MaineCare Services
An Office of the
Department of Health and Human Services

FOR DISCUSSION
DRAFT
PURPOSES ONLY

MaineCare

Value-Based Purchasing Strategy
Lewiston & Portland Regional Forums

April 17 and 19, 2012

https://www.maine.gov\dhhs\oms\vbp

Agenda

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- Welcome - MaineCare Director Stefanie Nadeau 9:00 – 9:15
- Context: High-Cost/ High Utilizer Member Profile 9:15 – 9:35
- Overview of DHHS Value-Based Purchasing Strategy 9:35 – 10:05
  - Accountable Communities
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Camden Coalition of Healthcare Providers (NJ) Study of MaineCare High Utilizers, 2009-10

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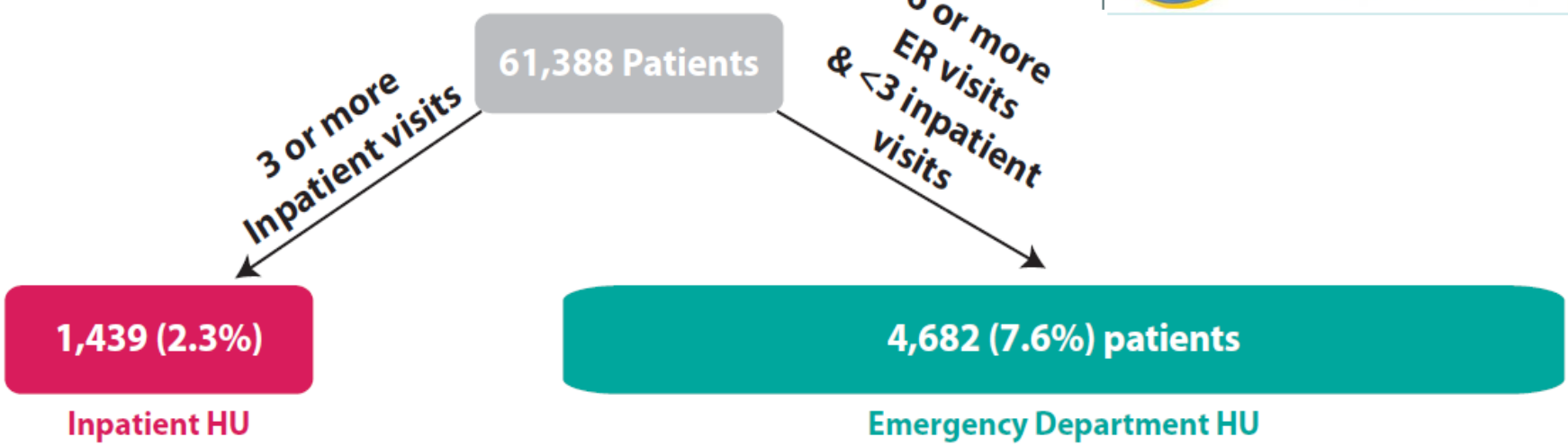
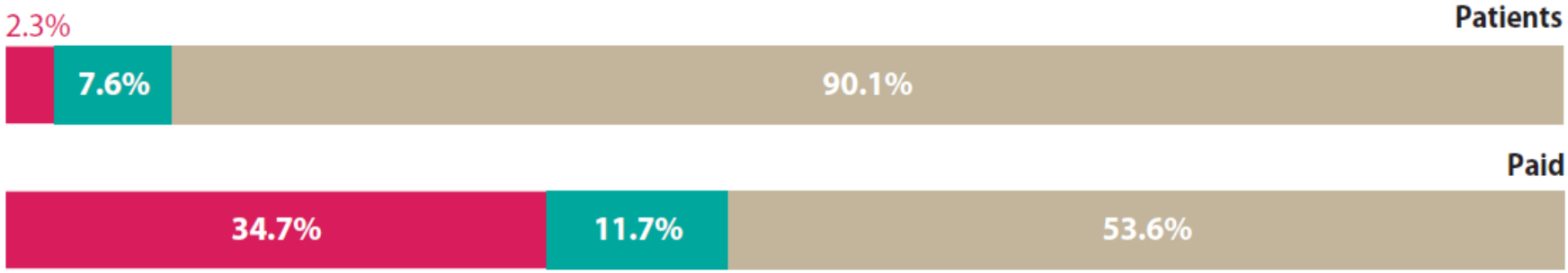
MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

Camden Coalition of Healthcare Providers
www.camdenhealth.org

How we define a High Utilizer



High Utilizers as a percentage of all patients and costs



Camden Coalition High Utilizer Study: Geography

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- 1% of all MaineCare patients accounted for over 30% of total hospital costs across the 3 counties; 20% accounted for 87% of costs.
- Portland, Bangor, Waterville and Augusta:
  - 46% of all High Utilizers in the 3 counties
  - 38% of the MaineCare population in the 3 counties
- Towns with the highest rates of High Utilizers among towns with at least 200 MaineCare members
  - Waterville (14.95%)
  - Lincoln (12.78%)
  - Winslow (12.25%)

Camden Coalition of Healthcare Providers
www.camdenhealth.org

Camden Coalition High Utilizer Study: Diagnoses

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Inpatient High Utilizers

- Most prevalent diagnoses:
  - Alcohol-related disorders (over twice as likely as non-High Utilizers)
  - Mood disorders
  - Chronic obstructive pulmonary disease and bronchiectasis (almost twice as likely)
- 1.8 times more likely to have an IP diagnosis of diabetes compared to non-High Utilizers
- 72% of all IP High Utilizers were over age 34

ED High Utilizers

- Almost 1.5 times more likely to have an ED diagnosis of "anxiety disorders"
- Almost 1.5 times more likely to have an ED diagnosis of "spondylosis; intervertebral disc disorders; other back problems”
- 1.4 times more likely to have a diagnosis of "Headache; including migraine".
- 67% of all ED High Utilizers were under age 35

Camden Coalition of Healthcare Providers
www.camdenhealth.org

DHHS Take-Away's

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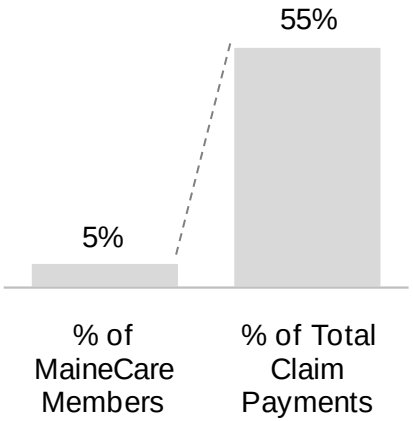
- A relatively small number of MaineCare members are responsible for a large percentage of the costs
- High utilizers cluster in "hot spots" across the state
- Improved integration of behavioral and physical health is a necessity
- Many high utilizers' health may be improved through access to primary care, preventive care, and chronic disease management



DHHS' strategy must:

- **Be community-based**
- **Address integration of behavioral and physical health**
- **Strengthen access to and use of patient-centered primary care**
- **Provide care management for high need members**

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Overview of Maine DHHS Value-Based Purchasing Strategy

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"Value-based purchasing:"

An expansive term that covers a range of initiatives focused on incenting the delivery of quality, cost effective care, from the individual provider to system levels.

