Section D. Information Systems and Data Collection

Refer to DRR Section D: Information Systems and Data Collection Setup

Supporting Documentation Available:

D1) Detailed IT infrastructure work plan with timeline and milestones

D2) Website address for GetBetterMaine: www.getbettermaine.org

D3) Business Associate Agreement MHMC & MaineCare (See SECTION H Documentation)

D4) Business Associate Agreement MQF & MaineCare; (See SECTION H Documentation)

Dates are Paid Thru	2013				
	7	8	9	10	11
Commercial Claims					
Statewide	**Q1 2013**			**Q2 2013**	
Identified				**8 2013**	
MaineCare					
Agreements	**DAA, DUA**				
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Ongoing updates					
Medicare					
Agreements				**Security**	**DUAs**
Implementation					
Ongoing updates					

	1	2	3	4	5
Commercial Claims					
Statewide	**Q3 2014**			**Q4 2014**	
Identified	**11 2014**			**2 2015**	
MaineCare					
Agreements					
Implementation					
Ongoing updates			**2 2015**		
Medicare					
Agreements					
Implementation					
Ongoing updates	**Q3 2014**			**Q4 2014**	

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11 2015			2 2016			5 2016
		2 2016			5 2016	
Q3 2015			Q4 2015			Q1 2016

8	9
	8 2016

Section E. HIT Infrastructure Alignment

Refer to DRR Section E: Alignment with State HIT Plans and Existing HIT Infrastructure

***Supporting Documentation Available*:**

E1) HIT Steering Committee (HITSC) minutes and activities at www.maine.gov/hit;

E2) HealthInfoNet (HIN) website: http://www.hinfonet.org

E3) Business Associate Agreement MHMC & MaineCare (See SECTION H Documentation)

E4) Business Associate Agreement MQF & MaineCare (See SECTION H Documentation)

Section G. Model Interventions

Refer to DRR Section G: Model Intervention, Implementation and Delivery

Supporting Documentation Available:

G1) MaineCare Health Homes SPA Final draft rule 07-18-2013

G2) Maine Draft ICM toolkit 3.4.1

G3) SPA 13-012 Approved letter 508 compliant July 2013

G4) ME 12-004 Health homes Approval letter Jan 2013

G5) LD 534 (To Improve Care Coordination For Mentally Ill)

G6) Maine Accountable Care Communities concept paper 8-14-2012

G7) Accountable Communities status update 07222013

G8) DRAFT Maine Benchmark PMPM Development Documentation 05-08-2013

G9) c2s091 (MaineCare Benefits Manual)

G10) c3s091 (MaineCare Benefits Manual)

G11) VBID Workgroup minutes 10-12-2012

G12) Approved SPA ME 12-004 (1)

G13) Approved SPA ME 12-004 (2)

G14) Draft Behavioral Health Homes SPA

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1.01 INTRODUCTION

The MaineCare Health Home Program (Program) provides services for MaineCare members with certain chronic conditions under a patient-centered care plan that describes, coordinates and integrates all of a member's clinical data, and clinical and non-clinical health care-related needs and services. The Program, approved by the Center for Medicare and Medicaid Services (CMS), is designed to implement processes and build infrastructure to provide integrated health care services and promote the use of Health Information Technology systems.

The Health Home Team consists of a Health Home Practice and a Community Care Team. Services are provided by the Health Home Practice, and for members with more intense health care needs, supplemented with services provided by the Community Care Team. All services are performed and coordinated under an individual Plan of Care to ensure optimal services delivery with no duplication or redundancy.

This policy governs Stage A of the Health Home Program. It is expected that the Department will also develop and seek CMS approval of a Stage B, Behavioral Health Home program, at which time MaineCare will promulgate a Health Home Stage B rule.

1.02 DEFINITIONS

1.02-1 Community Care Team (CCT) – A CCT is a multi-disciplinary, community-based, practice-integrated care management team that has applied and has a written approval letter from MaineCare to provide Community Care Team services, and has a Memorandum of Agreement with a Health Home Practice(s) to provide Health Home Stage A services for members with more intense health care needs.

1.02-2 Electronic Health Record (EHR) System –An Electronic Health Record System, a component of Health Information Technology, is a collection of health information of an individual MaineCare member in a digital format that is capable of being exchanged and shared among different health care settings, by a Department designated health information exchange(s), or a Department designated network connected enterprise-wide information system(s). The use of an Electronic Health System is an acceptable mechanism for meeting plan of care requirements.

1.02-3 Health Home Team– The Health Home Team consists of an Health Home Practice and a CCT. Services are provided by the Home Health Practice, and for members with more intense health care needs, supplemented with services provided by the Community Care Team. The Home Health Team works together to provide services under a member's Plan of Care. Each Health Home Practice and the CCT must have a Memorandum of Agreement that identifies the specific roles and responsibilities of the HHP and of the CCT to ensure optimum care and to avoid duplication of services.

1.02-4 Health Home Practice (HHP) – A Health Home Practice is a primary care Practice that has applied and has a written approval letter from MaineCare to provide Health Home Stage A Services.

1.02-5**Health Information Exchange (HIE**) – The HIE is a state-designated entity(s) that receives clinical and other health care data from providers for the purpose of sharing individual patient's health care data across computerized systems and secure exchange between patients, providers, insurers, government health programs, and quality entities, in accord with federal and State privacy, confidentiality and security laws.

1.02-6Health Information Technology (HIT) – HIT is the umbrella framework used to describe the comprehensive management of health information across computerized systems and secure exchange between patients, providers, insurers, government health programs, and quality entities. HIT includes integrated health care services, the use of E H Rs and electronic systems, the electronic exchange of health care data, and increased use of telehealth and remote services, as tools for improving the overall quality, safety and efficiency of the health delivery system.

1.02-7 Plan of Care – The Plan of Care is a patient-centered individualized plan developed by the HHP and the member that describes the member's available clinical data, and clinical and non-clinical health care-related needs and services and how the services will be integrated and coordinated. The Plan shall include member health care data, health goals, and the services and supports necessary to achieve those goals. The Plan also identifies the roles and responsibilities across the Health Home Team to ensure optimum care and to avoid duplication of services.

1.03 MEMBER ELIGIBILITY

1.03-1 Member Eligibility for Health Home Stage A Services

To be eligible for Health Home Stage A Services, the member must be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition which must be documented in the member's Plan of Care.

A member may not receive services under the Stage A and Stage B Health Homes Programs at the same time. If a member receiving Stage B Health Home services becomes ineligible for that service, the member may receive Stage A services, without being subject to the 12-month look-back in paragraph (A)(1) below, provided that the member meets applicable Stage A eligibility criteria,.

A. Two or More Chronic Conditions: A member with two or more of the following chronic conditions is eligible for Health Home Stage A services:

1) a mental health condition if the member has not received any of the following services during the 12 months prior to referral to the Health Home Stage A Program:

- a) For children:
  - i) Section 65
    - (1) Children's Home and Community Based Treatment
    - (2) Multi-systemic Therapy
    - (3) Functional Family Therapy
    - (4) Children's Behavioral Health Day Treatment
    - (5) Children's Assertive Community Treatment (ACT)
  - ii) Section 13 Targeted Case Management services for children with behavioral health disorders, but only if the child had three months of service-use during the 12 months prior to Health Home Stage A referral. Section 97 Appendix D:
    - (1) Child Mental Health- Level I
    - (2) Child Mental Health – Level II
    - (3) Intensive Mental Health for Infants and/or Toddlers
    - (4) Crisis Stabilization Residential Services
    - (5) Therapeutic Foster Care
    - (6) Therapeutic Foster Care- Multidimensional
    - (7) Temporary High Intensity Service
- b) For adults:
  - i) Section 17 Community Integration Services
    - (1) 17.04-2 Community Rehabilitation Services
    - (2) 17.04-3 Intensive Case Management
    - (3) 17.04-4 Assertive Community Treatment
    - (4) 17.04-5 Daily Living Support Services
    - (5) 17.04-6 Skills Development Services
    - (6) 17.04-7 Day Supports Services
    - (7) 17.04-8 Specialized Group Services
  - ii) Section 97:
    - (1) Appendix E
    - (2) Appendix F: for Persons with Severe and Prolonged Mental Illness ONLY

2) A substance use disorder;
3) Tobacco use;
4) Diabetes;
5) Heart disease;
6) Overweight or obese as evidenced by a body mass index over 25 for an adult or a height for weight at or above the 85th percentile for children;
7) Chronic obstructive pulmonary disease (COPD);
8) Hypertension;
9) Hyperlipidemia;
10) Developmental and intellectual disorders;
11) Circulatory congenital abnormalities;
12) Asthma;
13) Acquired brain injury; and
14) Seizure disorders.

B. One Chronic Condition and At Risk for Another Chronic Condition

A member diagnosed with any of the conditions in 1.03-1 (A) (1) through (11) is deemed to be at risk for a second chronic condition and is eligible for Health Home Stage A services.

A member with a single diagnosis of asthma, acquired brain injury, or seizure disorder is eligible for Health Home Stage A services if it is documented in the member's Plan of Care that the member is at risk for another chronic condition listed in 1.03-1(A).

C. Identification of Members Eligible for Health Home Stage A Services.

A MaineCare member shall be identified as being eligible for Home Health services as follows:

(1) MaineCare will conduct an analysis of MaineCare claims data from its current MMIS system to identify members who meet Health Home eligibility criteria.

(2) Health Home Practices may identify and refer to MaineCare additional members with whom the Practice has clinical EHR documentation of the member's eligibility for Health Home Stage A services using screening and assessment tools, and based on individual patient results.

D. Member Notification

A. MaineCare will notify members who meet Health Home Stage A eligibility criteria and who currently receive their primary care services from a provider that is an approved Health Home Practice; the benefits of participation; and that members may opt out of enrollment for Health Home services. Members who do not opt out within twenty-eight (28) days of the notification, will be automatically enrolled to receive services from their Health Home Practice on either the 1st or 15th of the next month.

B. Members who meet eligibility criteria, but who do not currently receive their primary care services from a Health Home Practice will receive written notification of the benefits of participating in a MaineCare Health Home and a list of Health Home Practices in their area. Members will be encouraged to respond within twenty-eight (28) days but may enroll at any time.

C. A member may choose to receive services from any approved Health Home Practice.

D. A member may opt out of Health Home Stage A Services or choose to transfer to a new HHP at any time by contacting MaineCare Member Services. MaineCare will notify the HHP in writing that a member has transferred to a new HHP or opted out of the Health Home Stage A Services as soon as practicable but no later than ten business days after being notified by the member.

E. If a member chooses to transfer to a new HHP, the current HHP/CCT must transfer all appropriate medical documentation, including the medical record and the Plan of Care, to the new HHP within ten business days of the notification by MaineCare.

1.03-2 Referral for Community Care Team Services

Subject to the 5% cap described in this subsection, the HHP, or the CCT associated with the HHP, may refer an enrolled Health Home Stage A member who has more intense health care needs as documented in the Plan of Care, to the CCT for additional services and supports, based on the following priorities:

1. Hospital Admissions

   a. 3 or more admissions in past 6 months, or
   b. 5 or more admissions in past 12 months, or

2. Emergency Department Utilization

   a. 3 or more E.D. visits in past 6 months, or
   b. 5 or more E.D. visits in past 12 months, or

3. A member with 3 or more chronic conditions, and/or failure to meet multiple treatment goals; or

4. Polypharmacy: A member using 15 or more chronic medications, and/or on multiple high-risk medications (e.g. insulin, warfarin, etc); or

5. High social service needs that interfere with care: A member who also has significant social service needs that result in high rates of avoidable utilization of medical services (e.g. members who are homeless, have an intellectual disability, substance abuse).

MaineCare may also notify the HHP and CCT of a member in need of CCT services based of the above criteria, or a determination that the member is high-cost or high-risk.

The total number of months of service delivered by the CCT on an annual basis shall not exceed 5% of the total number of HHP member months attested to by all of the CCT's affiliated HHPs. It is the responsibility of the CCT to verify that it has not exceeded the 5% cap through review of the monthly report on the Health Home portal maintained by the State. In the event that the CCT reaches the 5% cap and is temporarily unable to provide CCT services to additional members, the HHP will monitor the member's Plan of Care until notified by the CCT that the CCT no longer exceeds the 5% cap and can accept referrals.

<u>CCT Discharge Criteria</u>

1. The average duration of CCT services is expected to be between three to six (3 to 6) months with cessation of CCT services indicated when:

   A. The member has substantially achieved goals identified in the plan of care, as evidenced by:

a. Reductions in hospital or ED use; or
b. Ability to self-manage care in conjunction with appropriate supports; or
c. Substantial achievement/completion of goals as identified in plan of care.

B. Prolonged or consistent lack of involvement by member indicates that achieving goals identified in plan of care is unlikely; or
C. Member has received outreach for two months without successfully engaging in care; or
D. Member refuses engagement or continuation of services by the CCT .

2. After six months, MaineCare may review the member's Plan of Care and services delivered by the CCT to determine if ongoing CCT services are still required, need modification and/or if other more intensive services outside of the Health Home Stage A program are needed by the member.

1.04 PROVIDER PARTICIPATION IN HEALTH HOME STAGE A PROGRAM

1.04-1 Requirements for Participation: General

The Health Home Team consists of a Health Home Practice (HHP) and a Community Care Team (CCT) which work together to provide Health Home services to the eligible member pursuant to that member's Plan of Care. Services are provided by the HHP, and for members with more intense health care needs, supplemented with services provided by the CCT.

Each HHP and CCT comprising a Health Home Team must execute a memorandum of agreement which establishes processes and procedures for communication and coordination between the CCT and the HHP, including at least monthly meetings. While individual processes and procedures may vary according to the particular arrangements of the individual Health Home Teams, all members of the Health Home Team are subject to the requirements of this rule, including timelines and requirements for full implementation of Health Home Core Standards as described in Appendix A.

A. Requirements for Participation: Health Home Practice (HHP)

1. The HHP must have an executed MaineCare Provider Agreement.

2. The HHP must be a primary care practice site that provides care to MaineCare enrolled adults or children, is located in the state of Maine, and has at least one full-time primary care physician or nurse practitioner.

3. The HHP must complete an application and be approved by Maine Care as a Health Home Practice. Practices that participated in MaineCare's former Patient Centered Medical Home (PCMH) Pilot will be approved as an HHP without submitting a new application provided they meet all other criteria.

4. The HHP has fully implemented an Electronic Health Record (EHR) system and agrees to allow clinical health care data in the HIE to be used for the HIE purposes described in this rule.

5. Twenty-Four Hour Coverage, as defined in MaineCare Benefits Manual, Ch. VI - Section 1: Primary Care Case Management.

6. The HHP has received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) recognition by the date posted on the MaineCare Value-Based Purchasing website (www.maine.gov/dhhs/oms/vbp).

7. The HHP has established member referral protocols with area hospitals, which include coordination and communication on enrolled or potentially eligible HHP members.

8. Within 18 months of being approved as an HHP, the HHP's authorized representative must provide written confirmation to MaineCare that the HHP has fully implemented and can document implementation of all Core Health Home Standards as defined in Appendix A of this rule.

B. Requirements for Participation: Community Care Team (CCT)

1. The CCT must execute a MaineCare Provider Agreement;

2. The CCT must complete an application and be approved as a Community Care Team by MaineCare. Practices that participated in MaineCare's former Patient Centered Medical Home (PCMH) Pilot will be approved as a CCT without submitting a new application provided they meet all other criteria.

