



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

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MaineCare

Value-Based Purchasing Strategy Members Standing Committee Meeting

May 17, 2012

Update on Value-Based Purchasing Strategy Work



- **February 10:** Request for Information (RFI) results were posted online.
- **February and March:** The Department's Design Management Committee (DMC) met every week. They worked on the Accountable Communities and Health Homes projects.
- **May-early June:** The DMC is meeting again weekly to incorporate feedback from the **April public forums** into the initiative.

The DMC includes people from the Offices of:

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

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

- In April, the Department held four public meetings to discuss the Accountable Communities project.
 - **Bangor:** Monday, April 2
 - **Lewiston:** Tuesday, April 17
 - **Portland:** Thursday, April 19
 - **Augusta:** Wednesday, April 25
- Each public meeting had approximately 50-60 attendees.

CMS Health Homes – Affordable Care Act Section 2703

CMS’ “pre-approved” chronic conditions include:

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity



Health Homes: Additional Chronic Conditions Maine is Proposing to CMS

All populations:

- Chronic Obstructive Pulmonary Disease
- High blood pressure
- High cholesterol
- Tobacco use
- Developmental Disability (ID and Autism Spectrum)
- Acquired Brain Injury (ABI)

Children only:

- Seizure disorders
- Cardiac & circulatory congenital abnormalities

How do we define these chronic conditions? and how will we identify eligible members?

- MaineCare will look at claims data for people with certain diagnoses and/or receiving certain services.
- Health Home practices can identify members who are eligible to be part of the health home through electronic medical records. Practices can look at the records to see who is overweight, who smokes, etc.



Stage A Proposed Mental Health Diagnoses

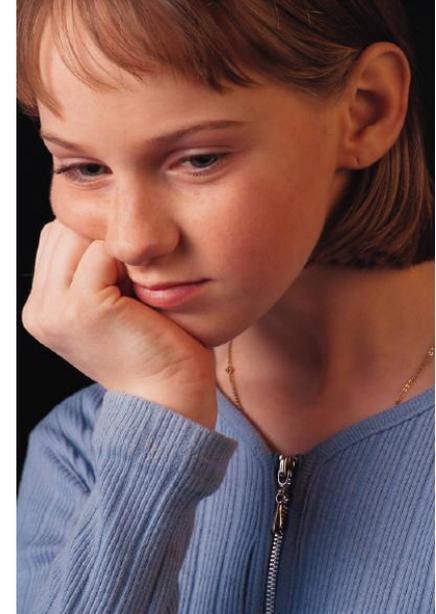
- Stress and adjustment disorders:
 - Acute reaction to stress
 - Adjustment reaction
- Personality disorders
- Disturbance of Conduct
- Disturbance of Emotions
- ADHD Hyperkinetic
- Neurotic Disorders
- Depression not elsewhere specified
- Other mental health disorders includes:
 - Sexual deviations and disorders
 - Physiological malfunction arising from mental factors
 - Special symptoms or syndromes, not elsewhere specified
 - Specific non-psychotic mental disorders due to organic brain damage
 - Psychotic factors associated with diseases specified elsewhere

Stage B Proposed Diagnoses for Serious Mental Illness in Adults

- Severe Mental Illness (SMI) Includes:
 - Schizophrenic Disorders
 - Major Depression
 - Bipolar and other affective disorders including:
 - » Manic Disorders
 - » Bipolar Affective Disorders
 - » Other and unspecified manic-depressive disorders
 - » Other and unspecified affective psychoses
 - Other psychoses including:
 - » Transient organic psychotic conditions
 - » Other organic psychotic conditions (chronic)
 - » Paranoid states or delusional disorders
 - » Other non-organic psychoses

Stage B Proposed Diagnoses for Serious Emotional Disturbance in Children

- Children using the following services and identified by procedure codes used in SFY2010:
 - Home & Community-Based Treatment (§65)
 - Children’s ACT (§65)
 - PNMI Stay (§97)
 - Inpatient Psychiatric Stay (§45 with Dx and §46)

