COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID
ONE ASHBURTON PLACE, 11TH FLOOR
BOSTON, MA 02108

COMPREHENSIVE PRIMARY CARE PAYMENT REFORM

REQUEST FOR INFORMATION

ISSUED: August 9, 2012

DOCUMENT #: 13CBEHSCPCPRFI

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I. INTRODUCTION

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (EOHHS) administers the Commonwealth of Massachusetts Medicaid program (MassHealth) pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers. Senate Bill 2400, "An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation" calls on MassHealth to develop alternative payment methodologies and transition enrollees to providers using these alternative payment methodologies. MassHealth is currently in the process of developing alternative payment methodologies, and seeks input through this Request for Information (RFI) on the proposed initiative, Comprehensive Primary Care Payment Reform.

The goal of MassHealth's Comprehensive Primary Care Payment Reform strategy is to improve access, patient experience, quality, and efficiency through care management and coordination, and integration of behavioral health and primary care. MassHealth believes that a strong primary care base is important in improving quality and efficiency while preserving access, through the patient centered medical home with integrated behavioral health services. The purpose of this initiative is to support primary care delivery transformation by giving primary care providers greater flexibility and resources to deliver care in the best way for their patients. The payment mechanism MassHealth plans to implement to support this delivery model is a comprehensive primary care payment combined with a shared savings / risk arrangement and quality incentives.

This initiative will be available to providers who are in MassHealth's managed care networks, including the Primary Care Clinician ("PCC") Plan and Managed Care Organizations. MassHealth anticipates supporting these Comprehensive Primary Care Payment Reform participants ("Participants") by providing timely data to support care coordination and cost management, and targeted technical assistance. MassHealth plans to launch a procurement within the PCC Plan for Primary Care Clinicians. MCOs would participate in a similar payment structure with these organizations, to be implemented contemporaneously with the Comprehensive Primary Care Payment Reform Initiative. MassHealth plans to implement this new initiative within a short timeframe, with a request for response (RFR) release planned in January 2013 and with 25% of managed care members enrolled with participating providers by July 2013, 50% by July 2014, and 80% by July 2015.

The proposed MassHealth Comprehensive Primary Care Payment Reform model is designed to support primary care delivery through practices that are consistent with a patient centered medical home with integrated behavioral health services. In this model, Participants will contract with MassHealth, and will commit to delivering care consistent with the Commonwealth's definition of a patient centered medical home, with a focus on behavioral health integration. Information on the Commonwealth's definition of a patient centered medical home can be accessed at http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/pcmhi/about/core-competencies.html.

This RFI describes a proposed Comprehensive Primary Care Payment Reform model across six dimensions: finance, quality, clinical delivery model, eligibility and application processes, data sharing, and member protections, and seeks broad input from all stakeholders. The intent is to design a model that will be attractive to a wide range of primary care practices and behavioral health providers, such that any primary care provider organization could potentially participate.

II. FINANCIAL MODEL

A. Introduction

Comprehensive Primary Care Payment Reform payments would be calculated pursuant to three distinct payment methodologies: first, a Comprehensive Primary Care Payment (CPCP), a risk-adjusted per member per month payment for a defined set of primary care and behavioral health services; second, a quality incentive payment described in further detail below; and third, a shared savings / risk payment, also described in further detail below. MassHealth would continue to pay fee for service for non-primary care services, but Participants would have incentives to coordinate those services as well. Participants would not be responsible for paying claims for non primary care services.

B. Comprehensive Primary Care Payment (CPCP)

The CPCP:

- Does not limit practices to revenue streams that are dependent on appointment volume or relative value units (RVU's);
- Gives practices added flexibility to provide care as the patient needs it. This may support expanding the care team, offering phone and email consultations, allowing group appointments, targeting appointment length to patient complexity, etc.;
- Allows a range of primary care practice types and sizes to participate;
- Provides support for behavioral health integration by including some outpatient behavioral health services in the CPCP; and
- Ensures support and access for high-risk members through risk adjustment based on age, sex, diagnoses, social status, comorbid conditions.

