MaineCare
Accountable Communities Overview

May 10, 2021

Accountable Communities (AC) Public Session Agenda

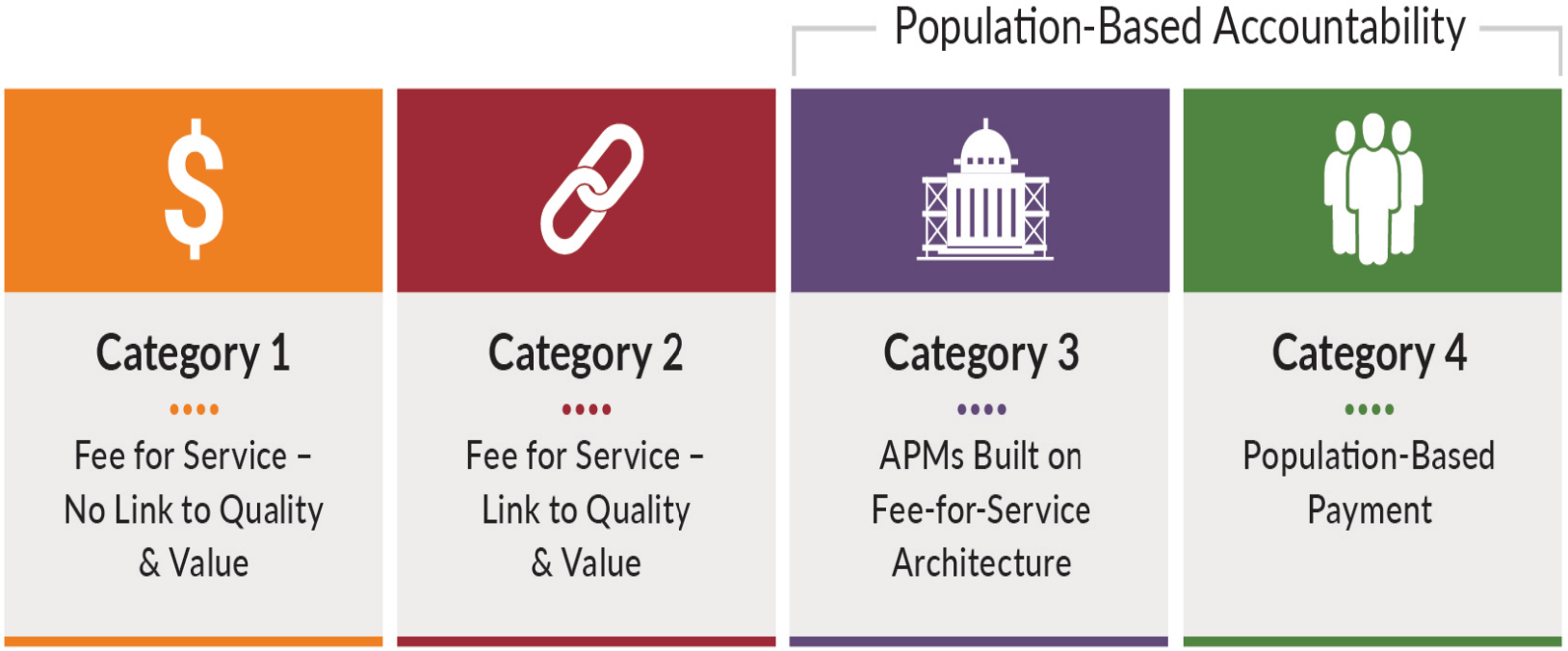
Subject	Slides	Estimated Time
AC Program 101	4-14	10 mins
AC Program Shared-Savings Methodology	15-29	20 mins
AC Program Requirements	30-35	10 mins
Priorities for AC Program Evolution	36-42	15 mins
Questions	43	5 mins

MaineCare Alternative Payment Model (APM) Goal

By the end of 2022,

40% of MaineCare service payments will be paid through APMs

(Category 2C or higher)



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

HCP LAN
Health Care Payment Learning & Action Network

AC PROGRAM 101

FUNDAMENTALS OF MEDICAID ACOs AND MAINECARE'S AC PROGRAM

AC 101: Important Terms

- **Actual Total Cost of Care (TCOC):** Total costs spent across both core and AC elected categories of service throughout the course of the performance year.
- **Benchmark TCOC:** The cost target ACs must beat in order to earn shared-savings.
- **Quality Measures:** Core and elective measures used to assess AC performance; measured against MaineCare non-AC and evidence-based benchmarks.
- **Shared-savings:** A payment mechanism whereby an AC receives an additional payment if spending for attributed patients is lower than a cost target—overall savings are contingent on an ACs performance on quality measures.

AC 101: Program Schematic

CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

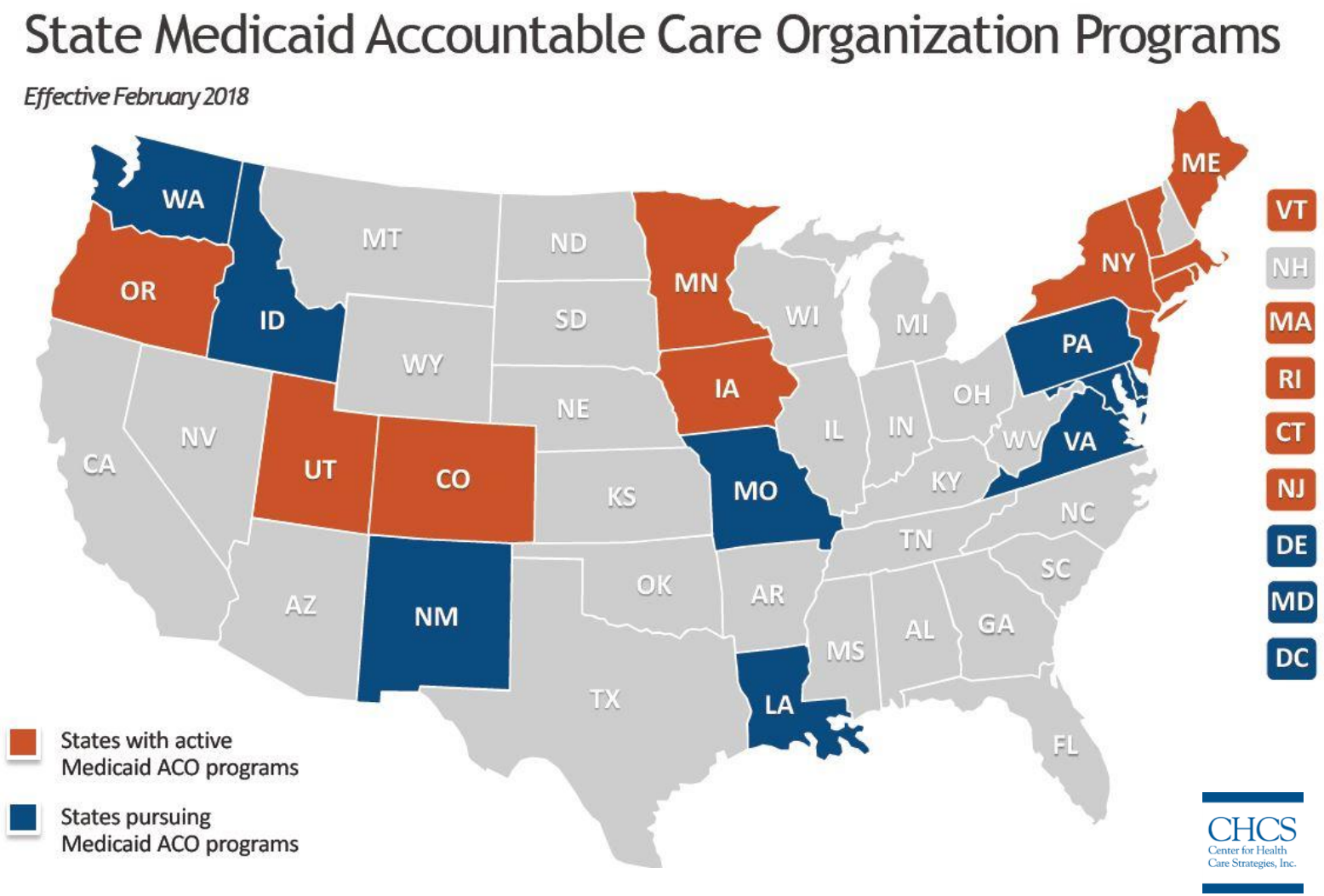
(e.g., shared savings with upside risk only)

