



# **MaineCare**

## **Value-Based Purchasing Strategy Portland Regional Forum**

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**September 26, 2013**

**<https://www.maine.gov/dhhs/loms/vbp>**

# Agenda

- Welcome 9:00 – 9:05
- Behavioral Health Homes 9:05 – 10:00
- State Innovation Model Context & Impact 10:00 – 10:30
- Break 10:30 – 10:45
- Accountable Communities 10:45 – 12:30



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Department of Health and Human Services*

*Paul R. LePage, Governor*

*Mary C. Mayhew, Commissioner*

# ***Behavioral Health Homes***



# *Agenda*

- What is a Behavioral Health Home
- Who can participate
- Benefits of the service model
- Consumer choice
- Provider qualifications and reimbursement
- Enrollment
- Next steps



# ***What is a Behavioral Health Home?***

- A new service being offered by MaineCare in January, 2014
- Per the Affordable Care Act, a Health Home offers:
  - Care Management of physical and mental health needs
  - Care Coordination and health promotion
  - Help in transitional care, including follow up
  - Support to help self-manage physical and mental health conditions
  - Referral to other services
  - The use of Health Information Technology to link services



# *Maine's Health Homes* *"Stage A"*

**Primary Care**



**Community Care Teams (CCTs)**



**Health Homes**

*Serves adults and children with  
chronic health conditions*



# *Maine's Behavioral Health Homes – "Stage B"*

**Licensed Community  
Mental Health Provider**



**A Primary Care Practice**

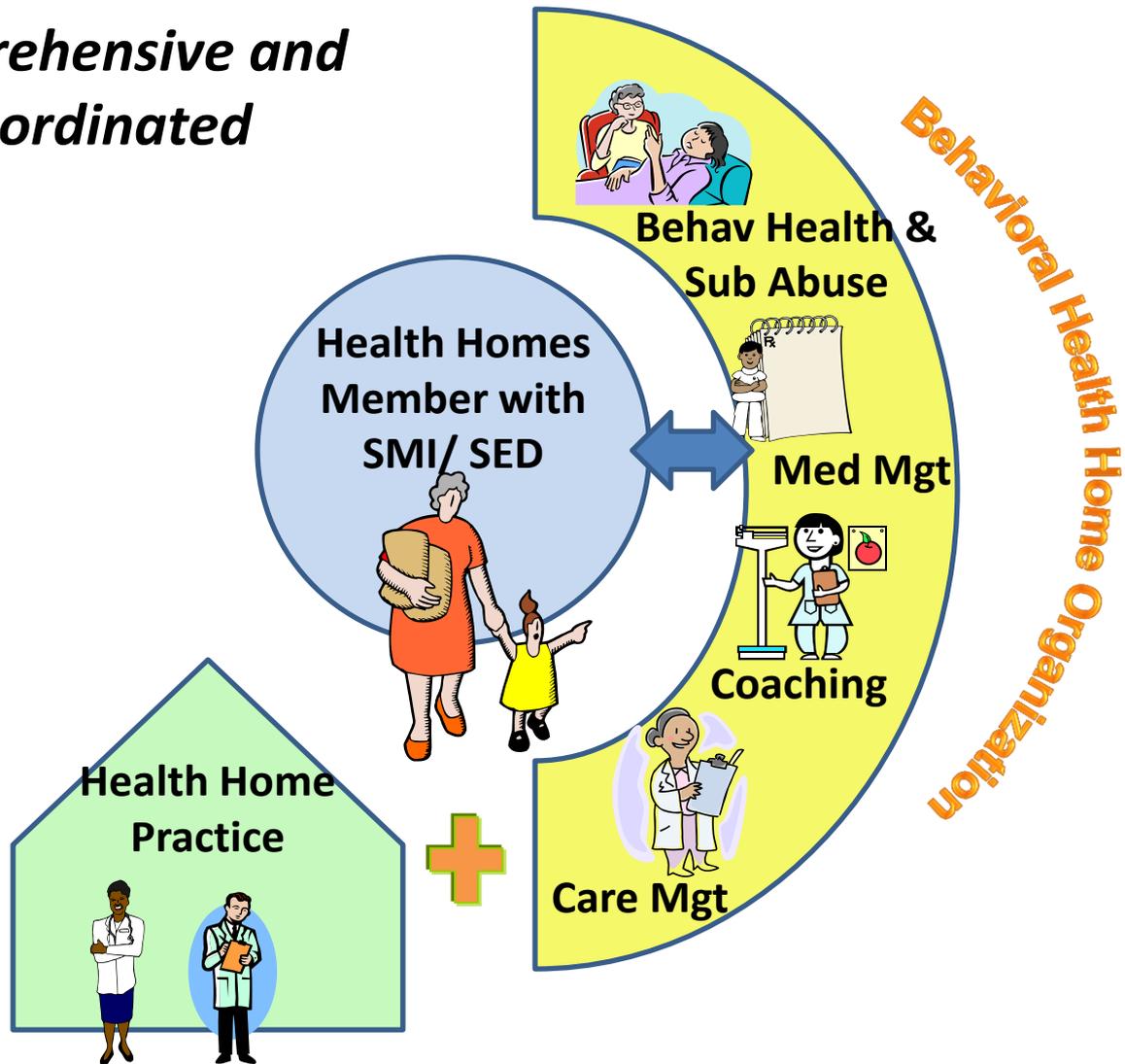


**Behavioral Health Homes**

*Serves adults and children with significant behavioral health needs*

# *Behavioral Health Homes:*

*Comprehensive and  
Coordinated*





# ***Who Can Participate in Behavioral Health Homes?***

- Adults with Serious Mental Illness
- Children with Serious Emotional Disturbance