MassHealth is still in the process of defining the services covered within the CPCP. The Comprehensive Primary Care Payment is envisioned to cover evaluation and management, case management, care coordination, and behavioral health coordination.
It would include, at a minimum, outpatient office visits by a primary care professional. Labs, immunizations, and other procedures that are generally carried out in a primary care office may also be included. Some defined set of outpatient behavioral health services may also be included.

MassHealth plans to base the CPCP on Medicare rates for services covered under Section 1202 of the Patient Protection and Affordable Care Act, at least until December 31st, 2014.

There may be different processes for pricing the CPCP based on the Participant. For example, a CPCP for a participating community health center (CHC) might be based on the existing visit rate,

or a CPCP for a participating hospital outpatient department might account for the PAPE (Payment Amount Per Episode) payment system.

MassHealth is considering a model in which MassHealth would pay claims FFS to the extent that a patient receives a service covered within the CPCP from a provider other than the Participant. Those payments would be recouped from the Participant to ensure a single payment by MassHealth for any service.

C. Quality Incentive Payment

The purpose of the quality incentive payment is to reward quality measurement and high-quality care. A Participant may be eligible for a quality incentive payment, even if it does not achieve savings under the shared savings / risk payment. A Participant's quality incentive payment would be based on an aggregated score based on performance on defined metrics, discussed in **Section III**, below. The first year of the initiative may require only pay-for-reporting if practices have not been collecting all the quality data indicated in the final contract.

D. Shared Savings/Risk Payment

The purpose of the shared savings / risk payment is to reward Participants for improving the efficiency of care provided to patients in the context of improved quality. Participants must meet defined quality standards to be eligible for shared savings payments. Improved quality performance will also result in a higher percentage payout of shared savings or decreased percentage of shared loss. The shared savings / risk payment will be based on calculating the risk adjusted expected spending for a population of patients and comparing it to actual spending on those patients on an annual basis. Participants would receive some percentage of the savings realized. MassHealth plans to offer three shared savings / risk tracks:

- Track 1: Upside / downside risk. This track would include downside risk (i.e., if actual spending exceeds expected spending, a Participant would owe money to MassHealth). While MassHealth would include risk corridors to limit financial liability, MassHealth or, as required under state law, another state entity would also review the financial status of applicants to ensure they are able to take on this level of risk. This track would be targeted at Participants that are already engaged in risk arrangements with other payors.

- Track 2: Transitioning into downside risk. For the first period of the initiative, Participants would not have downside exposure, but would transition into taking on risk. Risk corridors in this track may be narrower than risk corridors in Track 1. Similar to Track 1, the financial status of applicants would be reviewed ensure that they are able to take on this level of risk.

- Track 3: Upside risk only. The percentage of shared savings payments would be lowest in this track because Participants would have no downside exposure for the entire period. This track would be targeted at Participants who may not have the financial or technical capabilities to take on any risk for the total cost of care of their patients. In accordance with applicable state law and MassHealth policy, some review of financial capabilities may be required for this track as well, to ensure applicants are able to manage the risk inherent to the CPCP.

To the extent that a Participant assumes downside risk, it will need to specify how it would plan to pay any amount owed back to MassHealth, and any funds flow required among contracted providers.

MassHealth expects to consider mechanisms to limit Participant risk, including but not limited to risk corridors and exclusions of outlier patients in the calculations.

III. QUALITY METRICS

A. Quality Domains

MassHealth and state public health agencies have aligned on a preliminary set of domains to define high quality care in the context of this initiative. These domains are:

- **Enhanced access**: Improved access to primary care services through extended hours, partnerships with urgent care, or other means;
- **Patient-centeredness**: Patient involvement in decision making, increased focus on the patient experience;
- **Behavioral health integration**: Appropriate screening and testing for behavioral health conditions in primary care settings; enhanced coordination between behavioral health and primary care providers;
- **Care coordination**: Better management of care transitions, alignment on care plans with other providers; and
- **Improved health and wellness**: Measurable improvements in patient health and wellness outcomes.

B. Creating A Metrics Set

In selecting measures, MassHealth plans to prioritize measures that are:

- Broadly accepted and validated (e.g., NQF measures);
- Aligned with MassHealth's goals and quality domains;
- Able to be influenced by primary care physicians;
- Not currently at uniformly high level of performance across providers;
- Feasible to track and report; and
- Aligned with other EOHHS initiatives and other payors' programs.

