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MaineCare

Accountable Communities Initiative

October 15, 2013

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

Accountable Communities Agenda

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- Timeline: Looking Back and Forward
- Request for Application Key Dates
- High Level Overview of Accountable Communities Structure
- Accountable Communities Proposed Model Overview & Discussion
  - Leadership & Management
  - Coordination of the Full Continuum of Care
  - Payment Models
  - Total Cost of Care Savings Assessment Methodology
  - Quality Framework
  - Data Feedback to Providers
  - Request for Applications Process

Accountable Communities & Value-Based Purchasing Timeline to Date

- **Aug 2011:** VBP Strategy announced
- **Nov 2011:** Request for Information (RFI)
- **Spring 2012:** Value-Based Purchasing Forums reviewing proposed models for Health Homes and Accountable Communities
- **July 2012**: CMS releases guidance regarding policy considerations for Integrated Care Models (ICM), which include shared savings ACO models
- **September 2012**: State Innovation Model (SIM) application submitted
- **January 2013**: Health Homes implemented for members with chronic conditions (Stage A)

Throughout this time, MaineCare has refined its model though active engagement with:

- The Center for Health Care Strategies' national Medicaid ACO Learning Collaborative
- Its contracted actuarial team
- The DHHS Design Management Committee

Accountable Communities Timeline

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Date	Milestone
Sep 2013	Public Forums
Oct 2013	Release of Request for Applications (RFA)
Dec 2013	Eligible Accountable Communities Notified
Winter 2014	Contract Negotiations
Spring 2014	Implementation

Request for Applications (RFA) Key Dates

Activity	Date
RFA posted	October 9, 2013
Written Questions Due	October 23, 2013
Summary of Questions and Answers	November 6, 2013
Optional individual Q&A sessions with potential applicants	October 28 – November 8, 2013
Optional Notice of Intent/ Interest	November 15, 2013
Applications Due	December 9, 2013
Notice of Intent to Contract issued by State	December 20, 2013
Begin contract plenary sessions and negotiations	January 6, 2013
Performance Year begins	May 1, 2014

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

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The definition of an ACO depends on who you ask…

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

An entity or group of entities responsible for a population's health and health costs that:

- Is provider-owned and driven
- Has a structure with a strong consumer component and community collaboration to address the entire continuum of care
- Includes shared accountability for both cost and quality

Strategy to Achieve the Triple Aim

Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through four overarching strategies:

- Shared savings based on quality performance
- Practice-level transformation
- Coordination across the continuum of care
- Community-led innovation

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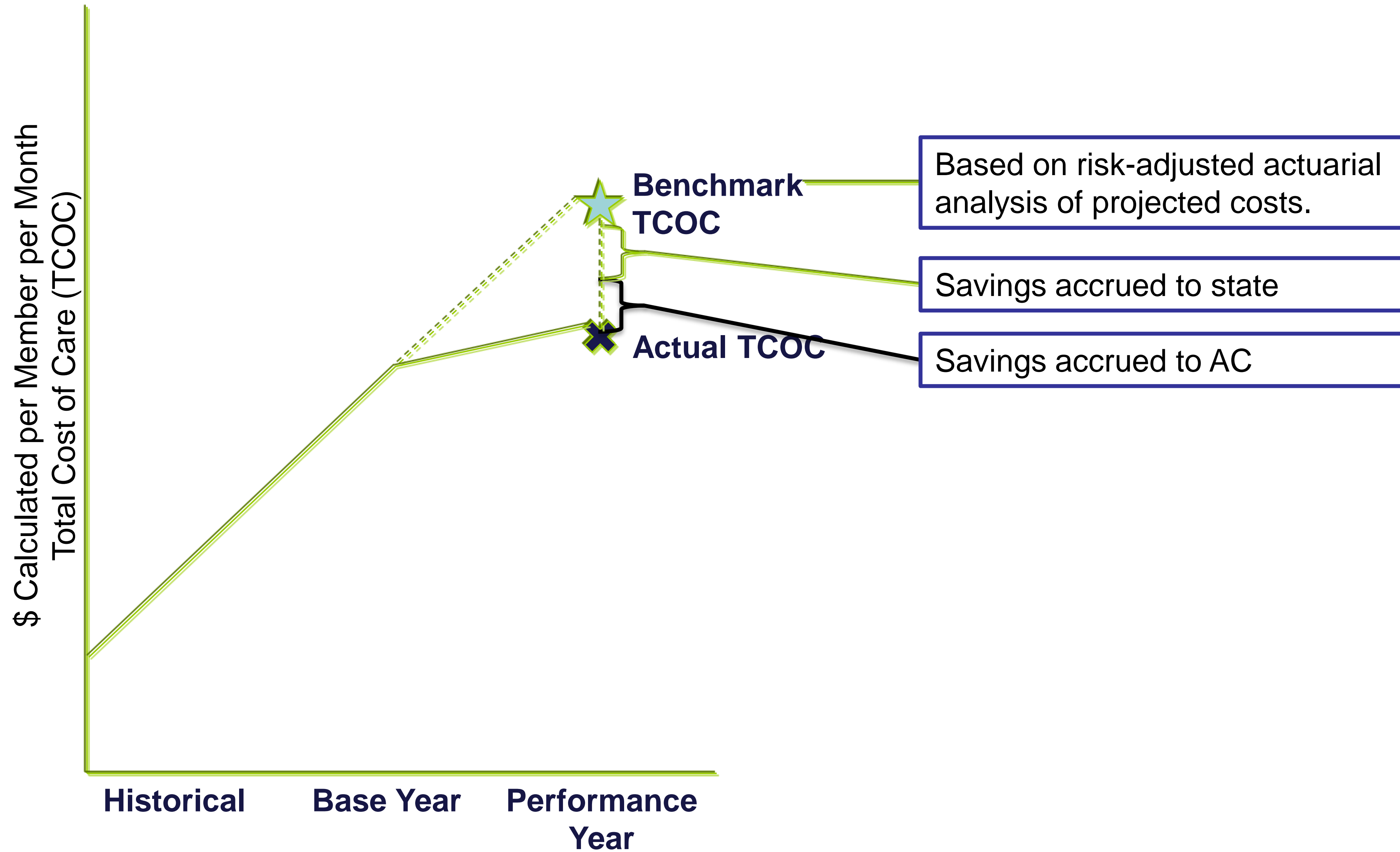
- Open to any willing and qualified providers statewide
  - Qualified providers will be determined through a Request for Application (RFA) process
  - Accountable Communities will not be limited by geographical area
- Members retain choice of providers
- Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate

Accountable Communities: Shared Savings Model



Who Can be an Accountable Community?

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- One or multiple provider organizations represented by a Lead Entity
- Providers must be MaineCare providers
- Include providers that directly deliver primary care services
- Have partnerships to leverage DHHS care coordination resources that support members with:
  - Chronic conditions, including developmental disabilities
  - Long Term Services and Support needs
  - Behavioral Health needs
- Demonstrate collaboration with the larger community to address:
  - Transitions of care
  - Population health
  - Psycho-social barriers

What does an Accountable Community look like?

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What could an Accountable Community look like?

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- Federally Qualified Health Center
- Critical Access Hospital
- Home & Community Based Waiver Services Provider

- Pediatrics Practice
- School Health Center
- Dentist Practice

- 2 Health Home practices
- Behavioral Health Home
- Pharmacy

- Single Health System

- Hospital
- 3 Hospital-owned Primary Care Practices
- 2 Nursing Facilities

- 4 Primary Care Practices
- 3 Behavioral Health Organizations

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Lead Entity Requirements

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Legal Entity will contract with the Department

- Receive and distribute any payments
- Hold contractual agreements with other providers sharing in savings/ loss under the AC
- Ensure the delivery of Primary Care Case Management (PCCM) services (1905(t)(1) of the Social Security Act
  - Primary Care Providers that "Locate, coordinate and monitor" health care services
  - 24 hour availability of information, referral and treatment in emergencies

Governance

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- Structure, roles, processes
- Transparent (access and communications)
- Includes MaineCare members

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Coordination of the Full Continuum of Care

Ensure coordination of primary, acute, and behavioral health care, as well as long-term services and supports

Direct Delivery of Primary Care

- Physicians, nurse practitioners, certified nurse midwifes, or physician assistants who:
  - Have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or
  - Practice in a rural health center, federally qualified health center, an Indian Health Services center, or School Health Center.

Coordination of the Full Continuum of Care

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Leverage DHHS Care Coordination Resources: Contractual agreement or other partnership with at least one provider under each category:

- Chronic Conditions, including Developmental Disabilities
  - Health Homes (Stage A), Targeted Case Management (TCM)
- Long Term Services & Supports
  - Home and Community Based Waiver (HCBS) case management
- Behavioral Health
  - Behavioral Health Homes (Stage B), TCM, Community Integration

Coordination of the Full Continuum of Care

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Leverage DHHS Care Coordination Resources:

- **Health Homes (Stage A)**: Accountable Communities that include a Health Home primary care site must extend an invitation to the partnering Community Care Team
- **Behavioral Health Homes (Stage B)**: Accountable Communities that include a Behavioral Health Home (Stage B) primary care site must extend an invitation to the partnering Behavioral Health Home Organization

Coordination of the Full Continuum of Care

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Community Partnerships: Accountable Communities must develop contractual or informal partnerships with

- All hospitals in the proposed service area
- Public Health Entities

And are encouraged to engage with other community-based organizations.