***This initiative closely aligns with current eligibility for community mental health services. People eligible for the following services will also generally be eligible for Behavioral Health Homes:***

- Adults: Community Support Services
- Children: Targeted Case Management



# *Why Behavioral Health Homes?*

- 20% of MaineCare members incur 87% of cost
- This 20% often have more than one long-term condition, such as:
  - **COPD**
  - **Diabetes**
  - **Mental Illness**
  - **Heart Disease**
  - **Substance Abuse**



# *Why Behavioral Health Homes?*

- Individuals with serious behavioral health conditions often have higher rates of other chronic illness: asthma, diabetes, heart disease
- When services are not coordinated:
  - People don't get the care they need, when they need it
  - No one provider is managing all the care
  - People get overwhelmed trying to manage everything they need to do to stay healthy by themselves

***Because of this, people often end up using the hospital or ER for things that could be prevented with better care and care coordination***



# *Why Behavioral Health Homes?*

- Federal commitment and financial incentives
- Mainecare has already developed a Health Home for people with chronic physical conditions (Stage A)
- Behavioral Health Homes will address the concerns of members with significant behavioral health needs:
  - Managing physical and mental health conditions together
  - Building strong relationships with primary care
  - Maintaining a recovery focus
  - Addressing co-occurring disorders and trauma-informed care



# *What are the benefits of a Behavioral Health Home?*

- PCP and mental health services work together to provide better care
- Team-based, comprehensive approach:
  - nurse care manager
  - peer support specialist
  - licensed clinical social worker
  - health home coordinator
- Manage health, wellness, and prevention services
- Provide peer services and other supports
- Case management; help with housing, transportation, etc.