- Increased transparency of cost and quality outcomes
- Reward for performance
- Reform payment to provide resources and incentives that enable a focus on care coordination within and across providers and practices

DHHS Value-Based Purchasing Strategy

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The Department has developed a Value-Based Purchasing strategy centered around three main goals to achieve the right care for the right cost.

Create Accountable Communities

Improve Transitions of Care

- ED Collaborative Care Management Initiative
- Health Homes focus
- Maine Quality Counts learning opportunities
- Payment reform discussion

Strengthen Primary Care

- Health Homes Initiative
- Reform of Primary Care Provider Incentive Payment program

Accountable Communities: What is an Accountable Care Organization (ACO)?

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The definition of an ACO depends on who you ask…

The Department is adopting the simple definition that an ACO is:

An entity responsible for population's health and health costs that is:

- Provider-owned and driven
- A structure with a strong consumer component and community collaboration
- Includes shared accountability for both cost and quality

Accountable Communities: How is an ACO different from a MCO?

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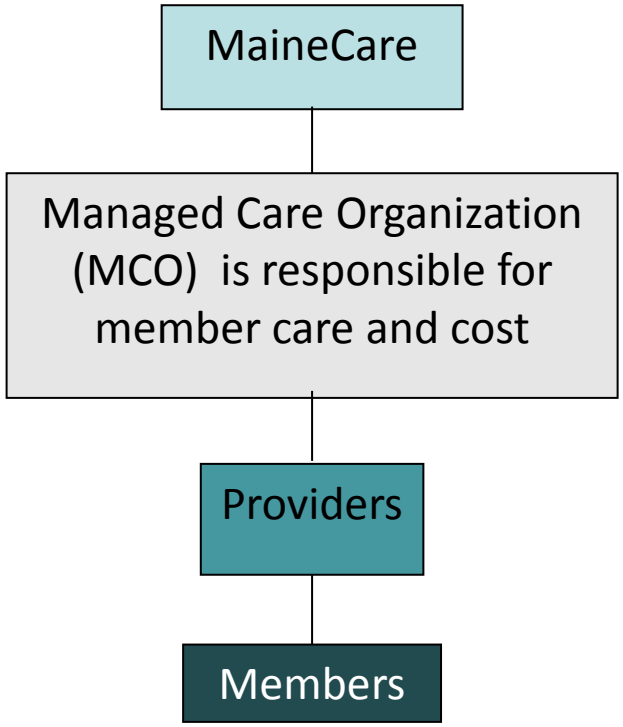
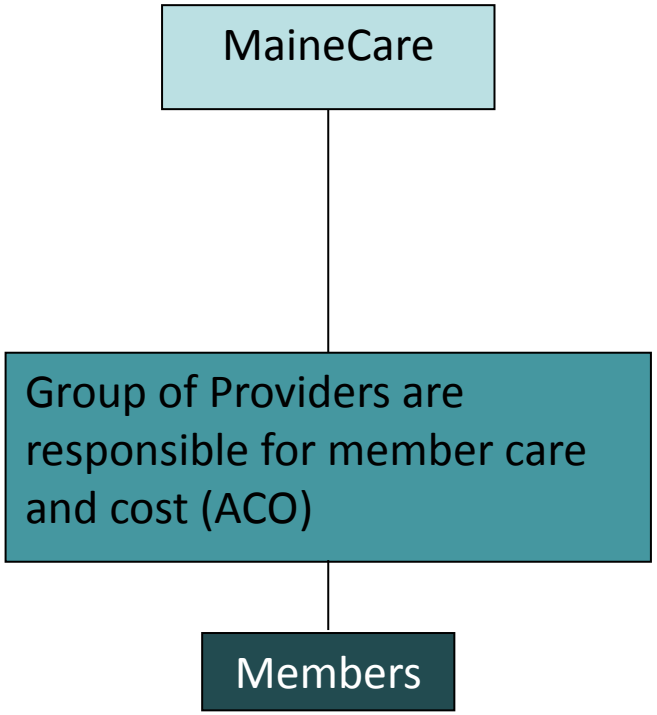
Managed Care Organization (MCO)



Accountable Care Organization (ACO)



MaineCare Accountable Communities

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Basic Components:

- Providers will be able to come together to engage in an alternative contract with the Department to share in any savings achieved for an assigned population
- The amount of shared savings will depend on the attainment of quality benchmarks
- Open to any willing and qualified providers statewide
  - Qualified providers will be determined through an application process
  - Accountable Communities will not be limited by geographical area
- Members retain choice of providers
- Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate
- Flexibility of design to encourage innovation

CMS Health Homes – ACA Section 2703

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- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid "State Plan Amendment"
- Health Homes may serve individuals with:
  - » Two or more chronic conditions
  - » One chronic condition and who are at risk for another
  - » Serious mental illness
    - – Adults with serious & persistent mental illness (SPMI)
    - – Children with severe emotional disturbance (SED)
- Dual eligible beneficiaries cannot be excluded from Health Home services

