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ADVANCING INTEGRATED HEALTHCARE

Clinical Strategy Meeting: Mass health Primary Care Health Reform & Social Risk Adjustment

June 16, 2023

Agenda

ADVANCING INTEGRATED HEALTHCARE

Item	Time
Welcome ***Pano Yeracaris, MD, MPH, Chief Clinical Strategist, CTC-RI***	5 min
Using SDoH Data to Guide Primary Care Sub-capitation in MassHealth ***Arlene Ash, PhD, MS, UMass Chan Medical School, UMass Analytics and MassHealth***	30 min
Primary Care in MassHealth's Newly Approved 1115 Demonstration: Driving Transformation and Equity with Value-based Payment ***Dr. Mohamed Dar, MD, Senior Medical Director for Payment and Care Delivery Innovation*** ***Martha Farlow, Policy Director for Payment and Care Delivery Innovation*** ***Tade Mengesha, Deputy Director for Integrated Fiscal Strategy***	30 min
Discussion & Questions All	20 min

CTC-RI Conflict of Interest Statement & CME Credits

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The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 03/18/2022 to 03/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Objectives

1. Learn about the tiered primary care subcapitation model for Mass Health (Massachusetts Medicaid.
2. Learn how social risk adjustment has been incorporated into the model and challenges ahead.
3. Consider and discuss implications for Rhode Island.

Primary Care in MassHealth's Newly Approved 1115 Demonstration: Driving Transformation and Equity with Value-based Payment

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Care Transformation Collaborative of Rhode Island

Presenters

Dr. Mohamed Dar, MD – Senior Medical Director for Payment and Care Delivery Innovation

Martha Farlow – Policy Director for Payment and Care Delivery Innovation

Tade Mengesha – Deputy Director for Integrated Fiscal Strategy

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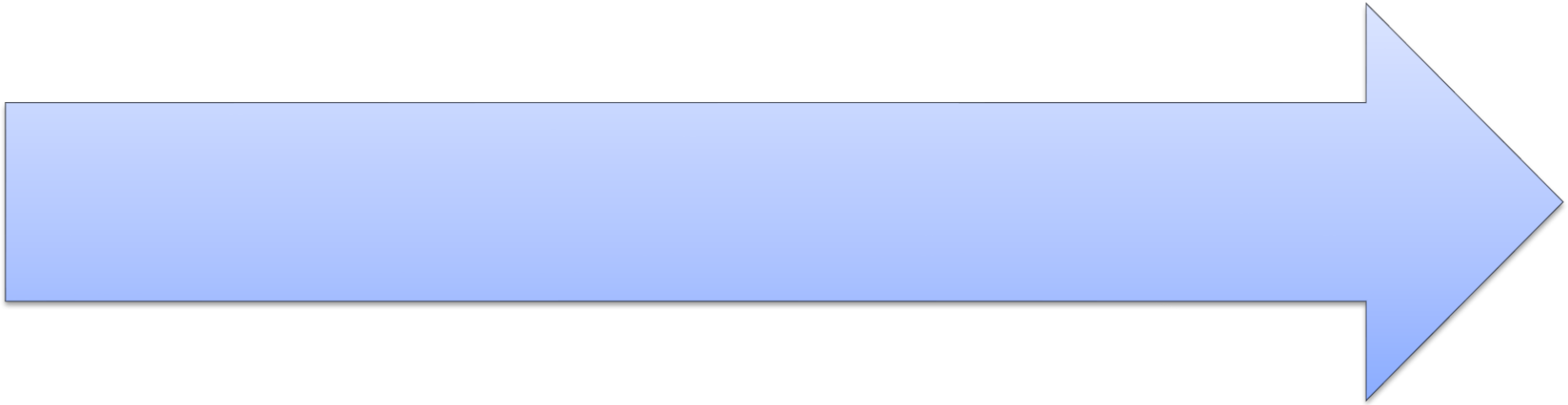
Questions and discussion



MassHealth's Primary Care Sub-Capitation launched in April, 2023

- **Authority** – The sub-capitation program is authorized through MA's 1115 waiver

- **Accountable Care Organizations (ACOs)** – sub-capitation sits within MassHealth's ACO program, accountable to quality, member experience, and TCOC
  - All primary care practices in the ACO program (~1,000) are required to participate
  - Model will serve all ACO members (~1.3m)

- **Clinical structure** – to account for provider readiness and capacity, and to continue incentivizing practice transformation, there are 3 clinical "tiers" of participation
  - Higher tiers have greater primary care delivery expectations (e.g., BH integration, team-based care, and increased access) and receive correspondingly higher payments

- **Rates structure** – prospective PMPM rates that are actuarially developed
  - Includes additional $115m per year in primary care rates for participating practices
  - For year 1, rates are based on historical utilization; in future years, MassHealth aims to move to a market rate that is prospectively risk-adjusted
  - To remove FFS incentives, no reconciliation of sub-cap payments to utilization

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Tier 1 Requirements

Practices shall meet all Tier 1 requirements to achieve this Tier Designation.