Additionally, in proposing a preliminary slate of measures, MassHealth considered the various populations to be served, including children, pregnant women, and individuals with chronic health care needs, including behavioral health.

MassHealth is cognizant of the need to minimize the administrative burden on Participants, both by including a reasonable number of metrics and aligning with other programs in the market. While there are approximately forty measures listed here, MassHealth anticipates narrowing this list.

MassHealth plans to identify subsets of measures from the final set of quality measures that will be used for monitoring the quality of care, for calculating incentive payments, and for evaluation of the overall success of the initiative. Over time, the use of each of these subsets may vary in terms of its relationship to payment, monitoring quality, or program evaluation.

C. Potential List of Metrics

The initial list of measures MassHealth is considering is set forth below. MassHealth plans to narrow this list of measures, for administrative simplicity and ease of provider tracking and reporting. The measures listed below are grouped by domain or patient population. National Quality Forum (NQF) numbers are provided for reference. Further information on NQF measures can be accessed at www.qualityforum.org.

Access

1. CAHPS: Getting Timely Care, Appointments, and Information (#5 & #6)

Patient-Centeredness

2. CAHPS: How Well Your Doctors Communicate, Patients' Rating of Doctor, Access to Specialists, Health Promotion and Education, Shared Decision Making, Health Status / Functional Status (#5 & #6)

Behavioral Health Integration

3. Depression screening (#418)
4. Antidepressant medication management (#105)
5. Initiation and engagement of alcohol / drug dependence treatment (#4)
6. Follow up after hospitalization for mental illness (includes children and adults) (#576)
7. ADHD medication management for children (#108)
8. SBIRT (alcohol abuse – not yet NQF endorsed)

Care Coordination

9. Ambulatory sensitive condition admissions: CHF (#277)
10. Medication reconciliation (meaningful use, Stage 1, core measure #7)
11. Percent of patients with at least one primary care visit in the past year
12. Diabetes hospital admission rates (#638)
13. Asthma hospital admission rates (#283)

Improved Health and Wellness

14. Influenza immunization (#41)
15. Pneumococcal vaccination (#43)
16. Adult weight screening and follow up (#421)
17. Tobacco use assessment and tobacco cessation intervention (#28)
18. Colorectal cancer screening (#34)
19. Mammography screening (#31)
20. Screening for high blood pressure
21. Diabetes composite (All or Nothing Scoring #729): Hemoglobin A1c control (<8 percent), LDL (<100), Blood pressure <140/90, tobacco non use, aspirin use
22. Diabetes mellitus: Hemoglobin A1c poor control (>9 percent) (#59)
23. Hypertension: Controlling high blood pressure (#18)
24. Ischemic Vascular Disease: Complete lipid panel and LDL control (<100 mg/dL) (#745), use of aspirin or other antithrombotic (#68)
25. Heart failure: Beta-blocker therapy for LVSD (#83)
26. CAD: Drug therapy for lowering LDL-cholesterol (#74); ACE inhibitor or ARB therapy for patients with CAD, diabetes and LVSD (#66)
27. Percent of PCP's who successfully qualify for an EHR program incentive payment
28. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58)

Pediatric Health

28. Asthma medication (#36)
29. BMI assessment and counseling (#24)
30. Adolescent immunization (#1506)
31. Developmental screening in first five years (#1448)
32. Well child visits, <15 months (#1392), 3-6 (#1516), adolescent
33. Childhood immunizations (#38)
34. A1c diabetes for children (#60)
35. Appropriate testing for children with pharyngitis (#2)

Women's Health

35. Prenatal and postpartum care (includes post partum depression screening) (NQF 1517)
36. Chlamydia screening (#33)
37. Cervical cancer screening (#32)

IV. CLINICAL DELIVERY MODEL

See attached document, "**MassHealth Comprehensive Primary Care Payment Reform: Clinical Delivery Model**".

V. ELIGIBLE ENTITIES AND APPLICATION PROCESS

A. Eligible Entities

A Participant in this model would be a Primary Care Clinician in the PCC Plan. MassHealth's current regulations provide that PCCs may be individual practitioners, group practices, CHCs, or hospital outpatient departments. MassHealth recognizes that individual practitioners would benefit from ways to form regional virtual affiliations in order to participate in this initiative, and would like to create processes for PCCs to be able to affiliate with each other to mutually invest in infrastructure and meet minimum enrollee requirements. MassHealth has not yet determined whether it would require a new provider agreement with a new legal entity in such situations.