B

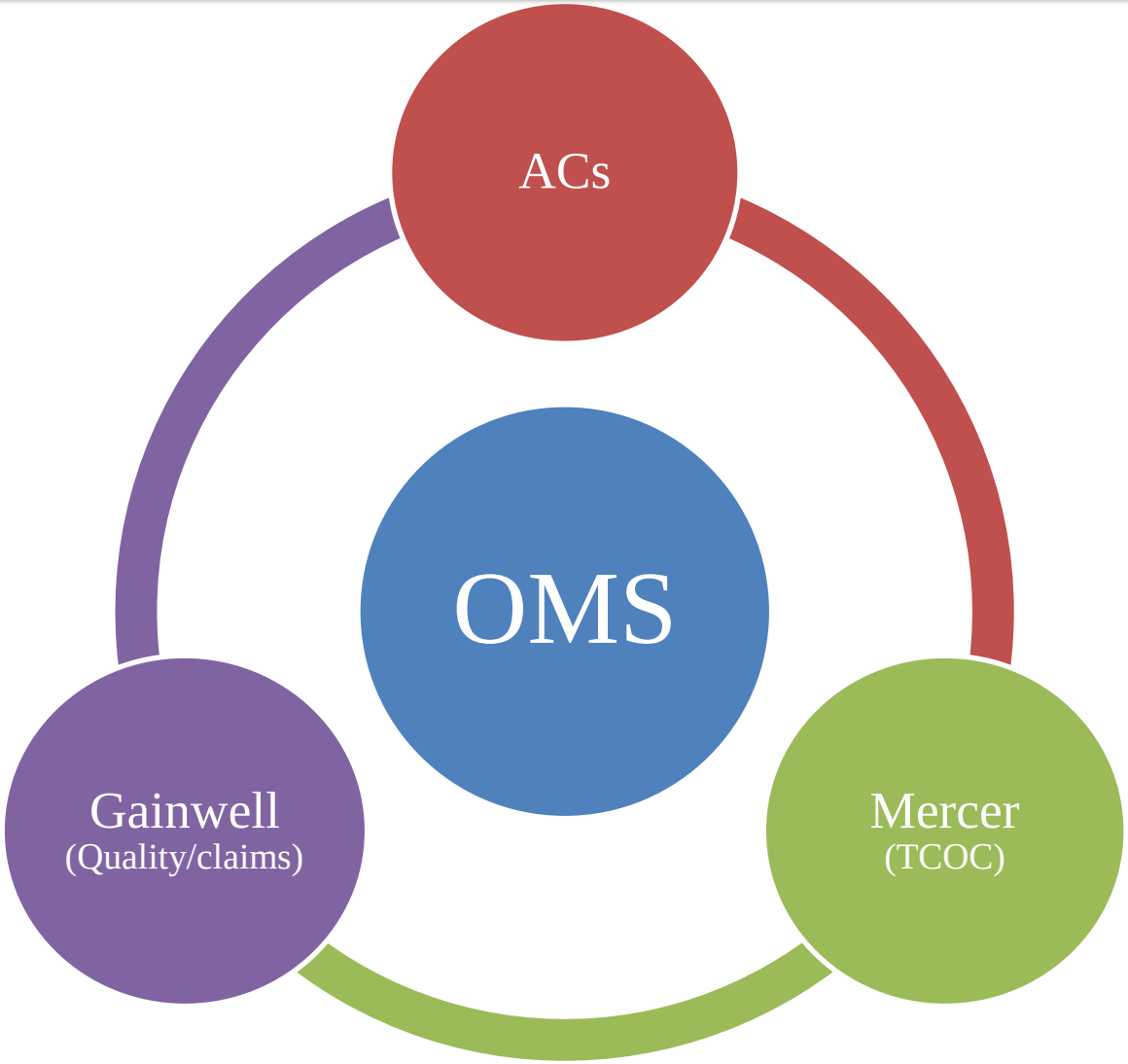
APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

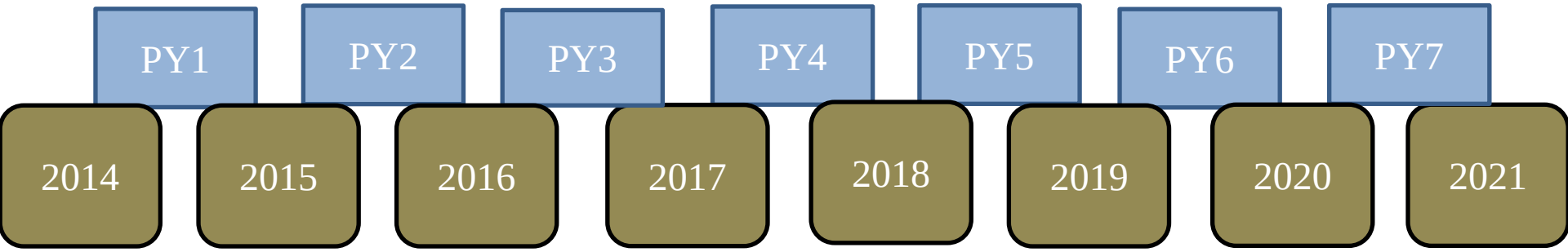
AC 101: Medicaid ACOs



AC 101: Key Players



AC 101: Current ACs and AC Performance Years (PYs)