* = may be provided by the ACO
* = may be met virtually

A. Care Delivery Requirements

- Traditional primary care
- Referral to specialty care
- Oral health screening and referral
- Behavioral health (BH) and substance use disorder screening
- BH referral with bi-directional communication, tracking, and monitoring
- BH medication management
- Health-Related Social Needs (HRSN) screening**
- Care coordination**
- Clinical Advice and Support Line**
- Postpartum depression screening
- Use of Prescription Monitoring Program
- Long-Acting Reversible Contraception (LARC) provision, referral option

B. Structure and Staffing Requirements

- Same-day urgent care capacity
- Video telehealth capability
- No reduction in hours
- Access to Translation and Interpreter Services

C. Population-Specific Requirements

Practices serving Enrollees 21 years of age or younger shall:

- Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT
- Screen for SNAP and WIC eligibility
- Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)
- Coordination with MA Child Psychiatry Access Program (MCPAP) and MA Child Psychiatry Access Program for Moms (M4M), which are state programs that provide quick access to psychiatric consultation and facilitate referrals for accessing ongoing behavioral health care
- Fluoride varnish for patients ages 6 months up to age 6

Tier 2 Requirements

* = may be provided by the ACO
* = may be met virtually

Practices shall meet all Tier 1 requirements and all Tier 2 requirements to achieve this Tier Designation.

A. Care Delivery Requirements

- Brief intervention for BH conditions
- Telehealth-capable BH referral partner

B. Structure and Staffing Requirements

- E-consults available in at least three (3) specialties
- After-hours or weekend session*
- Team-based staff role
- Maintain a consulting independent BH clinician*

C. Population-Specific Requirements

Practices serving Enrollees 21 years of age or younger shall:

- On-site staff with children, youth, and family-specific expertise
- Provide patients and their families who are eligible for SNAP and WIC application assistance

Practices serving Enrollees ages 21-65 shall:

- LARC provision, at least one option
- Active Buprenorphine Availability*
- Active Alcohol Use Disorder (AUD) Treatment Availability*

Tier 3 Requirements

* = may be provided by the ACO
* = may be met virtually

Practices shall meet all Tier 1 requirements, all Tier 2 requirements, and all Tier 3 requirements to achieve this Tier Designation.

A. Care Delivery Requirements

The practice shall fulfill at least one of the following three requirements:

- Clinical pharmacist visits*
- Group visits*
- Designated Educational Liaison for pediatric patients*

B. Structure and Staffing Requirements

- E-consults available in at least five (5) specialties
- After-hours or weekend session
- Three team-based staff roles
- Maintain a consulting BH clinician with prescribing capability*

C. Population-Specific Requirements

Practices serving Enrollees 21 years of age or younger shall:

- Full-time, on-site staff with children, youth, and family-specific expertise
- LARC provision, at least one (1) option
- Active Buprenorphine Availability*

Practices serving Enrollees ages 21-65 shall:

- LARC provision, multiple options
- Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up*

Sub-Capitation Code Set

CPT Code	Definition
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 20-29 minutes of total time spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-39 minutes of total time spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 40-54 minutes of total time spent on the date of the encounter.

CPT Code	Definition
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

G0009	ADMINISTRATION OF PNEUMOCCOCCAL VACCINE
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN
G0444	Annual depression screening

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Payment and Operations

Primary care sub-capitation payment flow

ACOs make prospective monthly panel-based payments for primary care

- Practices submit claims for all services provided, as today
  - For services that are not covered by the sub-capitation, providers are paid fee-for-service
  - For services that *do* fall under the sub-capitation, claims are 'zero-paid'
- Attribution is prospective and member-facing
- To determine whether a claim was primary care, MassHealth and ACOs look at:
  - Member attribution
  - The specialty of the practitioner who delivered the service
  - The sub-capitation code set

Payment and Operations

MassHealth sets primary care practice rates at the Tax Identification Number (TIN) level