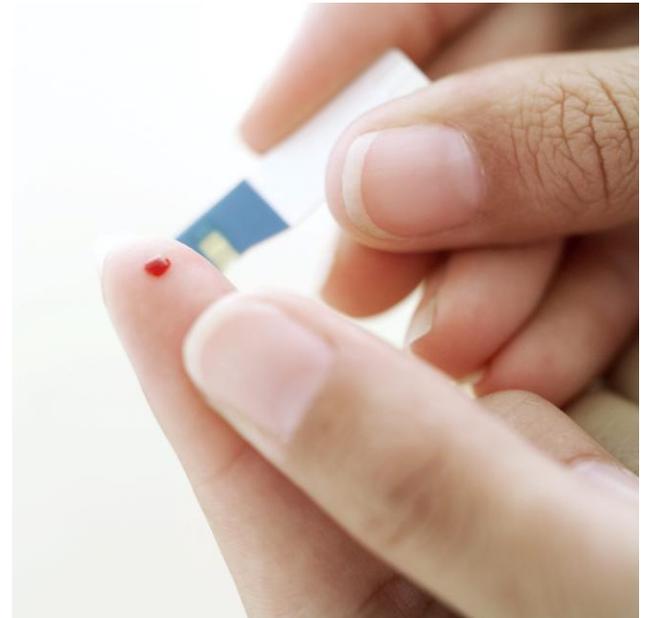


Chronic Condition Identification

- ICD-9 code list developed from various reference sources including:
 - AHRQ CCS
 - AHRQ MCC (Hwang)
 - Acquired Brain Injury workgroup
 - MaineCare Multiple Chronic Conditions project
 - NRI
 - MaineHealth Clinical Improvement Registry (CIR)
- Any mention of the diagnosis on any claim type will be considered.

Chronic Condition Identification (cont)

- Additionally, service use will be used to identify:
 - Developmental Disability
 - » MR Waiver Service Use (§ 26)
 - » ICFMR Service Use (§40)
 - Acquired Brain Injury
 - » Rehabilitative Service Use (§ 102)
 - Diabetes
 - » Use of Insulin



Identification of Members At-Risk for a Second Chronic Condition

A member with one of the following chronic conditions is automatically defined as at risk of another condition:

- Mental Health
- Substance Abuse
- Diabetes
- Heart Disease
- Obesity
- COPD
- Hypertension
- Hyperlipidemia
- Tobacco Use
- Developmental Disability
- Cardiac and circulatory abnormalities

A member with ABI, Seizure Disorder, or Asthma is not considered at risk for another condition.

CMS Health Homes – Required Measures



- Core Set of Quality Measures:
 - Adult Body Mass Index assessment (to see if member is overweight)
 - Ambulatory Sensitive Condition admission rate
 - Care transitions record transmitted to Primary Care Physician (within 24hrs)
 - Follow up after mental health admission
 - All-cause 30-day readmission rate
 - Depression screening & follow up
 - Treatment for alcohol/drug dependence
- State-Specific Goals & Measures:
 - Must set goals for Health Homes that can be measured (For example- less Emergency Department visits)
 - Must choose measures that show if a goal is reached

Proposed Maine-Specific Goal Areas & Quality Measures

1. Reduce inefficient healthcare spending:
 - ED admissions- overall and non-emergent
 - Non evidence-based imaging use
2. Improve children's health:
 - Well child visits
 - Developmental screening
 - *Behavioral health measure, TBD (ADHD or antipsychotic drug use)*
 - *Potential SCHIP survey re patient experience of care TBD*
3. Improve chronic disease management:
 - HEDIS measures on diabetes, cardiovascular, COPD, asthma
 - Chronic disease admission rate
4. Ensure evidence-based prescribing:
 - Percent participation in Prescription Monitoring Program
 - *Psychotropic drug use measure TBD*
 - *Med reconciliation measure TBD*
 - *Potentially avoidable prescription practices measure TBD*



Health Homes Timeline

Feb-Apr 2012:
Practices apply
to be part of
Health Homes

Fall 2012:
Stage A Health
Homes start

June 2012:
Community Care
Teams apply to be
part of Health
Homes

Winter 2013:
Stage B
Health
Homes start
for members
with SPMI &
SED

Lining up Accountable Communities with Medicare ACOs: Proposed Model



- Many providers in Maine are planning to be part of one of Medicare's ACO programs. The two ACO programs are the Medicare Shared Savings Program (MSSP) or the Pioneer ACO.
- MaineCare will match a lot of its Accountable Communities requirements with the MSSP, to make participation easier for providers.
- Under both Accountable Communities and the MSSP:
 - Patients keep their choice of doctors.
 - Patients are assigned to the ACO where they get most of their primary care services.
 - ACOs can share in savings they find in their patients' care.
 - ACOs can choose to:
 - » Share up to 50% of savings.
 - » Share up to 60% of savings. With this choice, they will share up to 10% of costs if the care costs more money than planned.