3. For CCTs that have implemented an Electronic Health Record (EHR) system, agreeement to allow clinical health care data in the HIE to be used for the HIE purposes described in this rule.

4. CCT staff shall consist of a multidisciplinary group of health care professionals under the leadership of a CCT Manager, a Medical Director, and a Clinical Leader:

   a. A CCT Manager provides leadership and oversight to ensure the CCT meets goals;

   b. At least four hours a month, a Medical Director must collaborate with the HHP to select and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings; and,

   c. A Clinical Leader directs care management activities across the CCT, without duplicating care management that is already in place in the HHP.

5. Within one year of a being approved as a CCT, the CCT's authorized representative must provide written confirmation to MaineCare that the organization has fully implemented and can document implementation of all Core Health Home Standards as defined in Appendix A of this rule.

1.04-2 Health Home Team Service Expectations and Responsibilities

The Health Home Practice is responsible for the development of the Plan of Care and completion of the assessments as described in paragraphs (A) and (B) below. Services described in paragraphs (C) through (H) may be performed by either the Practice or the CCTs, pursuant to the Plan of Care.

A. Development of the Plan of Care

It is the responsibility of the Health Home Practice to develop, with the member and if appropriate the guardian, a patient-centered Plan of Care that identifies each member's health goals, and the services and supports necessary to meet those health goals, including prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community-based services where appropriate. The Plan also identifies the roles and responsibilities across the Health Home Team to ensure optimum care and to avoid duplication of services. The use of an E H R and electronic systems may be used to meet Plan of Care requirements and be shared with the member at the time of each visit as a "visit summary" generated from the E H R system.

For members who have been referred to a CCT, the CCT will contribute to the Plan of Care by communicating its interactions and recommendations to the Health Home Practice. The CCT will stay informed about the member's care from the Health Home Practice through ongoing and regular communications as part of the Health Home Team, which may include E H R systems.

B. Assessment

It is the responsibility of the Health Home Practice to conduct the following screenings and assessments for all Health Home members:

a. Measurement of BMI in all adult patients as a baseline and at least every two years, and height for weight percent-for-age at least annually in all children.
b. During the second year of MaineCare participation and annually thereafter:
    i. Depression and substance abuse screening (PHQ9 and AUDIT, DAST) for all adults and substance abuse screening (CRAFFT) for adolescents.
    ii. ASQ or PEDS developmental screening for all children age one to three, and the MCHAT 1 for at least one screening between ages 16-30 months with a follow-up MCHAT 2 if a child does not pass the screening test.

C. **Comprehensive Care Management**

Comprehensive Care Management Services include:

1. Prospective identification of at-risk patients;

2. Conducting clinical assessments, monitoring and follow up of clinical and social service needs;
3. Communicating and coordinating care with treating providers;
4. Nurse care management (including patient visits prior to hospital discharge, in the primary care Practice, group visits or at home);
5. Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members);
6. Screening, brief intervention, and referral to treatment for mental health and/or substance use disorders; and
7. Medication review and reconciliation.

D. Care Coordination

Care Coordination services include coordinating and providing access to:

1. High-quality health care services informed by evidence-based clinical Practice guidelines;
2. Preventive and health promotion services, including prevention of mental illness and substance use disorders;
3. Mental health and substance abuse services; and
4. All clinical and non-clinical health-care related needs and services in accord with the plan of care.

E. **Health Promotion**

Health promotion services include:

1. Patient engagement and outreach, including confirmation of eligible Health Home patients' involvement with the Practice, and engagement of patients in care by phone, letter, HIT and/or community outreach;
2. Patient education and chronic illness self-management;
3. Screening for tobacco use;
4. Follow-up education with the member and family;
5. Promotion of evidence-based care for tobacco cessation, diabetes, asthma, hypertension, chronic obstructive pulmonary disease (COPD), hyperlipidemia, developmental and intellectual disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities, self-help recovery resources, and other services based on individual needs and preferences; and
6. Referral to established public health programs, diabetes education programs, cardiovascular health programs, and other chronic illness programs, including those identified through Healthy Maine Partnerships (enhanced community coalitions) and 211 system, and web sites concerning health promotion and chronic disease self-management.

F. Comprehensive Transitional Care

Comprehensive transitional care prevents avoidable readmissions after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility), and ensures proper and timely follow-up care. Services include:

a. Conducting follow up calls to discharged patients and ensuring that medication reconciliation and timely post-discharge follow up are completed; and
b. Facilitating transition to adult system of care for pediatric patients.

G. **Individual and Family Support Services**

The Health Home Team shall use approaches such as peer supports, support groups, and self-care programs to increase patient and caregiver knowledge about an individual's chronic illness(es), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. Individual and Family Support services may include:

1. Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, and other chronic diseases;
2. Chronic Disease Self Management;
3. Use of peer supports, support groups, and self-care programs; and
4. Information on Advance Directives

H. Referral to Community and Social Support Services

Community and Social Support Services include actively connecting patients to:

1. Community-based and other social support services;
2. Appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals;
3. Community organizations that offer supports for self-management and healthy living; and
4. Routine social service needs such as transportation assistance, housing, literacy, economic and other assistance to meet basic needs.

1.04-3 Termination of Participation by Provider or Department

MaineCare, the Health Home Practice, or the Community Care Team may terminate participation in the Health Home Stage A program without cause upon sixty (60) calendar days written notice to the other parties. If the HHP or the CCT voluntarily terminates participation, the termination may not be effective until all members who wish to receive Health Home Stage A services from another Health Home have been transferred to another HHP/CCT or after ninety (90) calendar days, whichever occurs first.

MaineCare may terminate participation immediately by giving written notice to the HHP or the CCT if MaineCare reasonably believes that conditions exist that place the health and safety of members in jeopardy.

The HHP or CCT may request an informal review of the MaineCare decision in accord with Chapter I. MaineCare reserves the right to transfer MaineCare members to a new HHP or prior to the decision of the appeal.

If an HHP or CCT closes or changes ownership or control, the authorized representative of the HHP or CCT must provide MaineCare a written notice of intent to terminate participation in the HHP program within 60 days.

1.05 NON-COVERED SERVICES

A member may receive Health Home Stage A services from only one HHP and one CCT at a time. Health Home Stage A Services do not preclude a member from receiving other medically necessary services, but members may not receive Health Home Stage A Services that duplicate other services.

A. Targeted Case Management

Members may choose to receive either Targeted Case Management services under Section 13, Targeted Case Management Services, or Health Home Stage A Services, but cannot receive both services.

B. Primary Care Case Management

Members who are enrolled in a PCCM will continue to be enrolled in that program, but PCCM Practices that participate as a Health Home Practice will not receive the PCCM per member per month (PMPM) fee for members enrolled in the Health Home Stage A program. Participating Health Home Practices will receive the PMPM rate as described in Chapter III, Section 91, as the total payment for these members.

1.06 REIMBURSEMENT

A. Reimbursement is specified in Chapter III, Section 91, Health Home Stage A Services Reimbursement.

B. HHP Reimbursement: Reimbursement for all enrolled members is on a PMPM basis. The HHP must attest that it has delivered the minimum billable service for that month, defined as:

   a. Patient engagement and outreach activities to the member, including activities necessary to confirm member participation in the HHP's panel and enroll the member in the Health Home; and/or
   b. Scanning the member's record for potential gaps in care; and/or
   c. Providing another Health Home Stage A service to the member pursuant to the Plan of Care.

C. CCT Reimbursement: Reimbursement for all enrolled members is on a PMPM basis. The CCT must attest that it has delivered the minimum billable service, defined as:

   a. Patient engagement and outreach activities: Patient engagement and outreach may qualify as a minimum billable service for no more than two consecutive months, after which time, the CCT must provide another Health Home service in an amount, duration, and scope that supports the goals in the member's Plan of Care. Patient engagement and outreach may again qualify

as a minimum billable service if the member received a Health Home service other than patient engagement and outreach in the previous month; and/or

b. Other Health Home Stage A services delivered in an amount, duration, and scope that supports achievement of goals identified in the member's Plan of Care.

D. Attestation shall be in the format determined by the Office of MaineCare Services and shall include provider number, member number, and month of service.

E. No reimbursement shall be made for duplicative services which are reimbursed under another section of the MaineCare Benefits Manual.

1.07 REPORTING REQUIREMENTS

Core Standards:

The Health Home Team shall report quarterly, in a MaineCare approved format, on implementation benchmarks for meeting Health Home Core Standards in Appendix A.

The Community Care Team shall report quarterly, in a MaineCare-approved format, on implementation benchmarks for meeting Community Care Team Core Standards in Appendix B.

Quality Measurement, Evaluation, and Monitoring Activities

The Health Home Practice and the Community Care Team shall participate in all quantitative and qualitative quality measurement, evaluation, and monitoring activities as required by the Department. The Health Home practice and the CCT shall work with the Department to identify, supply, and validate any and all claims-based or clinical data necessary to report on specified Health Home Quality Measures. A full list of these measures is available at the MaineCare Value-Based Purchasing website: http://www.maine.gov/dhhs/oms/vbp/index.html

The Health Home Practice and the Community Care Team shall support the use of health home and health care data to and from the E H Rs, electronic systems, the health information exchange, data quarterly reports, and other qualitative sources for quality improvement, to determine the accuracy of claims or claims payment, care management, and evaluation purposes.

APPENDIX A. CORE HEALTH HOME STANDARDS

Health Home Practice Core Standards

1. Demonstrated leadership
2. Team-based approach to care
3. Population risk stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families in implementation of PCMH model
8. Connection to community
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost- effective use of healthcare services
10. Integration of Health Information Technology (HIT)

APPENDIX B. Community Care Team Core Standards

1. Demonstrated leadership
2. Team-based approach to care
3. Population risk stratification and management
4. Community integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients and families in service implementation
8. Connection to community health organizations
9. Commitment to Reducing Waste, unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration of Health Information Technology

Executive Summary

Submitted previously as a separate document.

Program Description

Eligible participants/Beneficiary Population

Identify whether the program will be statewide or targeted to specific geographic area(s) and whether or not all beneficiaries can enroll in the program.

Maine's Accountable Communities (AC's) will be statewide and will not be targeted to specific geographic areas. MaineCare will engage providers and communities statewide to promote access to Accountable Communities.

The program will target all MaineCare members who receive full MaineCare benefits, including Categorically Needy, Medically Needy, SSI-related Coverage Groups, Home and Community-based Waiver members, and others.

Describe whether beneficiary enrollment will be mandatory or voluntary.

All beneficiaries that meet the eligibility requirements and that are identified through the attribution methodology will be automatically assigned to an Accountable Community. Members may opt out of sharing PHI. §1905(t)(3)(E), which provides for an enrollees right to terminate enrollment, does not apply to this project. §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because qualified AC entities will be prohibited by rule from activities designed to result in selective recruitment and attribution of individuals with more favorable health status. Members will experience no restrictions on access to MaineCare services currently available to them.

Describe how beneficiaries will be assigned or attributed to a provider, i.e., the process that establishes a relationship between beneficiary and provider.

Historical data will be used to assign/associate members with a particular Accountable Community prior to the beginning of the program performance year. Members who have 6 months of continuous eligibility or 9 months of non-continuous eligibility will be eligible for assignment.

Beneficiaries will be assigned to an AC based on their utilization patterns of the following procedural codes:

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Primary Care Services include procedure codes between 99201-99215, 99304-99340, 99341-99350, 99381-99387, 99391-99397; HCPC Codes G0402, G0438, G0439; Revenue Codes 0521, 0522, 0524, 0525.

1. Members will first be attributed to the Accountable Community where they have a plurality of PCP services with a primary care physician or practice.
2. Members not assigned under #1 will then be attributed to the Accountable Community in which they have 3 or more ER visits
3. If the member has not received PCP services and does not have 3 or more ER visits, the member will be excluded from the program.

MaineCare is also exploring the possibility of assigning members not assigned in #1 above to the Accountable Community where they receive targeted and behavioral health case management services.

Describe how beneficiaries will be notified about the program and their enrollment status, including what information they will receive, what they will be able to access, etc.

The State will notify MaineCare members of the program, including a description of how personal information will be used and Accountable Community payment incentives, through an annual mailing in the first quarter of each performance year. Notification will be sent to those members who are attributed to an Accountable Community entity at that point in time.

Specify if there are other federally-funded programs within the state serving clients with special needs who may be (or become) eligible for the expanded range of services.

Because a significant percentage of MaineCare members will be assigned to an Accountable Community, overlap with other federally-funded programs in the state serving individuals with special needs is likely, including but not limited to:

- Children and Youth with Special Health Care Needs
- Early Intervention/Title V
- SAMHSA Block Grant Funding
- Medicare

Eligible Provider Entities/Provider Characteristics

Identify whether the state will use a care management entity for this model (e.g., enhanced PCCM, networked PCCM, a managed care entity, etc.)

AC entities will provide FFS primary care case management services under authority of §1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. Payment to the Accountable Community will be based on performance on quality metrics and achievement of savings targets.

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If certain providers will be targeted, identify whether they will be targeted by provider qualifications, selective contracts (via 1915(b) waiver), or another factor?

Any willing Medicaid provider may participate as an Accountable Community; eligible providers will be determined through an application/screening process. A provider is eligible as long they meet the requirements outlined through that process.

Each Accountable Community must include at least one PCCM provider that will be responsible for the coordination, location and monitoring of services, and must agree to MaineCare rule and any contractual requirements to participate. Accountable Communities will form partnerships with primary care, specialty care, and other community entities in order to serve members. Accountable Communities may, given the characteristics and needs of their assigned members, include a specialized configuration of providers, services, and supports necessary to support the needs of a particular population (e.g., pediatric or geriatric services).

Accountable Communities must demonstrate capacity and agree to various criteria to be a part of the program. The following core expectations, which have been developed for MaineCare's Health Home Initiative, have been adapted to provide an aligned framework for Accountable Communities:

1. Demonstrated Leadership

The Accountable Community can identify at least one primary care physician or nurse practitioner as a leader who visibly champions a commitment to improve care, reduce cost, and improve patient experience of care across the Accountable Community and participating providers. This leader(s) takes an active role in working with participating providers and community resources to ensure a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the Accountable Community. This leader also participates as a member of the Leadership Team and participates in any AC Learning Collaborative opportunities.

2. Team-based Approach to Care

The Accountable Community supports a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.
The Accountable Community has committed to supporting participating primary care practices in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

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Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.

3. Population Risk Stratification and Management

The Accountable Community has adopted processes for proactively identifying and stratifying patients across its population who are at risk for adverse outcomes, and directing resources or care processes to help reduce those risks. “Adverse outcomes” is intended to mean adverse clinical outcomes and/or avoidable use of healthcare services such as hospital admissions, emergency department visits, or non-evidence based use of diagnostic testing or procedures.

4. Practice-integrated Care Management

The Accountable Community has clear process for providing care management services, and has identified specific individuals or participating providers to provide care management for assigned patients at high risk for experiencing adverse outcomes, including patients with chronic illness who are complex or fail to meet multiple treatment goals; patients identified at risk for avoidable hospitalization or emergency department use; and patients at risk for developing avoidable conditions or complications of illness.

