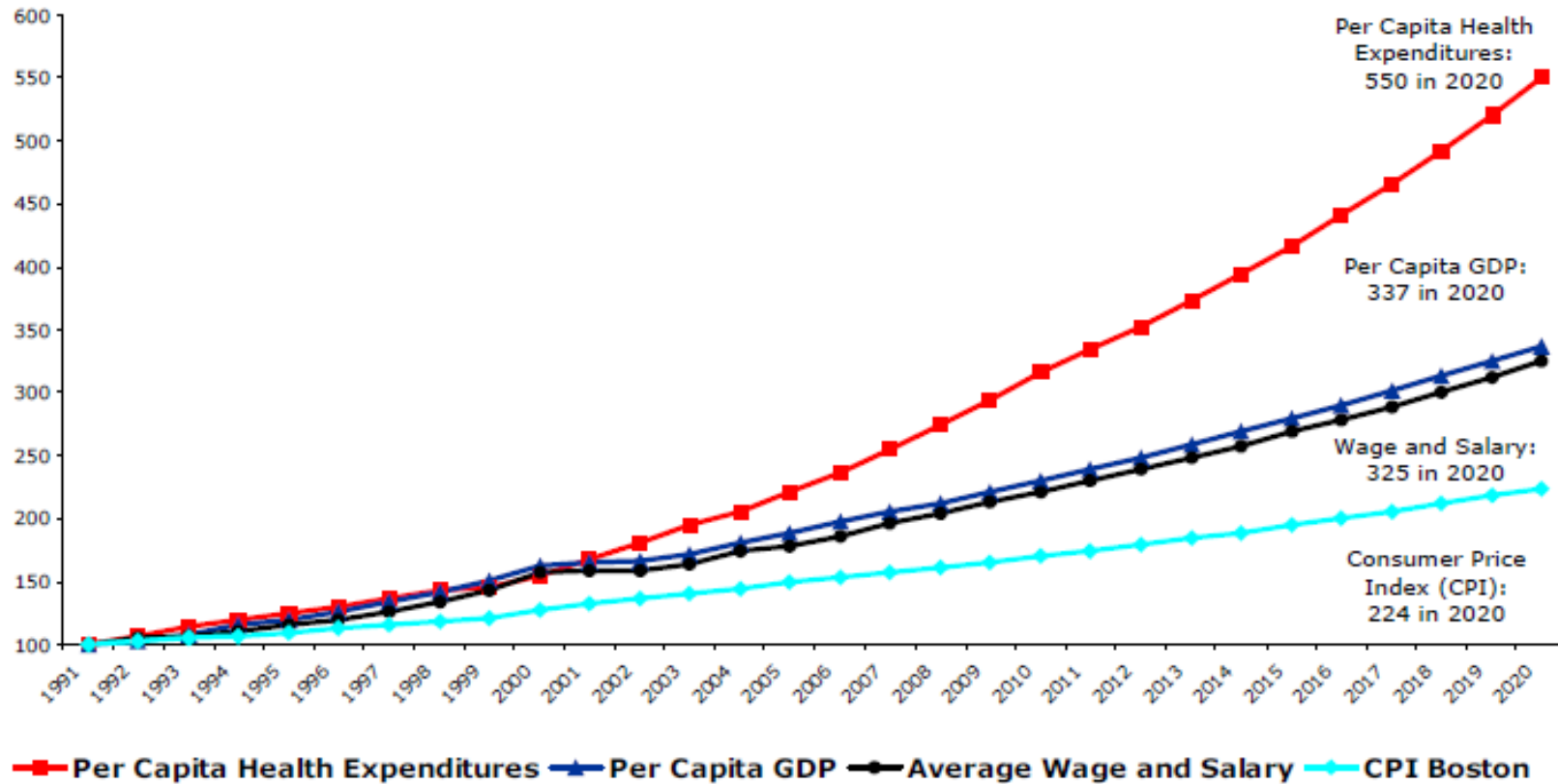
- **The importance of controlling cost**
- Market context
- Quality measures

Massachusetts has made significant progress in expanding access...

