To Align or Not to Align: State Options in Multi-Payer Patient-Centered Medical Home Initiatives

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To Align or Not to Align: State Options in Multi-Payer Patient-Centered Medical Home Initiatives

Tuesday, March 4, 2014
3:30 - 5:00pm EST

This webinar is made possible through the support of The Commonwealth Fund
Agenda

- 3:30 – 3:35pm – Welcome
- 3:35 – 3:40pm – Overview of Alignment in Multi-Payer Patient-Centered Medical Homes (PCMH)
- 3:40 – 3:55pm – Overview of State Initiatives
- 3:55 – 4:30pm – Conversation with State Panelists
- 4:30 – 4:50pm – Audience Question & Answer
- 4:50 – 4:55pm – Wrap-Up
Today’s Speakers

- **Moderator:** Mary Takach, Senior Program Director, National Academy for State Health Policy (NASHP)

- **State Panelists:**
  - Dr. Foster Gesten, Medical Director, Office of Quality and Patient Safety, New York State Department of Health
  - Dr. Diane Marriott, Project Manager, Michigan Primary Care Transformation Demonstration Project
  - Dr. Bob Rauner, Medical Director, SERPA-ACO; Project Lead, Nebraska Multi-Payer Patient-Centered Medical Home Initiative
NASHP Overview

- Non-partisan, non-profit dedicated to helping states achieve excellence in health policy and practice

- Works across agencies and branches of state government to advance health policy development, analysis, and solutions
  - Conducts policy analysis and research
  - Convenes forums for problem solving
  - Facilitates peer learning and provides technical assistance
Project Overview

The National Academy for State Health Policy’s Multi-Payer Medical Home Learning Collaborative

• Funded by The Commonwealth Fund

• Supports four states develop a multi-payer medical home initiative
  • Montana
  • Nebraska
  • Pennsylvania
  • West Virginia
Multi-Payer PCMH Activity

What Key Programmatic Components Can Be Aligned?

- Attribution and Assignment Methodologies
- Payment Methodologies (amount, method, timing)
- PCMH Qualification Standards
- Performance and Evaluation Metrics

Other components:
- Common definition, practice model (including care management implementation), practice training
Advantages and Disadvantages of Alignment

Alignment:
Advantages
• Easier for practices to understand the model and expectations
• No free riders!

Disadvantages
• Payers may need to make alterations to their operations to accommodate new methods

Flexibility:
Advantages
• May lessen the administrative investment required for payers to participate & encourage participation of those less willing to discuss proprietary information with competitors

Disadvantages
• Providers may find it more challenging to accommodate multiple variations in programmatic components
• Payers may make uneven financial contributions to practices
Overview of State Multi-Payer Initiatives
Michigan Primary Care Transformation Project (MiPCT)

- **Start/End:**
  - January 1, 2012 – December 31, 2014
- **Anti-trust/Convener:**
  - No/State of Michigan
- **Participating Payers:**
  - Medicare; Medicaid Managed Care plans; Commercial (BCBSM, BCN, Priority Health)

Website: [http://www.mipct.org](http://www.mipct.org)
Michigan Primary Care Transformation Project (MiPCT)

- Degree of alignment on:
  - Attribution: **Mostly aligned**
    - Mix of attribution and assignment by payer (common attribution method among payers)
  - Payment: **Mostly aligned**
    - Commercial payers and Medicaid pay same amount ($7.76 per member per month (PMPM) or equivalent); Medicare pays higher amount ($9.76 PMPM or equivalent)
    - Care management payment component is paid PMPM by some payers and via G/CPT codes by others
  - Qualification Standards: **Aligned**
    - July 2010 and ongoing either: 1) Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) Medical Home Designation or 2) NCQA Level 2 or 3
  - Performance/Evaluation Metrics: **Mostly Aligned**
    - Semi-annual performance incentive measure sets**
    - Payers with similar themes in preexisting incentive programs permitted to retain them
  - Multi-payer Data and Reporting: **Aligned**
    - MI Data Collaborative distributes multi-payer member lists and dashboards to Physician Organizations who distribute to their practices


Nebraska: Voluntary Multi-payer Patient-Centered Medical Home Initiative

Start/End Dates:
• January 1, 2014 – December 31, 2015

Anti-trust/Convener:
• No/Nebraska Legislature

Participating Payers:
• Commercial; Medicaid Managed Care

Website: http://news.legislature.ne.gov/dist35
Nebraska: Voluntary Multi-payer Patient-Centered Medical Home Initiative

Degree of alignment on:

- Attribution: **Somewhat Aligned**
  - Population-based model; cannot limit based on subset of diseases
- Payment: **Not Aligned**
  - Payment design left up to each payer and practice
- Qualification Standards: **Somewhat Aligned**
  - In the event a payer requires such standards for participation, payers agreed to accept NCQA, Joint Commission, URAC, and Nebraska Medicaid standards
- Performance/Evaluation Metrics: **Mostly Aligned**
  - Set of Adult and Pediatric Measures*
  - Payers may use additional metrics provided the practice agrees beforehand and is not required to submit additional data

New York: Adirondack (ADK) Region Medical Home Pilot

- **Start/End:**
  - January 1, 2010 – December 31, 2014
  - Medicare participation: July 1, 2011 – June 30, 2014

- **Anti-trust/Convener:**
  - Yes/New York Department of Health

- **Participating Payers:**
  - Medicare; Medicaid Fee-for-Service; Medicaid Managed Care; Commercial; State Employees; Self-Insured

Website: [http://www.adkmedicalhome.org/](http://www.adkmedicalhome.org/)
New York: Adirondack (ADK) Region Medical Home Pilot

Degree of alignment on:

- **Attribution:** Aligned
  - Standard attribution and assignment algorithm for non-health management organization (HMO) plans; primary care provider (PCP) assignment for HMO

- **Payment:** Mostly Aligned
  - All payers pay same amount - $84 per-member/per-year (PMPY)
  - Methodology/frequency can vary by payer (PMPM vs ‘plus up’ FFS)

- **Qualification Standards:** Aligned
  - NCQA Level-2 or Level-3 w/in 18 months
  - E-Prescribing w/in 6 months; patient registry; 24/7 telephonic access; Same day urgent care scheduling; patient surveys; quality improvement (QI) participation; health information exchange (HIE) connectivity

- **Performance/Evaluation Metrics:** Aligned
  - Common Metrics/Methodologies*

New York: Comprehensive Primary Care (CPC) Initiative Capital District-Hudson Valley Region

• Start/End:
  – November 1, 2012 – September 30, 2016

• Anti-trust/Convener:
  – Yes/Taconic Health Information Network and Community

• Participating Payers:
  – Medicare; Medicaid Managed Care; Commercial; Multi-Employer Plans (Taft-Hartley)

Website: http://www.thincrhio.org/comprehensive-primary-care-initiative.html
New York: Comprehensive Primary Care (CPC) Initiative Capital District-Hudson Valley Region

- Degree of alignment on:
  - Attribution: Not Aligned
    - But similar
  - Payment: Mostly Aligned
    - PMPM, incentive payments and shared savings vary in amount and structure
  - Qualification Standards: Aligned
    - CMS selected practices based on application to CPC Initiative; e.g. certified electronic health record (EHR) system, achieve Meaningful Use (MU) Stage 1, sufficient panel size relative to participating insurers, meet milestones
  - Performance/Evaluation Metrics: Mostly Aligned
    - Core measures but payers use their own for the ‘quality gates’ on shared savings
Conversation with State Panelists
Question #1

How did your initiative reach decisions between payers and providers on how much to align key programmatic components?
Michigan Primary Care Transformation Project (MiPCT)

- **Catalyst for MiPCT**: Medicare Advanced Primary Care Practice (MAPCP) demonstration
  - Built upon framework from commercial payer’s previous PCMH infrastructure
  - Opportunity to leverage MAPCP demonstration to secure commercial payer, Medicare, and Medicaid support and streamline commercial payer preexisting approaches
Nebraska: Voluntary Multi-payer Patient-Centered Medical Home Initiative

Bill introduced by Senator Gloor helped launch a small, two-year, Medicaid-only PCMH pilot in 2011

- Small PCMH Medicaid pilot in 2011 helped test the concept for NE legislators
- Legislation was introduced that would expand the pilot and mandate payer alignment in a multi-payer initiative
- Private payers then voluntarily convened around a ‘flexible’ multi-payer model to avoid passage of legislation
New York: Adirondack (ADK) Region Medical Home Pilot

- Primary care workforce shortages led to physicians driving the early formation of the ADK pilot in 2008-2009

- State Action Immunity provided payers with legal protection to discuss alignment of programmatic components, including payment and attribution methodologies

- Large number of insurers including some portion of self-insured

- Consensus driven process between providers and payers

- Medicare joined in 2011 through the Medicare Advanced Primary Care Practice (MAPCP) demonstration
New York: Comprehensive Primary Care (CPC) Initiative Capital District-Hudson Valley Region

- Degree of alignment determined by Centers for Medicare and Medicaid Innovation (CMMI)
  - Payers agreed to degree of alignment during application process
  - CMMI worked with each payer prior to the start of the initiative
- Payers aligned on payment approach, but not amount
- Mature multi-stakeholder governance committee
Can you describe any of the tensions between payers and providers that you encountered related to alignment, including the trade-offs between payers and providers?