Care management staff has clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.
Care management staff has defined methods for tracking outcomes for patients receiving care management services.

5. Enhanced Access to Care

The Accountable Community commits to preserving or enhancing access to its population of patients.
The Accountable Community ensures that participating primary care practices have systems in place that promote same-day access to healthcare providers using some form of care that meets patient needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.

6. Behavioral-Physical Health Integration

The Accountable Community promotes integrated care in its participating provider practices.

7. Inclusion of Patients & Families

The Accountable Community identifies at least two patients or family members to be part of its Leadership Team, and employs one or more mechanisms for routinely soliciting input from patients and families on how well the Accountable Community is meeting their needs.

8. Connection to Community Resources and Social Support Services

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The Accountable Community identifies and routinely makes referrals to local community resources and social support services that provide self-management support to individuals and their families to help them overcome barriers to care and meet health goals**.**

9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services

The Accountable Community makes a clear and firm commitment to reduce wasteful spending of healthcare resources and to improve the cost-effective use of healthcare services, including specific efforts in the following areas:

- Reducing avoidable hospitalizations through improved coordination of care;
- Improving care transitions and reducing avoidable re-hospitalizations;
- Reducing non-emergent emergency department visits;
- Reducing non-evidence-based use of advanced imaging – e.g. MRI, CT;
- Other areas identified as priorities in its assigned population.

10. Integration of health information technology (HIT):

The Accountable Community is working towards use of integrated HIT (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging) to support improved communication with and for patients, and to assure patients get care when and where they need and want it in a culturally and linguistically appropriate manner.

Describe HIT infrastructure, population management, and data collection and exchange requirements for eligible providers.

Pursuant to the core expectations of participation – noted above - Accountable Communities and their participating providers must be using or actively working towards use of integrated HIT (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging) to support patient care. In addition, Accountable Communities must demonstrate the ability to perform all MaineCare regulatory and any contractual requirements, including processes required in order to do the following:

- Promote evidence-based medicine.
- Promote patient engagement.
- Internally report on quality and cost metrics that enables the AC to monitor, provide feedback, and evaluate its AC participants and AC provider(s)/supplier(s) performance and to use these results to improve care over time.
- Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers, including the ability to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or

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transfer of care from a primary care physician to a specialist (both inside and outside the AC).

MaineCare functionality will also support Accountable Communities as follows:

Attribution: MaineCare will identify and assign members to Accountable Communities based on utilization of primary care or emergency department services. MaineCare is exploring the possibility of assignment through the receipt of targeted or behavioral health case management services as well. MaineCare's claims system will identify members at the practice/location/practitioner level, and align these providers to the Accountable Community for appropriate assignment.

Accountable Community Management Support: MaineCare will provide quarterly aggregate and PHI-level cost and utilization reports to Accountable Communities so that Accountable Communities may manage the cost and quality outcomes of the assigned population.

Shared Savings: MaineCare will analyze cost and quality data, primarily using MaineCare claims data, in order to identify shared savings/losses after the close of each implementation year.

Covered Services

Describe any potential limitations on amount, duration and scope of services.
Identify which delivery systems (e.g., primary care, long-term care, behavioral health, etc.) the new program will impact/include.

Accountable Communities will not pose any new restrictions or limitations to existing medically necessary services for MaineCare beneficiaries. MaineCare state plan option services will continue to be reimbursed via fee for service model and delivered within the Accountable Community/ ICM framework.

Identify services that will be coordinated by this program and whether/how the care coordination/ care management goes beyond the coordination currently provided to the target population.

Accountable Communities will need to ensure coordination, location and monitoring of health care services. AC entities must directly deliver or commit to coordinate with specialty providers, including behavioral health for non-integrated practices, and all hospitals in the service area.

Accountable Communities will not receive separate or additional care coordination payments: in order to improve quality and reduce cost, Accountable Communities will be expected to form partnerships, establish standards and procedures across providers and community resources, and to leverage existing care coordination resources – such as Health Homes, PCCM, and Targeted Case Management Services.

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Stakeholder Input

Briefly describe the opportunities for stakeholder (e.g., beneficiaries, advocates, health professionals, hospitals, clinics, tribes, etc.) input on the new program.

MaineCare convened stakeholders in October 2011 to introduce its Value-Based Purchasing strategy, and followed up this introduction with a series of meetings with providers, associations and other interested parties. In November 2011, DHHS issued a Request for Information (RFI) seeking feedback on the structure of Accountable Communities. 28 responses were received, the majority from the behavioral health community. Throughout this time period, MaineCare met regularly with a Member Services Committee (MSC) comprised wholly of MaineCare members to integrate their ideas, concerns and feedback. Working from a synthesis of the RFI responses and the feedback from the MSC, DHHS convened a multi-disciplinary Design Management Committee from across its Offices, representing substance abuse, mental health, developmental disabilities, elder services, public health, child and family services, and others, to structure a proposal for its Accountable Communities model. This proposal was shared with providers in three regional forums across the state in April 2012. In addition, Accountable Communities have been discussed and are featured as a standing agenda item on the MaineCareAdvisory Committee, which meets monthly and is attended by a wide variety of consumers, providers, and advocacy leadership. MaineCare has also provided regular updates and opportunity for feedback to Maine's Tribes via an in-person meeting and through monthly Tribal Consultation calls.

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Oversight and Monitoring

How will the State evaluate whether the program is effective?

What oversight functions will the state have to ensure that payments are improving care coordination, transforming practices, improving quality, etc.?

Accountable Communities will be expected to meet cost as well as quality metrics to share in savings.

The State plans to align its quality and oversight strategy with claims-based measures from the Medicare Shared Savings Program, where appropriate, and will also be adding behavioral health, children's health measures, and other indicators tailored to the MaineCare population. This will be further outlined in the Quality Strategy, to be submitted as a separate document.

MaineCare will monitor AC entities in Year One and will report to CMS, semi-annually regarding the targeted reviews of claims data, including quality measures, for the purpose of

ensuring that appropriate care is being delivered, and ensuring that potential problems are identified early. These reports will also include status updates regarding the progress of care delivery transformation, as discovered via various monitoring efforts including: participation in ACO learning collaboratives; data gathered as part of the state enforcement of health home requirements; and tracking the progress of AC entities' analysis of utilization and output data from the state as well as their own clinical data; and updates on the progress of expansion and formation of relationships and coordination with community partners.

Timeline

Submit a timeline for program development, implementation, and ongoing operations. Identify inter-dependencies if possible (e.g., CMS review of a SPA or waiver, related state legislation, state budget fiscal year, staff or workforce training, health plan contract or rate-setting cycles, certification of providers, pre-implementation reviews, etc.)

Timeline will be submitted as a separate document

Quality Strategy

Quality Strategy will be provided as a separate document.

Payment Methodology

Overview of Payment methodology

Provide an overview of the program's payment methodology (e.g., whether the state is implementing a global payment, what kind of global payment, whether the payment will be prospective or retrospective, whether the state is pursuing shared savings, whether the state is linking payment to quality, frequency of payments, etc.)

Maine's only payment methodology will be via shared savings, described in detail below.

Overview of Shared Savings methodology

If proposing a shared savings methodology, provide a general overview of the approach.

Providers that come together to form Accountable Communities will be incentivized to provide better care at lower cost via shared savings. Services delivered – either directly by the Accountable Community, or through participating providers - will continue to be paid for by

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MaineCare under the existing (largely fee for service) system. Accountable Communities will not be reimbursed through the ICM SPA for direct care delivery; the only payment received shall be through shared savings.

Fee for service rates to providers will not be changed as a result of the Accountable Communities initiative.

PMPM costs for a defined "total cost of care (TCOC)" for the assigned patient population will be compared to projected PMPM TCOC costs based on actuarial analysis. The AC will receive up to a specified percentage of demonstrated savings beyond a two percent threshold, back to the first dollar saved. The actual shared savings the AC receives depends on their performance on specified quality benchmarks.

Shared Savings payments will be made to qualifying AC entities under two models:

Model 1: Shared Savings Only

- Shared Savings Only AC entities may share in a maximum of 50% savings, tied to quality performance.
- Under this model, Accountable Communities are not subject to downside risk in any of the first three performance years.

Model 2 Shared Savings and Losses:

- AC entities may share in a maximum of 60% savings, tied to quality performance.
- Downside risk will be captured as follows:
    - No downside risk in first performance year;
    - In year two, accountable for up to 5% of any losses;
    - In year three, are accountable for up to 10% of any losses.

If different from the general ICM program, identify the beneficiary population to be included in the shared savings program and the approximate number of beneficiaries, if available.

Shared Savings will be calculated based on the population included for the Accountable Communities initiative; as noted above, this population includes all full MaineCare beneficiaries assigned through the attribution methodology.

Identify whether an actuarial analysis was needed/used to assess the validity of the shared savings structure and explain the assumptions used to develop its analysis.

An actuarial analysis is in process to develop projected PMPM costs for each Accountable Community. This projected PMPM cost will be compared to actual costs in order to calculate the shared savings payments for each Accountable Community. A rate development document that explains the methodology, as well as possible data sources, data adjustments, and assumptions will be provided along with the SPA submission.

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Provide a target number of beneficiaries who must be enrolled in the program to determine the statistical validity of the data and outcomes.

The State has investigated the minimum membership threshold ranges suggested by various programs below, and has considered the size of the Accountable Communities program and the services offered compared to these other programs as well as what is statistically valid within the historical data in order to determine an appropriate membership threshold.

CMS Medicare Advantage: 2,000
Medicare Share Savings: 5,000
State of Minnesota Hennepin County Health ACO Pilot: 12,000
CMS ACO Pilot: 15,000 unless located in rural area, in which case 5,000
New Jersey Medicaid ACO Demonstration Project: 5,000
Minnesota Statewide Health Care Delivery System ACO:

- 1,000 minimum where no downside risk;
- 2,000 minimum with two-way risk sharing model.

As a result of this analysis, Maine is proposing a minimum target number of beneficiaries for each of its two models:

Model 1: Shared Savings Only: minimum of 1,000 attributed patients.

Model 2 Shared Savings and Losses: minimum 2,000 attributed patients

Describe how the shared savings methodology will attribute beneficiaries to provider entities for the purposes of calculating shared savings.

MaineCare members will be attributed to Accountable Communities based on the following primary care procedure codes:

CPT Codes: 99201-99215, 99304-99340, 99341-99350, 99381-99387, 99391-99397;

HCPC Codes: G0402, G0438, G0439; Revenue Codes 0521, 0522, 0524, 0525

1. Members will first be attributed to the Accountable Community where they have a plurality of PCP services with a primary care physician or practice.
2. Members not assigned under #1 will then be attributed to the Accountable Community in which they have 3 or more ER visits
3. If the member has not received PCP services and does not have 3 or more ER visits, the member will be excluded from the program.

MaineCare is also exploring the possibility of assigning members not assigned in #1 above to the Accountable Community where they receive behavioral or targeted case management services. This would become #2, with assignment through ED use as #3.

Identify how often are payments will be made to providers. Describe how the shared savings payments will be reconciled to the other payments made to participating providers, (i.e., shared savings payments net of care coordination PMPMs or any other payments)

Payments made to providers for services to MaineCare members will not be affected: payments will continue to be made on a fee-for-service basis for the full menu of MaineCare medically necessary services.

The shared savings payment to Accountable Communities will be in addition to FFS payments made for actual delivery of services. This payment will be made annually, on a retrospective basis after the performance year.

Shared savings payments will be net of the PMPM payments made to providers for Health Home and PCCM services.

Describe whether the shared savings calculation includes all program health costs or excludes some claims or services. If it excludes some, describe why.

Each Accountable Community will be responsible for costs incurred for the following specified core services: inpatient, outpatient, emergency department, physician, pharmacy, mental health, substance abuse, hospice, home health, school-based primary care and school-based day treatment.

Accountable communities may also opt to include additional services: HCBS, nursing facilities (except physical, occupational, and speech therapy), private duty nursing, and dental services.

Only the core and any optional services provided to members attributed to each Accountable Community will be included in the projected PMPM cost development and actual PMPM costs to determine shared savings payments.

Services that are excluded from the Accountable Community initiative include non-emergency transportation, Private Non-Medical Institutions, and School-Based Rehabilitation.

Describe the source of the non-federal share that will be used to draw federal financial participation for claims under the model.

The funding source will not change from the current MaineCare program. After the end of the implementation year, allocated state MaineCare funds will be used to draw down the federal match for the applicable shared savings amount for each Accountable Community that has met both quality and cost benchmarks.

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The State is not putting extra dollars into the initiative and the State will not be using Inter-Governmental Transfers.

It is anticipated that both the costs and the funding will decrease as changes in the delivery system occur over time.

Shared savings: Total Cost of Care/Baseline Cost Calculations

Describe how the baseline costs of the shared savings program will be calculated, including what services and/or provider activities will be included in the calculation.

MaineCare will calculate a baseline PMPM cost based on past utilization data, assuming this data is found to be statistically valid. These target cost PMPMs will be compared to actual cost PMPMs to determine the level of savings. The target cost PMPMs will be developed using actuarial analysis and methodology similar to the development of capitation rates; the rate setting checklist will be used as guidance when developing target cost PMPMs. A rate development document that explains the methodology, as well as possible data sources, data adjustments, and assumptions will be provided along with the SPA submission.

The target cost PMPM will be compared to actual costs for the Accountable Community. (rather than comparing the actual costs to a comparison population's costs). Maine may review the cost and quality experience of other populations who are not in the Accountable Communities program as a part of its monitoring activities, but will not use this data in the shared savings payment calculation.

Describe whether the shared savings calculation excludes certain claims or services. If it excludes certain claims or services, describe the basis for the exclusion.

Each Accountable Community will be responsible for cost associated with specified core services and will have the choice to be responsible for any of the optional services. Only the core and optional services offered within each Accountable Community will be included in their target cost PMPM development and in their actual PMPM costs to determine shared savings payments.

For the purpose of calculating program savings, confirm whether the state will limit the inclusion of high cost claims above a certain dollar amount.

To reduce volatility, the State will truncate an assigned member's costs at a per patient annual cap amount according to the number of members assigned to an AC entity:

- Small Population =1,000-2,000 Attributed Participants
    - Annual Per-Enrollee Total Cost of Care (TCOC) Cap = $50,000
- Medium =2,000–5,000 Attributed Participants
    - Annual Per-Enrollee TCOC Cap = $200,000
- Large =5,000+ Attributed Participants

- Annual Per-Enrollee TCOC Cap = AC Choice between $200,000 or $500,000

Only the dollars above that threshold per patient annual cap will be removed. By incorporating these thresholds, the State reduces variation in costs, thereby lowering the risk of paying Accountable Communities savings or requiring Accountable Communities to pay losses that result from random variation. The State believes that truncating claims at a per member annual cap achieves an appropriate balance between limiting catastrophic costs and continuing to hold Accountable Communities responsible to increase efficiency for high-cost patients.

If the state makes or intends to make supplemental service payments please describe how those payments are factored into the total cost of care. Supplemental payments are sometimes structured as lump sum payments so states may need to make methodological adjustments to accommodate the payments.

Shared savings will be the only vehicle for payment under Maine's integrated care model. As discussed, Mainecare will continue to pay providers for services to MaineCare members through existing methods, such as fee for service.