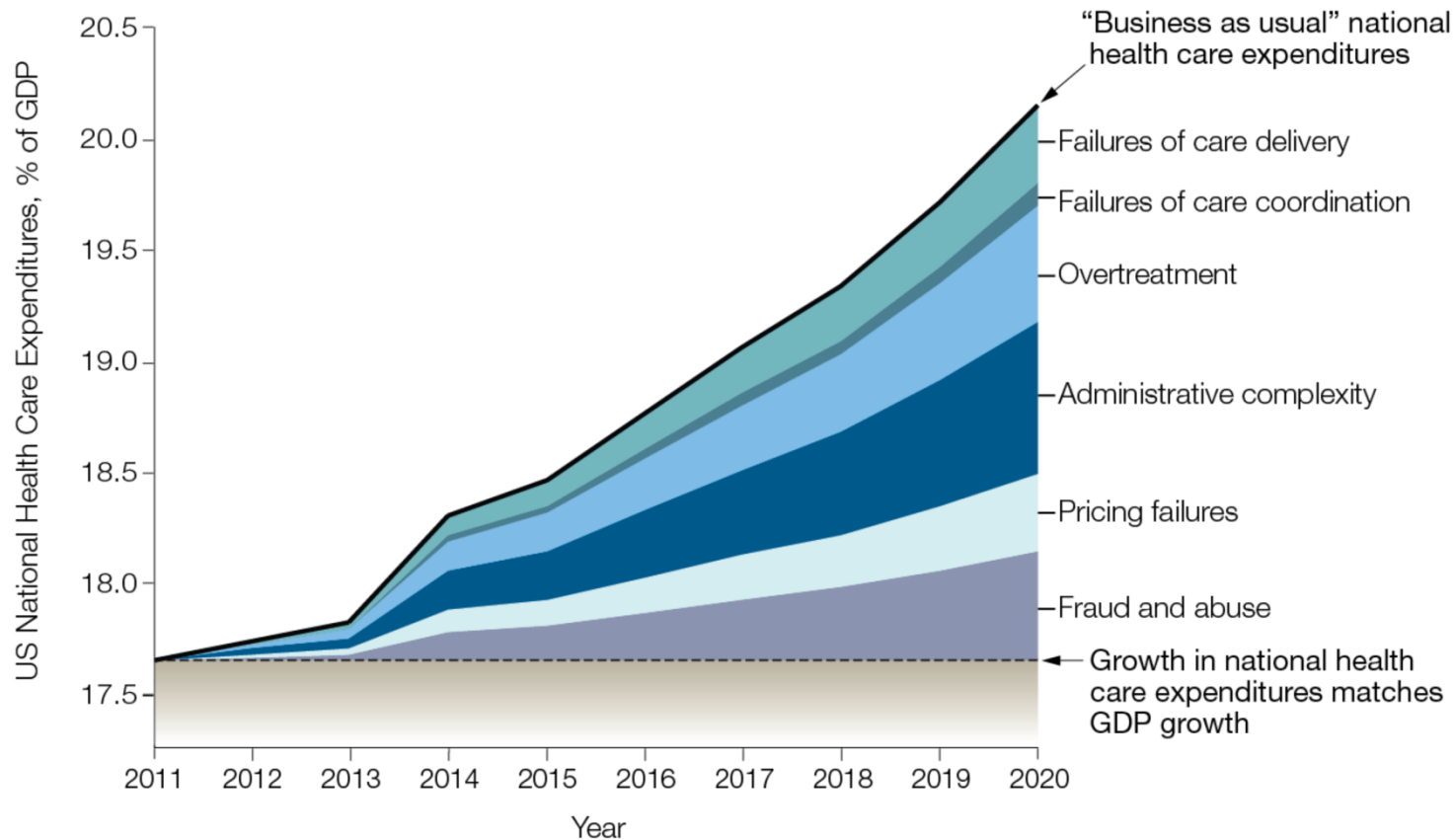
Percentage of uninsured adults in Massachusetts
(% of total adults in MA)



... however, health care spending growth in Massachusetts is unsustainable



There are significant opportunities to improve care delivery and financing in ways that could generate substantial savings over time



Donald Berwick and Andrew Hackbarth, "Eliminating Waste in US Health Care", JAMA. 2012; 307(14): 1513-1516.

This program is aligned with other payors' programs in Massachusetts

	Other Programs	Our Program
Cost accountability	<p>MSSP: Upside only and shared risk</p> <p>PCMHI: Upside only</p> <p>Pioneer: Shared risk, optional transition to population based payments</p> <p>AQC: Shared risk</p>	<p>Upside only and shared risk contracts</p>
Quality accountability	<p>MSSP/Pioneer: Earning potential tied to performance on 33 measures</p> <p>AQC: Bonus based on performance on 32 ambulatory measures and 32 hospital measures</p> <p>PCMHI: Mastery of 12 PCMH competencies and NCQA accreditation</p>	<p>Bonus based on performance on quality measures. Measures build on MSSP measures with additions for pediatrics and behavioral health</p>
Non-financial support	<p>MSSP/Pioneer: Medicare provides claims data</p> <p>AQC: BCBS provides claims data, RT notification of hospital utilizations and ED visits and technical assistance</p> <p>PCMHI: Payor provides claims data, some RT notification of hospital utilizations and ED visits , technical assistance and learning collaborative</p>	<p>Claims data, RT notifications, technical assistances</p>

Case studies have shown that these new payment methods are succeeding



Incentive structure

BCBS established global budget risk sharing contracts with physician groups.