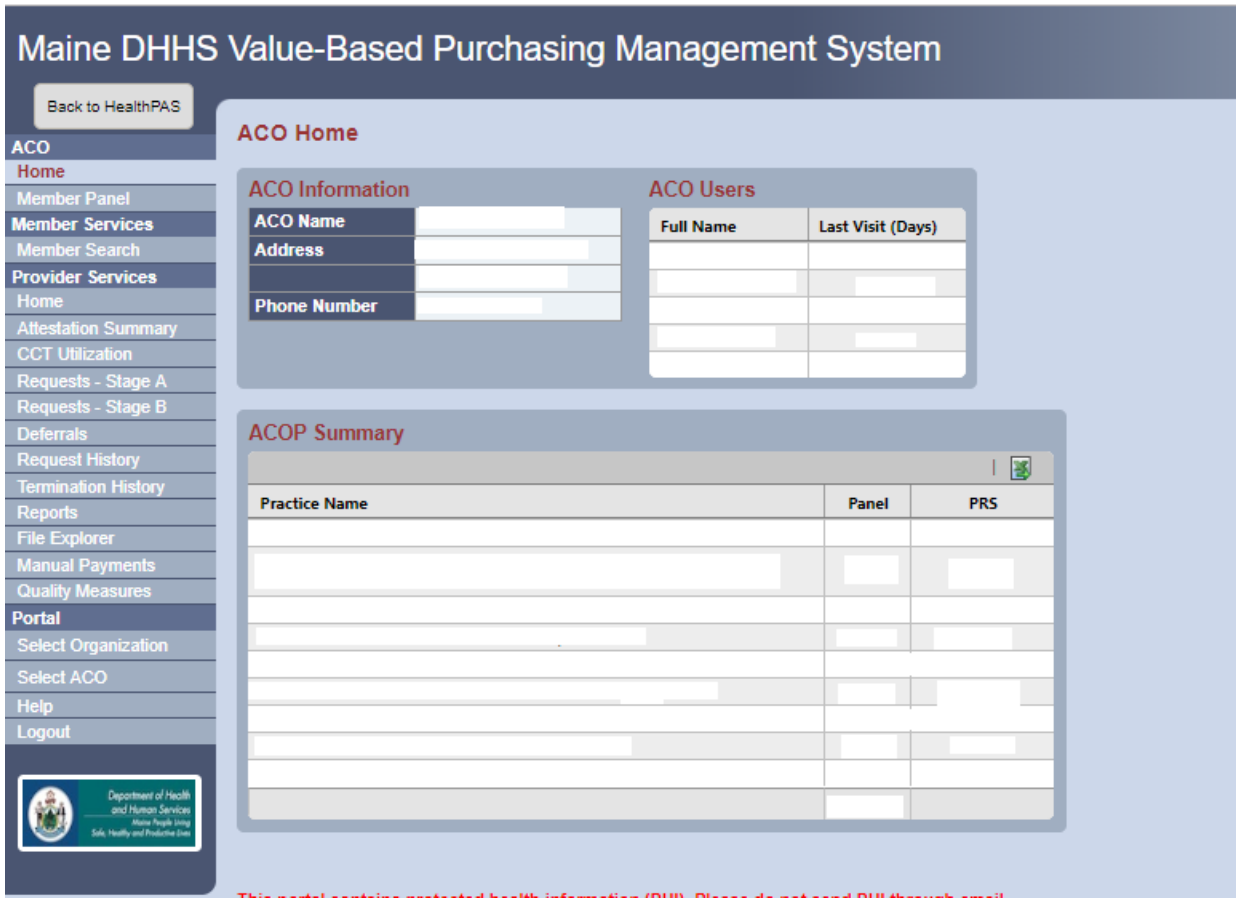


There are four ACs currently in the program:

- Community Care Partnership of Maine, LLC
- Kennebec Regional Health Alliance
- MaineHealth Accountable Care Organization
- Beacon Health, LLC

AC 101: Data Sharing, Convening, and Other Resources

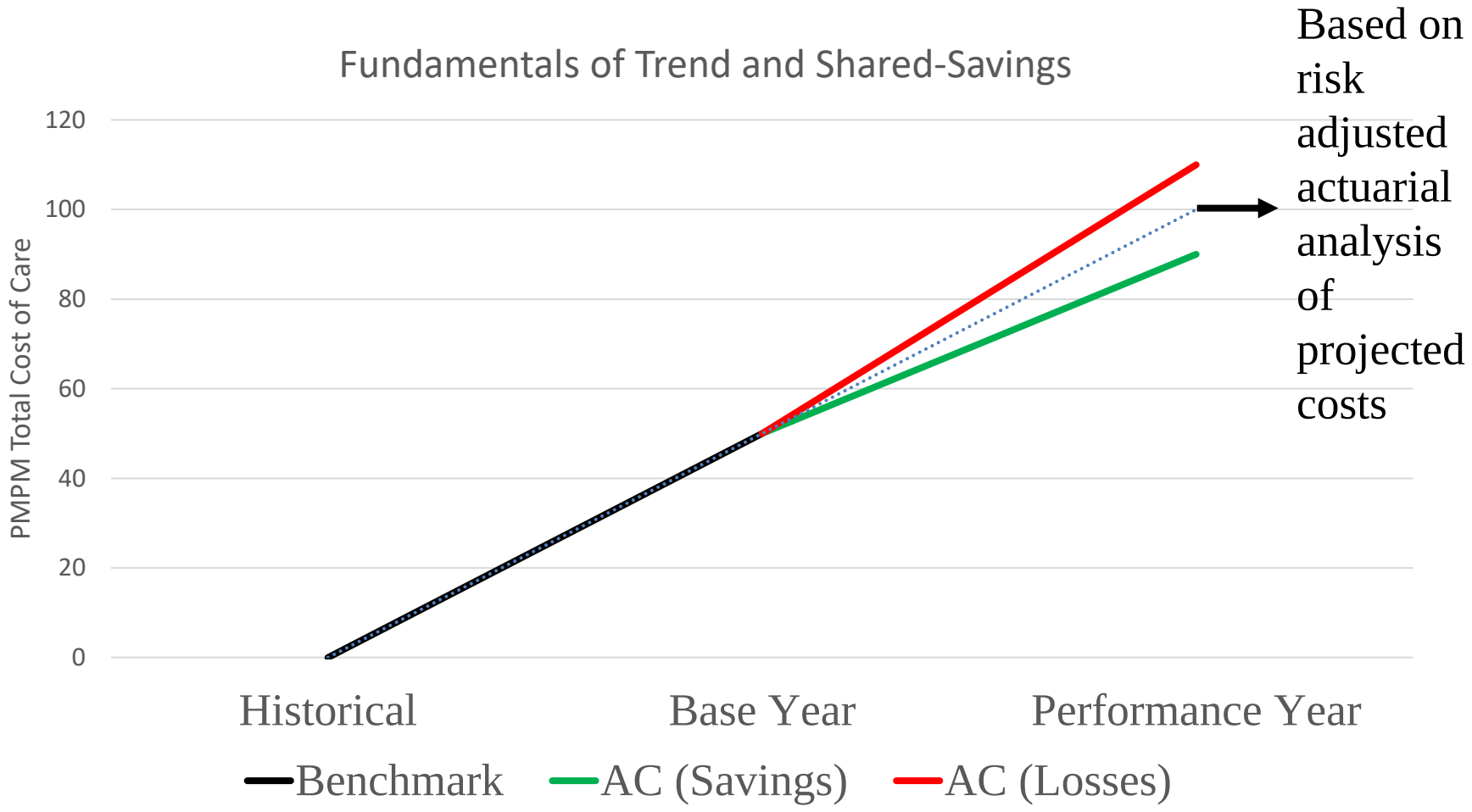
The Department provides ACs with regular patient cost and quality performance data.