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Shared Savings/ Loss Models

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	Model I	Model II
Minimum Attributed Members	1000	2000
Minimum Savings/ Loss Rate	+/- 2% (savings back to first $1)	+/- 2% (savings back to first $1)
Shared Savings Rate	50% max depending on quality	60% max depending on quality
Performance Payment	Performance payments capped at 10% of TCOC	Performance payments capped at 15% of TCOC
Shared Loss Rate	No downside risk	Shared loss payment percentage will vary based on quality performance, ranging from 40-60%.
Loss Recoupment Limit		•Yr 1: No downside risk •Yr 2: Risk capped at 5% TCOC •Yr 3: Risk capped at 10% TCOC

Model I & II Shared Savings Example For Accountable Community ABC

Benchmark TCOC for Yr 1: $500

Actual TCOC for Yr 1: $390

Risk Corridor: $500 * 0.98 = $490

Savings: Savings exceed the 2% risk corridor, so there will be shared savings.

Eligible savings to share: $500 - $390 = $110

Assuming a 100% score on its quality metrics, the shared savings are:

	Model I	Model II
Shared Savings Rate	$110 * 50% = $55 PMPM	$110 * 60% = $66 PMPM
Performance Payment Cap	$500 * 10% = $50 PMPM	$500 * 15% = $75 PMPM
Savings Received	$50 PMPM	$66 PMPM

Model II Shared Loss Example For Accountable Community XYZ, Years 2 & 3

Benchmark TCOC: $500

Actual TCOC: $570

Risk Corridor: $500 * 1.02 = $510

Loss: Loss exceeded the 2% risk corridor, so there will be shared losses.

Eligible loss for which liable: $570 - $500 = $70

Assuming a 100% score on its quality metrics, the shared loss is:

	Model II (Year 2)	Model II (Year 3)
Shared Loss Rate (1-shared savings rate)	$70 * (1-60%) = $28 PMPM	$70 * (1-60%) = $28 PMPM
Loss Recoupment Limit	$500 * 5% = $25 PMPM	$500 * 10% = $50 PMPM
Loss for which liable	$25 PMPM	$28 PMPM

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"Core" Services for Inclusion in TCOC

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Accountable Communities must be accountable for the cost of all "core" services. AC's need not directly provide all services.

Inpatient	Audiology
Outpatient	Podiatry
Physician/ PA/ NP/ CNM	Optometry
FQHC, RHC, Indian Health Services, School Health Centers	Occupational, Physical and Speech Therapy Chiropractic Services
Primary Care Case Management (PCCM), Health Homes	Behavioral Health Services
Pharmacy	Rehabilitative & Community Support Svcs
Hospice	Inpatient Psychiatric
Home Health	Outpatient Psychiatric
Lab & Imaging	Behavioral Health Homes
Ambulance	Targeted Case Management
Dialysis	Early Intervention
Durable Medical Equipment	Family Planning

Services Optional for Inclusion in TCOC

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Optional Service Costs

In addition to the core services, AC’s may choose to include the cost of the following services in their TCOC:

Dental
Children’s Private Non-Medical Institution (PNMI)
Long Term Services & Supports
Home and Community Based waiver services
Nursing Facilities
Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ MR)
Assisted Living Services
Adult Family Care
Adult Private Duty Nursing
Children's Private Duty Nursing
Personal Care Assistance (PCA)
Day Health Services

Services, not Members, may be excluded

Services Excluded from TCOC

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Excluded Services

The following services are excluded from the TCOC calculation:

Service	Reason for Exclusion
Private Non-Medical Institutions (non-children's only)	Restructuring service
Non-Emergency Transportation	Separate, capitated system
Other Related Conditions Home and Community Based Waiver	New service (no cost basis)

Services, not Members, may be excluded

Attribution Methodology

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1. Members with 6 mo continuous eligibility or 9 mo non-continuous eligibility
2. Members enrolled in a Health Home practice that is part of an Accountable Community
3. Members not captured in 2 who have a plurality of primary care visits with a primary care provider that is part of an AC
   - Evaluation and Management, preventive, and wellness services, Federally Qualified Health Centers, Rural Health Centers
4. Members not captured in 2 or 3 who have 3 or more ED visits with a hospital that is part of an AC.

Data Adjustments

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In order to calculate the projected benchmark TCOC, the baseline TCOC amount is adjusted for:

- Policy changes
- Trend
- Risk

Dollars will be removed above threshold claim caps for members based on AC size.