Maine's Health Homes Proposal

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Medical Homes

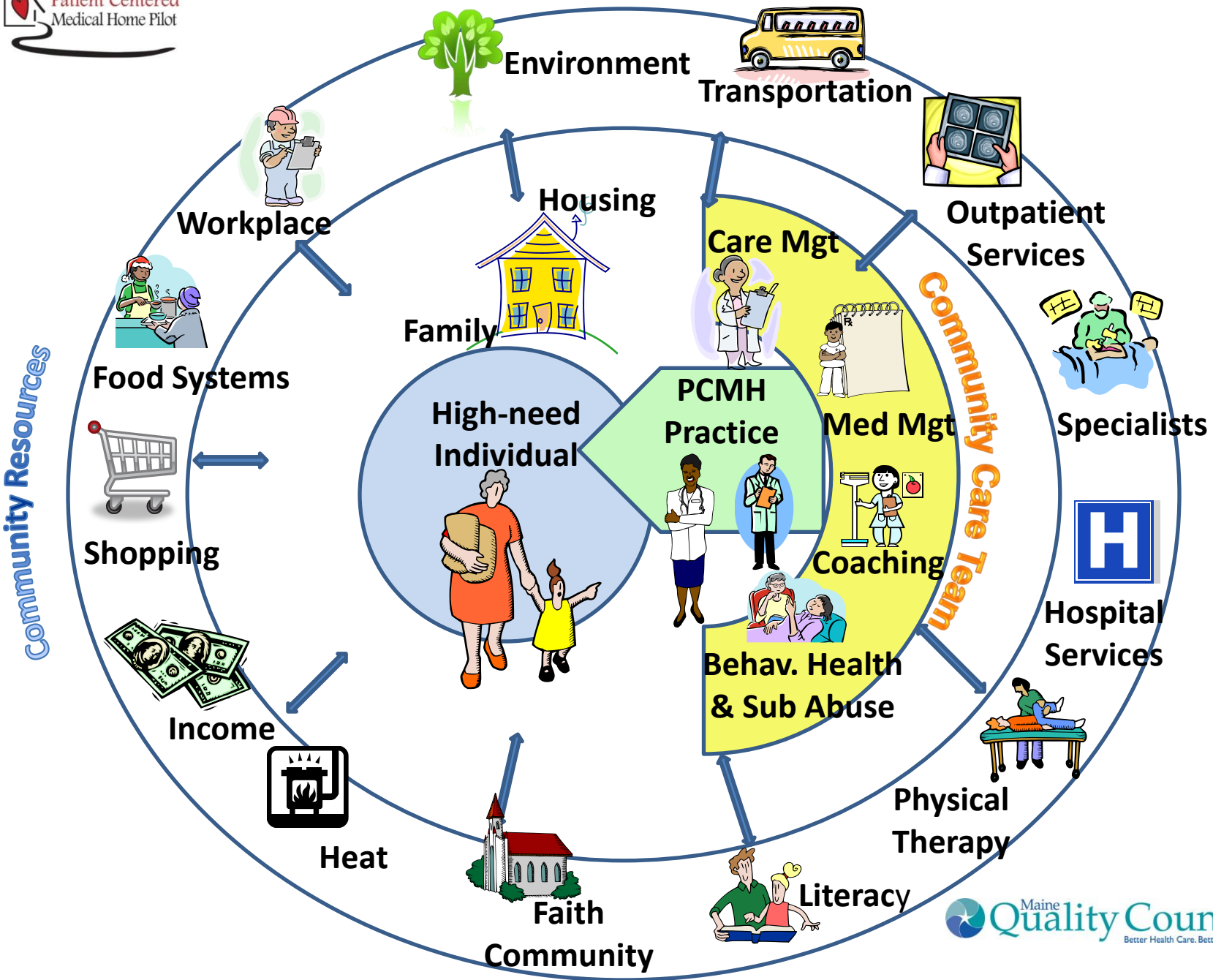
+

Community Care Teams (CCTs)

=

Health Homes

Maine PCMH Pilot Community Care Teams



Maine Health Homes Proposal

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The Maine Health Homes project will have two stages.

Stage A:

- Health Home = Medical Home practice + CCT (most of the payment goes to the medical home)
- Members who join the Health Home during this stage:
  - Two or more health problems that last a long time (chronic conditions)
  - One health problem that lasts a long time and the chance that the member may get another serious health problem.

Stage B:

- Health Homes = CCT that are experts in behavioral health + Medical Home practice (most of the payment goes to the CCT)
- Members who join the Health Home during this stage:
  - Adults with Serious and Persistent Mental Illness (SPMI)
  - Kids with Serious Emotional Disturbance (SED)

Maine Health Homes Proposal

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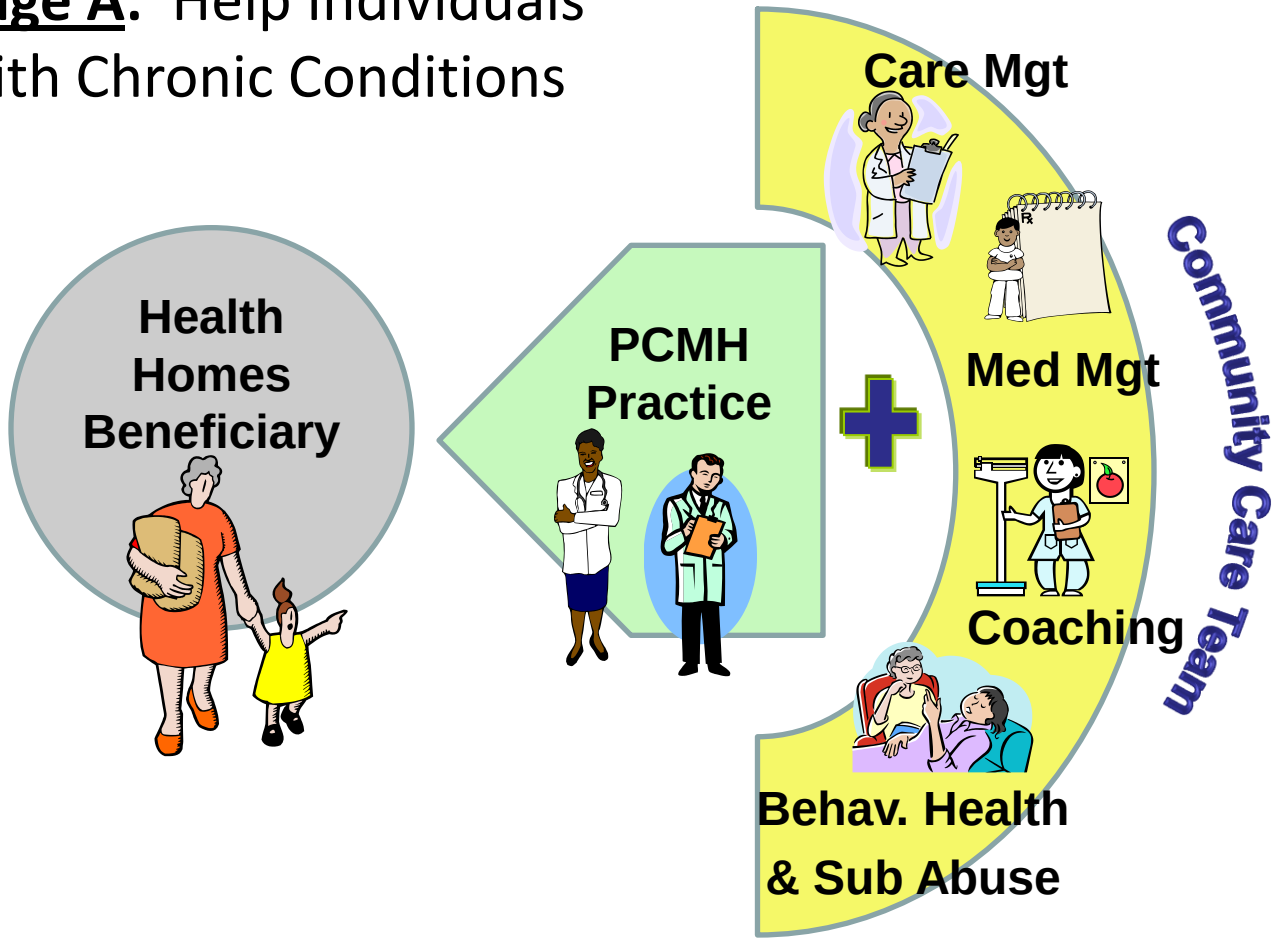
<u>Stage A</u>: Help Individuals with Chronic Conditions



