

Lab 4: Implementing Primary Care Population-Based Payments in Medicaid

Virtual Meeting 5 of 5

Primary Care Payer Action Collaborative

November 14, 2017

3:00-5:00 pm (EST)

1. Session Objectives

- Review considerations and processes specific to Medicaid in implementing a Track 2 alternative to fee-for-service payment model.
- Review the use of State Plan Amendments to authorize Track 2 alternative to fee-for-service payment.
- Clarify when 1115 demonstration authority would be needed to authorize Track 2 alternative to fee-for-service payment.
- Discuss State experiences so far in designing and implementing alternative to FFS CPC+ Track 2 alternative to fee-for-service payment in Medicaid.
- Identify open questions for possible future LAN PAC activity around Medicaid and CPC+.

2. Key Questions Raised on PAC Webinars to Date

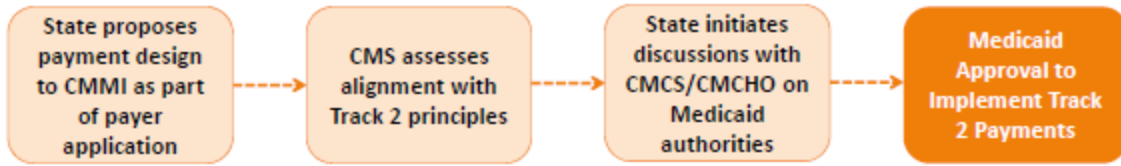
- How do common existing Medicaid primary care payment structures align or not align with CPC+ Track 2 alternative to fee-for-service payment principles and hallmarks?
- Can I use a SPA, or is 1115 Demonstration Authority required?
- What are other state Medicaid agencies in CPC+ doing for the Track 2 alternative to fee-for-service payment?

3. Medicaid-Specific Track 2 Alternative to FFS Payment Considerations

Medicaid Payers Participating in CPC+

- Eight Medicaid agencies have signed MOUs with CMMI to implement CPC+, including a Track 2 alternative to fee-for-service payment. Many CPC+ payers additionally have a Medicaid (MCO) line of business.
- CMS is eager to work with states on Track 2 alternative to fee-for-service payment. Once a CPC+ MOU is secured between CMS and a Medicaid agency, a state plan amendment (SPA), 1115 demonstration or other authority will be needed to implement Track 2 alternative to fee-for-service payments – both in Medicaid fee-for-service (FFS) and depending on the payment model design, authority may also be needed under Medicaid managed care.

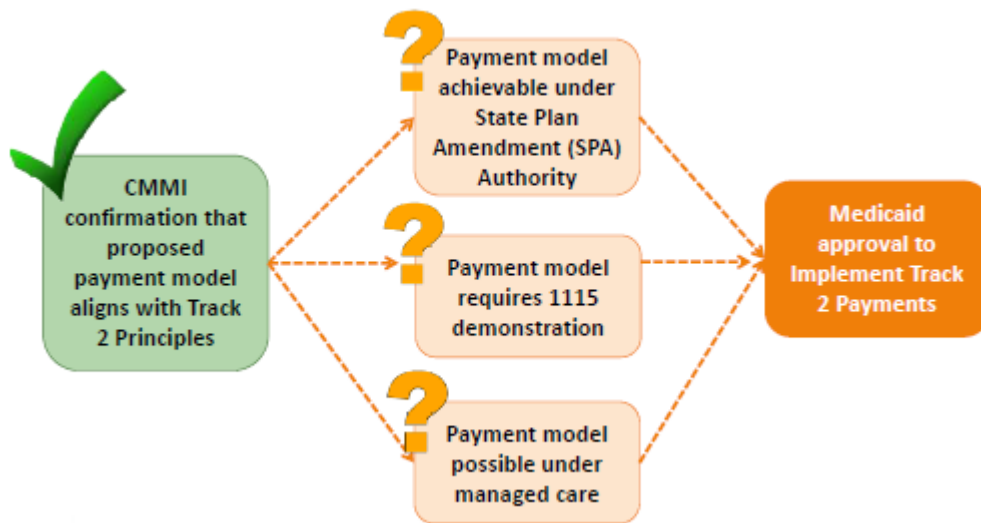
Process for Medicaid Track 2 Payment Approval