Shared savings: Trend Rate calculation

Describe how the trend rate will be calculated and what factors the state will use to adjust the baseline

Trends will be analyzed based on historical data. Industry trends and other published expected trends for comparable populations based on demographics and health status will also be taken into consideration.

Describe whether there will be different trending rates based on eligibility categories or service categories

The difference in trends by eligibility groups and service categories will be observed to determine if trends should vary at a more granular level or in aggregate. The baseline data will also be adjusted for program and policy changes. Final trends will be applied to the baseline data to arrive at the projection period. Varying trends by service category will be considered. Trends will be observed by service categories and if large differences exist, varying trends will be used.

Shared savings: Risk Adjustment

Provide an explanation of the risk adjustment methodology the state will use.

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Risk adjustment is being considered and will likely be utilized in the development of the target PMPM cost benchmarks. The target PMPM costs will be risk adjusted using historical experience.

The risk model software being evaluated includes CDPS and DXCG. The state is considering whether to apply risk adjustment to both the medical claims as well as pharmacy claims. On the medical side, the risk adjustment software will utilize diagnosis-based codes such as ICD9 codes as well as age and gender to assess the risk. On the pharmacy side, NDC codes as well as age and gender will be used to assess risk. If risk adjustment is performed, it will be applied across all populations, geographic regions and Accountable Communities. Risk adjustment will be cost-neutral and will not add any additional costs to the Accountable Communities program.

Describe what mechanisms will be in place to protect participating entities from excessive risk. (e.g., claims caps, catastrophic risk protection, minimum savings thresholds, exclusion of certain high-risk patients, exclusion of certain services, other)

To reduce volatility, the State will truncate an assigned member's costs at a per patient annual cap amount according to the number of members assigned to an AC entity:

- Small Population =1,000-2,000 Attributed Participants
    - Annual Per-Enrollee Total Cost of Care (TCOC) Cap = $50,000
- Medium =2,000–5,000 Attributed Participants
    - Annual Per-Enrollee TCOC Cap = $200,000
- Large =5,000+ Attributed Participants
    - Annual Per-Enrollee TCOC Cap = AC Choice between $200,000 or $500,000

Only the dollars above that threshold per patient annual cap will be removed. By incorporating these thresholds, the State reduces variation in costs, thereby lowering the risk of paying Accountable Communities savings or requiring Accountable Communities to pay losses that result from random variation. The State believes that truncating claims at a per member annual cap achieves an appropriate balance between limiting catastrophic costs and continuing to hold Accountable Communities responsible to increase efficiency for high-cost patients.

A 2% risk corridor will also be in place which correlates with the MSSP.

Shared Savings: Shared Risk

Confirm whether participating providers will be required to participate in a risk sharing arrangement in order to qualify for payment.

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Participating providers will not be required to participate in a risk-sharing arrangement in order to qualify for payment; providers may elect to participate in either the Shared Savings Only or Shared Savings/ Shared Risk model.

Describe any risk arrangement and the authority under which the state will implement the arrangement.

Model 2 will provide an option for providers to engage in risk sharing in order to qualify for a higher percentage of shared savings. Model 2 provides for no downside risk in the first year, 5% shared loss in the second year, 10% shared loss in year three.

The State will implement the arrangement under the authority of the ICM SPA.

Describe whether and how the state will recoup dollars from providers for losses.

In alignment with the Medicare Shared Savings Program, MaineCare will require that an Accountable Community participating in both shared savings and losses must submit for MaineCare approval documentation that it is capable of repaying losses equal to at least 1 percent of the Accountable Community's total cost of care for its assigned beneficiaries. An Accountable Community may demonstrate its ability to repay losses by obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit, or establishing another appropriate repayment mechanism that will ensure its ability to repay the MaineCare program.

Describe how providers will be aware that they are participating in a risk arrangement.

Accountable Communities will be required to provide a copy of their participation agreement with MaineCare to all participating providers and other individuals and entities involved in ACO governance. All contracts or arrangements between or among the Accountable Community, participants, providers/suppliers, and other individuals or entities performing functions or services related to Accountable Community activities must also provide notice that the Accountable Community is participating in a shared savings and shared loss arrangement with MaineCare.

Shared Savings: Calculating Savings or Losses

Describe how savings or losses will be calculated, including whether the state will use a pre/post methodology to assess change in costs relative to a projected budget, or will it use a control group methodology, or another approach.

MaineCare will calculate a baseline PMPM cost based on past utilization data, assuming this data is found to be statistically valid. These target cost PMPMs will be compared to actual cost PMPMs to determine the level of savings. The target cost PMPMs will be developed using actuarial analysis and methodology similar to the development of capitation rates; the rate

setting checklist will be used as guidance when developing target cost PMPMs. A rate development document that explains the methodology, as well as possible data sources, data adjustments, and assumptions will be provided along with the SPA submission.

Target cost PMPMs will not be adjusted for retrospectively observed trend information. The target cost PMPMs for each Accountable Community will be based on the trend projected at the beginning of the performance period. Retrospective trend adjustments may reduce transparency and cause speculation amongst providers. The State will monitor emerging trends of comparable populations with similar demographics and health status. In future years of setting the target cost PMPMs, Maine will adjust trend based on this emerging experience.

Identify the percentage of savings/losses that will be shared with participating entities and whether the amount will be tiered based on quality performance or some other factor.

- Accountable Communities that choose to participate under Model 1 (Shared Savings Only) share in a maximum of 50% of savings, based on quality performance, and are not accountable for any downside risk in any of the three performance years

- Accountable Communities that choose to participate in Model 2 (Shared Savings and Losses) share in a maximum of 60% of savings, based on quality performance, and are not accountable for any downside risk in the first performance year. However, in year 2, are accountable for up to 5% of any losses and in year 3, are accountable for up to 10% of any losses.

The actual amount of shared savings an AC will receive will depend on its performance on specified quality benchmarks. The state is in the process of determining the methodology it will use to calculate the amount of shared savings an AC will receive based on its performance.

Describe if and how quality will qualify a provider for the shared savings program.

The actual amount of shared savings an AC will receive will depend on its performance on specified quality benchmarks. The state is in the process of determining the methodology it will use to calculate the amount of shared savings an AC will receive based on its performance.

Quality measurement will align with Medicare Shared Savings Program quality measures, but will also be augmented by measures that reflect the MaineCare population and specific Maine quality goals. This will be detailed further in the Quality Framework, to be submitted as a separate document.

Shared Savings: Rebasing

Describe how benchmarking data will be rebased after an appropriate period of time to account for any delivery system reforms that have been fully integrated.

TBD

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Shared Savings: Cost Shifting

Describe how the state will ensure that costs are not being shifted to other health care settings/programs. For instance, if the State is excluding claims from a particular delivery system, will it calculate and track expenditures associated with the excluded services to ensure that population costs savings are truly realized, rather than shifted to the excluded system?

Maine will track the following to ensure that costs are not being shifted to other systems of care:

- Admissions to nursing facilities
- Admissions to residential treatment/residential care facilities
- Admissions to IMDs

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 12, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

RE: Maine 13-012

Dear Commissioner Mayhew:

We are now ready to approve State Plan Amendment (SPA) No. 13-012; attached you will find an approved copy of the SPA. As requested, this SPA is effective April 1, 2013.

The purpose of this SPA is to amend the State's approved Title XIX State Plan to update the deadline by which a Health Home must achieve Patient Centered Medical Home certification. This SPA is budget neutral.

If you have any questions regarding this SPA, please contact Kathryn Holt, Maine State Lead, at 617/565-1246, or at kathryn.holt@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, Director, Office of Maine Care Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

January 23, 2013

Mary C. Mayhew, Commissioner
Department of Health & Human Services
Commissioner's Office
11 State House Station
Augusta, Maine 04333-0011

Re: Maine State Plan Amendment (SPA) Transmittal Number 12-004

Dear Commissioner Mayhew:

The Centers for Medicare & Medicaid Services (CMS) Boston Regional Office has completed its review of Maine State Plan Amendment (SPA) Transmittal Number 12-004. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The State plan pages for this SPA were submitted and approved through the Medicaid Model Data Lab. To qualify for enrollment in a health home, Medicaid participants must have (a) two chronic conditions or (b) one chronic condition and the risk of developing another, from the following list of conditions: mental health; substance use disorder, asthma; diabetes; heart disease; BMI over 25 and other conditions that include tobacco use for risk of heart disease; chronic obstructive pulmonary disease; hypertension; developmental disability; autism spectrum disorder; acquired brain injury; seizure disorders and cardiac and circulatory congenital abnormalities. This SPA designates that a team of health care professionals, as described in Section 1945(h)(6) of the Social Security Act, is the health home provider.

We are approving this SPA with an effective date of January 1, 2013, and have included the approved State plan pages with this letter. In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect - January 1, 2013 through December 31, 2014, the Federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on January 1, 2015.

This approval is based on the State's agreement to collect and report information required for the evaluation of the health home model. States are also encouraged to report on the CMS' recommended core set of quality measures.

If you have any questions concerning this amendment or require further assistance, please contact me, or have your staff contact Kathryn Holt of my staff at 617/565-1246 or kathryn.holt@cms.hhs.gov. Thank you.

Sincerely,

/s/

Richard McGreal
Associate Regional Administrator

Enclosure

cc:
Stefanie Nadeau, Director of MaineCare Services

APPROVED JUNE 21, 2013 BY GOVERNOR

CHAPTER 326 PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND AND THIRTEEN

H.P. 353 - L.D. 534

An Act To Improve Care Coordination for Persons with Mental Illness

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1711-C, sub-§6, ¶A, as amended by PL 2011, c. 347, §6, is further amended to read:

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

(a) A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;

(b) A psychologist licensed under the provisions of Title 32, chapter 56;

(c) A social worker licensed under the provisions of Title 32, chapter 83;

(d) A counseling professional licensed under the provisions of Title 32, chapter 119; or

(e) A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this section to a state-designated statewide

health information exchange that satisfies the requirement in subsection 18, paragraph C of providing a general opt-out provision to an individual at all times and that provides and maintains an individual protection mechanism by which an individual may choose to opt in to allow the state-designated statewide health information exchange to disclose that individual's health care information covered under Title 34-B, section 1207;.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this paragraph to a health care practitioner or health care facility, or to a payor or person engaged in payment for health care, for purposes of care management or coordination of care. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2). A person who has made a disclosure under this subparagraph shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure;

Sec. 2. 34-B MRSA §1207, sub-§9 is enacted to read:

9. Disclosure for care management or coordination of care. Notwithstanding any provision of this section to the contrary, a health care practitioner may disclose without authorization health information for the purposes of care management or coordination of care pertaining to a client as provided in this subsection.

A. Disclosure is permitted to a health care practitioner or health care facility as defined in Title 22, section 1711-C, subsection 1.

B. Disclosure is permitted to a payor or person engaged in payment for health care for the purpose of care management or coordination of care.

C. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2).

D. A person who has made a disclosure under this subsection shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure.

Overview: The goal of Maine's Accountable Communities Medicaid ACO Initiative is to improve the quality and value of the care provided to MaineCare members and, through its contribution to system reform, the citizens of Maine as a whole. Through a new integrated care model - Accountable Communities - MaineCare will engage in alternative contracts with provider organizations that manage and/or deliver core and optional services to an attributed patient population. Accountable Communities that demonstrate cost savings and meet quality of care benchmarks may share in savings generated under the model. The new integrated care model will be offered statewide as a Medicaid state plan option.

Accountable Communities will achieve better care for individuals, better population health, and lower cost through three overarching strategies:

- Transformation of Care: Accountable Communities will align with and build on the core expectations of Maine's Multi-Payer Patient-Centered Medical Home pilot and Health Homes Initiative.
- Community-led innovation: Maine's Accountable Communities will be driven by identified local health care needs, resources, and solutions. While each Accountable Community will meet established provider qualifications, report on core quality measures and be responsible for a set of core services, Accountable Communities will also be afforded flexibility to structure services and solutions that fit locally identified priorities and context.
- Shared savings: Accountable Communities will benefit from a value-based purchasing strategy that supports more integrated and coordinated systems of care.

Current MaineCare Delivery System: MaineCare's state plan currently includes statewide Primary Care Case Management (PCCM), which pays participating physicians and practices a PMPM payment for providing comprehensive primary care, authorizing medically necessary referrals, providing or arranging 24 hour coverage, 7 days a week, and educating patients about MaineCare PCCM rules, seeking appropriate regular care and following practice rules.

This state plan option also supports MaineCare's participation in a multi-payer Patient-Centered Medical Home (PCMH) pilot. Moving forward, MaineCare's principal participation in the multi-payer PCMH pilot will be through its Health Homes Initiative, which will also include providers outside of the pilot. Maine also has several HCBS waivers that support adults and children with disabilities.

Beyond these features, MaineCare is predominantly a fee for service system. Through Accountable Communities, MaineCare will move away from its current volume-driven delivery system toward more value-based, integrated and coordinated systems of care.

Eligible Beneficiary Participation: All fully eligible Medicaid state plan beneficiaries, including dual eligibles, may be attributed to an Accountable Community. Because Maine has a small population with extensive rural areas, MaineCare hopes to maximize eligibility in Accountable Communities in order to leverage the model both for system transformation and actuarial validity.

Provider Qualifications: All Accountable Communities must include qualified PCCM providers. In addition, Accountable Communities must directly deliver or commit to coordinate with specialty services, including behavioral health, and must coordinate with all hospitals in the proposed service area. Accountable Communities must develop formal and informal partnerships with community organizations, social service

- Demonstrated leadership
- Behavioral-physical health integration
- Inclusion of patients & families
- Connection to community
- Commitment to waste reduction

agencies, local government, etc. Accountable Communities must also commit to core expectations that align with the state's multi-payer Patient-Centered Medical Home pilot and Health Homes Initiative (see box). Additional required activities align with Medicare Shared Savings Program (MSSP) criteria and include promoting evidence-based medicine and beneficiary engagement, internally reporting on quality and cost metrics, and coordinating care.

Existing Building Blocks:
PCCM: Over 95% of MaineCare primary care physicians participate in PCCM.

Multi-Payer Patient Centered Medical Home (PCMH) and MaineCare Health Homes: Through the multi-payer PCMH pilot, MaineCare, in partnership with Medicare, Anthem BCBS, Aetna, and Harvard Pilgrim Health Care, pays qualified PCCM practices on a PMPM basis. The multi-payer pilot will expand from its initial 26 practices to include 50 new practices in January 2013. MaineCare has worked closely with the multi-payer pilot to align with Maine's Health Homes Initiative. Upon approval of Maine's Health Homes SPA, anticipated for January 2012, MaineCare's participation in the multi-payer pilot will be through its Health Homes Initiative. In addition to the 76 practices participating in the multi-payer pilot, MaineCare has identified approximately 58 additional practices that are also eligible to qualify as Health Homes outside of the multi-payer pilot. In all, 134 practices (approximately one-third of MaineCare primary care providers) will meet criteria to be Health Homes. Maine's PCMH pilot and Health Homes initiative include Community Care Teams (CCTs). CCTs throughout the state partner with PCMH practices to better coordinate and connect the highest need patients to additional healthcare and community resources. Under Maine's Health Home initiative, the PCMH and the CCT together form the Health Home.

