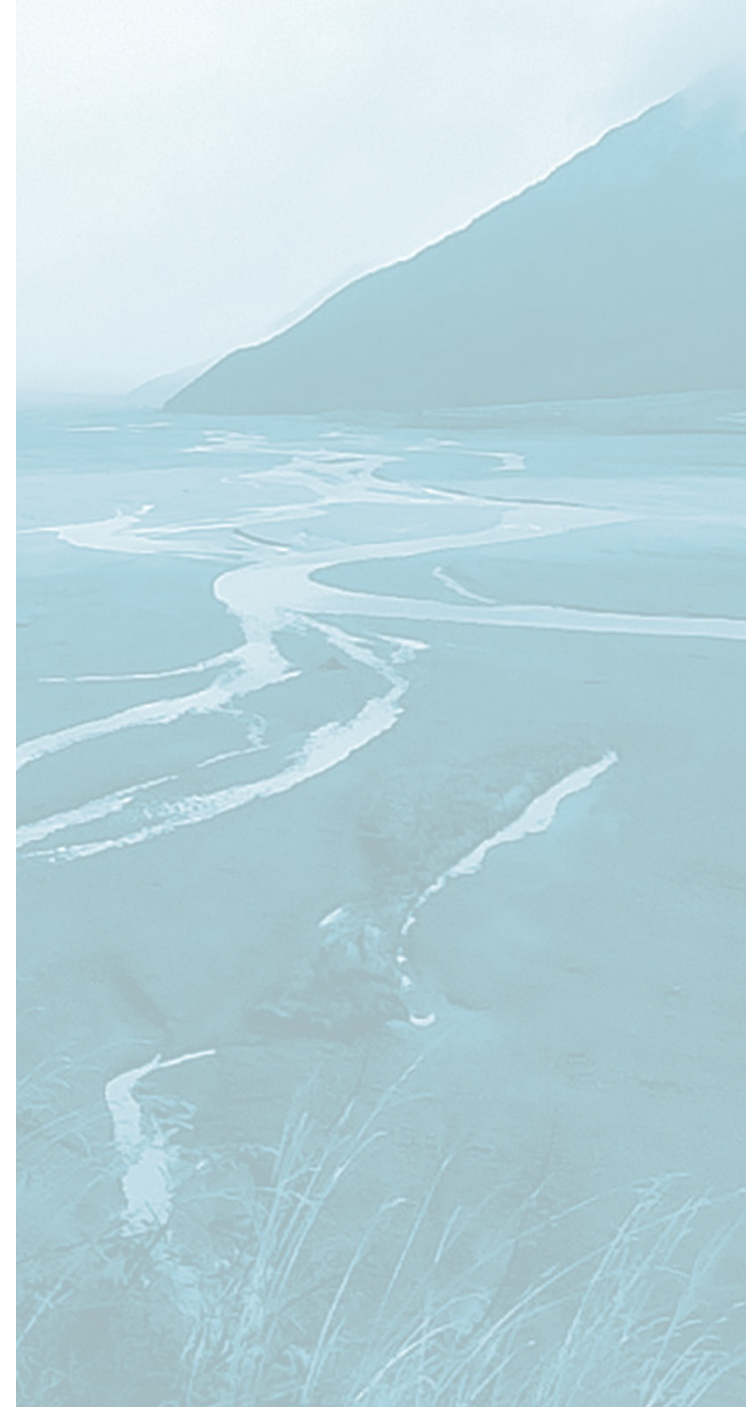


# Payment Reform and Value Improvement at Mosaic Medical

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# Speakers



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# Agenda

- About Mosaic / Background
- Mosaic's Value Based Pay Evolution
- Current Medicaid Payment Streams
- Impacts, Challenges, and Mulligans

# Mosaic Medical System



**Mission:** to improve the health and well-being of the individuals, families, and communities we serve

# Services Offered at Mosaic Medical

- Primary Care
  - Family Medicine
  - Pediatrics
  - Internal Medicine
  - Complex Care
  - Prenatal/OB
- Behavioral Health
  - Behavioral Health Consultants
  - Substance Abuse Support (MAT)
  - Chronic Pain Management
  - Mental Health Prescribing
- Nutrition
- Clinical Pharmacy
- Dental and Oral Health