- For 2023, each practice rates is based on its individual historical primary care utilization, along with prospective adjustments, to mirror expected 2023 primary care costs for individual practices. This means a practice's overall member acuity is embedded in the 2023 rates.
  - In future years, MassHealth is aiming to move towards a market rate with appropriate adjustments for acuity, such as the Primary Care Activity Level (PCAL) model (more on PCAL later)
- In addition to rates based on historical experience, practice PMPMs include enhanced payments by clinical tier, intended to invest in and catalyze practice transformation to meet tier requirements. Higher tiers receive higher investment to support higher expectations

RY23 clinical tier enhanced payments		
	Pediatric members	Adult members
Tier 1 PMPMs	$5	$4
Tier 2 PMPMs	$7	$6
Tier 3 PMPMs	$13	$10

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Using SDoH Data to Guide Primary Care Sub-capitation in MassHealth

UMass Chan Medical School
UMass Analytics and MassHealth
Presented by Arlene Ash

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Care Transformation Collaborative of Rhode Island - Virtual Meeting
June 16, 2023

A bit about me …

- Math PhD, Health Services Researcher since 1984
- Professor and PQHS Division Chief at UMMS since 2009
  https://www.umassmed.edu/PQHS
- I predict ***population-based*** **outcomes** (“per person-year”) from medical and social risk factors
  - E.g., ***cost*** and other health outcomes
- Models are used to make fair
  - Payments to health plans *or* provider practices (sub-capitation)
  - Judgments about plan performance (“quality”)

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Disclosure

- I was a lead developer of the original CMS risk adjustment models (the framework for HHS's "HCC model") and co-founded a company to develop and license similar risk models commercially
- I have no current financial ties to Cotiviti, Inc., the company that now licenses DxCG models to MassHealth and others
- My modeling work for MassHealth uses Cotiviti's DxCG and RxCG models

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Outline

1. Why is risk adjustment important for primary care sub-capitation?

2. What is PCAL and what is its purpose?

3. Building the PCAL model
   a) Constructing the PCAL outcome
   b) Identifying PCAL predictors
   c) What does the current model look like?

4. Summary

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1. Why is risk adjustment important?

- **Capitated payment** is consistent with a population-based health paradigm
  - A plan or provider group doesn't get more money for each thing it does
  - It is paid for the members it enrolls and their *expected* level of need for care

- RA is used to calculate expected level of need
  - If you drop a complex patient, you lose the higher payment that comes with that person.
  - If you add a simple patient, you get a reduced amount appropriate to that patient's needs.

- Risk-adjusted predictions are important not for their absolute value but for their relative value.
  - A plan with 1.1 x average risk will be paid 10% more than average.

2. What is PCAL?

- PCAL is the **Primary Care Activity Level**
  - We *use cost/utilization data to calculate a **PCAL outcome*** for each person to reflect their apparent level of need for primary care.
  - We then build a **PCAL model** to *predict that outcome from patient characteristics* (ignoring utilization)
  - The PCAL model output is the **expected cost of the resources needed by a primary care team to care for people**.

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2. PCAL's Purpose

- The problem:
  - Existing fee-for-service (FFS) PCP *payments* don't support comprehensive care.
  - Existing procedure codes and bills do not record all services rendered.
  - Current *efforts* also fall short of what is needed.

- With PC sub-capitation, we can increase total PC spending, and free practices from FFS-driven distortions, but must decide how to allocate that money among provider groups.

- Key principles:
  - Pay more overall.
  - Pay practices more for signing up patients who need more PC attention.
  - Use payments to counter existing inequities, such as underspending in historically disadvantaged communities.

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3. Building the PCAL model – conceptual framework

- PCAL (Primary Care Activity Level) was developed in 2012 by Arlene Ash and Randall Ellis, then at Boston University, to risk adjust primary care spend
- It was updated by UMass Chan using MassHealth data to capture primary care activities for Medicaid members in Massachusetts in 2019
- The PCAL *outcome* "proxies" the cost of comprehensive primary care
  - It is the sum of some non-primary care spending and all primary care spending
- PCAL predictors are like those in other MassHealth models
  - They are patient characteristics, *not* measures of utilization or cost.
- PCAL *predictions* are normalized to calculate PCAL-based *payments*, so that their sum equals the policy-determined total PCP care budget

3a. Constructing the PCAL outcome

Current encounter records were used to *infer* the extra primary care resources needed to *prevent or manage* the other kinds of care episodes that some members are likely to experience.