Maine Health Homes Proposal

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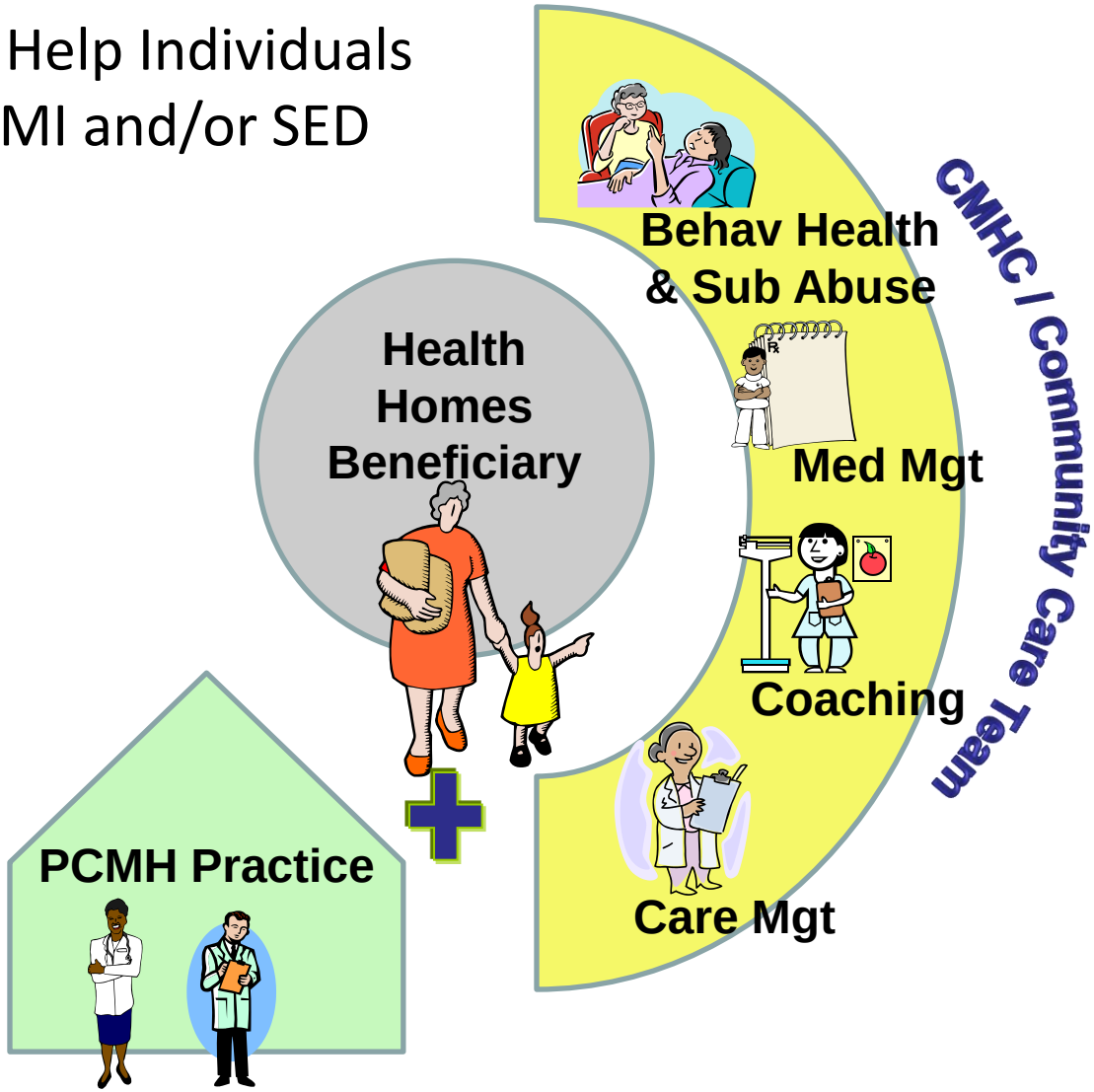
Stage B: Help Individuals with SPMI and/or SED



How do Health Homes and Accountable Communities fit together?