How these decisions were resolved?
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<th>Michigan MiPCT</th>
<th>Nebraska Multi-Payer PCMH</th>
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| **Attribution/Assignment Methods** | • Mix of attribution & assignment  
• Payers using attribution use same methodology | • Population-based model  
• Cannot limit based on subset of diseases | • Mix of attribution & assignment  
• Payers using attribution use same methodology | • Payers use individual, but similar methodology |
| **Payment Methods** | • Commercials/Medicaid pay $7.76 PMPM  
• Medicare pays $9.76 PMPM | • Payment at discretion of each payer and contracted practice | • Payment methodology & frequency varies  
• All payers pay $84 PMPY | • Payment approaches similar, amounts vary |
| **Qualification and Certification Standards** | • BCBSM Physician Group Incentive Program (PGIP) Medical Home Designation | • Varies by payer  
• Payers may use NCQA, Joint Commission, URAC, Nebraska Medicaid standards | • NCQA Level-2 or Level-3 w/in 18 months  
• Plus additional requirements (e.g. e-prescribing) | • CMMI set standards: certified EHR, meet MU 1, phased milestones |
| **Performance and Evaluation Metrics** | • Two phases; adult and peds sets  
• Semi-annual performance incentive measure sets | • Set of Adult and Pediatric Measures | • Common metrics/methodologies | • Common core, but variable by payer for shared savings |
Question #3

Are there particular key programmatic features that are more necessary to align across payers than others?
Views From Michigan

• **Key Components to Align (In a Perfect World!)**
  - Payment Amount, Method, and Timing
  - Data Elements Required (of payers, practices)
  - Common attribution/assignment model
  - Clinical model

• **Nice to Align (If Possible)**
  - Performance incentive metrics and application
  - Training
Views from Nebraska

Key Programmatic Components to Align:

- Need to accept a common definition and apply to all patients (otherwise it’s just a disease management program)
- Allow clinics to choose PCMH certification program
- Mandate a dollar payment, but allow the market to determine the amount
- Use common quality measures to decrease work needed to be done by practices
Key Programmatic Components to Align:
- Practice qualifications
- Attribution and assignment methodologies
- Measures
- Goals
- Governance
Question #4

What plans, if any, does your initiative have for sustainability beyond a time-limited initiative?

Will you need to revamp any programmatic components to make them more or less flexible if this initiative is to continue or expand?
Michigan Primary Care Transformation Project (MiPCT)

What does sustainability mean?
- To the Health Plan: Added value for their customers
- To the Practice: Maintaining and growing care management staffing, processes, and roles
- To the Physician Organization: Payment reform for care management

Sustainability progress in MiPCT:
- Payer-by-Payer discussions and ‘Sustainability Statement’ at 2013 Annual Summit
- Addition of payer: Priority Health
- State Innovation Model (SIM) potential
- Medicaid radar screen and co-director leadership
- Milbank advocacy and leadership
- Return on investment (ROI) - Physician Organization subgroup financial modeling
Sustainability:

• Plan on publicly reporting number of pilots each plan implements on a yearly basis as well as any success each achieves

• Plan to add obstetric/women’s health quality measures in 2014
New York: Adirondack (ADK) Region Medical Home Pilot

**Sustainability**

- Beginning discussions
  - Payment reform – shared savings
  - Debate on PMPM support (how much? For what?)
  - Improving data infrastructure
    - More timely, more integrated

**Revamp**

- Advanced Primary Care model in State Health Improvement Plan (SHIP) and potential State Innovation Model (SIM)
- ‘Medical Neighborhood’, behavioral health integration, focus on ‘value’
New York: Comprehensive Primary Care (CPC) Initiative Capital District-Hudson Valley Region

• Sustainability
  – State Health Improvement Plan (SHIP)

• Revamp
  – Move health plans from Healthcare Effectiveness Data and Information Set (HEDIS) measures to mix of HEDIS and clinical quality measures (CQM)
  – Local market evaluation on quality/cost
Audience Q&A

Audience members: Please feel free to type your questions into the chat box.
For More Information...

Please visit:

- www.nashp.org
- http://www.nashp.org/med-home-map
- www.statereforum.org
- www.pcpcc.net
Thank you for joining today’s webinar!

You will be directed to complete a short evaluation at the conclusion of this webinar.

We appreciate your participation – your feedback guides our work.