CPC+ Alignment Principles for Track 2 Alternative to FFS Payments

- Track 2 alternative-to-FFS payments must include the following hallmarks:
 - Depart from FFS in a way that would be a relative improvement to FFS (*i.e., payments must pay practices equally or beyond FFS payments*).
 - Payment is sufficient to bring patients into alternative forms of care (*i.e., payments must support practices in providing non-visit based care*).
 - Payment does not preclude comprehensiveness (*i.e., payers should emphasize whole-person care, while meeting CMS care delivery requirements*).
 - Work drives towards a regional, multi-payer initiative (*i.e., payers should collectively work towards Track 2 goals*).

4. Pathways to Track 2 Alternative to FFS Payments in Medicaid



Streamlined State Plan Amendment Option



- This example pairs traditional primary care payment with an increased care management fee payment. Under this model, practices receive a care management fee supplementing primary care payments and exceeding those payments paid under Track 1.
- To align with State Plan Rules, this model cannot include prepayment of FFS payments.

- CMS has issued State Medicaid Director letters (*see www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf*) that provide guidance around this payment type, and emphasize the flexibility states have in arranging care management fees on top of a FFS system. For example, under statute, care management fees can be used to pay for “coordinating, locating, and monitoring services”. As outlined in the State Medicaid Director letter linked above, states may offer payment incentives to providers, or reimburse for direct and indirect actions to improve outcomes.
- Payments are still subject to Medicaid payment rules (freedom of choice, beneficiary protection, etc.).
- Utilizing State Plan authority to implement a Traditional Primary Care Payment with an Increased Care Management Fee aligns with CMMI Track 2 Alternative to FFS payment Hallmarks.

State Q&A:

- One state noted that it is difficult for states to come up with new funds for an enhanced primary care payment model. Colorado, for example, already has a PMPM for care management within its Accountable Care Collaboratives. It is not clear where Track 2 funding will come from beyond these already-allocated PMPM amounts.
- Is there any cap that CMMI would prefer that states not exceed in care management fee payments?
 - The care management fee for Track 2 is fairly substantial; however, there is no specified floor or ceiling for these payments. So long as the care management payment is higher relative to Track 1 practices, it is acceptable.
- Generally, changing rates triggers Access Monitoring Review plans. Would a similar review apply for these payments?
 - *CMS will review and issue a response at a later date.*

1115 Demonstration Option



- 1115 Demonstration authority is needed when a proposed payment does not meet state plan rules (e.g. to pre-pay for services that otherwise would be reimbursable under FFS). If a state chose to implement a Medicare FFS-like Track 2 model for Medicaid providers, an 1115 Demonstration would be required.
 - Other consumer-side actions such as waiving comparability or freedom of choice would similarly trigger a need for 1115 Demonstration authority.
- Every 1115 Demonstration is a unique discussion with CMS, both in terms of demonstration content and budget neutrality. All 1115 Demonstrations must comply with certain public notice rules.

State Q&A:

- How does CMS define “prepayment” of services where an 1115 Demonstration will be needed? Colorado has been developing a primary care Alternative Payment Models (APMs) that place +/-4% of payment at risk based on whether practices meet quality targets (i.e., align Track 2 payment processes with MACRA initiatives). Could a state put some portion of the increased care management fee and FFS payment at risk, effectively lowering FFS rates? And if so, would this model require a waiver?
 - *CMS will consider this question.*
 - *Montana also expressed interest in hearing the response to this question.*

Managed Care Option



- States may have increased flexibility in implementing Track 2 alternative to fee-for-service payments under Medicaid managed care.
- The recent Medicaid Managed Care Final Rule supports states’ delivery system reform and innovation efforts. The Rule allows states to direct managed care plans to make specific payments, including Track 2 alternative to fee-for-service payments.