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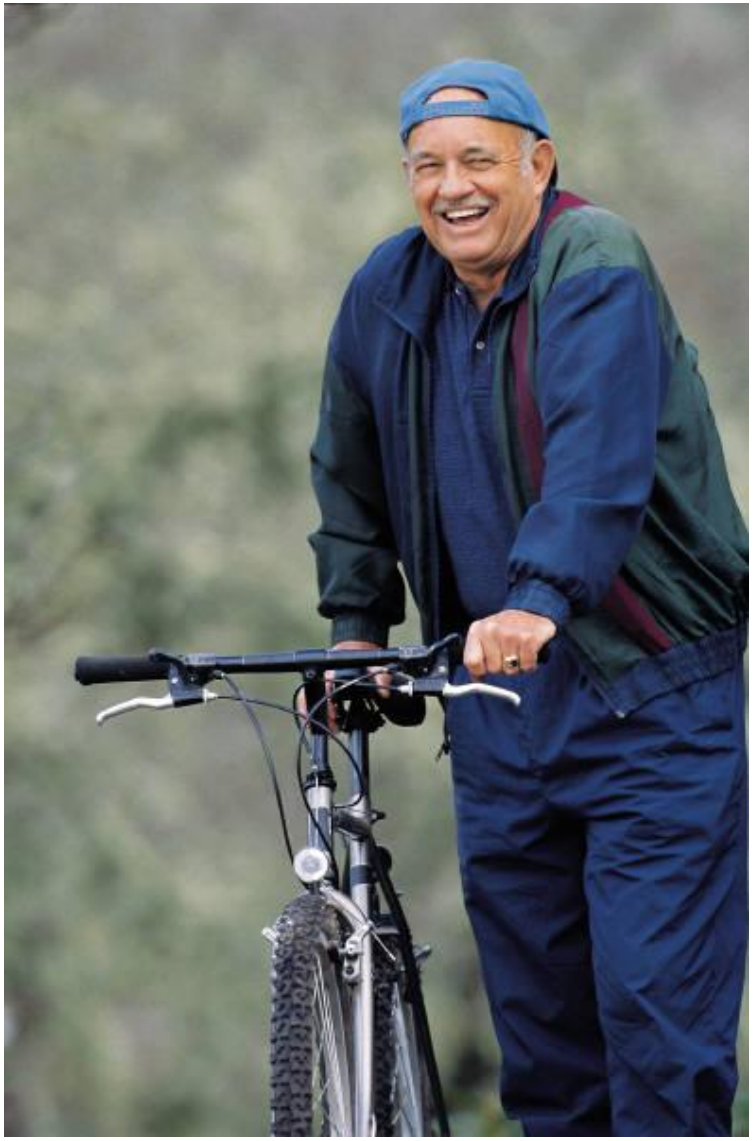
The Bike

=

Accountable Community

The AC can be looked at as a tool or vehicle to get to where you want to go-- but a bike is not any good without a rider!

For MaineCare, the “bike” (or AC) is a vehicle that allows providers to come together to share in any savings they achieve from providing coordinated, quality care.



How do Health Homes and Accountable Communities fit together?

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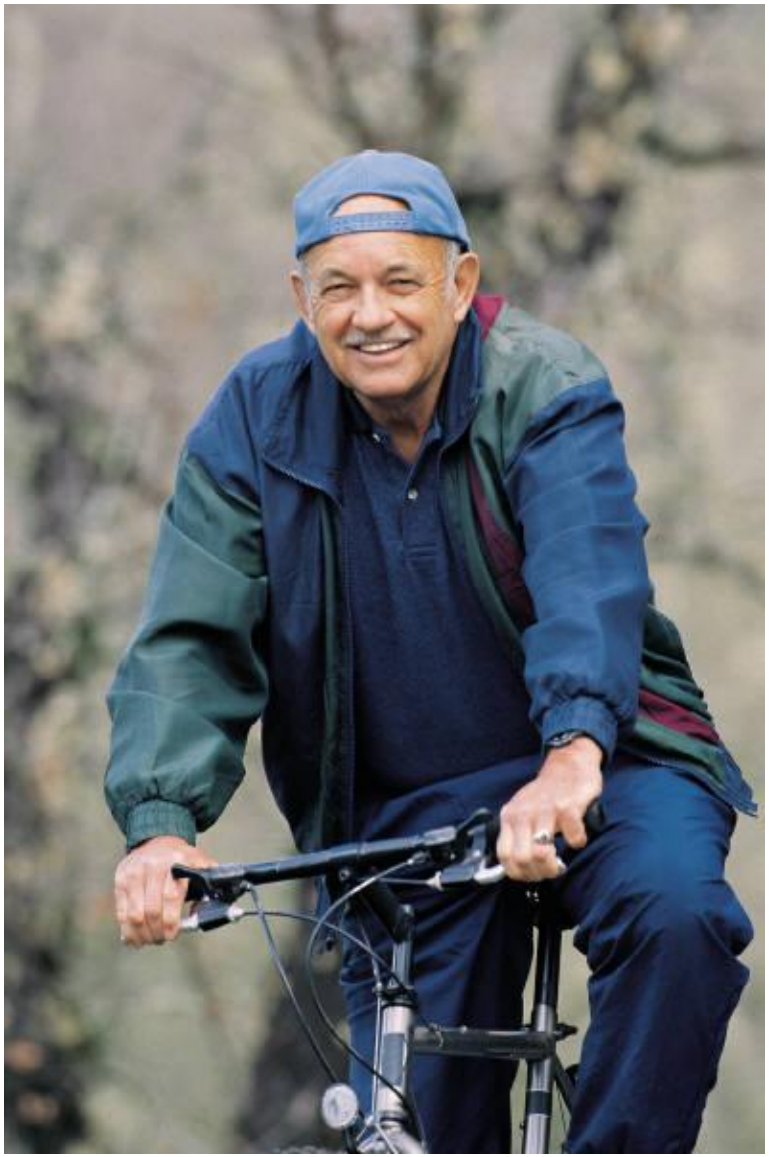
The Rider

=

Health Home

A Health Home is an on-the-ground model to provide more coordinated and high quality care. A Health Home makes an excellent "rider" for an AC "bike."

In the interest of flexibility, MaineCare is not requiring that Health Homes be a part of Accountable Communities. They do, however, provide a natural foundation.



Collaboration

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A rider needs to work together as part of a team in order to win a race.

Providers, whether part of Accountable Communities, Health Homes, or both, will need to work together and with the larger community to succeed at reducing costs and improving the health of members.