# ***How does this affect other MaineCare services?***

- Services currently received through targeted case management or community integration will be received through the BHH
- Certain other services will be considered a duplication; members can choose which service they would like to receive
- Members will choose a PCP that partners with their behavioral health organization
- Members can stay with their current services, or try a Behavioral Health Home.
- People can opt out of the service at any time



# *What are the provider qualifications?*

## Mental health providers must:

- Be licensed community mental health providers
- Provide medication management OR have an MOA with a MM provider
- Have expertise in co-occurring disorders
- Adopt an EHR within a timeframe specified by MaineCare (no more than two years after approval as a Behavioral Health Home Organization).
- Participate in the Behavioral Health Home Learning Collaborative
- Comply with team-based care model
- Partner with at least one qualified practice
- Commit to meeting and reporting on Core Expectations, including enhanced access to care, comprehensive consumer/family directed care planning, commitment to reducing waste and unnecessary health care spending, integration of Health Information technology



# *What are the provider qualifications?*

## Primary care providers must:

- Complete a Health Home primary care practice application and be approved by MaineCare
- Have implemented an Electronic Health Record (EHR) system.
- Provide Twenty-Four Hour Coverage, as defined in MaineCare Benefits Manual, Ch. VI - Section 1: Primary Care Case Management.
- Have received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition by date determined by MaineCare
- Have established member referral protocols with area hospitals, which include coordination and communication on enrolled or potentially eligible HHP members.
- Must partner with a community mental health provider that is approved to deliver Behavioral Health Home services.
- Commit to Core Expectations for Health Home practices



# *How will providers be reimbursed for services?*

**Payment is structured to support both the PCP and the community mental health provider to coordinate care:**

Primary Care practice	\$15/PMPM
Behavioral Health Organization	\$270.00/PMPM for children \$300.00/PMPM adults

**Mainecare is also proposing to CMS an additional \$35.00 PMPM during the first three months of start up for additional engagement, education, and outreach**



# ***What are the assumptions built into the rates?***

Staff	FTE per 200 members
Clinical Team Leader (LCSW)	0.75
HH Coordinator (MHRT/OCFS equivalent)	7/8
Peer Specialist	1
Nurse Care Manager	Child: 0.50 Adult: .75
Medical Consultant	0.02
Psychiatrist	0.02

***assumptions also include 30% fringe and 30% administrative overhead***



# ***What are the assumptions built into these rates?***

- Different service expectations:
  - Minimum billable service is one hour per member, per month for the Behavioral Health Home organization
  - Services can be delivered by any member of the team and may be in person, by phone, in a group setting
  - Team meetings and collateral contacts included
  - Health promotion and wellness activities
  - Providers serve and bill for all eligible members, not only members that are seen in person
  - Six month review/continuing stay criteria TBD



# ***How will eligible consumers find out about this service?***

- Education and information activities planned for this fall
- Consumers who receive services from a provider that plans to offer BHH services will receive information and written notice about the service and can opt out if not interested
- Consumers who receive services from non-participating providers will receive information about where they can receive the service in their area if interested
- Consumers can continue to receive their current services with their current service provider if they choose
- May decide to join or leave the service at any time



# *Where are we now?*

- Consumer, family, and provider discussion and feedback is ongoing:
  - RFI released in April
  - Discussion and meetings with consumers, providers, families
  - MaineCare convening a BHH Stakeholder Advisory Group
- Application process for interested providers: October, 2013
- MaineCare State Plan Amendment submission: October
- MaineCare Behavioral Health Homes target implementation date: January, 2014



# *More information?*

MaineCare's Value-Based Purchasing Website:

<http://www.maine.gov/dhhs/oms/vbp/>

[kitty.purington@maine.gov](mailto:kitty.purington@maine.gov)

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# ***Maine State Innovation Model (SIM)***



# The 'Maine' SIM

## Theme: Collaboration

*“If you bring the appropriate people together in constructive ways with good information, they will create authentic visions and sustainable responses to issues and opportunities within their communities and organizations.”*

- David Chrislip, Collaborative Leadership Strategist



# *Current System*

- Fee for Service
- Acute events
- Issue of the day
- Episodic care
- Fragmented care
- Driven by patient decision to access(who & when)
- Suboptimal utilization & cost



# ***Maine State Innovation Model (SIM) Hypothesis***

By providing a cohesive, streamlined framework for health care reform and innovation which includes fostering engaged consumers and communities, transforming delivery systems to support accountable and integrated patient-centered primary care, and aligning public and private payment, accountability, quality and data infrastructure, Maine will realize improved quality of care and service while positively impacting health outcomes, population health and cost.



