Commonwealth of Massachusetts

Executive Office of Health and Human Services

Public Payer Commission

May 5, 2014

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Outline

- Approval of Minutes
- Reminder of statutory charge and schedule of work
- Designing integrated payment systems in Medicaid
- Discussion of key design issues

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Statutory Charge

- Section 270 of Chapter 224 of the Acts of 2012 created the Special Commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on providers and on health insurance premiums in the Commonwealth.
- The Commission's charge was further amended by Section 153 of Chapter 38 of the Acts of 2013.

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Updated Draft Workplan

January	Overview of Commission Administrative Tasks Introduction to MassHealth Payment
March	Prioritization of Areas for Payment/Cost Analysis Overview of Medicare Payment Issues (Dr. Katherine Baicker)
April	Innovations in Payment (Medicaid Managed Care Entities)
May	Issues in Payment Integration in Medicaid (Tricia McGinnis, MassHealth)
June	Cost-Shifting Behavioral Health Presentation
July	Long Term Care Presentation Discuss Findings and Recommendations
August	Additional Topics as Needed Finalize Report

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Integrated Payment Systems in Medicaid: Discussion

- MassHealth has developed a number of programs designed to drive innovation:
  - Senior Care Organization (SCO) and Program of All-inclusive Care for the Elderly (PACE)
  - Patient Centered Medical Home Initiative (PCMHI)
  - Primary Care Payment Reform (PCPR)
  - One Care
  - Pediatric Asthma Bundled Payment Pilot
  - Health Homes (in development)
- In its 1115 demonstration waiver renewal extension request, MassHealth requested authority for a future Accountable Care Organization (ACO) model to be implemented across MassHealth's managed care programs. With PCPR as its foundation, this future ACO model would:
  - Shift the contracting entity from a Primary Care Clinician (PCC) to an ACO;
  - Adjust the payment model to encourage providers to take on higher levels of risk;
  - Modify quality metrics and delivery model requirements to extend beyond a medical home to a "medical neighborhood."

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Integrated Payment Systems in Medicaid: Discussion

- MassHealth would like input from the Commission on a number of guiding principles and priorities as it sets out to develop this program.
- As a first step, MassHealth plans to conduct extensive stakeholder outreach and would like to use the outputs of today's discussion to inform those discussions.

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Member Attribution

- Attributing members to provider entities forms the foundation of any integrated/bundle-payment model
  - Attribution is key to determining panel sizes, and thereby scaling payment as well as risk to their appropriate levels for each provider entity
  - Attribution allows for greater provider responsibility for individual members, and opens the door to patient-centered medical homes, and other team-based models of care
- In selecting, developing, and implementing an attribution methodology for integrated payment models at MassHealth, we must account for a number of concerns, including operational feasibility, data quality, and the needs of our members. We would like to use this opportunity to solicit the Commission's input on priorities and principles which we can use to guide that decision-making
- Key questions:
  - How should we maximize member choice while also promoting efficient, integrated networks?
  - Should attribution model vary geographically across the state? Should it vary across member populations?
  - Should ACO assignment be transparent to members? Should the member experience of opting into an ACO differ from selecting a non-ACO PCC or PCMH?

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Process and Structure of ACO Model Development

- The goal of payment integration at MassHealth is to improve and coordinate care for our members. Therefore, our aim is to develop models that can work for a range of providers, not just a select few
  - Our provider population varies enormously with respect to ACO participation and readiness, clinical and financial integration, panel size, public payer mix, volume, financial security, and a number of other characteristics
  - Alignment and cohesive payment design can go a long way to facilitating providers' transformation and improvement
  - Coordination with providers, individualized attention, and a case-by-case approach can allow for more organic growth and safer escalation of provider risk-bearing
- Key questions:
  - Should MassHealth work towards a "one size fits all" model for integrated care, or should we develop a flexible, modular design that can apply to a wider range of provider circumstances?
  - What are the major considerations MassHealth should keep in mind to ensure that providers experience a responsive design?
  - In what ways can MassHealth best take advantage of opportunities for alignment with Medicare, MassHealth MCO, and commercial payer approaches to integration? What types of alignment are most useful to providers?

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Financial Model and Risk

- ACO models are partly defined by payment mechanisms, generally structured around a bundle of at-risk services. PCPR offers an example of the choices inherent in model design:
  - PCPR restricts the capitated bundle to primary care services, and gives participants the option to choose one of two enhanced bundles that loop in behavioral health services. Providers are fully at risk for services in their bundle, although downside risk is limited by a Hold Harmless provision. Providers are also at lesser risk for services outside the bundle, receiving a Shared Savings payment if those services come out lower than predicted. The share increases along with performance, and, while there is an upside-only option (at least initially), providers who opt into an upside/downside arrangement receive higher shares of savings. Shares are also enhanced based on quality performance, and for providers who opt to have LTSS included (by default it is not)
- Key questions:
  - What range of services should MassHealth hold ACOs responsible for? Should that bundle of services vary from one ACO to another, and if so should MassHealth consider limiting that flexibility in some way? What are some types of services that should be optional?
  - How should the foundational payment be structured? For example, a capitated model, a withhold model, FFS payments with a global budget, etc. What are some advantages and disadvantages of these approaches?
  - In what ways (e.g., level of risk, breadth of at-risk services, extent of clinical and financial integration) should MassHealth ACOs go beyond current efforts like PCPR?

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Other Dimensions for Consideration

Are there other design or operational issues that MassHealth should prioritize as it moves forward? For example:

- Data/analytic resources
- Methodological tools
- Quality/performance measures
- Consumer engagement/education/outreach