ACs also benefit from:

- MaineCare's VMS Portal with monthly claims data;
- AC forums to engage in peer-learning, data-sharing, and collaboration on program changes; and
- Technical Advisory Committee meetings between key players

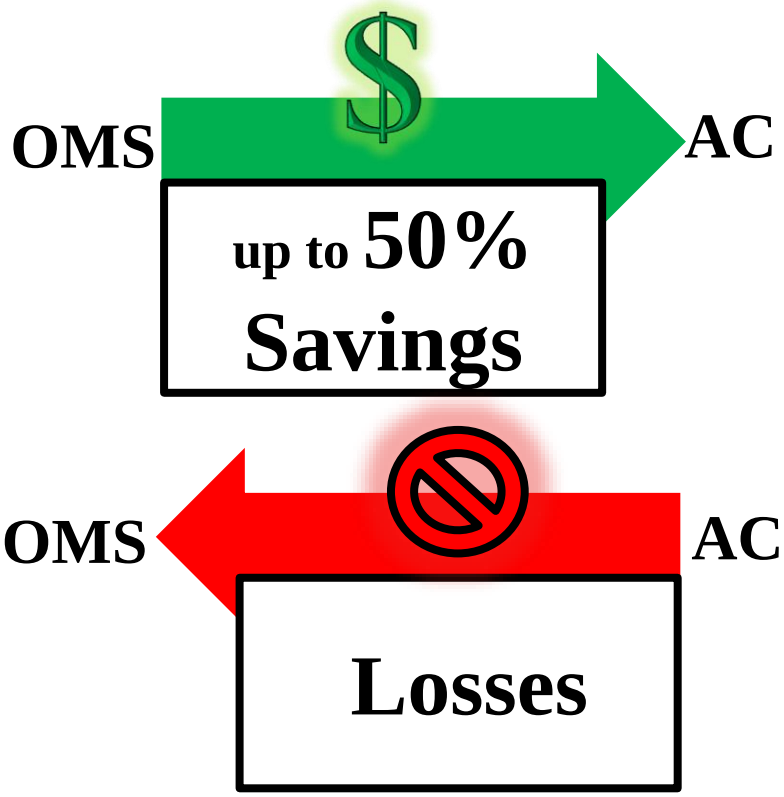
AC 101:
A look at Shared-Savings



AC 101:
A look at Shared-Savings

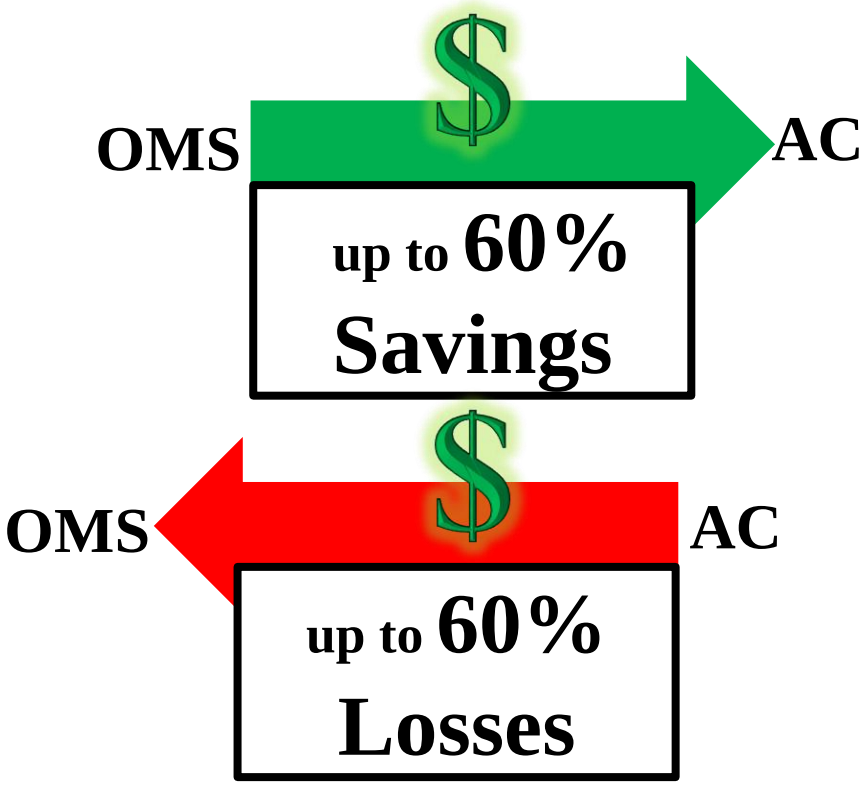
Model 1:

– Upside only



Model 2:

– Upside and downside



AC Program 101: Program Structure

Model #1	Model #2
Requires minimum of 1,000 members	*Requires minimum of 2,000 members*
• Eligibility for savings requires meeting min. savings rate – Dependent on size of AC attributed members	• Eligibility for savings/losses requires meeting min. savings rate – Dependent on size of AC attributed members
• Share in a maximum of 50% of savings, based on quality performance. – Cap at 10% of benchmark TCOC	• Share in a maximum of 60% of savings, based on quality performance. – Cap at 15% of benchmark TCOC
• No downside risk	• Liable for 40-60% of losses, based on quality performance – Cap of 10% of benchmark TCOC