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Stakeholder Engagement to Date

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- **Aug 2011:** VBP Strategy announced.
- **Oct 2011:** Stakeholders from Managed Care Initiative convened to review the new strategy. New plan for stakeholder engagement announced.
- **Oct 2011 – Jan 2012:** 1:1 meetings between MaineCare and providers.
- **Oct 2011 – Apr 2012:** 4 meetings with Member Standing Committee.
- **Nov 2011:** Request for Information (RFI) posted.
- **Dec 2011:** 28 RFI responses received.
- **Feb 2012**: RFI synthesis posted online.
- **Feb – Mar 2012**: DHHS Design Management Committee (DMC) met weekly to develop proposed models for Accountable Communities and Health Homes.

The DMC includes representatives from the Offices of:

- MaineCare
- Maine Center for Disease Control
- Adult Mental Health
- Adults with Cognitive & Physical Disability Services
- Children & Family Services
- Elder Services
- Health Information Technology
- Quality Improvement
- Substance Abuse

and the Muskie School of Public Service at the University of Southern Maine.

BREAK

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Accountable Community Eligibility Requirements

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Accountable Communities must:

- Be assigned a minimum number of MaineCare members, to be determined
- Include MaineCare-enrolled providers
- Deliver primary care services
- Directly deliver or commit to coordinate with specialty providers, including behavioral health for non-integrated practices, and all hospitals in the proposed service area.
- Commit to:
  - Integration of behavioral and physical health
  - Demonstrated leadership for practice and system transformation
  - Inclusion of patients & families as partners in care, and in organizational quality improvement activities and leadership roles
  - Developing formal and informal partnerships with community organizations, social service agencies, local government, etc. under the care delivery model
  - Participation in Accountable Community and/or ACO learning collaborative opportunities

Accountable Communities "Core: Services: RFI Responses

- **Main criterion for selection of "core" services**: For which services is it reasonable to hold most provider organizations accountable to reduce avoidable costs and improve health outcomes through better coordination of care?
  - The majority of responders, including behavioral health organizations and health systems, recommended the inclusion of all physical and behavioral health services.
  - Some health systems suggested initially excluding long term care, developmental disabilities and substance abuse.
  - Some behavioral health organizations suggested initially excluding emergency, crisis and inpatient as part of the core services.
  - One hospital system, some behavioral and long term care providers would include long term care as core services.

Accountable Communities "Core" Services Recommendations

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Services, **not** members or providers, may be excluded from the total cost of care for which the Accountable Communities is responsible. ***All medical costs for these members would still be included.***

Accountable Communities must include all "core" services. Accountable Communities may choose to include services listed as optional.

Core:

- Inpatient
- Outpatient
- Emergency Department
- Physician
- Pharmacy
- Mental Health
- Community Integration
- Substance Abuse

Optional:

- Private Non-Medical Institutions (PNMIs)
- Waiver
- Nursing Facilities (except physical, occupational and speech therapy that occurs at the facilities)
- Targeted Case Management
- Early Intervention
- Private Duty Nursing Services
- Transportation
- Dental

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Members Served and Provider Choice

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Eligible Members

- Accountable Communities will serve all fully Medicaid eligible MaineCare members, including members dually eligible for Medicare.
- Services, **not** members, may be excluded from the total cost of care for which the Accountable Communities is responsible.

Provider Choice

- Many RFI responders recommended that the Department align the Accountable Communities member protections with the beneficiary protections under the Medicare Shared Savings Program (MSSP).
- Accordingly, members will be aligned with, rather than enrolled in, Accountable Communities. ***Member freedom of choice is not restricted.***
- The Department is interested in exploring near and longer-term options for encouraging personal accountability among members, including incenting informed, healthy and cost efficient choices.

Member Protections: Notification

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The Department is proposing to align Accountable Communities member protections requirements with the MSSP.

Accountable Communities providers must:

- Post signs in their facilities in settings where primary care services are provided, indicating their participation in Accountable Communities,
- Make available standardized written notices in plain language developed by the Department notifying members of the provider's participation in Accountable Communities and the potential for MaineCare to share member identifiable data with the Accountable Community.

Member Protections: Data Sharing

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- Accountable Communities providers have the option to contact members from their list of assigned members in order to notify them of the Accountable Community's participation in the program and the AC's intent to request member identifiable data.
- If neither the AC nor MaineCare receives notice within 30 days that the member declines data sharing, the AC can request identifiable data from the Department.
- The AC must repeat the notification and opportunity to decline data sharing during the next face-to-face encounter with the member.
- If a member declines to share their identifiable data,
  - Providers may still share medical record information amongst themselves as allowed under HIPAA
  - MaineCare may still include the member's de-identified data in aggregate reports and calculations

Member Protections: Marketing

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- The Department will limit and monitor the use of member communications related to Accountable Communities to ensure appropriate use.
- Accountable Communities:
  - Must use template language when available
  - Must comply with the prohibition against "providing gifts or other remuneration to [members] as inducements for receiving items or services from or remaining in, an ACO or with ACO providers/suppliers…(425.304)."
  - May be terminated for no-compliance with these regulations.

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Proposed Attribution Methodology

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The Department is proposing to align its Accountable Communities member attribution methodology largely with the MSSP. Differences accommodate MaineCare's claims system and/or population differences.

1. ID members who received "primary care services" defined by HCPC codes or, for FQHCs, revenue center codes
2. ID members who received specified services from primary care practices
3. These members are then assigned to the AC if and where the AC primary care practice was responsible for the plurality of primary care visits.
4. Members that did not receive any primary care services from primary care practices are assigned to ACs where they received a plurality of visits for primary care services from specialists
5. Members who are not assigned through a primary care or specialist practice will be assigned to the AC associated with the hospital where the member receives the majority of their ED care.