Hampden County Physician Associates with Mercy Medical Center entered into a prospective global payment arrangement with a managed Medicare provider

MGH Primary Care Group demonstration project embarked on a 3-year shared savings demonstration with CMS

Patient population

BCBS HMO or point-of-service enrollees.

5,100 managed Medicare members

2,500 high-cost Medicare enrollees

Outcomes improvement¹

2.6% increase in proportion of patients meeting chronic care quality thresholds

45% drop in hospital admissions
7% decline in average length of stay

4% lower mortality
13% drop in ED visits
20% lower hospitalization rate

Cost improvement

Intervention associated with a 1.9% medical savings relative to control group.

12% lower cost than a comparable population

7% lower cost than a comparable population after accounting for care management fees

What do we mean by high-quality care?

- **Enhanced access:** Improved access to primary care services through extended hours, partnerships with urgent care, or other ways means
- **Patient-centeredness:** Patient involvement in decision making, increased focus on the patient experience
- **Behavioral health integration:** appropriate screening and testing for behavioral health conditions in primary care settings; enhanced coordination between behavioral health and primary care providers
- **Care coordination:** better management of care transitions, alignment on care plans with other providers
- **Improved health and wellness:** actual improvements in patient health and wellness outcomes; may need to have separate measures geared towards differently populations and conditions (e.g., pediatric measures, chronic disease measures)

We have an initial list of measures, but hope to work with stakeholders to narrow the list to 20-30 measures

- **Domains**
 - **Access**
 - **Patient-centeredness**
 - **Behavioral health integration**
 - **Care coordination**
 - **Improved health and wellness**
 - **Women's health**
 - **Pediatric health**
- **These measures were based on the Medicare ACOs.**
 - **Measures appropriate to Medicaid & PCPR were added.**

Initial List of Measures

Access

- CAHPS: Getting Timely Care, Appointments, and Information (#5 & #6)

Patient-centeredness

- CAHPS: How Well Your Doctors Communicate, Patients' Rating of Doctor, Access to Specialists, Health Promotion and Education, Shared Decision Making, Health Status / Functional Status (#5 & #6)

Behavioral health integration

- Depression screening (#418)
- Antidepressant medication management (#105)
- Initiation and engagement of alcohol / drug dependence treatment (#4)
- Follow up after hospitalization for mental illness (includes children and adults) (#576)
- ADHD medication management for children (#108)
- SBIRT (alcohol abuse)

Initial List of Measures, Continued.

Care coordination

- Ambulatory Sensitive Conditions Admissions: CHF (#277)
- Medication Reconciliation after discharge from an Inpatient facility
- Percent of patients with one primary care visit in the past year
- Diabetes hospital admission rates (#638)
- Asthma hospital admission rates (#283)

Improved health and wellness

- Influenza immunization (#41)
- Pneumococcal vaccination (#43)
- Adult weight screening and follow up (#421)
- Tobacco use assessment and tobacco cessation intervention (#28)

Initial List of Measures, Slide 3

Improved health and wellness, cont

- Colorectal cancer screening (#34)
- Mammography screening (#31)
- Screening for high blood pressure
- Diabetes Composite (All or Nothing Scoring #729): Hemoglobin A1c Control (<8 percent), LDL (<100), Blood pressure <140/90, Tobacco Non Use, Aspirin Use
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) (#59)
- Hypertension: Controlling high blood pressure (#18)
- Ischemic Vascular Disease: Complete Lipid Panel and LDL Control (<100 mg/dL) (#745), Use of Aspirin or other antithrombotic (#68)
- Heart Failure: Beta-blocker therapy for LVSD (#83)
- Drug therapy for lowering LDL-cholesterol (#74); ACE inhibitor or ARB therapy for patients with CAD, Diabetes and LVSD (#66)
- Percent of PCP's who Successfully Qualify for an EHR Program Incentive Payment

Initial List of Measures, Slide 4

Women's Health

- *Prenatal and postpartum care (includes post partum depression screening) (NQF 1517)*
- *Chlamydia screening (#33) Cervical cancer screening (#32)*

Pediatric Health

- *Asthma medication (#36) BMI assessment and counseling (#24)*
- *Adolescent immunization (#1506)*
- *Developmental screening in first five years (#1448)*
- *Well child visits, <15 months (#1392), 3-6 (#1516), adolescent*
- *Childhood immunizations (#38)*
- *A1c diabetes for children (#60)*

Discussion Questions

Right List of Measures?

What goals for improvement?

What QI processes?

What else?