Integrated Delivery Systems: Maine's health care landscape features several large provider-driven integrated delivery systems in diverse areas of the state, as well as a strong Primary Care Association, whose FQHC membership is very engaged in both MSSP and Maine's Value-Based Purchasing Strategy. Accountable Communities will build on these strengths and unify diverse initiatives by aligning payment, practice/system transformation, and quality incentives under an overarching ACO model.

Stakeholder Engagement: The Department began stakeholder outreach regarding the Accountable Communities Initiative a year ago this fall. Following an in-person and online introduction to the model, MaineCare leadership met with a broad array of providers, culminating in a Request for Information in early winter. A multi-disciplinary team from across Maine's Department of Health & Human Services drafted a proposed model based on the synthesis of information from the RFI, and presented the proposal at a series of regional forums in the spring. Throughout this time, MaineCare has consulted regularly with an advisory group of MaineCare members. Since the forums, MaineCare has initiated work with an actuarial team and continued to meet with provides to refine the model.

Strategic Collaboration: MaineCare enjoys strategic partnerships with nationally recognized organizations advancing payment and delivery system reform in Maine. MaineCare has collaborated closely with Maine Quality Counts, a regional Quality Improvement organization transforming practices into multi-payer medical homes and supporting Community Care Teams to serve the state' s highest need patients, on its PCMH and Health Homes Initiatives. The Maine Health Management Coalition brings together the state's largest self-insured employers, payers and providers in public partnership with the State to achieve improved quality, transparency, and payment and delivery reform. MaineCare works with the Coalition to align performance measures, payment and delivery reform objectives.

Gaps in existing infrastructure:

Capacity in Rural areas: As noted, Maine has several large, integrated health systems in diverse geographic areas that will likely meet the criteria to participate in the Accountable Communities initiative. However, some of the more rural regions of the state may face challenges in developing an Accountable Community. In order to build capacity and support access to the service on a statewide basis, MaineCare is partnering with the Maine Primary Care Association to conduct outreach, education, and convene with FQHCs and other safety net providers in rural areas of the state to promote capacity.

Data: Access to data – especially real-time data needed in the management and oversight of Accountable Communities – also represents a gap in infrastructure. MaineCare is currently working closely with HealthInfoNet, the Muskie School at the University of Southern Maine, and additional partners such as the Maine Health Management Coalition to develop the data resources and tools to address these gaps.

Payment Methodology: Under the Accountable Communities Initiative, the fee for service system will continue, along with global care coordination fees under PCCM and Health Homes. The total cost of care for attributed beneficiaries will be tracked in comparison to a baseline per member per month amount. Accountable Communities will have the opportunity to share in any achieved savings under one of two models, structured to mirror the MSSP models:

1. Model 1 will have no shared or downside risk, but will have the opportunity to share in up to 50% of savings achieved.
2. Model 2 will be a shared risk and savings model that allows the Accountable Community to share in up to 60% of savings. Under Model 2, Accountable Communities will have no downside risk in the first year, 5% in the second year, and 10% in the third year.

The amount of shared savings will be dependent upon the Accountable Community's performance on determined quality benchmarks. The calculation of shared savings as it relates to quality of care will align with the MSSP methodology described in 42 CFR 425.502.

Existing SPA/Waiver authorities affected by the program:

- Maine will amend its Medicaid State Plan to create Accountable Communities under the ICM authority.
- Dual eligibles will not be excluded from participation.
- Accountable Communities' shared savings methodology will be described.

Services delivered under Maine's HCBS waiver(s) may be included as optional services under the Accountable Community; however, this will not require a change in waiver authority.

Potential barriers or obstacles to implementation: Gaps in existing infrastructure present challenges to implementation: as previously noted, data infrastructure and lack of service capacity in rural areas may pose challenges. These challenges are being addressed through partnerships with a number of different entities across the state.

Lack of human resources at the state level is also a frequent barrier to implementation of system reform. Again, Maine is fortunate to have existing partnerships with private entities, including the Maine Health Access Foundation, which has provided resources to assist MaineCare in its Value-Based Purchasing reform effort.

Week of: 7/21/2013

Managed Care Initiative: Accountable Communities

Overall Status

Key Escalation Issues

- Project timeline needs to be revisited

Accomplishments / Activities

Key Accomplishments (Over Last Week)	Key Upcoming Activities (This Week)
• Received updated eligibility table for the most recent Change Request and uploaded the table	• Check new data • Answer any questions that may arise from the attribution, target cost, and shared savings methodology write up

Key Meetings

Recent Interactions (Over Last Week)	Scheduled Interactions (This Week)
	• Status update call

On Track	Off Track: Impact to Milestone
Off Track: Potential Impact to Milestone	Complete

Milestones

Key Milestones	Start	Finish	Status
Data request prepared and sent	4/9/12	5/4/12	
Create attribution methodology flow chart	4/30/12	5/4/12	
Draft outline of rate methodology	4/30/12	5/11/12	
Collect and validate data	5/7/12	6/15/12	
Incorporate providers' feedback as collected by Maine as directed by Maine	5/7/12	5/18/12	
Draft detailed rate methodology	5/14/12	5/21/12	
Update rate methodology for inclusion in SPA	5/22/12	5/31/12	
Draft responses for CMS ~~Program Characteristics Template~~ Concept Paper	5/29/12	~~6/29/12~~ ~~7/31/2012~~ 8/15/2012	
Finalize CMS Toolkit/Template	5/9/12	~~11/2012~~ 3/4/13	
Finalize rate methodology for inclusion in SPA	~~7/2/12~~ TBD	~~7/15/12~~ TBD	
Identify key cost variables & drivers	~~6/13/12~~ TBD	~~7/18/12~~ TBD	
Review provider applications	~~6/25/12~~ TBD	~~8/15/12~~ TBD	
Develop base data and identify potential data adjustments	~~6/18/12~~ TBD	~~8/25/12~~ TBD	
Support selection of providers for Accountable Communities program	~~7/16/12~~ TBD	~~8/31/12~~ TBD	
Finalize attribution methodology, base data, and adjustments	~~9/3/12~~ TBD	~~9/14/12~~ TBD	
Finalize target cost PMPMs	~~9/14/12~~ TBD	~~8/30/2013~~ TBD	

Risks / Issues

Risk / Issue	Resolution Strategy

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MaineCare Value-Based Purchasing

Benchmark Cost PMPM Development Documentation

July 29, 2013

State of Maine Accountable Communities Benchmark Cost PMPM Development

The State of Maine ("State" or "we") is moving from a fee-for-service reimbursement model to a value- based purchasing model that involves the creation of Accountable Communities for MaineCare's Medicaid program. Deloitte Consulting LLP ("Deloitte Consulting") has been retained by Maine to help develop benchmark per member per month (PMPM) costs for each participating Accountable Community. The Accountable Communities will provide services to a specified patient population within an agreed upon total cost of care PMPM under shared savings and optional risk-sharing arrangements. In addition to the benchmark cost PMPM and shared savings/risk-sharing payments, the quality of care and patient experience will be measured and will be incorporated into the shared savings/risk sharing arrangements.

The enclosed report provides a detailed description of the methodology that will be used to develop the benchmark cost PMPMs for each participating Accountable Community. The methodology will be consistent with Centers for Medicare and Medicaid Services requirements for Medicaid managed care capitation rate development and appropriate for the population covered by the program. Further, the methods we plan to use in developing the proposed benchmark costs will conform to the appropriate Standards of Practice promulgated by the Actuarial Standards Board. These benchmark costs will be estimates of future events. It may be expected that actual experience will vary from the proposed future values.

Executive Summary

Benchmark cost PMPMs for the MaineCare Accountable Community program will be developed for a one year period which is anticipated to be from October 1, 2013 through September 30, 2014. The benchmark cost PMPMs will be developed on the basis of past claim experience and membership data with a base period of the most recent 12 months of data available to Deloitte Consulting. Note that we will analyze and utilize experience from at least dates of service of September 1, 2010 to December 31, 2012 with run out through March 2013. We will review this base data as well as market trends, to determine the appropriate adjustments such as trend, outliers, completion, etc. to project our base experience data into the effective period. The benchmark cost PMPMs will be developed for the State's defined Medicaid population as well as the services covered in the program and specific to each Accountable Community.

This report details the data and adjustments that will be used in the development of the benchmark cost PMPMs. The following is a list of the sections included in this document:

- **Section 1 - Population**: Identifies the anticipated population to be included in the benchmark cost development process

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- **Section 2 - Services**: Summarizes the anticipated service category groupings to be included in the benchmark cost development

- **Section 3 – Effective Periods**: Defines the proposed benchmark cost PMPM effective dates

- **Section 4 – Benchmark Cost Cells**: Identifies the potential benchmark cost cells to be developed

- **Section 5 – Benchmark Cost Development**: Will detail the base data and adjustments that will be applied in the development of the benchmark cost PMPMs

    - 5.1 – Attribution Methodology
    - 5.2 – Base Period Data
        - 5.2.1 – Data Validation and Base Period Selection
        - 5.2.2 – Base Data Adjustments
        - 5.2.3 – Summarized Base Data for Projection
    - 5.3 – Data Adjustments
        - 5.3.1 – Programmatic Adjustments
        - 5.3.2 – Utilization and Unit Cost Trend
        - 5.3.3 – Other Adjustments
    - 5.4 – Regional and Accountable Communities Adjustment Factors
    - 5.5 – Risk Adjustment

- **Section 6 – Final Benchmark Cost PMPMs**: Will show the final benchmark cost PMPMs by population and Accountable Community

- **Section 7 – Risk Sharing/Shared Savings:** Will be developed to show how savings will be calculated and shared

Section 1 - Population

Maine's Accountable Communities ("AC's") are expected to be statewide assuming there are providers within each region that meet the requirements to participate and apply to be in the program. Specific geographic areas will not be targeted for the program. The program will target all MaineCare members who receive full MaineCare benefits, including Categorically Needy, Medically Needy, SSI-related Coverage Groups, Home and Community-based Waiver members, and others.

The population included in the benchmark cost PMPM development will be based on all members with full benefits that will be attributed to an Accountable Communities program. For further information on how a member will be attributed to an Accountable Community see Section 5.1 – Attribution Methodology.

The benchmark cost PMPMs are expected to be an aggregate PMPM for all population groups for each Accountable Community. However, the analysis behind the build-up of the PMPMs will likely be segregated by population groups. The possibility of having separate benchmark cost PMPMs for each population group for each Accountable Community will be considered but may lead to a lack of credibility due to less people in each PMPM cohort. We will utilize crosswalks to identify and segment the eligibility data in order to develop benchmark cost PMPMs by population within the Medicaid program. Below is a list of the Maine Medicaid populations, which will be analyzed to help determine if there will be any segmentation in rates:

- Adults
- Children
- Aged/Disabled
- Dual Eligible

Adults and Children populations will be identified based on the age of the member. The Age/Disabled population will be identified through Recipient Aid Category ("RAC") codes. Dual eligible members are anticipated to be identified through a Dual Eligible indicator in the data.

Section 2 - Services

The State has identified "core services" for which all Accountable Communities will be responsible. Additionally, the State has identified a list of "optional services" that Accountable Communities may choose to include.

Core services include:

- Inpatient
- Outpatient
- Emergency Department
- Physician
- Pharmacy
- Mental Health
- Substance Abuse
- Hospice
- Home Health
- School-based primary care and school-based day treatment

Optional services include:

- Home and Community Based Services
- Nursing Facilities (except physical, occupational and speech therapy that occurs at the facilities)
- Private Duty Nursing Services
- Dental

Services that will be excluded include:

- Non-Emergency Transportation
- Private Non-Medical Institutions (PNMIs)

- School-Based Rehabilitation

The State will provide a cross walk that defines the “core” and “optional” services to be included for the Accountable Communities program. These “core” and “optional” services will be defined by allocation provider type and specialty.

We will analyze the historical experience for both the “core” and “optional” services across the State Medicaid program by population and Accountable Community. Certain service categories within the “core” or “optional” services may be grouped together for the benchmark cost development process due to the similarities of the type of service, reimbursement methodology, or to increase the credibility since some services have very low utilization. The service groupings will be determined through analysis of the claims data. The following factors will be taken into consideration when grouping services:

- Types of service (for example, Mental Health, Substance Abuse, Early Intervention, etc.)
- Reimbursement methodology (for example, DRG, Revenue Code, CPT/HCPC, etc.)
- Place of service (for example, Hospital, Physician’s Office, Nursing Home, etc.)

Benchmark cost PMPMs will be developed by including “core” services in the benchmark cost PMPM development, to be consistent for each Accountable Community, and then an add-on or adjustment factor would be applied to the core service benchmark cost for the Accountable Community specific “optional” services

At this time, any Accountable Community provided services that are not identified as either “core” or “optional” services will not be included in the development of the benchmark cost PMPMs.

Section 3 - Effective Periods

The benchmark cost PMPMs will be developed for a one year period based on when the program will be implemented which is anticipated to be October 1, 2013 through September 31, 2014.

Section 4 – Benchmark Cost Cells

It is anticipated that one aggregate benchmark cost PMPM will be developed for each Accountable Community. However, we will consider varying the benchmark cost PMPM by population group assuming the data for a given cohort is credible.

Waiver Program/Benchmark Cost Cohort – As discussed in Section 1 of this document, we will analyze the different Medicaid populations in our aggregate benchmark cost PMPM

development. The initial population benchmark cost PMPMs will be analyzed further to determine if additional rating cohorts within the specified populations, such as age and gender, make sense. This may be due to significant differences in costs among cohorts belonging to the same population.

Accountable Community – It is anticipated the benchmark cost PMPMs will vary by each Accountable Community to account for regional differences and the historical claims experience for current Medicaid members' being attributed to the Accountable Community. The development of the Accountable Community specific benchmark cost PMPMs will be developed in one of two ways:

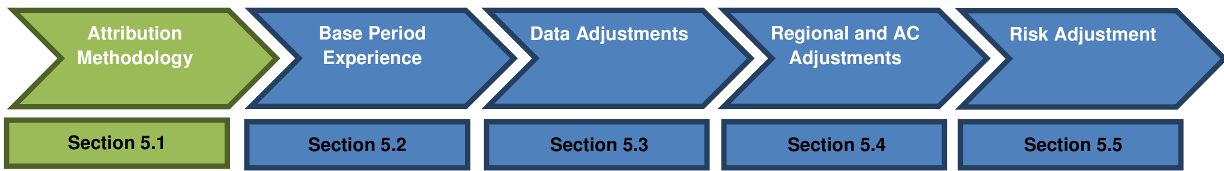
1. Depending on the historical data availability and credibility for claims that would have been attributed to the Accountable Community, benchmark cost PMPMs may be developed using specific historical claim experience for only that Accountable Community.
2. Alternatively, if using Community attributed claims experience is not fully credible, we may develop statewide or regional benchmark cost PMPMs and then determine Accountable Community specific adjustments to account for any population or experience differences.

Section 5 – Benchmark Cost Development

The following sub sections detail how members will be assigned to each Accountable Community and how the benchmark cost PMPMs for each Accountable Community will be developed. To determine the benchmark costs, different scenarios will be studied for unit cost and utilization trend assumptions to determine the allowed benchmark cost for each Accountable Community. This benchmark cost PMPM will then be used in comparison to the actual PMPM for the attributed members of each Accountable Community to determine any savings. This comparison and shared saving methodology will be described in the Section 7.