Prospective vs. Retrospective Alignment

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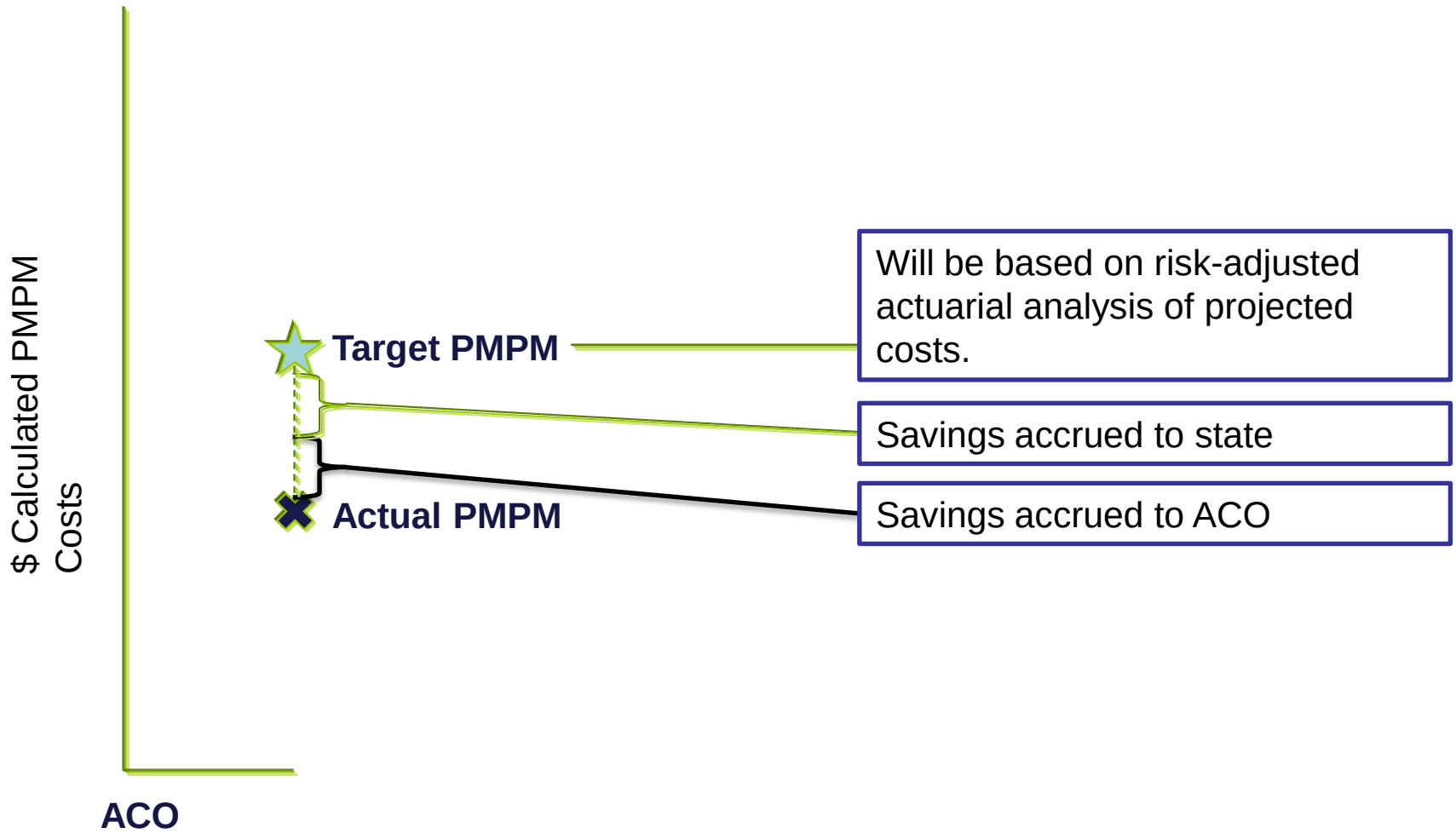
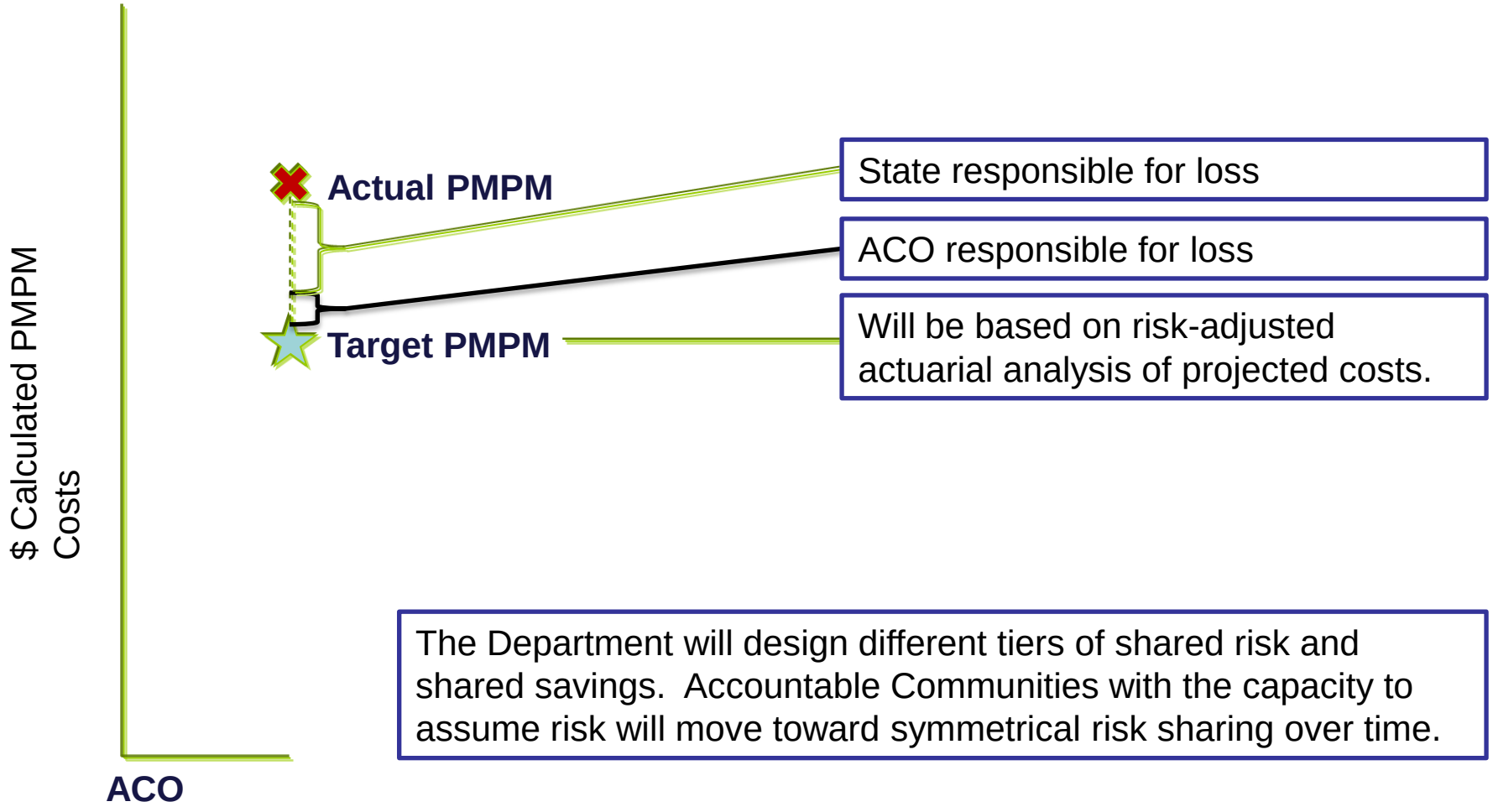
The Department is proposing a prospective alignment methodology based on Medicare's Pioneer, vs MSSP ACO, as it does not feel it would be fair to add members at the end of the year for whom the AC did not know it was accountable.