**Maine SIM Triple AIM GOALS:**

- Reduce costs to National Average
- Improve health in key health categories
- Improve patient experience scores
- Increase practice experience participation

**State of Maine as a Leader**

- Public Reporting
- Share best practices
- What's working, what's not?

Public Reporting

**Payer Populations**

- MaineCare
- Medicare
- Maine Community Health Options
- Commercial
- Self-Insured Employers

**PAYMENT REFORM**  
Chair: MHMC

- VBP Development & Learning
- Health Care Cost Workgroup
- Behavioral HCC Workgroup
- VBID

**Data and Analytic Infrastructure**  
Chair: HealthInfoNet

To support:

- Payment Reform
- System Delivery Reform
- Consumer Engagement

**SYSTEM DELIVERY REFORM**  
Chair: Quality Counts

- PCMH, HH & ACO Learning Collaboratives
- Leadership Development Behavioral Health Collaborative

**MAINE CDC**

- Patient Engagement
- Diabetes Prevention
- CHWPilot



## Multi-Payer ACO's

Core measures for  
public reporting and  
value-based payment

## Integrated Patient- Centered Care

Multi-Payer Patient-  
Centered Medical  
Homes, Health Homes  
and Behavioral Health  
Homes

Leadership • Consumer Engagement •  
Community Linkages • Workforce Education

Health Information/ Tools • Access and Analytics



# ***SIM's Relationship to These Existing Models***

***Allows for the development and implementation of the tools and resources necessary to continue transformation from current system to one based on Advanced Primary Care Model***

- Data collection, analysis & reporting
- Workforce development
- Leadership development
- Market shift to fund a new delivery model
- Informed decision making by the patient and the system
- Population health interventions



# ***SIM's Direct Impact***

- PCMH and Health Home model value, based upon both outcome and cost measures, will result in continuation beyond the two year multi-payer pilot and federal enhanced match period. Other payers will join support for practices receiving Medicaid payments only.
- Access to health information for patients and providers will result in acceptance of shared decision making.
- Real-time transparent reporting.
- EHR incentives for Behavioral Health organizations.
- Population health initiatives become part of the healthcare delivery system in a seamless integrated fashion.
- Workforce and leadership development specific to transformation to new healthcare delivery model.



# Timeline

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Model	Pre-existing	Jan-13	Oct-13	Oct-14	Oct-15	Oct-16
SIM		■	■	■	■	■
PCMH	■	■	■	■	■	■
FQHC APC	■	■	■	■	■	■
Health Homes		■	■	■	■	■
Behav Health Homes				■	■	■
Pioneer ACOs	■	■	■	■	■	
MSSP ACOs	■	■	■	■	■	
Commercial ACOs	■	■	■	■	■	■
ACO MaineCare				■	■	■



# *Value of SIM – A Bridge from Here to Tomorrow*

- Helps transition from current fee for service to value-based purchasing.
- Helps transition process from providers intervening with patients on an acute and episodic basis to one in which the patient with a team of healthcare staff take ownership of their disease.
- Coordination of care replaces fragmentation of care.
- Patient becomes member of care team and is continuously engaged.
- Appropriate utilization and cost will be realized.



# *The Triple Aim is realized*

## **Improved patient experience**

- Patient is a partner in managing his/her own health.
- Access to health information that is real time and transparent.
- Workforce that is trained to engage the patient in a new and more effective way.



# *The Triple Aim is Realized*

## **Improved quality of care and service**

- Real time reporting empowers practices to engage the patients in a more meaningful and focused care plan.
- Leadership development and practice learning collaboratives lead to improved health outcomes.
- Integration of Behavioral Health and primary care.



# *The Triple Aim is Realized*

## **Reduced cost**

- A shift in care from episodic to continuous through the primary provider results in less fragmentation.
- Market shift to match care delivery model decreases volume-based incentive.
- Utilization becomes more aligned with pattern of disease management.
- Cost reduced through less need to access high cost delivery services.