Included in this section is a description of the attribution methodology, base data, adjustments made to the base data, projections to move the base data into the appropriate rating year, and any additional add-on Accountable Community specific costs.

5. 1 – Attribution Methodology



Accountable Communities will serve all full benefit MaineCare members, including members dually eligible for Medicare. The program is planning to prospectively assign members prior to

the beginning of the program performance year based on historical claims analysis to each Accountable Community as the State feels it would not be appropriate to add members at the end of the year for which the Accountable Community did not know it was accountable. These members will be aligned to an Accountable Community based on the following criteria:

Members who have 6 months of continuous eligibility or 9 months of non-continuous eligibility during the most recent 12 months of base data will be eligible for assignment. Beneficiaries meeting this criteria will then be assigned to an Accountable Community based on the following claims experience criteria.

Primary Care Services are defined by the following set of codes: procedure codes between 99201-99215, 99304-99340, 99341-99350, 99381-99387, 99391-99397; HCPC Codes G0402, G0438, G0439, T1015; Revenue Codes 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983; Diagnosis Codes V700, V703, V705, V706, V708, V709.

A member will be attributed to an Accountable Community based on the following hierarchy:

1. Members will first be attributed to the Accountable Community where they had a plurality of primary care services (as defined above) with a nurse practitioner, primary care physician, primary care practice, rural health center, federally qualified health center or an Indian Health services provider.

2. Members not assigned under #1 will then be attributed to the Accountable Community in which they received targeted case management or community support services as defined by procedure code T1017 at a behavioral healthcare provider.

3. Members not assigned under #1 or #2 will then be attributed to the Accountable Community in which they had 3 or more ER visits.

4. If the member does not meet the above outlined criteria, the member will not be assigned to an Accountable Community and will be excluded from the program.

Each performance year, the attribution analysis will be re-run to account for any members that moved or are no longer in the Medicaid program.

Depending on how many members are allocated to each Accountable Community and the credibility for each community, benchmark cost PMPMs will be set for each Accountable Community based on historical claims experience of the assigned members. If the amount of members assigned to an Accountable Community is not fully credible the benchmark cost PMPM for those members will be evaluated in conjunction with regional or state wide benchmark costs. For this either a regional benchmark cost will be set or a state wide benchmark cost will be set and adjusted for regional differences based on the location of each Accountable Community.

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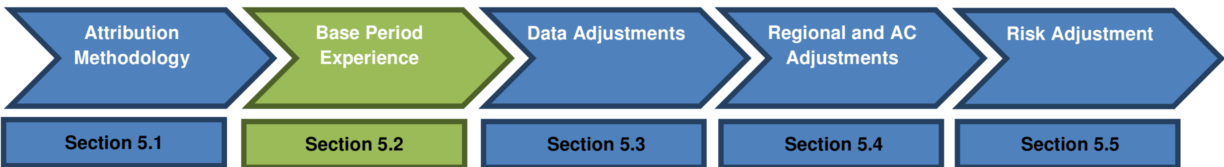
5. 2 – Base Period Data



5.2.1 – Data Validation and Base Period Selection

In the development of the proposed benchmark cost PMPMs, the State's enrollment, claims and other data will be relied upon. Only services covered under in the Accountable Communities program will be considered. After the collection and loading of data, the accuracy and reliability of the data will be assessed based on available State reports and standard checks for completeness. This will include comparing the data to available cost reports, as well as validation to prior experience. Part of the data review will involve splitting the claims by high level service category (Inpatient, Outpatient, Professional, Pharmacy, etc.) and reviewing them for reasonableness; however, Deloitte Consulting will not perform an independent verification as to the accuracy of these data.

MaineCare FFS claims data incurred from September 1, 2010 to December 31, 2012 with claims run out through March 2013 from the MIHMS claim system will be used. For the benchmark cost development, we will use January 2012 through December 2012 as the base period data, and the September 2010 through December 2011 data to investigate any emerging trends, outliers, develop completion factors, and supplement the base period data, if necessary. As we work with the base data for the benchmark cost PMPM development we will consider the quality of the data and adjust for any data issues that may impact our analysis and projections. We will appropriately adjust the base period data for known data issues, such as:

- **Core and Optional Service Data Anomalies:** We will summarize the data by each of the core and optional services to validate if there are any unusual trends by service. If any of the services' base data does not seem valid, we will work with the State to summarize costs based on financial reporting information they have available.

- **Implementation of new claims system:** The state implemented a new claims system ("MIHMS") in September 2010. Through analysis of the SFY 2011 data, we have encountered some data anomalies which we are working with the state to resolve.

5.2.2 – Base Data Adjustments

If deemed necessary, we will make adjustments to the base period to construct benchmark costs to reflect populations and services covered during the effective period and appropriately modify the base data to represent a complete compilation of the historical experience. The following is a list of some adjustments that may be considered to complete the base data:

- Incurred But Not Paid ("IBNP") Adjustments

- Third Party Liability ("TPL") Adjustments
- Retroactivity Adjustments
- Payments and Recoupments not Processed through MIHMS

IBNP Adjustments: In order to account for any claims that may still be outstanding in the base data, we will use Incurred But Not Paid (IBNP) adjustments to complete the data.

Third Party Liability ("TPL") Adjustments: If any additional TPL data is received, the base data will be adjusted to properly reflect the appropriate impact of TPL payments, including both cost avoidance and pay and chase type claims.

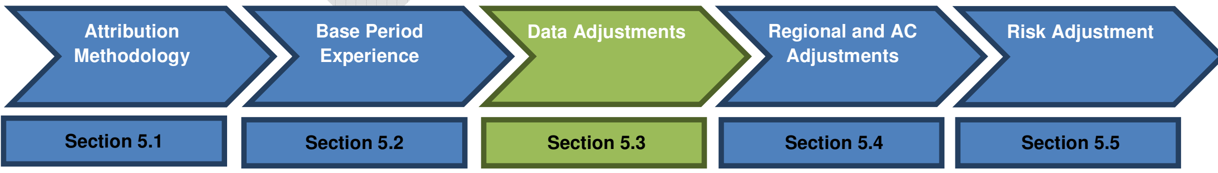
Retroactivity Adjustments: Claims and member months for clients who are retroactively eligible for Medicaid must be excluded from the fee-for service base if the providers are not obligated to cover the cost incurred in this period. Appropriate adjustment for retroactivity will ensure that the benchmark cost PMPMs properly match the risk.

Payments and Recoupments Not Processed Through the MIHMS Claims System: Any payments and recoupments not processed through MIHMS will be included in the base data. This may include payments such as the Prospective Interim Payments. Prior to 7/1/2011 the State reimbursed inpatient and outpatient in-state claims for Acute, Critical Access, and Psych hospitals through interim payments that were then cost settled 1-3 years after the State fiscal year. The claims system reflects no payment for these claims as they are conducted offline. We will receive a summary of these payments by hospital and State fiscal year to make adjustments to the data.

5.2.3 – Summarized Base Data for Projection

For purposes of showing the base period data prior to application of trend and further adjustments to get to the effective period, we will summarize the completed base data by member, population group, and each of the core and optional service categories over the experience period. By summarizing the data in this way, we will ensure each population group and service category receives all data adjustments.

5.3 – Data Adjustments



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5.3.1 – Programmatic Adjustments

We will make any programmatic or policy changes that take place between the base period and effective period. These programmatic changes are accounted for in the programmatic change adjustment and applied to the adjusted base data.

- Payment Rate Adjustments
- Policy Change Adjustments

Payment Rate Adjustments: When legislative (or executive) action results in changes to state FFS payment rates, it is necessary to adjust historical experience to reflect such changes. We will identify the applicability of such adjustments, and measure the impact on the base data PMPMs when necessary.

Policy Change Adjustments: Policy change adjustments are made to account for budget actions through statutory changes. These projected changes in expenditures are due to rate, benefit, or eligibility changes occurring after the base period. Adjustments are made for any policy changes to bring historical data to the effective period. These adjustments could be applied to trend or base data.

Changes in reimbursement structure: The State has modified their reimbursement structure for some hospital facilities during the experience period (e.g. moving from the above noted prospective interim payments to DRGs). There are additional reimbursement structure changes that are expected to happen for additional hospital facilities that will need to be adjusted for.

5.3.2 – Utilization and Unit Cost Trend

In developing separate utilization and unit cost trend estimates we will analyze the22 months of historical data that will be used for the benchmark cost PMPM development. We will conduct a regression analysis and apply smoothing techniques to understand the historical utilization and unit cost trends. For our trend analysis we may combine populations to increase the credibility of the trend rates and minimize the volatility. The unit cost trend will take into consideration future budget allocations.

Trends will be analyzed at the high level service category level by population group. Depending on the volatility and credibility of trends at the service category level, we may group services to better understand the historical trend pattern. We will compare the calculated trends to expected trends, Medicaid benchmarks, national indices, published studies, and across the state (by region or county) for reasonableness if available.

5.3.3 – Other Adjustments

If necessary, the assumptions regarding other adjustments to be made will be based on available data, experience gained from other programs (ACOs, FFS, capitated models, etc.), and research of publicly available data, if available.

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Listed below are samples of other adjustments we will consider making, but is not an all-inclusive list.

- **High Cost Member Adjustments:** In order to smooth any potential volatility as a result of an abnormal distribution of catastrophic claims, we will review high cost members. Dollars with be summarized at the member level for each core and optional service as well as in total.

  To reduce volatility, the State will truncate an attributed member's costs (only including services covered for the attributed Accountable Community) at a per member annual cap amount according to the number of members assigned to the Accountable Community entity:

  - Small Population = 1,000-2,000 attributed members
    - Annual Enrollee Total Cost of Care ("TCOC") Cap = $50,000
  - Medium = 2,000–5,000 attributed members
    - Annual Enrollee TCOC Cap = $200,000
  - Large = 5,000+ attributed members
    - Annual Enrollee TCOC Cap = AC Choice between $200,000 or $500,000

  Only the dollars above that threshold for any given member will be removed. The dollars below the threshold will be included in the benchmark cost PMPM calculating. By incorporating these thresholds, the State reduces variation in costs, thereby lowering the risk of paying Accountable Communities savings or requiring Accountable Communities to pay losses that result from catastrophic random variation. The State believes that truncating claims at a per member annual cap achieves an appropriate balance between limiting catastrophic costs and continuing to hold Accountable Communities responsible to increase efficiency for high-cost patients.

- **Benefit Differences Adjustments:** Any benefit changes made between the base period and the effective period will be reviewed and considered. We will determine what adjustments should be made based on only those services covered for the Accountable Communities Program.

- **Population Differences Adjustments:** We will review and consider if there will be any changes in the population covered between the base period and the effective period, based upon such criteria as geography or ability of particular Accountable Communities to cover a required minimum number of members. However, since the data used for the benchmark cost PMPM represents the actual population attributed to the Accountable Community, this adjustment is unlikely unless the population is only partially credible.

- **Third Party Liability (TPL):** If TPL collections will take place for the Value-based Purchasing Program, we will make an adjustment to the benchmark costs to account for

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the appropriate level of collections anticipated for each of the Accountable Communities. For example, if it is anticipated there will be fewer TPL collections within the Value-based Purchasing Program than the providers previously collected, we will make an adjustment for this.

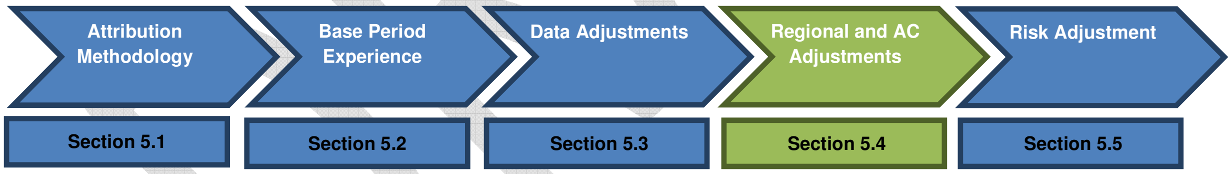
- **Pharmacy Rebates:** If the Accountable Communities are expected to receive pharmacy rebates, we will make an adjustment to their benchmark cost PMPMs. If the Accountable Communities plan to contract with the same PBMs as part of the Value-based purchasing Program and expect to receive the same level of pharmacy rebates as they did previously, then it is not anticipated that an adjustment will be made.

- **Administrative Costs (Care Coordination and Care Management Fees):** We will consider administrative costs for the Accountable Communities. They may incur additional costs for coordinating care, hiring case managers and other similar services which may be built into the benchmark cost PMPMs.

- **Disproportionate Share Hospital (DSH):** We will consider DSH payments, but we believe these will be covered separately for the experience period and will not be considered part of the benchmark cost PMPMs.

- **Graduate Medical Education (GME):** We will consider GME payments, but we believe these will be covered separately for the experience period and will not be considered part of the benchmark cost PMPMs.

5.4 – Regional and Accountable Communities Adjustment Factors



We will have attributed members in the 12 month experience period to an Accountable Community. At this point the data for each Accountable Community will be summarized by each core and optional service. We will examine the credibility of the data for each Accountable Community based on the number of members attributed and the shared savings model chosen by the Accountable Community (see Section 7 for a description of the models).

The credibility thresholds were determined based on research from other Accountable Care type programs including:

- CMS Medicare Advantage: 2,000 members

- Medicare Share Savings: 5,000 members

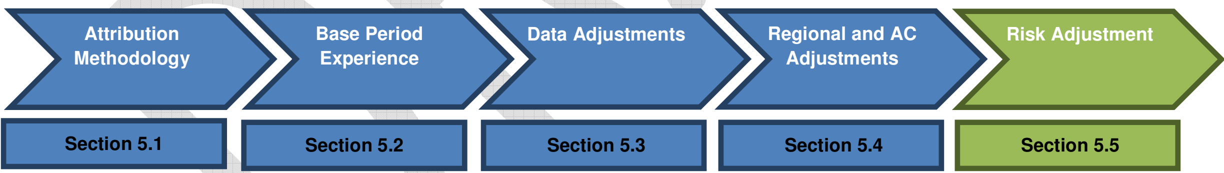
- State of Minnesota Hennepin County Health ACO Pilot: 12,000 members
- CMS ACO Pilot: 15,000 unless located in rural area, in which case 5,000 members
- New Jersey Medicaid ACO Demonstration Project: 5,000 members
- Minnesota Statewide Health Care Delivery System ACO:
    - 1,000 member minimum where no downside risk;
    - 2,000 member minimum with two-way risk sharing model.

As a result of this analysis, the State is proposing the minimum target number of beneficiaries for each of its two models to be considered statistically valid as follows:

- Model 1: Shared Savings Only: minimum of 1,000 attributed members
- Model 2 Shared Savings and Losses: minimum 2,000 attributed members

If it is determined that using an Accountable Communities attributed members' claims experience is not fully credible, we will develop statewide or regional benchmark cost PMPMs and then determine Accountable Community or regional specific adjustments to account for any population or experience differences. To account for differences throughout the state, we will develop regional and, if necessary, Accountable Community adjustment factors which will be applied to the statewide per capita benchmark cost PMPM to determine the regional and Accountable Community benchmark cost PMPMs.