B. Minimum Enrollee Thresholds

A Participant would need to have a specified minimum number of lives attributed to it, across the PCC Plan and participating MCOs, or would need to affiliate with other Participants to meet that threshold. The attribution process would rely on the existing system of patients selecting primary care providers. MassHealth is currently considering a minimum for upside-only Participants of 3,000-5,000; there may be a higher requirement for Participants taking on risk.

C. Involvement of PCMHI Practices

EOHHS currently manages the Patient Centered Medical Home Initiative ("PCMHI"), a multipayer approach to supporting medical homes in forty six practices across the state. EOHHS would encourage PCMHI practices to participate in the Comprehensive Primary Care Payment Reform Initiative, and receive a CPCP. Practices receiving per-member-per-month payments and shared savings under PCMHI may have PCMHI payments modified if PCMHI and Comprehensive Primary Care Payment Reform Initiative payments are duplicative.

D. Required Capabilities

MassHealth has developed the following preliminary list of required capabilities for each Participant:

- The Participant must be able to report on all the quality metrics;
- The Participant must qualify for HIT incentive payments from either Medicare or Medicaid;
- The Participant must create and maintain a patient registry. The registry shall be used for patient tracking, patient risk stratification, and analysis of patient population health status and individual patient needs;
- The Participant must offer, either itself or through contract, all of the services covered by the Comprehensive Primary Care Payment and included in the care model;
- The Participant must offer the twelve Patient Centered Medical Home Core Competencies, and must state how it meets or plans to meet the standards for behavioral health integration laid out (see attachment); and

- Participants that are owned by health systems that include acute hospitals must describe an approach to reimbursing both employed and network primary care physicians that incentivizes the delivery of comprehensive primary care as defined in this RFI.

MassHealth is still defining which capabilities would be required at the outset versus over the course of the initiative.

E. Application Elements

MassHealth has developed the following preliminary list of application elements.

- Attestation that the Participant can provide all of the services in the Comprehensive Primary Care Payment;
- Evaluation of current capacity of the Participant to meet the desired clinical delivery model;
- Practice transformation plan. This plan should lay out the path for the Participant to meet all of the foundational elements of the clinical delivery model by the end of the first year of the initiative;
- Plan for notifying members of participation in the Comprehensive Primary Care Payment Reform initiative;
- Finance plan. The Participant must present its plan for allocating payments. If the Participant is applying for a shared savings / risk track that includes downside risk, it must describe how it will raise those funds; and
- Information management plan. The information management plan should lay out how the Participant plans to use data (through the health information exchange, the claims portal, electronic medical record connections with other providers, or other mechanisms) to change practice behavior.

VI. IT INFRASTRUCTURE AND DATA SHARING

MassHealth recognizes that to effectively coordinate care across settings, Participants need accessible, timely, and accurate data. To that end, there are several data streams MassHealth anticipates that Participants would receive.

- Timely notification of ED visits and hospital admissions / discharges. Timely notification of acute care events can be essential to primary care practices pursuing appropriate follow up procedures. In the PCC plan, hospitals are currently required to notify PCCs when their patients are seen in the ED or admitted in a timely fashion. However, there is little infrastructure to support hospitals in communicating this information to PCCs in a standardized, automated fashion. The health information exchange may provide a medium term solution to this problem, but may not suffice in the near term. MassHealth is open to exploring multiple approaches to ensuring timely notification of ED visits and hospital admissions / discharges, including potentially having hospitals relay information on a daily basis to a central repository, which then transfers information out to practices. MassHealth is particularly interested in stakeholder feedback in this area.

- Access to claims-based data and analysis. Claims data can help practices track utilization of patients, to help meet cost and quality targets. MassHealth may pursue a path of offering both access to raw data and providing some aggregated reports based off that data. MassHealth envisions a common approach to claims and encounter data across the PCC and MCO plans, with the understanding that individual MCOs may produce supplemental reports and data. MassHealth is particularly interested in stakeholder feedback regarding the content and supporting technology for such reports.

