MaineCare Primary Care 2.0

November 2020
Big Picture: Need for Primary Care Payment Change

• Fee-for-service payments have not supported…
  ▪ Flexibility of service delivery to meet patient needs
  ▪ Team-based approach to care
  ▪ Funding of valuable non-provider roles (e.g. care management, pharmacists, Community Health Workers)
  ▪ Proactive, population-oriented approach to care
  ▪ Provider accountability and incentives for high value care

• Chronic under-investment in primary care has..
  ▪ Eroded capacity to react quickly, innovatively
  ▪ Diminished capacity for primary care to withstand financial stressors
MaineCare Primary Care Evolution Goals

- Incent proactive, flexible, whole-person focused primary care
- Align with Centers for Medicare and Medicaid Innovation Primary Care First (PCF) Initiative
- Support meaningful practice change through value- and population-based payments
- Improved health and health care outcomes
Alternative Payment Models

Category 1
Fee for Service - No Link to Quality & Value

Category 2
Fee for Service - Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group
MaineCare designing new value-based payment model designed to simplify and integrate MaineCare’s three current primary care programs:

- Primary Care Case Management (PCCM)
- Primary Care Health Homes (HHs)
- Primary Care Provider Incentive Program (PC-PIP)

Implementation Goal: July 2021
MaineCare Primary Care 2.0

Payment Structure:

- Primary Care Fee-for-Service Visits*
- Prospective Population-Based Payments (Performance-adjusted)
- Total Primary Care Payment

*Transitioning to a flat rate and larger percent of payments as non-visit based

- Population- and risk-adjusted
- Enhancements available based on practice characteristics and alignment with Accountable Communities program
- Adjusted for performance on <10 measures
Primary Care 2.0 Transformations

Current State

- Non-FFS support is not risk-adjusted at the practice level.
- Some funds are tied to chronic condition eligibility.
- Most practices have no payments tied directly to quality; for others the tie is weak. Priority focus areas are not clear.

Primary Care 2.0

- Redistribute funds to better support advanced practice characteristics and care for high-needs members while rewarding practices for quality and cost outcomes.
- Practices will have portion of reimbursement tied to a set of ~10 performance measures that reflect DHHS priorities, impact on costs, and PCF alignment.
Population-Based Payments

Population Risk Adjustment

Practice Characteristics

Population-Based Payments
(Performance-adjusted)
Primary Care 2.0 Proposed Risk Stratification

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Generally Well</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$TBD</td>
<td>$TBD</td>
</tr>
<tr>
<td>Adults</td>
<td>$TBD</td>
<td>$TBD</td>
</tr>
<tr>
<td>Aged, Blind, Disabled</td>
<td>$TBD</td>
<td>$TBD</td>
</tr>
<tr>
<td>Duals</td>
<td>$TBD</td>
<td>$TBD</td>
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- Allows for MaineCare to adjust the dollars to address potential issues with using risk scores for children.
Population-Based Payments

Population Risk Adjustment

Practice Characteristics

Population-Based Payments (Performance-adjusted)
Primary Care 2.0 Transformations

Current State

MaineCare has outdated and incomplete PCP expectations

Primary Care 2.0

Primary Care 2.0 will include updated practice expectations aligned with Department priorities
# Primary Care 2.0 Practice Characteristics

<table>
<thead>
<tr>
<th>Base Level</th>
<th>Intermediate Tier 1 AND</th>
<th>Advanced Tier 2 AND</th>
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<tbody>
<tr>
<td>• Provide 24/7 coverage</td>
<td>• NCQA – PCMH</td>
<td>• High-level of quality</td>
</tr>
<tr>
<td>• Electronic Health Record</td>
<td>• HealthInfoNet connection</td>
<td>• Participate in AC w/ coordinated population health strategy</td>
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<tr>
<td>• Screening &amp; follow-up (e.g. developmental, lead, SUD, MH)</td>
<td>• Collect and track social health needs</td>
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<tr>
<td>• Immunizations</td>
<td>• MoU with 1+ BHH;</td>
<td></td>
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<tr>
<td>• Participate in TA and data-drive quality improvement</td>
<td>• Ability to refer to CCTs</td>
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<tr>
<td>• Contraceptive counseling and post-partum transitions of care</td>
<td>• Offer telehealth</td>
<td></td>
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<tr>
<td>• Preventive services</td>
<td>• Offer evidence-based community health worker (CHW) services directly or through partnerships with CCT/CBO</td>
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<tr>
<td>• Member education on ED/urgent care/Primary Care</td>
<td>• Offer SUD Treatment (TBD)</td>
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**Suggestions?**
## Primary Care 2.0 Proposed Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Alignment</th>
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<tbody>
<tr>
<td>Controlling High Blood Pressure*</td>
<td>Primary Care First (PCF), AC, Health Home Core Set, Adult Core Set, MSSP</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>PCF, MIPS, MSSP, Maine SHIP</td>
</tr>
<tr>
<td>Tobacco Use: Screen &amp; Intervention</td>
<td>AC, MIPS, MSSP, Maine SHIP</td>
</tr>
<tr>
<td>Adolescent Well-Care</td>
<td>DFLC, DHHS priority, Child Core Set</td>
</tr>
<tr>
<td>Lead Screening</td>
<td>AC, CDC, DHHS priority</td>
</tr>
<tr>
<td>Acute Hospital Utilization</td>
<td>PCF, similar in Health Homes Core set</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>AC, Children’s Core Set, Children’s Cabinet</td>
</tr>
<tr>
<td>Antidepressant Med Management</td>
<td>Adult Core Set</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>PCF (ages 65+)</td>
</tr>
<tr>
<td>Total Cost of Care^</td>
<td>PCF</td>
</tr>
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**Suggestions?**
Primary Care 2.0 Visit Rates

**Year 1:** Same as today

**Year 2 - TBD:** A flat rate for eligible primary care visits to your practice. Reduces billing and revenue cycle burden, payment predictability.

**End Goal:** All payment is through prospective, capitated, payments and there is no FFS visit reimbursement.
MaineCare has a robust Health Home program and technical assistance team that is not being fully leveraged across the other primary care programs.

MaineCare will utilize and enhance its Health Home program team to support the Primary Care 2.0 program.
Alignment of Primary Care 2.0 & DHHS Goals

- Advance Alternative Payment Model goals & VBP
- Support team-based care
- Promote proactive, population-based care
- Support innovative workforce models – e.g. CHWs
- Increase access to behavioral health services
- Provide a foundation of care coordination within primary care

- Promote primary care infrastructure to meet rural health needs
- Support efforts to identify & address social health needs
- Support pandemic preparedness & response
Questions?

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