Stakeholder Feedback re Community Participation

Many providers, especially behavioral health organizations, that attended the forums in April were concerned that larger hospitals and health systems would want to do everything themselves. They fear that large hospitals and health systems would not work with community organizations and providers or let them be part of the Accountable Community.



Original Proposed Accountable Community Requirements Focused on Collaboration



Accountable Communities must:

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

Community Collaboration: What else Should the Department Do?

- Here are some ideas:
 - Conduct forums and outreach through the Department’s offices to make sure providers are aware of and understand the Accountable Communities Initiative.
 - Require that Accountable Communities involve community organizations in AC leadership.
 - Let providers know what other organizations are interested in being part of different Accountable Communities, so they can “find” each other.
 - Provide learning opportunities through Department offices to help Accountable Communities work well within the community.
- **Other ideas?**

Accountable Communities: Choosing “Core Services”



- The Department has to choose what services the AC will be responsible for. The AC will manage the cost and quality of these services.
- The Department can't make providers responsible for all services because there are some services providers don't have control over. For example, providers don't decide how much waiver services cost or who should get those services.
- The Department plans to have a list of “core services” that all Accountable Communities will be responsible for. The Accountable Communities can include services that are not on the “core” list if they want to.
- The question the Department has tried to answer is: “For which services should we expect most provider organizations to improve health and bring down costs by coordination of care?” Coordination of care means all doctors, specialists, hospitals, and others have to work together.

Original Accountable Communities “Core” Services Recommendations



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

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

Core:

- » Inpatient
- » Outpatient
- » Emergency Department
- » Physician
- » Pharmacy
- » Mental Health
- » Substance Abuse

Optional:

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

Stakeholder Recommendations & Questions: Core Services

- Stakeholder concern:
 - PNMI: If PNMI and/or residential treatment are not a part of the core services, AC providers may try to send members to PNMI/ residential treatment. By doing this, the members don't cost the AC as much but the members may not need the residential level of care and would be more expensive for the state.
 - DMC Response: The DMC appreciates this concern and would like to have the goal of including residential treatment and other services currently under PNMI in the AC core services. However, we have to wait to see what PNMI services will look like in the future. Providers need to deliver these services for a year so we know exactly how much they cost. We need to know how much the services cost before we can expect ACs to save money on them.

Stakeholder Recommendations & Questions: Core Services Continued

- Stakeholder questions:
 - Will the following services be included as core services?
 - » School-based services
 - » Home Health & Hospice
- DMC Response:
 - Many providers of school-based services are the same providers of services outside of the school. However, school-based services often provide access to services for kids that might not get any services otherwise. The Department needs to discuss if including school-based services under the AC core services could make it harder for kids to get services.
 - Home Health & Hospice should be included under the core services. They are short term services that can reduce other hospital-related costs for members.
- DMC decision: We need to have three categories of services: “excluded” as well as “core” and “optional.” This is because transportation will have a separate risk-based system and there is too much changing with PNMI to include it right now.

AFTER FEEDBACK: Accountable Communities

“Core” Services Recommendations



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

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

Core:

- » Inpatient
- » Outpatient
- » Emergency Department
- » Physician
- » Pharmacy
- » Mental Health
- » Substance Abuse
- » **Hospice**
- » **Home Health**

Optional:

- » Waiver
- » Nursing Facilities (except physical, occupational and speech therapy that occurs at the facilities)
- » Targeted Case Management
- » Private Duty Nursing Services
- » Dental

Excluded:

- » **Transportation**
- » **Private Non-Medical Institutions (PNMIs)**

Accountable Communities Quality Measures Recommendation

- Align with the 33 MSSP performance measures:
 - Start with claims-based measures
 - Include clinical outcomes once there is an easier way to collect them
- Add required Health Homes measures that address behavioral health:
 - Follow-up after mental health admission
 - Depression screening & follow up
 - Treatment for alcohol/drug dependence
- Align children's health measures with the proposed additional Health Homes measures/ Improving Health Outcomes for Children (IHOC):
 - Well child visits (pediatrics)
 - Developmental screening (pediatrics)

Accountable Communities Timeline

