

ATTACHMENT U Primary Care Payment Protocol

The Commonwealth must complete this Protocol and submit to CMS for annual review and approval, in accordance with STC 8.7 and the Schedule of Deliverables for the Demonstration Period in the STCs.

Section 1: General Information and Updates

1. Summary of changes since previously approved protocol, if applicable:

N/A - RY23 is the initial year of implementation.

2. Timeframes for the primary care payment arrangement with Primary Care ACOs and participating primary care practices.

- a. Applicable period for this payment arrangement (e.g., performance year beginning Jan. 1, 2024 through Dec. 31, 2024): *April 1, 2023 through December 31, 2023 (RY23)*
- b. Requested start date for payments (for example, Jan. 1, 2024): *April 1, 2023*

3. Estimated total dollar amount (federal and non-federal dollars) of this primary care payment: *The estimated payment amount for this primary care initiative for Primary Care ACOs (PCACOs) for RY23 is \$153.2M.*

- a. Estimated federal share: *The estimated federal share is \$91.9M, or approximately 60% of the total primary care sub-capitation amount*
- b. Estimated non-federal share: *The estimated non-federal share is \$61.3M, or approximately 40% of the total primary care sub-capitation amount.*

The estimated total dollar amount and the estimated federal share should be described for the period in Question 2. For mid-year adjustments, the Commonwealth should include the change from the total and federal share estimated in the previously approved Protocol.

Section 2: Payment Methodology

1. Describe how the payment arrangement intends to recognize value or outcomes over volume of services.

Practice rates include a "Tier" add-on. Practices attest to one of three clinical Tiers (e.g., Tier 1, Tier 2, or Tier 3) with each subsequent Tier corresponding to increased clinical requirements and correspondingly higher rates. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care. Since rates increase by Tier, practices are incentivized to meet higher clinical standards to advance in Tier status.

Payments from PCACOs to primary care practices are prospective and therefore not based on volume during the payment period and will not be reconciled to utilization after the payment period. This shift away from fee for service represents a fundamental recognition of value over volume.

- 2. Provide a detailed description of the payment methodology, including utilization of services, provider types in this payment arrangement, provider requirements for the payments, payment adjustments (e.g., clinical tiers and criteria), the timeframes for payments, and any supporting documentation describing how the primary care payments were developed.**

MassHealth members select their primary care provider practice when they are enrolled in a PCACO. For members who do not select voluntarily, MassHealth assigns a primary care provider practice and informs the member of the assignment. Each primary care practice in the ACO program only works with one PCACO. At any given time, all members in a PCACO are attributed to a primary care provider practice, and PCACOs and PCPs track this attribution in close to real time. PCACOs are required to make prospective payments to primary care practices on a per member per month (PMPM) basis, based on attributed population and a defined set of services/codes. Sub-capitation rates are based on historic utilization, including considerations for relevant demographics and risk.

All primary care practices participating in a PCACO are eligible for and required to participate in the primary care payment methodology described in this Protocol. Rates are set at a "Primary Care Entity" level, which corresponds to the Tax ID of the primary care practice. Primary Care Entities include hospital outpatient departments, physicians and group practices, and community health centers. Primary Care Entities may be comprised of multiple primary care practice sites. Payment rates for Primary Care Entities are set based on the tier and provider type of their constituent primary care practices.

Annually, each primary care practice site in a Primary Care Entity will attest as to whether it meets the clinical Tier criteria for Tier 1, Tier 2, or Tier 3. Through the tiered primary care payment model, increased payment is tied to enhanced care delivery expectations and responsibilities. There are three different tier levels at which practices can participate. Tier criteria focus on team-based care, behavioral health integration, health-related social needs screening and referral, population health management, access during expanded hours, and, for practices serving members under age 21, child and family-focused care (e.g., fluoride varnish, coordination with schools and early education settings). As practices develop clinical capacities, they will have the opportunity to participate in higher Tiers, through an anticipated annual process.