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# ***Accountable Communities***

# Accountable Communities Agenda

- Timeline: Looking Back and Forward
- 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 through 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

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

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

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

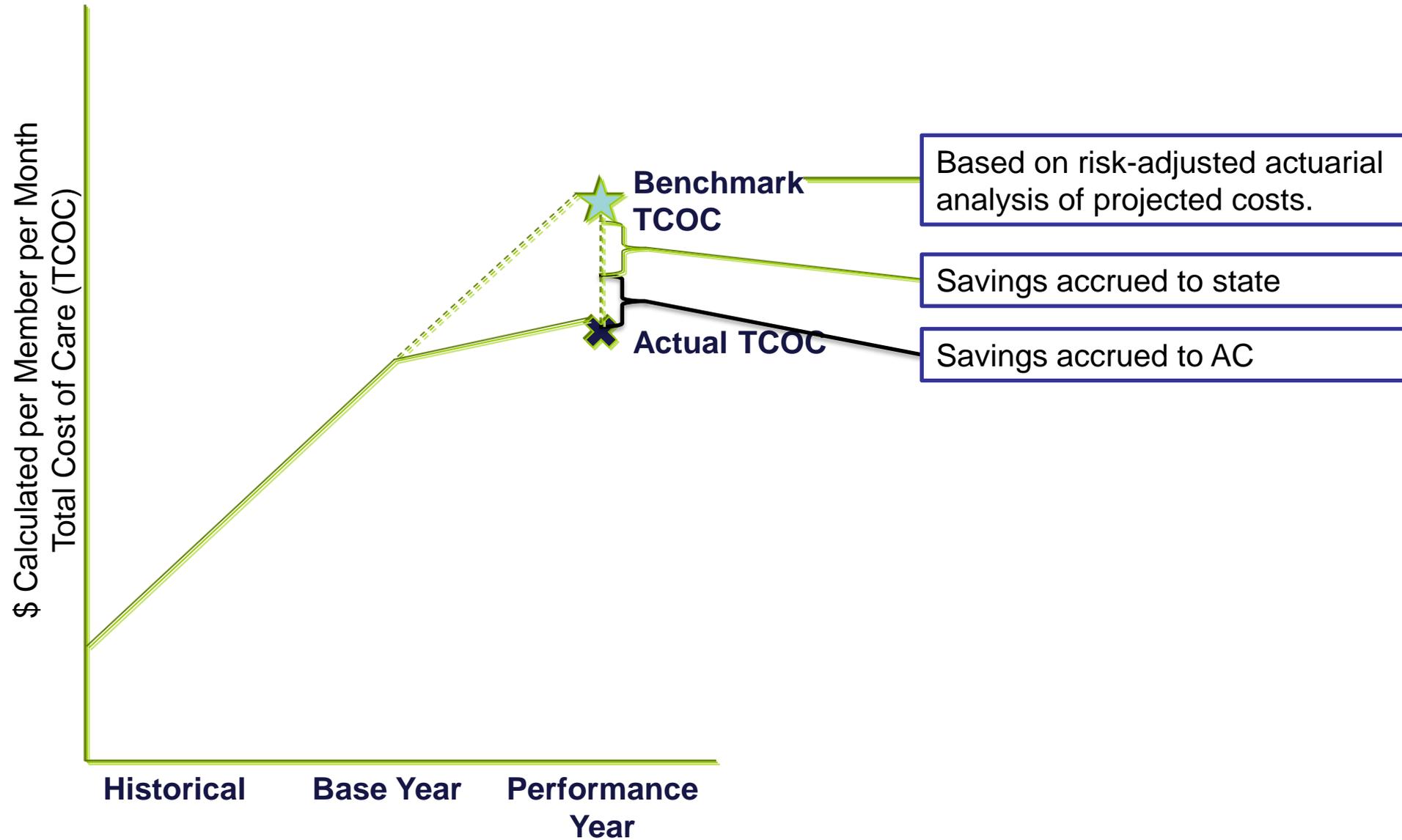
# Strategy to Achieve the Triple Aim

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

- 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?