5.5 – Risk Adjustment



Risk adjustment is being considered and will likely be calculated in the development of the benchmark costs. The risk scores will be calculated using the same historical experience as the benchmark cost PMPMs. The benchmark cost PMPMs may not be risk adjusted but the risk score inherent in them will be calculated, or the benchmark cost PMPMs may be adjusted to a 1.0 risk basis. When compared to the actual PMPMs, the actual PMPMs will be adjusted to the same risk basis.

The risk model software being utilized by the State is DCG (Diagnostic Cost Groupings) developed by Verisk. It is a regression model based on age, gender, and diagnosis codes. The state is considering whether to apply risk adjustment to both the medical claims as well as pharmacy claims. On the medical side, the risk adjustment software will utilize diagnosis-based

codes such as ICD9 codes as well as age and gender to assess the risk. On the pharmacy side, NDC codes as well as age and gender will be used to assess risk.

If risk adjustment is performed, it will be applied across all populations, geographic regions and Accountable Communities. Risk adjustment will be cost-neutral and will not add any additional costs to the Accountable Communities program.

Section 6 – Final Benchmark Cost PMPMs

Each Accountable Community will have costs summarized for each core and optional service. All data for the members attributed to an Accountable Community will be adjusted as described above to develop the benchmark cost PMPMs. All benchmark cost PMPMs will include all core services. Additive adjustments will be made to these PMPMs for optional services included for a given Accountable Community.

Section 7 – Risk Sharing/Shared Savings

Accountable Communities will be incentivized to provide better care at lower cost in order to receive shared savings. Services delivered – either directly by the Accountable Community, or through other providers - will continue to be paid for by MaineCare under the existing (largely fee for service) payment system.

Benchmark cost PMPMs for each Accountable Community will be developed based on actuarial analysis as described above. Benchmark cost PMPMs will not be adjusted retrospectively for observed trend information if the observed trends differ from the trends used in the benchmark cost PMPM development. The State believes retrospective trend adjustments may reduce transparency and cause speculation amongst providers. The State will monitor emerging trends of comparable populations with similar demographics and health status for comparison purposes and for future benchmark cost PMPM projections. In future years of setting the benchmark cost PMPMs, Maine will adjust trend based on this emerging experience.

After the first effective year, the benchmark PMPM costs will be compared to actual PMPM costs for the attributed member population. Note these actual PMPM costs will be adjusted for high cost members depending on the size of the Accountable Community as described above in the high cost member adjustment of Section 5.3.3. The actual PMPMs will also be risk adjusted in order to be on the same risk basis as the benchmark cost PMPMs.

The Accountable Community will receive up to a specified percentage of demonstrated savings as long as they achieve savings beyond a 2% risk corridor, back to the first dollar saved. The actual shared savings the Accountable Community receives also depends on their performance on specified quality benchmarks.

Shared Savings payments will be made to qualifying Accountable Community entities under the two models noted above in Section 5.4

Model 1: Shared Savings Only

- The communities will share in a maximum of 50% savings dependent on quality performance
- The communities will not be accountable for any downside risk in any of the three performance years
- Savings can only be shared if the Community exceeds the savings beyond the 2% risk corridor threshold

Model 2: Shared Savings and Losses

- The communities will share in a maximum of 60% savings dependent on quality performance
- The communities will not be accountable for any downside risk in the first performance year
- In year 2, the accountable communities are responsible for up to 5% of any losses
- In year 3, the accountable communities are responsible for up to 10% of any losses
- Savings and losses will only be shared if the Community exceeds the 2% risk corridor threshold

Examples of the shared savings calculations are included in the Appendix.

With either of the two models, the State will be incorporating various quality measures based on patient/caregiver experience, patient/caregiver safety, and clinical outcomes. The State is still determining the appropriate scoring method of performance on these quality measures and determining allowable shared savings. One proposal for the shared savings is as follows:

- **Year 1:** In order to receive full 50% or 60% shared savings (depending on model), the Accountable Community must achieve 100% reporting on quality measures and meet at least 30th percentile on level of performance.
- **Years 2 and 3:** The Accountable Community must meet 30th percentile level of performance for 70% of measures in each domain to be eligible for shared savings. The amount of total shared savings depends on total performance score.
- The performance of measures scored for performance vs. reporting increases each year
    - **Year 1:** All metrics reported
    - **Year 2:** 25 out of 33 performance metrics achieved
    - **Year 3:** 32 out of 33 performance metrics achieved

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APPENDIX

Example Shared Savings Calculations

Example 1:

Risk Adjusted Benchmark Cost PMPM for Accountable Community ABC for year 1: $500

Risk Adjusted Actual PMPM for Accountable Community ABC for year 1: $495

Risk Corridor = $500 * 0.98 = $490

Savings: Since the Accountable Community didn't achieve savings beyond the 2% risk corridor, there are no savings shared with the Accountable Community.

Example 2:

Risk Adjusted Benchmark Cost PMPM for Accountable Community XYZ for year 1: $500

Risk Adjusted Actual PMPM for Accountable Community XYZ for year 1: $485

Risk Corridor = $500 * 0.98 = $490

Savings: Since the Accountable Community achieved savings beyond the 2% risk corridor, there will be shared savings. Assuming the Accountable Community reported 100% of quality metrics the shared savings are:

- Eligible savings to share: $500 - $485 = $15 PMPM
- Model 1 Savings Year 1: $15 * 50% = $7.5 PMPM
- Model 2 Savings Year 1: $15 * 60% = $9 PMPM

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1.02 DEFINITIONS

1.02-1 Community Care Team (CCT) – A CCT is a multi-disciplinary, community-based, practice-integrated care management team that has completed an application and been approved by MaineCare to provide Community Care Team services.

1.02-2 Electronic Health Record (EHR) – An Electronic Health Record means a systematic collection of electronic health information about individual MaineCare members. It is a record in digital format that is capable of being shared across different health care settings, for example by way of network-connected enterprise-wide information systems and other information networks or exchanges.

1.02-3 Health Home – The Health Home consists of an Health Home Practice and CCT working together to provide Health Home Services to eligible MaineCare members.

1.02-4 Health Home Practice (HHP) – A Health Home Practice is a primary care practice that has completed an application and been approved by MaineCare to provide Health Home Services.

1.02-5 Plan of Care – The Plan of Care is a patient-centered plan that describes, coordinates and integrates all of a member's clinical data, and clinical and non-clinical health care-related needs and services. The Plan of Care shall include member health care data, member health goals, and the services and supports necessary to achieve those goals. This may include, but not be limited to, prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services.

1.03 PROVIDER REQUIREMENTS

The HHP and CCT must meet requirements as set forth in this Section.

1.03-1 Health Home Practice (HHP)

1. The HHP must execute a MaineCare Provider Agreement.
2. The HHP must be a primary care practice site that provides care to adult or children members, is located in the state of Maine, and has at least one full-time primary care physician or nurse practitioner.
3. The HHP must sign or be a party to a MaineCare Provider/Supplier Agreement.
4. The HHP must complete a Health Home Practice application and be approved as a Health Home Practice by MaineCare.

1.03 PROVIDER REQUIREMENTS (cont.)

5. The HHP has fully implemented an Electronic Health Record (EHR).

6. The HHP has received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) Recognition.

7. The HHP has an executed contract with a CCT.

8. The HHP has established member referral protocols with area hospitals.

9. Within one year of a practice's participation as a MaineCare HHP, the HHP certifies that it has fully implemented the following Core Health Home Standards:

   a. **Demonstrated Leadership** – The HHP identifies at least one primary care physician or nurse practitioner as a leader within the practice who champions the implementation and continued maintenance of Core Health Home Standards.

      The primary care leader(s) work with other providers and staff in the HHP to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.

      The primary care leader participates as a member of the practice Leadership Team and participates in Health Home learning opportunities regarding Health Home implementation offered by the Department.

   b. **Team-Based Approach to Care** – The HHP has implemented a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.

      The HHP utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, including one or more of the following:

      - through greater use of planned visits;
      - integrating care management into clinical practice;
      - delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians;
      - expanding patient education; and,
      - providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

1.03 PROVIDER REQUIREMENTS (cont.)

c. **Population Risk Stratification and Management** – The HHP has adopted processes to identify and stratify patients across their population who are at risk for adverse outcomes, and adopted procedures that direct resources or care processes to reduce those risks.

"Adverse outcomes" means a negative clinical outcome and/or avoidable use of healthcare services such as hospital admissions, emergency department visits, or non-evidence based use of diagnostic testing or procedures.

d. **Enhanced Access** – The practice enhances access to services for their population of patients, including:

- The HHP has a system in place that allows patients to have same-day access to their healthcare provider using some form of care that meets their needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.

- The HHP has processes in place to monitor and ensure access to care, e.g., tracks wait time to third next available appointment.

e. **Practice Integrated Care Management** – The HHP has processes in place to provide care management services, and identifies specific individuals to work with the practice team to provide care management for patients at high risk of experiencing adverse outcomes.

Care management staff have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.

Care management staff have processes for tracking outcomes for patients receiving care management services.

f. **Behavioral Physical Health Integration** – HHP has completed a baseline assessment of their behavioral-physical health integration capacity during the first year of MaineCare Health Home participation.

Using results from this baseline assessment, HHP has implemented one or more specific improvements to integrate behavioral and physical health care, including one or more of the following:

- Implemented processes to routinely conduct a standard assessment for depression in patients with chronic illness;

- Hired a behavioralist into the practice to assist with chronic condition management; and,

1.03 **PROVIDER REQUIREMENTS** (cont.)

- Co-locate behavioral health services within in the practice.

g. **Inclusion of Patients and Families** – HHP includes members and family members as documented and regular participants at leadership meetings, and/or practice has in place a member and family advisory process to identify patient-centered needs and solutions for improving care in the practice.

HHP has processes in place to support members and families to participate in these leadership and/or advisory activities (e.g., after hours events, transportation, stipends, etc.).

HHP has implemented systems to gather member and family input at least annually (e.g. via mail survey, phone survey, point of care questionnaires, focus groups, etc.). HHP has processes in place to design and implement changes that address needs and gaps in care identified via member and family input.

h. **Connection to Community Resources and Social Support Services** – HHP has processes in place to identify local community resources and social support services.

HHP has processes in place to routinely refer patients and families to local community resources and social support services, including those that provide self-management support to assist members in overcoming barriers to care and meeting health goals.

i. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** – The HHP has processes in place to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services as evidenced by at least one initiative that targets waste reduction, including one or more of the following:

- Reducing avoidable hospitalizations;
- Reducing avoidable emergency department visits;
- Reducing non-evidence-based use of expensive imaging, such as MRI for low back pain or headache;
- Working with specialists to develop new models of specialty consultation that improve patient experience and quality of care, while reducing unnecessary use of services; and,
- Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources.

1.03 PROVIDER REQUIREMENTS (cont.)

j. **Integration of Health Information Technology** – HHP uses an electronic data system that includes identifiers and utilization data about patients. Member data is used for monitoring, tracking and indicating levels of care complexity for the purpose of improving patient care.

The system is used to support member care, including one or more of the following:

- The documentation of need and monitoring clinical care;
- Supporting implementation and use of evidence-based practice guidelines;
- Developing plans of care and related coordination; and,
- Determining outcomes (e.g., clinical, functional, satisfaction, and cost outcomes).

1.03-2 Community Care Team (CCT)

1. The CCT must execute a MaineCare Provider Agreement;

2. The CCT must complete a Community Care Team application and be approved as a Community Care Team by MaineCare;

5. The CCT must have executed a contract with one or more HHPs to provide Health Home services; and,

6. CCT staff shall consist of a multidisciplinary group of health care professionals under the leadership of a CCT Manager, a Medical Director, and a Clinical Leader. Their responsibilities are:

a. A CCT Manager provides leadership and oversight to ensure the CCT meets goals;

b. A Medical Director (at least 4 hours/month) collaborates with the HHP to select and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings; and,

c. A Clinical Leader directs care management activities across the CCT, and does not duplicate care management that is already in place in the HHP.

Additional CCT staff may consist of a nurse care coordinator, nutritionist, social worker, behavioral health professional, case manager, pharmacist, care manager or chronic care assistant, community health worker, care navigator, health coach and/or other staff approved by the state.

1.04 MEMBER ELIGIBILITY

In order to be eligible for Health Home Services, the member must be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition. All diagnoses must be documented in the member's Plan of Care.

1.04-1 Chronic Conditions

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in Section 13 and Section 17 of this Manual);
2. a substance use disorder;
3. tobacco use;
4. diabetes;
5. heart disease;
6. overweight or obese as evidenced by a body mass index over 25;
7. Chronic Obstructive Pulmonary Disease (COPD);
8. hypertension;
9. hyperlipidemia;
10. developmental and intellectual disorders;
11. circulatory congenital abnormalities;
12. asthma;
13. acquired brain injury; and
14. seizure disorders.

1.04-2 At Risk for Another Chronic Condition

1. A member is deemed to be at risk for another chronic condition if the member has been diagnosed with any of the following:

    a. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in Section 13 and Section 17 of this Manual);
    b. a substance use disorder;
    c. tobacco use;
    d. diabetes;
    e. heart disease;
    f. overweight or obese as evidenced by a body mass index over 25;
    g. chronic obstructive pulmonary disease (COPD);
    h. hypertension;
    i. hyperlipidemia;
    j. developmental and intellectual disorders; or,
    k. circulatory congenital abnormalities

1.04 MEMBER ELIGIBILITY (cont.)

2. A member with a diagnosis of asthma, acquired brain injury or seizure disorder, is eligible for Health Home Services if it is documented in the member's Plan of Care that the member is at risk for another chronic condition.

1.04-3 Additional Requirements for Eligibility for Community Care Team Services

Members who are eligible for Section 91 services, with more intense health care needs may be eligible for CCT services, in addition to HHP services.

The HHP assesses Section 91 members for eligibility for CCT services.

The members referred to CCT by the HHP shall not exceed 5% of the HHP's total assigned members.

To be eligible for CCT services, a member must meet one of the following criteria:

1. Hospital Admissions

   a. 5 or more admissions in past 12 months
   b. 3 or more admissions in past 6 months, or

2. Emergency Department Utilization

   a. 3 or more E.D. visits in past 6 months, or
   b. 5 or more E.D. visits in past 12 months

3. Members identified by the Department as high-risk or high-cost

4. Polypharmacy: members using 15 or more chronic medications, and/or on multiple high-risk medications (e.g. insulin, warfarin, etc)

5. High social service needs that interfere with care: Eligible members who also have significant social service needs that result in high rates of avoidable utilization of medical services (e.g. members who are homeless, have an intellectual disability, substance abuse).

Following resolution or stabilization of members' high/ complex needs, the CCT will end services for the member and refer the member back to the HHP for Health Home services, pursuant to their Plan of Care.

1.04-4 Member Assignment

1. The Department shall assign members to a Health Home.

1.04 MEMBER ELIGIBILITY (cont.)

a. Members who meet Section 91 eligibility criteria, and who were receiving Health Home Services under Chapter VI, Section 1 of this manual, Primary Care Case Management, will receive written notification from the Department that their provider has become a Health Home provider. If their PCCM provider becomes a Section 91 provider, members will receive information about the benefits of participating in a Health Home and be notified of their ability to opt out of enrollment in these services. If the member does not opt out within twenty-eight (28) days of the letter, the member will be automatically enrolled by the Department in Health Home services on either the 1st or 15th of the month.

b. Members who meet Section 91 eligibility requirements, but who did not receive services under Chapter VI, Section 1, Primary Care Case Management, will receive written notification of the benefits of participating in a MaineCare Health Home and a list of Health Homes in their area. Members will be encouraged to respond within twenty-eight (28) days of receiving the letter, but may also enroll at a later date.

c. Health Home Services are optional services. A member may opt out of Health Home Services. Members who elect to receive Health Home services may choose to receive the service from any qualified Health Home (consisting of one HHP and one CCT).