- Patient panel information. Participants would need to receive regular reports from payors of the complete list of patients on their panel, potentially with risk stratification analyses from the payors. Again, this could be done either through detailed specifications to ensure standardization across payors, or through a centralized mechanism.

Processes for sharing patient-identifiable data would need to comply with current privacy, security and patient protection laws. MassHealth is considering various mechanisms for managing compliance for such data, which may include opt-in or opt-out processes for members.

VII. MEMBER PROTECTIONS

Member protection is a key priority for MassHealth in this initiative. Key elements of our member protection plan will include:

- Choice of PCC: Members remain free to switch primary care providers at any time, and may switch to a PCC that is not participating in this initiative.

- Patient experience in quality incentive payments: Patient experience survey data will serve as a key quality domain for quality incentive and shared savings payments (see above, in **Section III, subsection C**).

- Notification requirements: Participants will be required to notify patients of participation in this initiative and the impact on patients, including any changes in practice operations that will affect patients (see above, in **Section V, subsection E**).

- Choice of specialty provider: Members will be able to receive services covered in the CPCP from providers other than the Participant, and those other providers will be able to bill MassHealth (see above, in Section II, part b). Some services may still require a referral from a PCC, but at this point MassHealth does not anticipate adding to that list of services through this initiative.

VIII. QUESTIONS

A. Respondent Information

1. In what geographic areas in Massachusetts do you provide services?

2. If you provide services, how many people do you serve annually?

3. If you provide services, what kinds of direct services do you provide?

4. If you do not provide services, what is your role in the health care system?

5. If you provide services, do you do so in the context of a patient-centered medical home model? Are you NCQA certified, and if so, at which level? Are you a participant in the Patient Centered Medical Home Initiative?

6. If you are a PCC or primary care provider, would you respond to the Comprehensive Primary Care Payment Reform RFR, as it has been described above? Why or why not? If not, what changes would you recommend that would make this initiative interesting to you?

B. Financial Model

1. The CPCP is intended to support high quality, patient centered care. What features of our proposed model support these goals? What features should be modified to better advance them?

2. What would be particularly challenging about receiving payments in this fashion? How could MassHealth mitigate those challenges?

3. The Comprehensive Primary Care Payment is envisioned to cover evaluation and management, case management, care coordination, and behavioral health coordination. Beyond that, what services should be included in the CPCP bundle? To the extent that MassHealth includes outpatient behavioral health services in the CPCP, which services should be included?

4. Do the shared savings tracks offer an appropriate range of paths for the diverse providers that may be interested in becoming Participants?

5. Do you have any additional feedback on considerations in developing the finance model?

C. Quality Metrics

1. Are there additional domains of measurement that MassHealth should consider adding?

2. Within the enumerated domains, or any others that are suggested, are there any additional measures MassHealth should consider, given the above-described goals?

3. Which measures, if any, would you suggest removing from consideration, and why?

4. Which measures would you recommend be tied to financial incentives for quality performance? Is there a minimum denominator size for measures tied to incentives? Are there other criteria that MassHealth needs to consider when determining measures for incentive payments?

5. Which measures would you recommend be used as reporting-only metrics?

6. Would you recommend adding a measure on hospital readmissions? If so, which types of readmissions would you recommend as a measure? Which specific measure? Would you recommend a behavioral health readmission measure?

7. Of the above list of measures, which are the five or ten that you would consider to be of the highest importance for measuring the quality of care?

8. Do you have any overall comments on the set of measures presented here you would like to make?

9. As the field of quality measurement is constantly evolving, should MassHealth consider making changes to the measurement set over time? How often should measures be changed? If so, how should that be accomplished?

10. Do you recommend sub-measure analysis for specific populations, e.g. children, pregnant women, behavioral health conditions? If yes, how should this sub-measure analysis impact assessment of quality performance?

11. This initiative will likely require CAHPS measure collection at the practice level. How should MassHealth align with concurrent efforts by practices and other payors to support survey data collection?

D. Clinical Delivery Model

1. To the extent that you have experience implementing the twelve capabilities of the Patient Centered Medical Home and behavioral health integration, what approaches have you used? Please describe the challenges you have faced, and what role a managed care entity might play in managing those challenges.