The model combines:

- All primary care service costs
- Fractions of the dollars spent on other services, such as
  - Specialty care
  - Hospital care
  - ED care
  - Prescription drugs

Principle: Members expected to incur these other health care costs may be likely to need (and benefit from) more attention from their primary care teams

Type of Activity	% of All Such Costs Contributing to Constructed PCAL	% of PCAL
Primary care activities	100%	64%
Specialty care related	6%	20%
Hospital care related	6%	1%
ER spending	30%	5%
Rx spending	9%	10%

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From: MassHealth, Risk Adjustment Methodology RY2023, October 2022. Available at link by scrolling down to "Risk Adjustment Methodology RY2023."

3b. Identifying PCAL predictors

1) Measuring medical complexity
2) Measuring social determinants of health (SDoH)

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3b1. Measuring medical complexity

- MassHealth uses Diagnostic Cost Group and Pharmacy Group (DxCG and RxCG) scores to summarize total medical morbidity.
  - The DxCG model (v4.2, model #88) yields a relative risk score (RRS) derived from age, sex, and diagnoses recorded in clinician encounters (e.g., ambulatory care visits and hospitalizations).
  - The RxCG model (v4.2, model #86) relies on prescriptions filled and paid for by Medicaid, in lieu of the diagnoses that inform the DxCG score, to summarize risk.
- RxCG scores are used to mitigate the advantage that groups achieve through aggressive diagnostic upcoding.

3b2. Measuring social complexity

- In 2014, MassHealth asked UMass to develop a payment model based on both medical complexity and social determinants of health factors (SDoH).
  - Previously they had been using the DxCG risk score exclusively for RA.
  - The SDoH model for global capitation was first implemented in October 2016, and has been updated several times since.
- We used variables identified in that work to flag SDoH-based risks for PCAL.

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3b2. Finding SDoH data

- Some ICD-10 codes refer to social risk (e.g., homelessness)
- Eligibility, enrollment records reveal additional risks
  - Program entitlement due to disability
  - Client of the Dept. of Mental Health or Dept. of Developmental Services
  - Frequent address changes and “tough” neighborhood (Neighborhood Stress Score)

3b2. Neighborhood Stress Score (NSS)

- Measure of “economic stress” summarizing 7 census variables identified in a principal components analysis
  - % of families with incomes < 100% of FPL
  - % < 200% of FPL
  - % of adults who are unemployed
  - % of households receiving public assistance
  - % of households with no car
  - % of households with children and a single parent
  - % of people age 25 or older who have no HS degree
- NSS is standardized (Mean = 0; SD = 1)

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How is expected PCAL calculated?

PCAL 2022 Model		
PCAL_22	**Coef.**	**t**
RxCG RRS	288	262
RxCG-spline-5	-233	-147
DxCG RRS	523	419
DxCG-spline-5	-124	-65
DxCG-spline-20	-288	-61
Serious Mental Illness	180	56
Opioid Use Disorder	400	82
Alcohol Use Disorder	117	22
Other Substance Use Disorder	224	41
Serious Emotional Disturbance	54	10
Other Disabled	50	14
DDS (not DMH)	557	79
DMH Client	1115	94
NSS7+ x DxCG	**5**	**NA**
Rural Area	22	5
Housing Problems x DxCG x BH	41	90

PCAL independent variables / model design

- Largely consistent with current MassHealth payment model, with some differences:
  - Non-linear relationship with DxCG and RxCG*
  - Fewer BH/SUD variables
  - Several variables excluded (e.g., newborn complexity) that lacked clear correlation with PCAL
  - Coefficient "5" for the {neighborhood stress score X morbidity score} interaction is *chosen* for policy reasons
- Overall model R-squared is 68.8%

*For example, DxCG scores up to 5 get $523 per DxCG point. If a member has a DxCG score of 10, their coefficient will be (523*5) + ((523-124)*5) . These "splines" fit the data better than straight lines do.

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From: MassHealth, Risk Adjustment Methodology RY2023, October 2022. Available at link by scrolling down to "Risk Adjustment Methodology RY2023."

4. Summary

- Society needs to invest more in primary care.
- Primary Care sub-capitation requires risk adjustment to *encourage and support care for medically and socially complex patients*.
- The PCAL model is designed to estimate the resources a PC team needs to care for its patients.
  - It was designed to provide appropriate and equitable payments to each PC team.
  - It is empirically driven but modified to start to address historical inequities.
- Additional policy levers will be needed to achieve the key policy goals of this exciting primary care sub-capitation initiative.

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Let's discuss!

Arlene.Ash@umassmed.edu
for the UMass Chan-MassHealth Analytics Team

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Evaluation & CME Credits

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THANK YOU

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