Accountable Community Size (Attributed Members)	Annual Enrollee TCOC Claims Cap
Small = 1,000-2,000	$50,000
Medium = 2,000–5,000	$200,000
Large = 5,000+	$500,000

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Quality Framework in Progress

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Criteria for Selection of Metrics:

- Metrics measure success of the Triple Aim
- Maximize alignment of metrics with currently reported metrics in the State and nationally (MSSP, Health Homes, PTE, IHOC, etc) to the extent feasible and appropriate
- Address populations and needs prevalent in Medicaid
  - Children
  - Behavioral health
  - Long Term Services & Supports
  - Chronic conditions
- Address performance area meaningful for Maine's population, healthcare processes and structure
- Measure set reflects a mix of process and outcomes measurement, and short and long term impacts
- Minimize reporting burden to providers, to extent feasible
  - Keep number of metrics to a reasonable number
  - Preference for claims-based measures
- Measure performance (vs reporting only) beginning in first performance year
- Incorporate measures that safeguard against "creaming, skimping and dumping" of patients (ie, focusing on lower cost patients at the expense of higher need patients)
- Metrics are clinically meaningful
- Measures highlight differences between providers

Quality Domains

- Patient Experience
- Care Coordination/ Patient Safety
- Preventive Health
- At Risk Populations

DRAFT Quality Measures to Date (In Progress)

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Measure	Alignment	Reporting
Patient Experience of Care • Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)	Maine Quality Forum Initiative	Provider Reporting only in first year, all-payer
Care Coordination/ Patient Safety • Ambulatory Care Sensitive Conditions Admissions • All Condition Readmissions • Non-Emergent ED Use • Imaging for low back pain • Follow-up After Hospitalization for Mental Illness • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • LDL testing in patients with atypical antipsychotics • Use of High-Risk Medications in the Elderly • Percent of PCPs qualify for EHR Program Incentive Payment	• Health Homes • Comparable to Medicare Shared Savings Program	• Claims • State collection and reporting (EHR measure)

DRAFT Quality Measures to Date (In Progress)

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Measure	Alignment	Reporting
Preventive Health (Adults Only) • Influenza immunizations (adults) • Mammography Screening	• HealthInfoNet • Comparable to Medicare Shared Savings Program	• Reporting only yr 1 • Claims
Preventive Health (Children Only) • Developmental Screening 0-3 • Well Child Visits ages 3-6, 7-11, 12-20	• Maine Improving Health Outcomes for Children (IHOC) • Maine Health Homes Measures	Claims
At-Risk Populations • Diabetes HEDIS measures (HbA1c, Eye Care, LDL, Nephropathy) • Asthma Medication Management • Spirometry Testing for COPD • Children's out of home placement rate	• Health Homes • Comparable to Medicare Shared Savings Program	Claims
To Be Determined • *Maternal Health* • *Long Term Services & Supports*		Claims

Draft Quality Framework, cont.

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

- The proportion of measures scored for performance, vs reporting, increases each year
- Equal weighting across domains
- Setting a minimum attainment level (Medicare = 30th percentile) below which Accountable Communities would not receive shared savings/ may be placed on a corrective action plan.
- Selecting a benchmark for Maine Accountable Communities (state, national, relative performance or performance against fixed benchmarks)

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Data Feedback to Providers

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Reports to Accountable Community providers will include the following:

- Utilization report for high risk members (monthly)
- Attributed member roster (quarterly)
- Actual TCOC compared to benchmark (quarterly)
- Claims-based quality performance measures for attributed population (quarterly)

Under the State Innovations Model (SIM) grant, the State will also be providing real-time notifications of Members' Emergency Department visits, Inpatient Admissions, and missed labs to Accountable Community Care Managers.

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Application Process

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- RFA is posted on DHHS VBP Accountable Communities webpage: http://www.maine.gov/dhhs/oms/vbp/accountable.html
- Application will be completed on SurveyMonkey
- Application will be open for 2 months
- Applications must identify by due date:
  - Lead entity
  - Primary Care providers (used for attribution)
- Applicants have until contract finalization to identify partnerships to meet Continuum of Care requirements
- Eligible applicants will be notified within two weeks of application due date of the Department's desire to enter into contract negotiations

Notice of Interest/ Intent Survey

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Facilitation of Provider Identification to form Accountable Communities

With consent, the Department will post:

- Respondent contact information
- Respondent's Region(s) of location
- Respondent's Intent to apply/ Potential interest in applying
- Any kinds of provider organization(s) being sought by respondent
- Region(s) where respondent is seeking provider organization(s)
- Respondent's provider type and/ or services delivered

Notice of Interest/ Intent Survey Link:
https://www.surveymonkey.com/s/MaineCareACInterest

Thank you!

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