2. Are there domains of behavioral health integration other than the five listed here that should be added?

3. Do the elements of integration within each domain appropriately cover the range of that domain? Are there any additional elements to consider including?

4. Does the defined set of "foundational elements" strike an appropriate balance between setting an ambitious goal and maintaining a feasible target for practices?

5. Does the delivery model as specified strike an appropriate balance between being broad enough to allow practices to innovate in how they achieve elements of integration and being specific enough to ensure adherence to high standards?

6. What facilitation or guidance from payor-based experts or care management professionals is useful to the practice? How should payor-based care management programs interface with practice-based care managers? Have you implemented care coordination and clinical care management? If so, please describe your model for delivering these services. What challenges did you face? How did you integrate risk stratification of patients into care coordination and care management processes?

7. Do you have any pre-existing partnerships with community based clinical and non-clinical resources that assist you in providing patient-centered care? Do you interact with other state entities (e.g., DMH, DYS) in care coordination and care management? How could MassHealth leverage and support those resources?

8. What are the unique challenges that behavioral health providers may face in participating in this initiative? What steps could MassHealth take to address these?

E. Eligible Entities and Application Process

1. MassHealth is attempting to create an application process and set of eligibility criteria that make it feasible for independent practices with small staffs to band together to participate without necessarily requiring hospital involvement. Does this framework meet that goal? If you are an independent primary care practice, would you consider joining an affiliation that does not include a hospital?

2. MassHealth is attempting to strike a balance between a contract management structure that ensures that practice transformation occurs and minimizing the administrative burden on participating provider organizations. Does this approach seem likely to accomplish those goals? What feedback would you have on it?

3. MassHealth is interested in seeking feedback about the appropriate affiliation process for smaller providers. Should smaller providers affiliating to jointly invest and meet minimum enrollee thresholds be required to form a new legal entity? What requirements should MassHealth place on these affiliations? What responsibilities should be required to sit at the PCC level (in each primary care practice) versus at the affiliation level (aggregated across primary care providers)? How should MassHealth regulate the funds flow between the affiliated entity (if there is one) and the PCCs?

F. IT Infrastructure and Data Sharing

1. Is it preferable to receive claims based data and analysis in a single feed across payors, or to receive a standardized set of reports from each payor? If there is an additional delay in data associated with channeling through a single feed, would that delay be worth the benefit of a simpler system?

2. Is it more important to provide access to raw claims data, or to a defined set of aggregated reports based on claims data? If you are a provider organization, do you currently have or plan

to have the ability to analyze raw claims data? Is a list of high risk patients something your practice would find useful?

3. What mechanisms would work best for ensuring timely notification of ED visits and hospital admissions / discharges in the interim period while the Health Information Exchange gains scale? While hospitals and primary care practices may have one-off relationships to ensure this communication, what infrastructure might allow a broader solution? Should payors participate in this process, or is the role of the payor simply to provide incentives for hospitals to share this information?

G. Member Protections

Is this set of member protections sufficient? What additional member protections may be required?

IX. RFI RESPONSE INSTRUCTIONS

A. RFI Submission Instructions

The deadline for receipt of RFI responses is **September 7, 2012, by 5:00 pm** (Eastern Time). Responses may be submitted in one of the following ways:

- **By email to**: Lisa.d.wong@state.ma.us; or

- **In writing to**: Lisa D. Wong, Procurement Coordinator
  Executive Office of Health and Human Services
  One Ashburton Place, 11th Floor
  Boston, MA 02108

B. RFI Format

All parties interested in responding to this RFI should use the attached template (Attachment A) for responding to the questions in Section VIII above. The questions in the template are identical to the questions found in Section VIII of this RFI. Parties interested in responding to the RFI should prepare an electronically submitted response or a typewritten response to the questions listed in Section VIII above, using the attached template.

EOHHS prefers to receive electronic submissions but will also accept typewritten responses. Any typewritten response should be double-sided/single-spaced. Parties responding in hard copy should submit one original and three copies of their response.

The first page of the response shall be a cover letter that includes the following information:

- Respondent's name, organization and address; and
- Respondent affiliation or interest (health organization, health care provider, community member, professional association/trade group, health care consultant, advocate/advocacy organization, consumer/patient, government organization).