- 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?

- 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

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

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

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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 midwives, 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.

- 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

## 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

**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

	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% TCOC.
Loss Recoupment Limit		<ul style="list-style-type: none"> <li>•Yr 1: No downside risk</li> <li>•Yr 2: Risk capped at 5% TCOC</li> <li>•Yr 3: Risk capped at 10% TCOC</li> </ul>

# 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

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
Pharmacy	Behavioral Health Services
Hospice	Rehabilitative and Community Support Services
Home Health	Inpatient Psychiatric
Lab & Imaging	Outpatient Psychiatric
Ambulance	Targeted Case Management
Dialysis	Early Intervention
Durable Medical Equipment	Family Planning

# Services Optional for Inclusion in TCOC

## Optional Services

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

Dental	
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

## *Excluded Services*

The following services are excluded from the TCOC calculation:

<b>Service</b>	<b>Reason for Exclusion</b>
Private Non-Medical Institutions	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**

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

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

## 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)

Measure	Alignment	Reporting
<p><b>Patient Experience of Care</b></p> <ul style="list-style-type: none"> <li>• CG CAHPS</li> </ul>	<p>Maine Quality Forum Initiative</p>	<p>Provider Reporting only in first year, all-payer</p>
<p><b>Care Coordination/ Patient Safety</b></p> <ul style="list-style-type: none"> <li>• Ambulatory Care Sensitive Conditions Admissions</li> <li>• All Condition Readmissions</li> <li>• Non-Emergent ED Use</li> <li>• Imaging for low back pain</li> <li>• Follow-up After Hospitalization for Mental Illness</li> <li>• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</li> <li>• LDL testing in patients with atypical antipsychotics</li> </ul>	<ul style="list-style-type: none"> <li>• Health Homes</li> <li>• Comparable to Medicare Shared Savings Program</li> </ul>	<ul style="list-style-type: none"> <li>• Claims</li> <li>• State collection and reporting (EHR measure)</li> </ul>

# DRAFT Quality Measures to Date (In Progress)

Measure	Alignment	Reporting
<p>Preventive Health (Adults Only)</p> <ul style="list-style-type: none"> <li>Influenza immunizations (adults)</li> <li>Mammography Screening</li> <li><i>Maternal Health: prenatal and postnatal visits (TBD)</i></li> </ul>	<ul style="list-style-type: none"> <li>HealthInfoNet</li> <li>Comparable to Medicare Shared Savings Program</li> </ul>	<ul style="list-style-type: none"> <li>Reporting only yr 1</li> <li>Claims</li> </ul>
<p>Preventive Health (Children Only)</p> <ul style="list-style-type: none"> <li>Developmental Screening 0-3</li> <li>Well Child Visits ages 3-6, 7-11, 12-20</li> </ul>	<ul style="list-style-type: none"> <li>Maine Improving Health Outcomes for Children (IHOC)</li> <li>Maine Health Homes Measures</li> </ul>	<p>Claims</p>
<p>At-Risk Populations</p> <ul style="list-style-type: none"> <li>Diabetes HEDIS measures (HbA1c, Eye Care, LDL, Nephropathy)</li> <li>Asthma Medication Management</li> <li>Spirometry Testing for COPD</li> <li><i>Children's out of home placement (TBD)</i></li> <li><i>Long Term Services &amp; Supports (TBD)</i></li> </ul>	<ul style="list-style-type: none"> <li>Health Homes</li> <li>Comparable to Medicare Shared Savings Program</li> </ul>	<p>Claims</p>

# 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 = 30<sup>th</sup> 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)

# Agenda

- Timeline: Looking Back and Forward
- 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

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.

# Agenda

- Timeline: Looking Back and Forward
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# Application Process

- RFA will be issued on DHHS VBP website
- 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

## 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



# Thank you!

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<https://www.maine.gov/dhhs/oms/vbp>