AC Program 101: Growth and Results

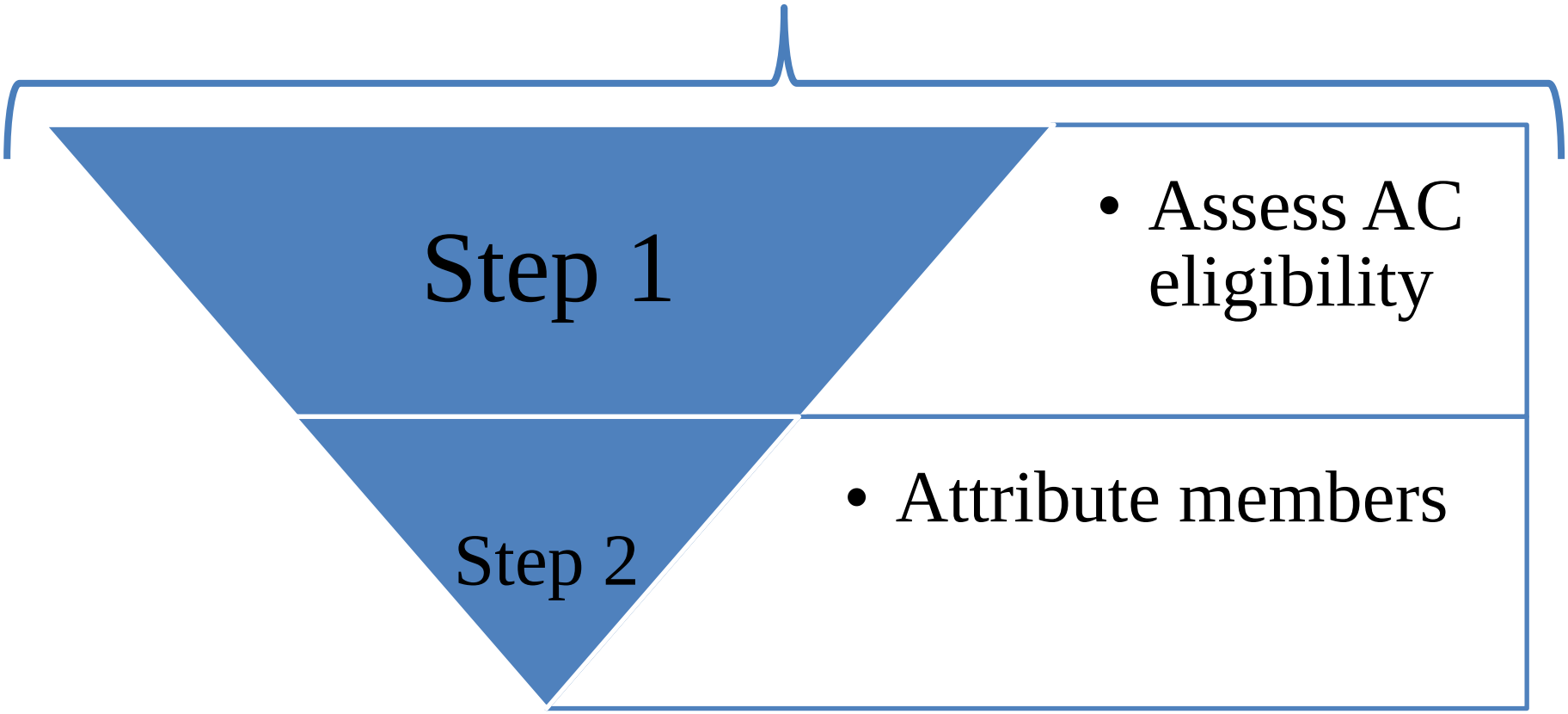
	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY7
Practices	26	67	80	85	90	101	194
Members	32,070	45,781	52,067	54,283	59,443	68,732	111,166
Savings achieved	$5.41M	$9.69M	$8.96M	$6.75M	$4.02M	TBD	TBD
Shared savings payments	$961,454	$1.59M	$1.52M	$975,510	$782,812	TBD	TBD

AC PROGRAM SHARED-SAVINGS METHODOLOGY

CALCULATING SHARED-SAVINGS PAYMENTS IN MAINECARE'S AC PROGRAM

AC Program Methodology: Member Attribution

March 2021: 355,893 MaineCare Members



AC Program Methodology: Member Attribution

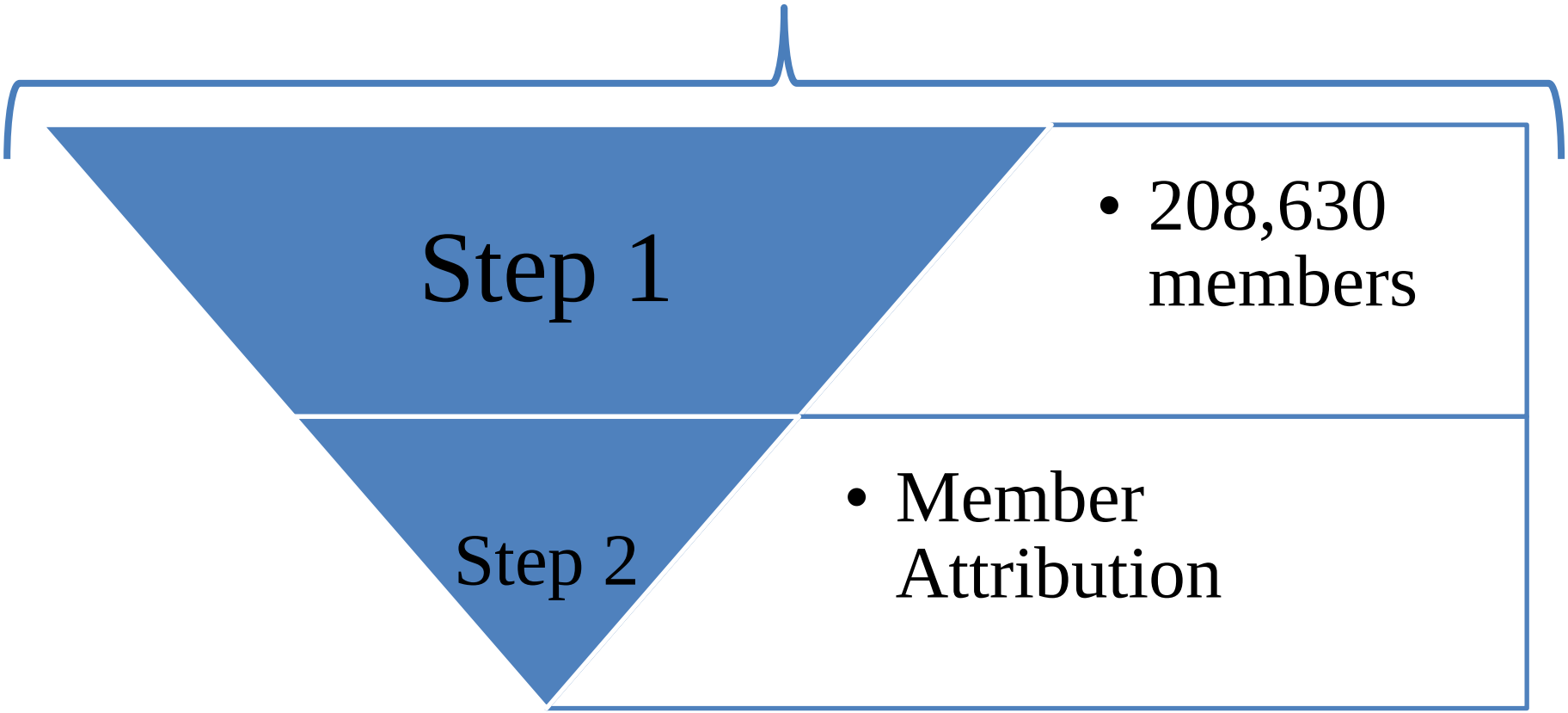
- Step 1: Determining member eligibility for AC attribution (including to the comparison group):
  - Member has full MaineCare
  - MaineCare members are eligible for the AC Program if, over the most recent 12-month period, they have:
    - Six (6) months of continuous MaineCare enrollment, or
    - Nine (9) months of non-continuous MaineCare enrollment