State Q&A:

- Tennessee, a managed care state, noted that it is emphasizing alignment across Managed Care Organizations (MCOs), particularly in terms of setting Track 2 payments. The state cannot be overly prescriptive but must ensure that goals and programs are consistent across MCOs, including setting thresholds for Track 2 payments. The state requested more information about other states’ progress in implementing Track 2 payments.

Discussion from Medicaid Payers

- **What are FFS states’ plans for Track 2? What pre-CPC+ primary care payment model you they building on?**
 - Montana: Before CPC+, Montana had two value-based Medicaid programs: a Patient-Centered Medical Home (PCMH) initiative with four Federally Qualified Health Centers (FQHCs), and a PMPM program paying capitated rates to providers seeing high-risk patients with multiple comorbidities. Montana’s proposed CPC+ model aligns with the Medicare model in that it includes PMPM care management fees and performance-based incentive payments. Montana has been considering seeking a Section 1115 Demonstration to implement Track 2 payments but would prefer to avoid this pathway. Montana currently contracts with 49 practices in CPC+.
 - Colorado: During CPC Classic, CMS paid care management fees on Colorado’s behalf. Since then, Colorado has implemented a Medicaid reform model called Accountable Care Collaboratives across the state. Under CPC+, Colorado is implementing FQHC payment reform that puts FQHC payment at risk based on

quality metrics. Track 2 implementation has been paused due to other priorities and to allow for data collection, but will eventually be rolled out to 500 practice sites.

- Arkansas: Arkansas has a robust PCMH program that has enrolled 90% of primary care providers. Currently, Track 2 implementation is on hold pending the state’s Medicaid Management Information System’s upgrade. In the meantime, the state is considering how to “sell” legislators and providers on the new payment model and putting payment at risk.
- Many Arkansas practices are engaged in CPC+ Track 2 payment for Medicare but not Medicaid, likely because Medicaid reimbursements are lower than those for Medicare. Providers are comfortable with the PCMH upside-only risk payment model in the State, but may be reluctant to adopt downside risk in Medicaid. **How are managed care states and plans thinking about CPC+ Track 2?**
 - Oregon: Oregon has 16 Coordinated Care Organizations (CCOs) that are similar to Medicaid Accountable Care Organizations or managed care plans, and are paid by the state under a global budget. CCOs are held to a 3.4% increase in annual spend and must comply with cost, quality and utilization measures. Each CCO applied to CPC+ independently, while the Oregon Health Authority manages CPC+ for the separate FFS population (100,000 members). Open questions remain for how the state will receive Medicaid matching dollars up front for the CPC+ Track 2 payment. The State noted it is not clear which match rates are applicable.
 - A plan observed that as Track 1 has been implemented, some reimbursement rates are significantly higher than those for Medicaid FFS, and this difference is even larger under Track 2. The plan asked if Medicaid reimbursement under Track 2 approaches Medicare or commercial rates, whether there is any point at which CMMI will want to reconsider Track 2 enhanced payments?
 - *CMMI will review and discuss offline.*
 - Tennessee: In contrast, the innovative aspects of the Track 2 payment model have not yet been challenged by the state’s legislature, possibly because policymakers are looking to develop provider accountability.
 - Tennessee utilizes episodes of care model as its alternative-to-FFS payment. Each episode is designed with a window of time for service and care delivery. Episodes span conditions and instances of acute care needs. The state coordinates with MCOs to develop penalties and rewards based on episode outcomes. All Medicaid providers are currently participating in the episodes of care model.
 - Tennessee is in the process of building on its PCMH model to implement Track 2 payment. The state identifies providers at the TIN level and has contracted with 29 to date to implement the episodes of care model. An additional 41 providers will join in 2018.

- **Other questions**
 - Should providers submitting financial reports to CMS this year include their Track 2 payments? How should those be accounted for?
 - Yes, providers need to account for Track 2 payments. CMMI will follow up with additional information as needed, but recommends requesting assistance from regional leads.

Session Recording: <http://hcp-lan.org/workproducts/pac/PAC-Lab4.mp4>