# Themes and Lessons

- Comprehensive primary care, need for wraparound services
- Importance of data and analytic investment
- Close partnership between Quality Improvement, Population Health, and Data and Analytics teams
- Leadership buy-in: necessity of explaining ‘the WHY’
  - Critical for Operational and Clinical leaders
- State and payor relationships

# Early Influences/Context

- Partnerships with regional healthcare community (e.g., CO Health Council)
- Strong partnership with local Medicaid MCO
- Recognition of important role of comprehensive primary care
- Early adopter of Behavioral Health Integration
- Recognition that being data-savvy in a pay-for-value environment was critical



# **Mosaic's Value-Based Pay Evolution**



# Care Team Evolution

## 2003

- Community Health Worker role

## 2010

- Created RN Care Coordinator role with panel management duties
- Behavioral Health integration

## 2011

- Clearly-defined teams co-located
- Wrap-around care coordinated by team triad of: RNCC, Team Care Assistant, & CHW

## 2013

- Launched “Ambulatory ICU” with case rate

## 2014

- Diabetes pathway development, health coaching

## 2016

- Launched substance abuse disorder with MAT services

## 2019

- RN roles re-evaluated, development of RNCM role

# Payment Evolution

## 2010

- P4P quality incentive program with local Medicaid Managed Care Organization (MCO)

## 2012

- Capitation payment model with MCO
- PCPCH (OR-version of PCMH) supplemental PMPM payments

## 2013

- **Launch of Oregon's Advanced Payment and Care Methodology (APCM)**
- ACA expansion planning (panel sizes, complexity, projections, etc.)

## 2014

- ACA expansion
- “Gainshare” contract for Medicaid patients with hospital system

## 2016

- Quality incentive contract with Central Oregon IPA

## 2017

- Joined Medicare Accountable Care Organization (ACO)

# IT, Data, and QI Evolution

## 2011

- OCHIN Epic EMR implementation
- Hired Director of Quality and Analytics (now Director of Value Improvement)

## 2012

- **Hired first data analyst**
- Model for Improvement, Quality Boards, huddles, PDSAs

## 2013

- Investment in data infrastructure (Tableau, data warehousing), 2<sup>nd</sup> data analyst
- Population health specialist role (panel management, bulk outreach)

## 2014

- Patient-level “Total cost of care” data files from CCO

## 2015

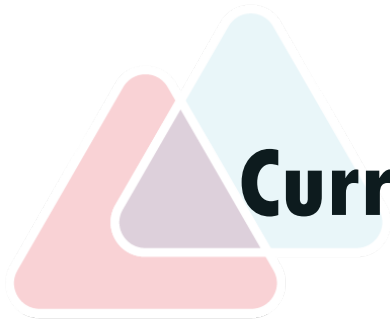
- Further investment in data: 3<sup>rd</sup> FTE; data prep software
- Constructed risk-tiered Population Health Model

## 2016

- Manager of Quality Improvement, Population Health Manager, 2<sup>nd</sup> Population Health Specialist
- “Value Improvement” department

## 2017

- Quality Medical Director” role



# **Current Medicaid Payment Streams**

# Medicaid Payment Streams (1)

- **Alternative Payment and Care Model (APCM)**
  - Oregon launched the first Medicaid (2013) alternative payment model (replacing PPS payment) developed in coordination with Oregon Primary Care Association (OPCA)
  - Capitated payment with downside risk tied to quality metric performance
  - FFS carve outs include prenatal, MH/BH, oral health

# APCM Goals

“Align payment with an efficient, effective, emerging care model that lowers overall costs while improving quality, access, and health equity for all.”

- Focus on patients over billable visits
- Foster comprehensive, interdisciplinary care teams
- Provide access to care beyond the PCP exam room
- Encourage addressing social determinants of health



# APCM Role

- Predictable, timely funding structure allowed creativity with staffing and services.
- APCM priorities provided external validation of Mosaic's vision and strategic direction.
- OPCA's leadership and vision.
- Strong support from State officials reinforced value of what we do.
- Partnerships, learning, sharing with peers.