Interested Parties are invited to respond to any or all of the RFI questions; please respond to as many as you feel are appropriate. Responses, including the template and any attachments thereto, should be clearly labeled and referenced by name in the RFI response documents.

The RFI does not obligate EOHHS to issue a Request for Responses (RFR) nor to include any of the RFI provisions or responses in any RFR. No part of the response can be returned. Receipt of RFI responses will not be acknowledged.

X. ADDITIONAL RFI INFORMATION

A. Comm-PASS

This RFI has been distributed electronically using the Commonwealth Procurement Access and Solicitation System (Comm-PASS). Comm-PASS is an electronic mechanism used for advertising and distributing the Commonwealth of Massachusetts' procurements and related files. No individual or organization may alter (manually or electronically) the RFI or its components except for those portions intended to collect the respondent's response. Interested parties may access Comm-PASS at http://www.comm-pass.com. Questions specific to Comm-PASS should be made to the Comm-PASS Help Desk at comm-pass@osd.state.ma.us.

B. RFI Amendments

Interested parties are solely responsible for checking Comm-PASS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to interested parties who fail to check for amended RFIs.

C. Use of RFI Information

Information received in response to this RFI shall serve solely to assist the Commonwealth in the development of policy. No information received in response to this RFI is binding on the Commonwealth or any of its agencies. Responding to this RFI is entirely voluntary and will in no way affect consideration of any proposal submitted in response to any subsequent procurement or solicitation. Responses to this RFI become the property of the Commonwealth of Massachusetts and are public records under the Massachusetts Freedom of Information Law, M.G.L.c.66, section 10 and c.4, section 7, clause 26, regarding public access to such documents. However, information provided in its response to this RFI and identified by the respondent as trade secrets or commercial or financial information shall be kept confidential to the extent permitted by law and shall be considered by EOHHS as exempt from disclosure as a public record (see Massachusetts General Laws, Chapter 4, section 7(26) g. This exemption may not apply to information submitted in response to any subsequent procurement solicitations.

ATTACHMENT A
COMPREHENSIVE PRIMARY CARE PAYMENT REFORM
RFI RESPONSE TEMPLATE

Please use this template to respond to the questions contained in the RFI. The questions in the template are identical to the questions found in **Section VIII** of the RFI. ***Interested parties are invited to respond to any or all of the questions; please respond to as many as you feel are appropriate.***

SECTION VIII.A. Respondent Information
1. In what geographic areas in Massachusetts do you provide services?
2. If you provide services, how many people do you serve annually?
3. If you provide services, what kinds of direct services do you provide?
4. If you do not provide services, what is your role in the health care system?
5. If you provide services, do you do so in the context of a patient-centered medical home model? Are you NCQA certified, and if so, at which level? Are you a participant in the Patient Centered Medical Home Initiative?
6. If you are a PCC or primary care provider, would you respond to the Comprehensive Primary Care Payment Reform RFR, as it has been described above? Why or why not? If not, what changes would you recommend that would make this initiative interesting to you?

SECTION VIII.B. Financial Model
1. The CPCP is intended to support high quality, patient centered care. What features of our proposed model support these goals? What features should be modified to better advance them?
2. What would be particularly challenging about receiving payments in this fashion? How could MassHealth mitigate those challenges?
3. The Comprehensive Primary Care Payment is envisioned to cover evaluation and management, case management, care coordination, and behavioral health coordination. Beyond that, what services should be included in the CPCP bundle? To the extent that MassHealth includes outpatient behavioral health services in the CPCP, which services should be included?
4. Do the shared savings tracks offer an appropriate range of paths for the diverse providers that may be interested in becoming Participants?
5. Do you have any additional feedback on considerations in developing the finance model?

SECTION VIII.C. Quality Metrics
1. Are there additional domains of measurement that MassHealth should consider adding?
2. Within the enumerated domains, or any others that are suggested, are there any additional measures MassHealth should consider, given the above-described goals?
3. Which measures, if any, would you suggest removing from consideration, and why?
4. Which measures would you recommend be tied to financial incentives for quality performance? Is there a minimum denominator size for measures tied to incentives? Are there other criteria that MassHealth needs to consider when determining measures for incentive payments?
5. Which measures would you recommend be used as reporting-only metrics?
6. Would you recommend adding a measure on hospital readmissions? If so, which types of readmissions would you recommend as a measure? Which specific measure? Would you recommend a behavioral health readmission measure?