AC Program Methodology: Member Attribution

- Step 1 continued:
  - Over the most recent 12-month period, members must also have:
    - Received primary care Health Homes services, or;
    - Had at least one (≥1) visit with a PCP
    - Had at least three (≥3) ED visits with an ED

AC Program Methodology: Member Attribution

March 2021: 355,893 MaineCare Members



AC Program Methodology: Member Attribution & Roster

- Step 2: Determining member attribution to AC Lead Entity
  - The Department or its agent (Mercer) will attribute eligible members to an AC Lead Entity using enrollment, claims, and encounter data analyses from the most recent 12-month period

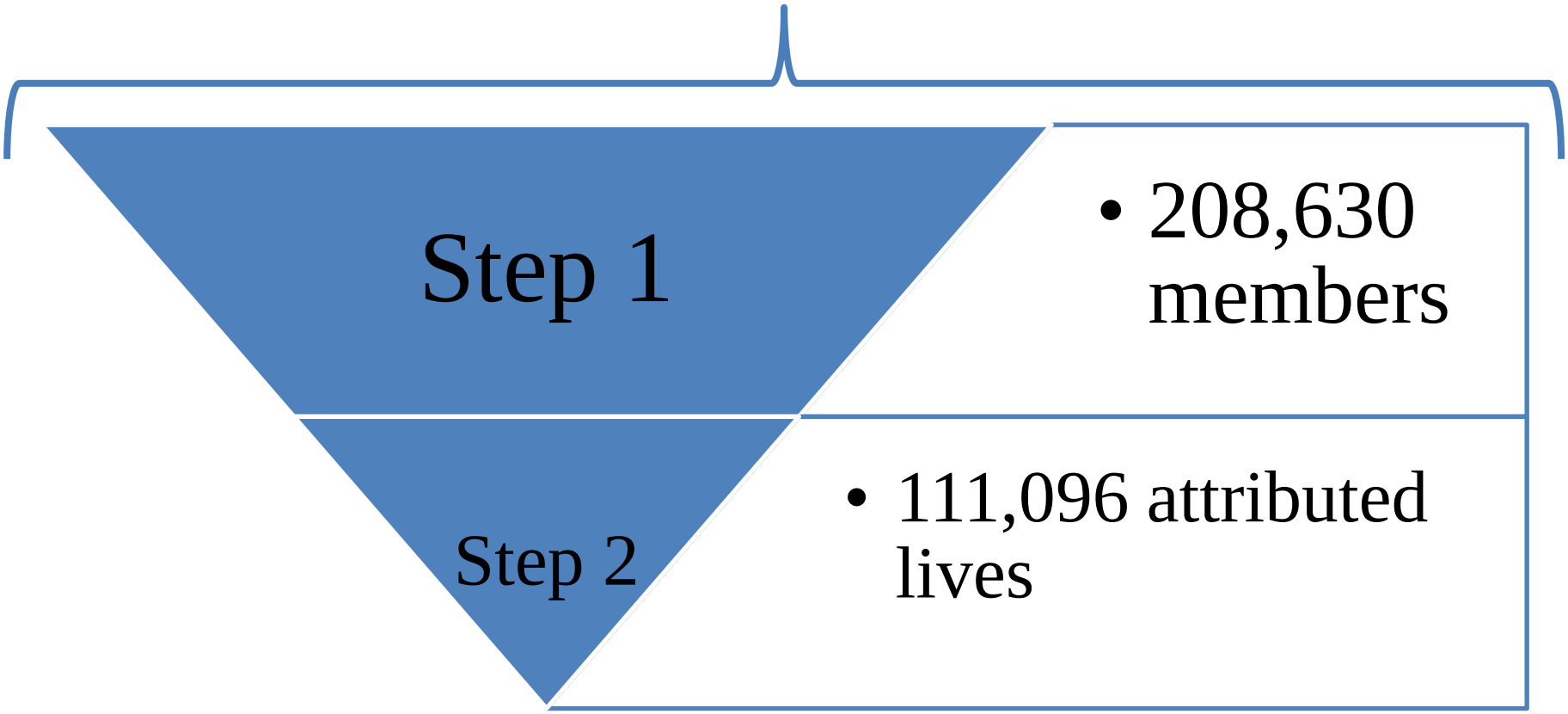
AC Program Methodology: Member Attribution

Attribution of MaineCare members to ACs is done one of three ways:

35%	64%	< 1%
Health Home members at practices that are also part of an AC	Non-Health Home members who have a plurality of primary care visits with a primary care practice that is part of an AC	Members not captured in previous methodology who have three or more ED visits with a hospital that is part of an AC

AC Program Methodology: Member Attribution

March 2021: 355,893 MaineCare Members



AC Program Methodology: Member Attribution

AC Attributed Members Are Divided Into Four Population Categories

Group	Definition
Duals	Duals are members also covered by Medicare. MaineCare is a secondary payor. Includes children.
Non-Dual, Aged, Blind, Disabled (ABD)	Members who meet SSA disability criteria but do not receive SSA benefits. Includes children.
Adults	Non-dual, non-ABD members 21 years of age and older.
Children	Non-dual, non-ABD members under 21 years of age.