# Medicaid Payment Streams (2):

- **PMPM Through Regional Coordinated Care Organization**
  - Started in 2012
  - Capitation for patients assigned to Mosaic
  - Dependence on patients' Medicaid status led to hiring of additional enrollment assistors
  - FFS carve outs include wellness visits, prenatal, MH/BH, oral health



# Medicaid Payment Streams (3)

- **Shared Savings Contract with Hospital**
  - Hospital services are capitated
  - Local hospital has financial withhold tied to quality and utilization targets paid to both hospital and providers

# Medicaid Payment Streams (additional)

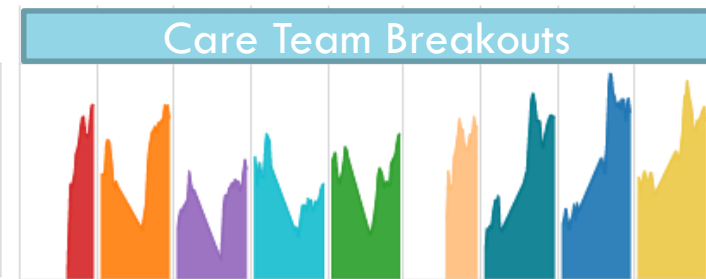
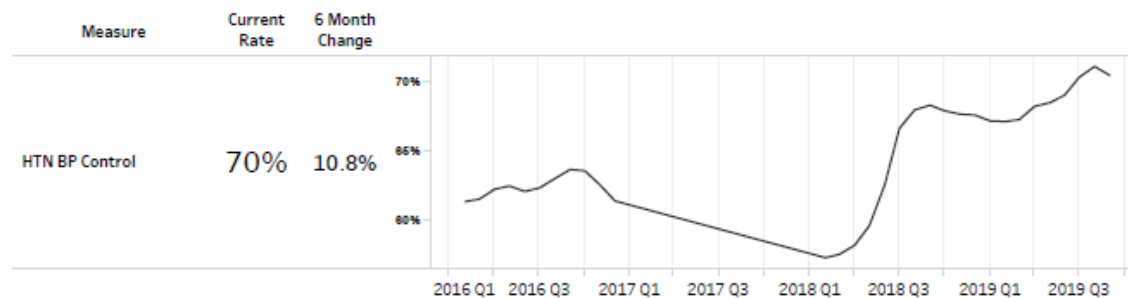
- **Quality Bonus with local Independent Practice Association**
  - Mix of standard CQMs and process measures
  - Funded through small PMPM taken by IPA
- **Coordinated Care Organization (CCO) Surplus**
  - Shared by hospital, specialists, and primary care organizations

# Impact of Mosaic's “Value” Focus

- Building of integrated clinical teams
  - Dental, BH, Substance Abuse, Pharm, Nutrition, Care Managers
- Serving patient needs outside of traditional face-to-face PCP visits
  - Phone visits
  - Clinician-led Group Visits
  - Patient Education Classes
  - Patient Portal
  - TelePsych
- Improved culture regarding use of data and improvement within Mosaic and with payors and community

# Quality Improvement: Hypertensive BP Control

Report Date Range:  
2/9/2016 to 9/29/2019



- “All hands on deck” QI project
- Similar project ongoing for diabetes management (A1c Control and Minnesota D5 Composite)

# Challenges

- Disparate requirements across payors
- Culture shift from FFS to value
- Uncertainty in how to measure “success”
- Uncertainty/risk in funding streams
- Culture of sharing the care (trust, role clarity, communication, hiring, training, accountability)
  - Optimizing org structure, lines of authority, decision-making process.
  - Lack of best practices in certain roles and focus areas

# Mulligans

- Ensuring operational and clinical leadership buy-in
- Practice improvement staff need to be highly relational and facilitative
- Value Improvement department reported through Operations, now reports Clinically

# Future Work

- Continue paradigm shift to “share the care,” including use of team-based performance metrics.
- Continue to develop risk stratification model and associated pathways that reflect a holistic view of the person.
- Team ownership of assigned “population”
- Alignment among payment models, incentives, metrics.
  - Improved contracting.
- Improve joy in practice, provider/staff well being.
- Increase Value Based Contracts with focus on Medicare



# Thank you for participating!



For questions, please email:

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