1.05 COVERED SERVICES

1.05-1 Comprehensive Care Management

The HHP and/or the CCT will coordinate and provide access to comprehensive care management, care coordination and transitional care across settings for Health Home-eligible individuals. Levels of care management may change according to member needs over time.

The HHP shall develop a Plan of Care with each Health Home member. The Plan of Care shall be recorded in the member's record, and in the HHP's electronic health record (EHR) and include the member's health goals, and the services and supports necessary to achieve those goals (including prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services as needed). HHP services shall also include:

1. Prospective identification of at-risk patients;

2. Clinical assessments, monitoring & follow up of clinical and social service needs;

3. Medication review & reconciliation; and,

4. Communicating and coordinating care with treating providers

1.05 COVERED SERVICES (cont.)

As part of care management, HHPs shall conduct the following screenings and assessments for all of their assigned Health Home members:

1. Measurement of BMI in all adult patients at baseline and at least every two years, and BMI percent-for-age at least annually in all children.

2. During the second year of MaineCare participation as a Health Home practice and annually thereafter:

   a. Depression and substance abuse screening (PHQ9 and AUDIT, DAST) for all adults with chronic illness, and substance abuse screening (CRAFFT) for adolescents.

   b. ASQ or PEDS developmental screening for all children age one to three, and the MCHAT 1 for at least one screening between ages 16-30 months with a follow-up MCHAT 2 if a child does not pass the screening test.

Comprehensive Care Management for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Comprehensive Care Management.

CCT Services

The CCTs shall have access and contribute to the Plan of Care for Members with high needs, either directly through the EHR, or through secure messaging. The CCT shall also provide:

a. Medical assessments and complete community/social service needs assessments;
b. Nurse care management (including patient visits prior to hospital discharge, in the primary care practice, group visits or at home);
c. Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members);
d. Behavioral health (brief intervention, cognitive behavioral therapy, motivational interviewing, and referral);
e. Substance abuse services (screening, brief treatment and referral);
f. Psychiatric prescribing consultation for providers (provided by psychiatrist); and,
g. Medication review and reconciliation.

1.05 COVERED SERVICES (cont.)

1.05-2 Care Coordination

The HHP will provide care coordination services that:

1. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

2. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

3. Coordinate and provide access to mental health and substance abuse services; and,

4. Develop a Plan of Care for each member that coordinates and integrates all clinical and non-clinical health-care related needs and services, as appropriate.

Care Coordination for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Care Coordination. The HHP shall provide the same care coordination to members that have been referred to CCTs as those that have not been referred.

CCT Services

The CCT shall provide intensive and comprehensive care coordination to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care. The CCT's efforts shall be performed in coordination with, and not duplicate services delivered by, the HHP.

1.05-3 Health Promotion

The HHP shall promote member education and chronic illness self-management beginning with screening for tobacco and alcohol use, as primary causes of chronic illness. Health Promotion shall include follow-up education with the member and family, and referrals to community-based prevention programs and resources.

Health Promotion for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Health Promotion. The HHP will support continuity of care through coordination with the CCT, and will

1.05 COVERED SERVICES (cont.)

promote evidence-based care for tobacco cessation, diabetes, asthma, hypertension, COPD, hyperlipidemia, developmental and intellectual disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities, self-help recovery resources, integrated behavioral health and other services based on individual needs and preferences.

CCT Services

The CCT will provide additional health promotion services for the highest need members through community-based outreach and care management sessions with the patient. Outreach and engagement functions will include aspects of comprehensive care management, care coordination, and linkages to care that address all of a member’s clinical and non-clinical care needs, including health promotion.

1.05-4 Comprehensive Transitional Care

The HHP will provide Comprehensive Transitional Care to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility), and to ensure proper and timely follow-up care. This service include conducting follow-up calls to discharged Members and ensuring that medication reconciliation and timely post-discharge follow-up are completed, and facilitating transition to adult systems of care for pediatric patients.

Comprehensive Transitional Care for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Comprehensive Transitional Care. The HHP will support the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow-up visit.

CCT Services

The CCT will provide the following Comprehensive Transitional Care services:

1. Intensive and comprehensive care management support to address member’s complex needs and/or help members overcome barriers to care, while coordinating care with the Health Home practice team;

2. Conduct follow-up calls to discharged members and ensure that medication reconciliation and timely post-discharge follow-up are completed, and may conduct a home visit if indicated; and,

1.05 COVERED SERVICES (cont.)

3. Ensure that a timely follow-up visit with the HHP is scheduled, and help address barriers such as transportation needs to ensure that the visit occurs.

1.05-5 Individual and Family Support Services

The Health Home Team shall employ approaches which may include but are not limited to peer supports, support groups, and self-care programs to increase member and caregiver knowledge about an individual's chronic illness(es), promote the member's engagement and self-management capabilities, and help the member improve adherence to their prescribed treatment. Individual and Family Support Services shall include, but not be limited to:

1. Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, and other chronic diseases;
2. Chronic Disease self-management;
3. Use of Peer Supports, support groups, and self-care programs; and,
4. Information on Advance Directives.

Individual and Family Support Services for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Individual and Family Support.

CCT Services

The CCT provides self-management support to members, i.e. (1) health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, other chronic disease; (2) chronic disease self-management education and skill-building, such as linking to Living Well programs.

1.05-6 Referral to Community and Social Support Services

The Health Home practice team provides referrals to community and social support services relevant member needs, actively connecting members to community organizations that offer supports for self-management and healthy living, and routine social service needs.

1.05 COVERED SERVICES (cont.)

Referral to Community and Social Support Services for Members Referred to CCTs

CCT Services

The CCT shall provide referrals to community, social support and recovery services to members, connect members to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, economic and other assistance to meet basic needs.

1.06 NON-COVERED SERVICES

A member may only receive Health Home services from one CCT and one HHP. Health Home Services do not preclude a member from receiving other medically necessary services. Members may not receive Health Home Services that duplicate services from other sections of this manual.

1.07 REPORTING REQUIREMENTS

In addition to the documentation and reporting requirements of the MaineCare Benefits Manual, Chapter I, Section I, the CCT and the HHP shall report quarterly, in the format determined by the Department, on activity and improvement in the following domains:

1. Leadership
2. Team-based approach to care
3. Population risk stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families in implementation of PCMH model
8. Connection to community resources and social support services
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration of health information technology (HIT)

1.08 REIMBURSEMENT

1. Reimbursement is specified in Chapter III, Section 91.

2. Minimum Requirement for an HHP to receive the per member per month (PMPM) reimbursement: In order to be eligible for a PMPM, for each member for each calendar month, the HHP is required to provide at least one Section 91 Covered Services to a member eligible for Section 91 services, and in accordance with the member's Plan of Care.

3. Minimum Requirement for a CCT to receive the per member per month (PMPM) reimbursement: In order to be eligible for a PMPM, for each member for each calendar month, the CCT is required to provide at least one Section 91 Covered Service to a member eligible for Section 91 services, and in accordance with the member's Plan of Care.

4. Payment will be made as specified above, so long as the service provided is not a duplicative service which is reimbursed under another section of the MaineCare Benefits Manual.

Health Home Practices

Health Home practices will be reimbursed at a rate of $12.00 per member per month.

Community Care Teams

Community Care Teams will be reimbursed at a rate of $129.50 per member per month.

Value **B**ased **I**nsurance **D**esign Workgroup Meeting Minutes for 10/12/12

Attendees: Tony Marple,-Mercy Health System, John Condon- Acadia Benefits, Eric Waters-PenBay Medical Center, Janice Kimball-City of Portland, Elizabeth Mitchell, Nancy Morris and Amy Deschaines, Maine Health Management Coalition

Agenda Item	**Comments**	**Decision**	**Next Steps**
1. Introduction of all participants	N/A	N/A	N/A
2. Approve Minutes of last meeting	Minutes reflected the prior meeting discussions.	The minutes were accepted as drafted.	Post to Mehmc.org under VBID Workgroup as accepted.
3. MaineHealth Wellness Plan Design	Last year moved to an outcomes based wellness program for financial incentive (bmi, tobacco free, blood sugar, cholesterol, etc.) HRA and biometrics – considered participating in wellness program This year: HMO and CDHP – price for entry is health assessment and biometrics – you can have access to these affordable plans. Then incentives for making targets. Don't participate is $1500/$2500 per year more forced into 3rd plan ER contribution into health savings account Don't test or test negative for tobacco - $1200 fee Uptick in tobacco treatment services, onsite counseling is booked	N/A Informational	N/A

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	Can quit and be retested to have the tobacco penalty taken away No out-of-pocket for tobacco products or programs 10,500 members have taken biometrics Lot of interest in CDHP plan – costs less than HMO, plus employer contribution		
4. VBID Plan Ratings on GetBetterMaine	Reviewed the "Buying Value" chart: shopping and looking for healthcare coverage figure out who does the things to get a more valuable health plan, but BV is shielding the plan (insurance carrier) names (MA 1, etc.). We will start to list name of health insurance plans available in Maine, like we list the providers and hospitals – how close they come to offering a VBID plan Consumer Reports example of Maytag – have to list all plans Eric: Who is ultimate customer for reviewing these plans ratings Nancy: business people (brokers, small businesses and big businesses) Eric: MaineHealth – would you look at something like this? Laurie – possibly – they are going to design their own plan, there could be some value for smaller plans and large would go through an RFP process with a broker – this could have value for small to mid size employers Nancy: VBID start to say is it really helping us to change it up, base it on the science (these benefits have high-return on investment – less science/questionable, don't cover) – Jerry Cayer example of the number of people doing billing in critical access	N/A This was for discussion purposes only	

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	Slim down and standardize administrative functions of plans – should this group look at this? Laurie: army of people who deal with claims denials Nancy: $86K per provider Eric: admin piece – critical question – unless Medicare changes its ways we won't have a significant benefit – how much time we spend on Medicare – focus on what we'd like to see for coverage, preventive, etc. more value as a group. Admin we could spend loads of time on this. Tony: lots of different layers, etc. Nancy: So we agree as a group to put admin aside and concentrate on what services have strongest ROI, clearing path, encouraging other activities		
5. Review Plan Design Chart State of Oregon Safeway Medicare Anthem HSA	State of Oregon: healthcare services in different buckets (high-value return, preference sensitive, incentive for shared decision-making, evidence is less clear on effectiveness – this is where higher deductible and coinsurance kick in), smoking charge Safeway: reference based pricing, wellness is also a major focus and embedded into Safeway philosophy Laurie: Safeway's initial savings was part of cost shifting, there was some overstatement of those savings, they do have outcomes based incentives Eric: rate of participation? Part-time, low pay, affordability to afford Laurie: this may not have been available to the bargaining units.	Have actuary price out the following plan design components: 1. Full coverage of preventive 2. PCMH investment, Shared Decision Making and local care management 3. Good incentives around radiology and ED use – different copays / High copay for ED 4. PCP selection at open enrollment	

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	Eric: gas station, convenient stores – great deal of turnover but this is the population that needs the wellness support. Nancy: Somerset county pilot with Andy Spaulding – looking to go after that very population, see more options Laurie: socio-economic, hard to get through via plan design if not benefit eligible or not affordable Tony: what might be a good plan design for group A may not be good for group B, demographics will drive plan design choice Nancy: some people won't fit that mold, older men with back problems, people who are about to start a family – notion of each plan needs to be different – benefits the science is behind it or not – wellness plan could be different strategy Elizabeth: how to go from menu to what we think would be common elements of design Nancy: preventive at 100% is value-based, no other plan that says these services have more value, these have less – there are some assumptions John: example of Medicare and their state employee program – want to steer group a little differently, plan design came with physicians around the table, ACO product, annual physical, incentives, physician side from a value-based, diabetics compliant – get free meds, Elizabeth: low-back program with BIW, copays were an issue, can be an important guide with what is happening in the market, Eastern Maine's plan – chose health system to be their plan John: plan design that could go into effect for 1/1/2014, common themes, health plans don't cover everything the	5. Requirement for annual physical 6. Tier by quality? What is the standard deviation? 7: Price component 8. Strong incentives for tobacco cessation and BMI (premium differentials) 9. 100% coverage for tobacco cessation programs 10. Complete health assessment	

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	same, have Mercy, MaineMed, etc. what are the procedures you are arguing about, get someone at each large organization that we are appealing most and get those basic things fixed, you have to demand this of your health plans, need legitimate framework that produces these things – these aren't controversial but nobody is doing it Nancy: this is the way we want to pay for these items? Tony: sometimes it isn't the coverage – prescreening, obese, weight reduction program, protocols and individual responsibility, some payers are interested some aren't Laurie: bariatric surgery example of protocols, sometimes built into services, concept of aligning with providers, etc. look at what providers are being incented for and employers build that into plan design Elizabeth: Coalition come out with set of recommendations, what do you need, what would you like to see to enhance appropriate utilization Andi: what about PCMH models, shared decision making imbedded, support incentives for participation from provider and employee Elizabeth: APC notification on website John: 3 boxes 1. Standardized – what wellness incentives make sense (biometrics, smoking cessation, WOW program statewide? – can be implemented regardless of your insurance company) – trying to get away from "shopping" 2. Providers – what do you want to see – forget what Anthem has out there – what would help you? Select PCP at open enrollment		

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	Andi: steering, volume, basic tools would be wonderful to have them approve – there are other things about the negotiation, we need to be realistic about how far this plan can go, incentives for PCMH, selection of PCP – this is a delicate discussion between insurer and provider Elizabeth: we can only put information out there about best practice Andi: quality information, this is exactly the information we want out there Elizabeth: the intention of this VBID plan is to just show which plans out there are offering the pieces we need in a plan – the things you (payers) and clinicians want in a plan Laurie: start with basic principals and then build upon, make some people personally accountable Recommendations: 1. Full coverage of preventive 2. PCMH investment, Shared Decision Making and local care management 3. Good incentives around radiology and ED use – different copays / High copay for ED 4. PCP selection at open enrollment 5. Requirement for annual physical 6. Tier by quality? What is the standard deviation? 7: Price component 8. Strong incentives for tobacco cessation and BMI (premium differentials) 9. 100% coverage for tobacco cessation programs 10. Complete health assessment		

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	Employer as own ACO – you have access to your employees' 40 hour week, responsibility is team, Jax has local providers come into labs, don't push into one direction over the other Jax steer volume to outside of community – fine to save money but if your hospital closes up, need to find balance (Tony: depends on point of view / Eric: just acknowledge) Elizabeth: are there alternative services that can be done elsewhere Andi: really strong incentives for tobacco cessation and BMI (premium differentials, concrete rewards and wellness program with complete coverage for tobacco cessation programs and evidence based) Health assessment, annual physical, tobacco cessation, BMI, choose a PCP, - build on other layers John – wants to push Oregon thing off, so much interest from employers on wellness piece Laurie: want to lower costs for community, focused on wellness, looking to provider community for assistance Tony: consistency about health improvement around employers and insurance companies		

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