- Members are assigned prospectively based on historical claims analysis.
- After the performance year, members who moved and/or received more than 50% of their primary care services in a non-contiguous geographic region to the AC will be excluded.

Accountable Communities: Will start with a shared savings model



Accountable Communities:
Over time, some communities will assume shared risk.



Accountable Communities Proposed Shared Savings/ Losses Models

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The Department proposes that the Accountable Communities Initiative feature two models:

1. Shared Savings Only

   Eligible Accountable Communities: those that do *not* consist of an integrated health system:

   - Share in a maximum of 50% of savings, based on quality performance
   - Are not accountable for any downside risk in any of the three performance years

2. Shared Savings & Losses

   Eligible Accountable Communities: any Accountable Communities that can demonstrate capacity for risk sharing

   - Share in a maximum of 60% of savings, based on quality performance
   - Are not accountable for any downside risk in the first performance yea
   - In year 2, are accountable for up to 5% of any losses.
   - In year 3, are accountable for up to 10% of any losses.

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Accountable Communities Quality Measures Recommendations

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- Align with majority of 33 MSSP performance measures:
  - Start with 7 CAHPS survey, 1 claims-based, and 1 EHR incentive program measures.
  - Introduce alignment of the 22 clinical outcomes once technological solution is achieved to ease burden of reporting.

Patient/Caregiver Experience		
1.	CAHPS: Getting Timely Care, Appointments, and Information	Survey
2.	CAHPS: How Well Your Doctors Communicate	Survey
3.	CAHPS: Patients' Rating of Doctor	Survey
4.	CAHPS: Access to Specialists	Survey
5.	CAHPS: Health Promotion and Education	Survey
6.	CAHPS: Shared Decision Making	Survey
7.	CAHPS: Health Status/Functional Status	Survey
Care Coordination/ Patient Safety		
8.	Risk-Standardized, All Condition Readmission	Claims
11.	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	EHR Incentive Program Reporting

Accountable Communities Quality Measures Recommendations, cont.

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- Substitute more general Health Homes measure for Ambulatory Care-Sensitive Condition Admissions in place of two MSSP measures specific to COPD, asthma in older adults, and Congestive Heart Failure.

- Add required Health Homes measures:
  - Start with claims-based measures for follow-up after mental health admission and treatment for alcohol/drug dependence
  - Add clinical measures for depression screening & follow up and BMI assessment later on.

- Align children's claims-based health measures with the proposed additional Health Homes measures/ Improving Health Outcomes for Children (IHOC):
  - Well child visits (pediatrics).
  - Developmental screenings (pediatrics).

- Continue alignment with Maine Health Management Coalition's Pathways to Excellence initiatives.

Accountable Communities Quality Measures Recommendations, cont.

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The Department is discussing whether/ how to align with the MSSP method of scoring performance and determining total allowable shared savings

MSSP

- Year 1: In order to receive full 50 or 60% shared savings (depending on model), ACO must achieve 100% reporting on measures and meet at least 30th percentile level of performance
- Years 2 & 3: ACO must meet 30th percentile level of performance for 70% of measures in each domain to be eligible for shared savings. Amount of total allowable shared savings depends on total performance score.
- The proportion of measures scored for performance, vs reporting, increases each year
  - Year 1: all reporting
  - Year 2: 25/33 performance
  - Year 3: 32/33 performance

Data Sharing

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In alignment with the MSSP, the Department proposes to provide quarterly:

- Aggregate Reports on metrics, utilization and expenditure data
- Reports of assigned members

Accountable Communities may request the minimum identifiable data monthly necessary to carry our health care operations. The use of identifiable data must be limited to coordinating care and improving the quality and efficiency of care. Data may not be used to reduce, limit or restrict care.

DISCUSSION

Agenda

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- Welcome - MaineCare Director Stefanie Nadeau 9:00 – 9:15
- Context: High-Cost/ High Utilizer Member Profile 9:15 – 9:35
- Overview of DHHS Value-Based Purchasing Strategy 9:35 – 10:05
  - Accountable Communities
  - Health Homes
  - How Accountable Communities & Health Homes relate
- Model design process and stakeholder engagement to date 10:05 – 10:10
- BREAK 10:10 – 10:25
- Accountable Communities Proposed Model Overview & Discussion
  - Accountable Community requirements & “core” services 10:25 – 10:45
  - Members served & member protections 10:45 – 11:05
  - Attribution, shared savings & losses 11:05 – 11:25
  - Performance measures & data sharing 11:25 – 11:45
- Accountable Communities timeline & next steps 11:45 – 12:00

Accountable Communities Timeline

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April 2012:

Public Forums

May 2012: Finalization of proposed model

Early Summer 2012:

-Release of Accountable Communities Application

-Submit State Plan Amendment to CMS

Fall 2012:

Implementation

Public Forums

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Department of Health and Human Services

- The Department will have four public meetings to discuss the Accountable Communities project.
  - **Bangor**: Monday, April 2, 9-12, Dorothea Dix Old Auditorium, 656 State St
  - **Lewiston**: Tuesday, April 17, 9-12, Ramada Inn, 490 Pleasant St
  - **Portland**: Thursday, April 19, 9-12, Italian Heritage Center, 40 Western Ave
  - **Augusta**: Wednesday, April 25, 1-4, Maine Dept of Transportation, Main Conference Room, Child St.

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Thank you!

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