7. Of the above list of measures, which are the five or ten that you would consider to be of the highest importance for measuring the quality of care?
8. Do you have any overall comments on the set of measures presented here you would like to make?
9. As the field of quality measurement is constantly evolving, should MassHealth consider making changes to the measurement set over time? How often should measures be changed? If so, how should that be accomplished?
10. Do you recommend sub-measure analysis for specific populations, e.g. children, pregnant women, behavioral health conditions? If yes, how should this sub-measure analysis impact assessment of quality performance?
11. This initiative will likely require CAHPS measure collection at the practice level. How should MassHealth align with concurrent efforts by practices and other payors to support survey data collection?

SECTION VIII.D. Clinical Delivery Model
1. To the extent that you have experience implementing the twelve capabilities of the Patient Centered Medical Home and behavioral health integration, what approaches have you used? Please describe the challenges you have faced, and what role a managed care entity might play in managing those challenges?
2. Are there domains of behavioral health integration other than the five listed here that should be added?
3. Do the elements of integration within each domain appropriately cover the range of that domain? Are there any additional elements to consider including?
4. Does the defined set of "foundational elements" strike an appropriate balance between setting an ambitious goal and maintaining a feasible target for practices?

5. Does the delivery model as specified strike an appropriate balance between being broad enough to allow practices to innovate in how they achieve elements of integration and being specific enough to ensure adherence to high standards?
6. What facilitation or guidance from payor-based experts or care management professionals is useful to the practice? How should payor-based care management programs interface with practice-based care managers? Have you implemented care coordination and clinical care management? If so, please describe your model for delivering these services. What challenges did you face? How did you integrate risk stratification of patients into care coordination and care management processes?
7. Do you have any pre-existing partnerships with community based clinical and non-clinical resources that assist you in providing patient-centered care? Do you interact with other state entities (e.g., DMH, DYS) in care coordination and care management? How could MassHealth leverage and support those resources?
8. What are the unique challenges that behavioral health providers may face in participating in this initiative? What steps could MassHealth take to address these?

SECTION VIII.E. Eligible Entities and Application Process

1. **MassHealth is attempting to create an application process and set of eligibility criteria that make it feasible for independent practices with small staffs to band together to participate without necessarily requiring hospital involvement. Does this framework meet that goal? If you are an independent primary care practice, would you consider joining an affiliation that does not include a hospital?**

2. **MassHealth is attempting to strike a balance between a contract management structure that ensures that practice transformation occurs and minimizing the administrative burden on participating provider organizations. Does this approach seem likely to accomplish those goals? What feedback would you have on it?**

3. **MassHealth is interested in seeking feedback about the appropriate affiliation process for smaller providers. Should smaller providers affiliating to jointly invest and meet minimum enrollee thresholds be required to form a new legal entity? What requirements should MassHealth place on these affiliations? What responsibilities should be required to sit at the PCC level (in each primary care practice) versus at the affiliation level (aggregated across primary care providers)? How should MassHealth regulate the funds flow between the affiliated entity (if there is one) and the PCCs?**

SECTION VIII.F. IT Infrastructure and Data Sharing
1. Is it preferable to receive claims based data and analysis in a single feed across payors, or to receive a standardized set of reports from each payor? If there is an additional delay in data associated with channeling through a single feed, would that delay be worth the benefit of a simpler system?
2. Is it more important to provide access to raw claims data, or to a defined set of aggregated reports based on claims data? If you are a provider organization, do you currently have or plan to have the ability to analyze raw claims data? Is a list of high risk patients something your practice would find useful?
3. What mechanisms would work best for ensuring timely notification of ED visits and hospital admissions / discharges in the interim period while the Health Information Exchange gains scale? While hospitals and primary care practices may have one-off relationships to ensure this communication, what infrastructure might allow a broader solution? Should payors participate in this process, or is the role of the payor simply to provide incentives for hospitals to share this information?

SECTION VIII.G. Member Protections

Is this set of member protections sufficient? What additional member protections may be required?