The development of Rate Year 2023 primary care payment rates uses the same base data and follows a similar methodology to that used in developing the Rate Year 2023 Total Cost of Care Benchmarks for PCACOs. Primary care rates are developed for each Rating Category.

Claims and encounters included in the primary care payment base data meet the following criteria:

- 1. Primary Care Entity: The provider billing the claim must be in the same Primary Care Entity as the primary care provider to which the member is assigned.*
- 2. Service: Claims must contain at least one primary care service, defined by a set of codes.*
- 3. Specialty: Claims must be for services rendered by a primary care provider (excludes specialists).*

Individual claims are excluded from the base data if they do not meet these criteria. Base data is price-normalized to align unit cost levels to the applicable MassHealth standard unit price for primary care services.

Primary care trend assumptions are applied consistent with the underlying trend assumptions used for ACO market rate development. These trend assumptions include adjustments for the Coronavirus Disease Public Health Emergency, among other assumptions. Adjustments were also applied to the Primary Care Entity-specific rates to minimize volatility associated with a small membership and/or claims volume.

Primary Care Entity-specific blended rates are developed by applying base adjustments, trend and prospective adjustments to the Primary Care Entity-specific unadjusted base data at the Rating Category level.

MassHealth will make prospective payments to PCACOs at the beginning of each month. PCACOs must make the PMPM payments to Primary Care Entities after receiving payment from MassHealth.

MassHealth will continue to ensure that any FQHCs that participate in the primary care payment program as part of a PCACO are paid an amount at least equal to what they would be paid under their applicable PPS rates. Calculation of the PPS wrap payments for FQHCs participating in this payment arrangement through a PCACO are set forth in the FQHC SPA .

Please refer to Section 4 of this document for additional detail about payment requirements.

Section 3: Quality of Care and Health Outcomes

- 1. Describe how Primary Care ACOs and participating primary care practices will be assessed on access to care and health outcomes for beneficiaries receiving services through this payment arrangement.** Please include a table with performance measure information (i.e., measure title, identifiers (NQF # and ACO #), and measure steward), the defined performance period, and the performance baseline and targets for the performance period. Note, indicate the year of data used to establish the performance baselines and targets. These may be added after the first year of the payment arrangement.

The State will assess Primary Care ACOs and participating primary care practices on access to care and health outcomes for beneficiaries receiving services through this arrangement through the independent evaluation of the State's 2022-2027 1115 Demonstration, as well as through an evaluation of the Quality Measures listed below.

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target
<i>Follow-Up After Emergency Dept Visit for Mental Illness (7 day); NCQA</i>	<i>CY 2023</i>	<i>TBD (Expected Q1 2025)</i>	<i>Attainment: 63.00 Goal: 76.00</i>
<i>Follow-Up After Emergency Dept Visit for AOD Abuse & Dependence (7-day); NCQA</i>	<i>CY 2023</i>	<i>TBD (Expected Q1 2025)</i>	<i>Attainment: 19.00 Goal: 26.00</i>
<i>Screening for Depression and Follow Up Plan; CMS</i>	<i>CY 2023</i>	<i>TBD (Expected Q1 2025)</i>	<i>Attainment: 29.00 Goal: 58.00</i>

Section 4: ACO Contracts

1. Describe the contractual obligations in the ACO's contract for this primary care payment.

Detailed contract obligations are outlined in the MassHealth PCACO Contract in Section 2.14.A.

Participation in this payment model is a requirement of PCACO-participating primary care practices.

MassHealth will make payments for certain primary care services to PCACOs in the form of a capitated, PMPM payment. PCACOs will then be required to make prospective payments to their participating primary care provider practices. MassHealth will specify a per-member per-month rate for each Primary Care Entity.

The primary care payment program includes three Tiers, at which primary care practices may participate, with increasing sets of clinical expectations by tier. Tier 1 site expectations will target primary care practices in earlier stages of practice improvement, while Tier 2 and Tier 3 practices will have higher clinical expectations. Criteria for each Tier are outlined in PCACO Contract Appendix D.

MassHealth will work with PCACOs to collect information on payment, utilization, and quality.