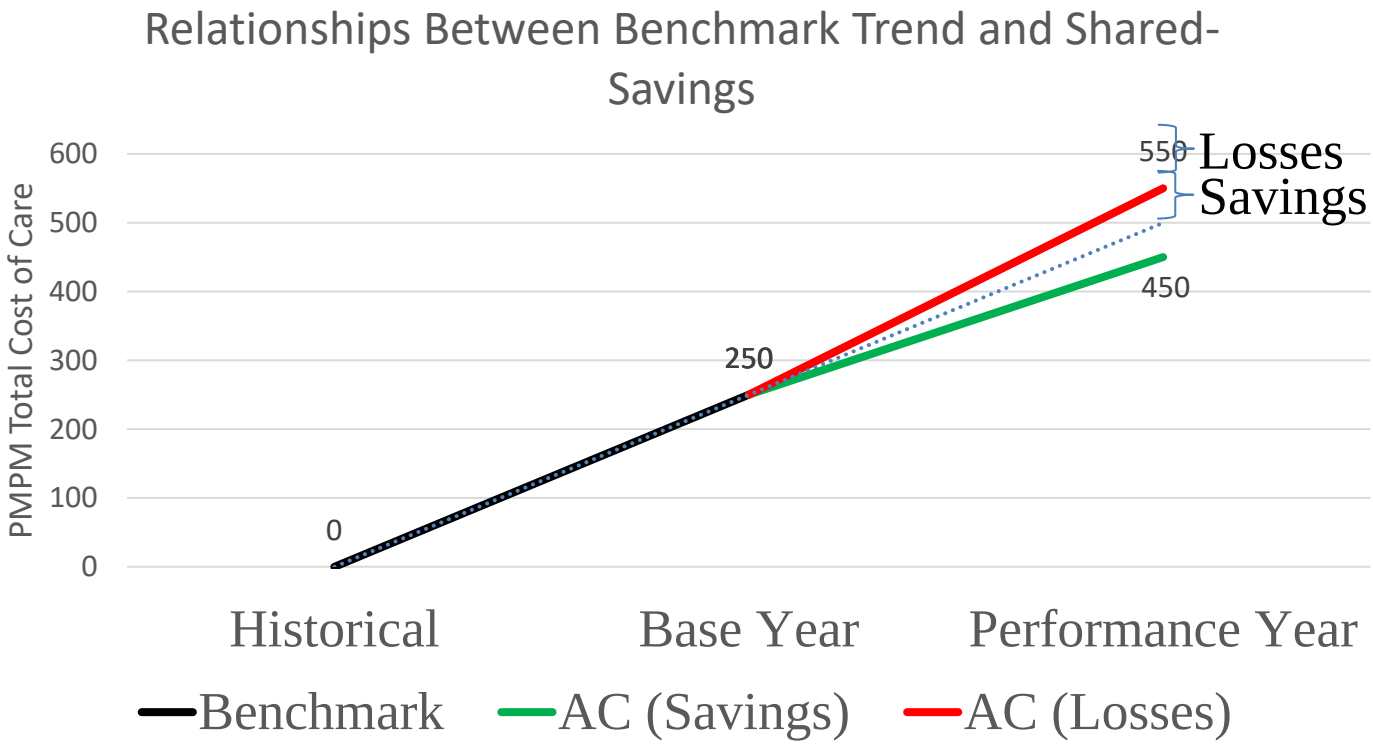
AC Program Methodology: AC TCOC

AC's Total Cost of Care (TCOC) is structured with Core and Optional Services.

Core	Optional
General Acute Inpatient	Adult Family Care Home
Psychiatric Inpatient	Assisted Living Services
General Acute Outpatient	Children's PNMI
Psychiatric Outpatient	Day Health
Primary Care	Dental
Physician Specialty	HCBS Waiver Services
Behavioral Health	ICF-ID
Laboratory/Radiology	Nursing Facility
Long-Term Care	Personal Care
Durable Medical Equipment	Private Duty Nursing
Other (i.e., Dialysis, Family Planning, PT/OT, Optometry, Podiatry, etc.)	
Pharmacy	

AC Program Methodology: AC TCOC

Policy Adjustment → Completion Adjustment → Trend Adjustment → Risk Adjustment → Claim Cap Adjustment



AC Program Methodology: Quality Measures

PY7 Quality Measures

Chronic Conditions

- Spirometry Testing/COPD
- Controlling High Blood Pressure
- Diabetic Glucose
  - (a) HbA1c Poor Control
  - (b) HbA1c Testing*

Behavioral Health

- Screening for Depression
- Tobacco Use: Screening and Cessation
- Concurrent Use of Opioids and Benzodiazepines
- Follow-Up After Hospitalization for Mental Illness*

Obesity

- BMI Screening and Follow-Up Plan

Avoidable Use

- Prevention Quality Indicator: Chronic Conditions
- Non-Emergent ED Use
- Plan-All Cause Readmission

Patient Experience

- Patient Experience Survey

*Elective measures noted with an **

Pediatrics

- Developmental Screening
- Follow-Up Care of Children Prescribed ADHD Medication
- Pediatric Well-Care Visits
  - (a) Well-Child Visits Ages 0-15 Months
  - (b) Well-Child Visits Ages 3-6 Years
  - (c) Well-Child Visits Ages 7-11 Years
  - (d) Adolescent Well-Care Visit
- Childhood Immunization Status
- Adolescent Immunization Status
- Primary Caries Prevention Intervention*
- Lead Screening in Children *

AC Program Methodology: TCOC & Shared-Savings

Model 1

Benchmark TCOC	$500
Actual TCOC	$450
Attributed Member Months	120,000
PMPM Savings	$50
Savings as % Benchmark	10%
Attributed Members	10,000
Savings Threshold*	2%

* Eligible for Shared-Savings

AC Program Methodology: Quality Measures & Shared-Savings

Model 1

Benchmark TCOC	$500
Actual TCOC	$450
Attributed Member Months	120,000
PMPM Savings	$50
Savings as % Benchmark	10%
Attributed Members	10,000
Savings Threshold	2%
50% PMPM Savings	$25
Quality Score	75%
Preliminary Gross PMPM Shared Savings Payment	$18.75

AC Program Methodology: Final Shared-Savings Calculation

Model 1

Preliminary Gross PMPM Shared Savings Payment	$18.75
Care Management Fees (CMF) to Deduct (HH, PCCM, CCT)	$500,000
PMPM CMF	$4.17
Preliminary Net PMPM Shared Savings Payment	$14.58
Adjusted Net PMPM**	$14.58
Total Payment	**$1,750,000**

** Assessment for whether the Preliminary Net PMPM exceeds 10% of benchmark

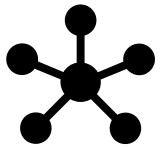
AC PROGRAM REQUIREMENTS

REQUIREMENTS TO BECOME AN AC LEAD ENTITY

AC Program Requirements: Examples of AC Configurations

A single health system with their hospital-owned practices and RHCs

A group of primary care providers and a local critical access hospital



Network of FQHCs and independent hospitals

ACs partners:

- Behavioral Health Home Organizations
- Nursing facilities
- Dental clinics
- Home health agencies
- Community-based organizations
- Many more!

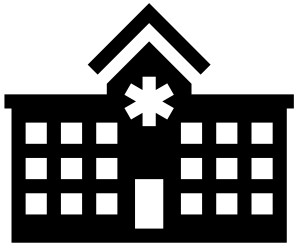
AC Program Requirements

- Fulfill all requirements in AC contract
- Collaborate with MaineCare to ensure there is a:
  - Signed AC Contract
  - Submission of participating primary care practice service locations and rendering providers for attribution
  - Selection of any elective services and/or quality measures

AC Program Requirements

Maintain status as a business eligible to:

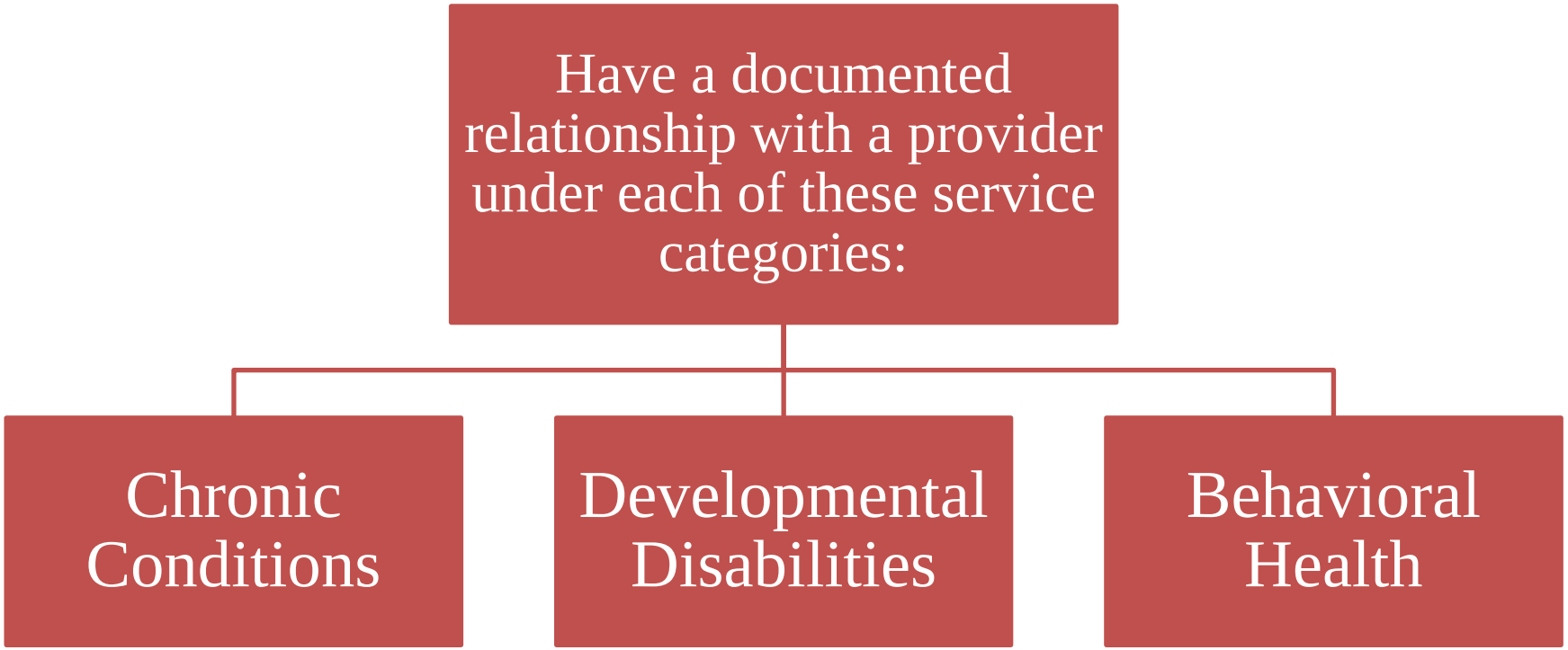
- Send/receive losses/ savings payments



Maintain status as, employ, or contract with a provider that meets the following requirements:

- A physician, physician group practice, or entity employing physicians identified as the following:
  - Specialty designation of family practice, pediatrics, geriatrician, obstetrics or gynecology
  - Rural Health Center, FQHC, School-Based Health Clinic, Indian Health Center

AC Program Requirements



AC Program Requirements

AC lead entity shall have an AC governing body

The governing body has the authority to execute the functions of an AC lead entity. They're also responsible for the oversight and strategic direction of the AC lead entity.

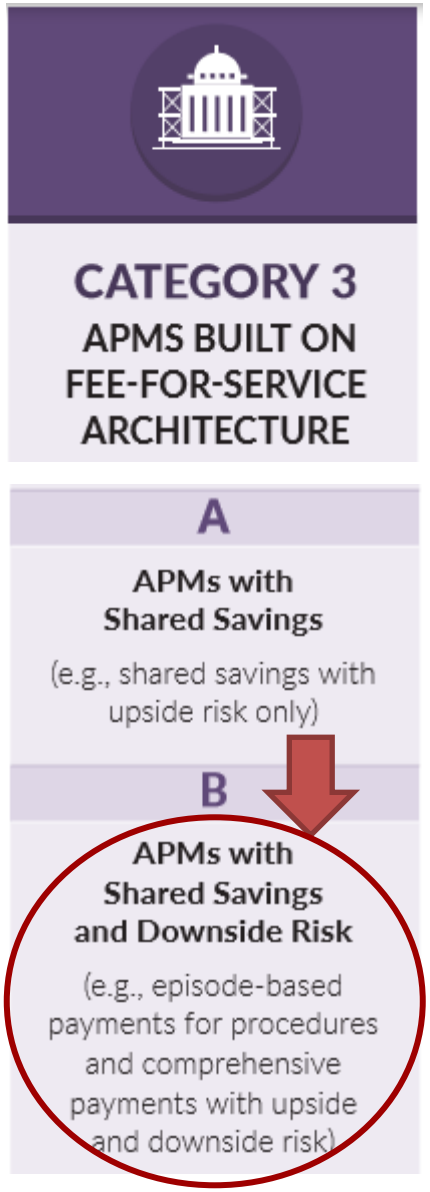
Coordinate with all hospitals within the AC's service area.

Coordinate with a Public Health Entity within the AC's service area.

GOALS FOR AC PROGRAM EVOLUTION

WHAT'S NEXT FOR THE AC PROGRAM?

AC Program Goals: AC Next Steps



- Incent ACs to be accountable for the cost of the full scope of Medicaid covered services
- Incent ACs to participate in a shared risk model
- Ensure ACs are assessing for and addressing health related social needs
- Grow the AC program in terms of health system/practice group participation and attributed MaineCare member lives
- Improve the utility of MaineCare data provided to ACs to assist data-driven strategy and decision-making
- Improve the collaboration between MaineCare and the ACs and between the ACs and community-based organizations

AC Program Goals: Glidepath

Between June - December 2020, OMS—with technical assistance from Manatt Health and funding from the Maine Health Access Foundation—developed a glidepath for the next stage of the AC program.

OMS and Manatt developed the revised program recommendations in four stages:

1. **Interview AC Lead Entities and participating providers** to understand strengths and challenges of existing program
2. **Conduct detailed best practice review** of successful Medicaid ACO programs in other states (Massachusetts, Minnesota and Rhode Island)
3. **Develop recommendations for next phase of AC program,** including a glidepath for PY 8 – PY 10
4. **Share proposal with AC Lead Entities and providers** for discussion and feedback

AC Program Goals: Components of the Glidepath

Downside Risk	*New Requirements*
▪ **Implement gradual assumption of downside risk,** with opportunities to reduce downside risk by adopting special initiatives ▪ **Adopt financial risk mitigation strategies**, to address impact of COVID-19	▪ Implement new reporting requirements related to AC governance and coordination
Program Investments	***Alignment of OMS VBP Programs***
▪ Focus on **optimizing existing MaineCare payment streams** to support population health ▪ Improve OMS/AC data exchange and analytics, through a new AC **Technical Advisory Committee**	▪ **Align methodologies and requirements** across MaineCare and multi-payer initiatives to support State policy goals and minimize administrative burden for providers.

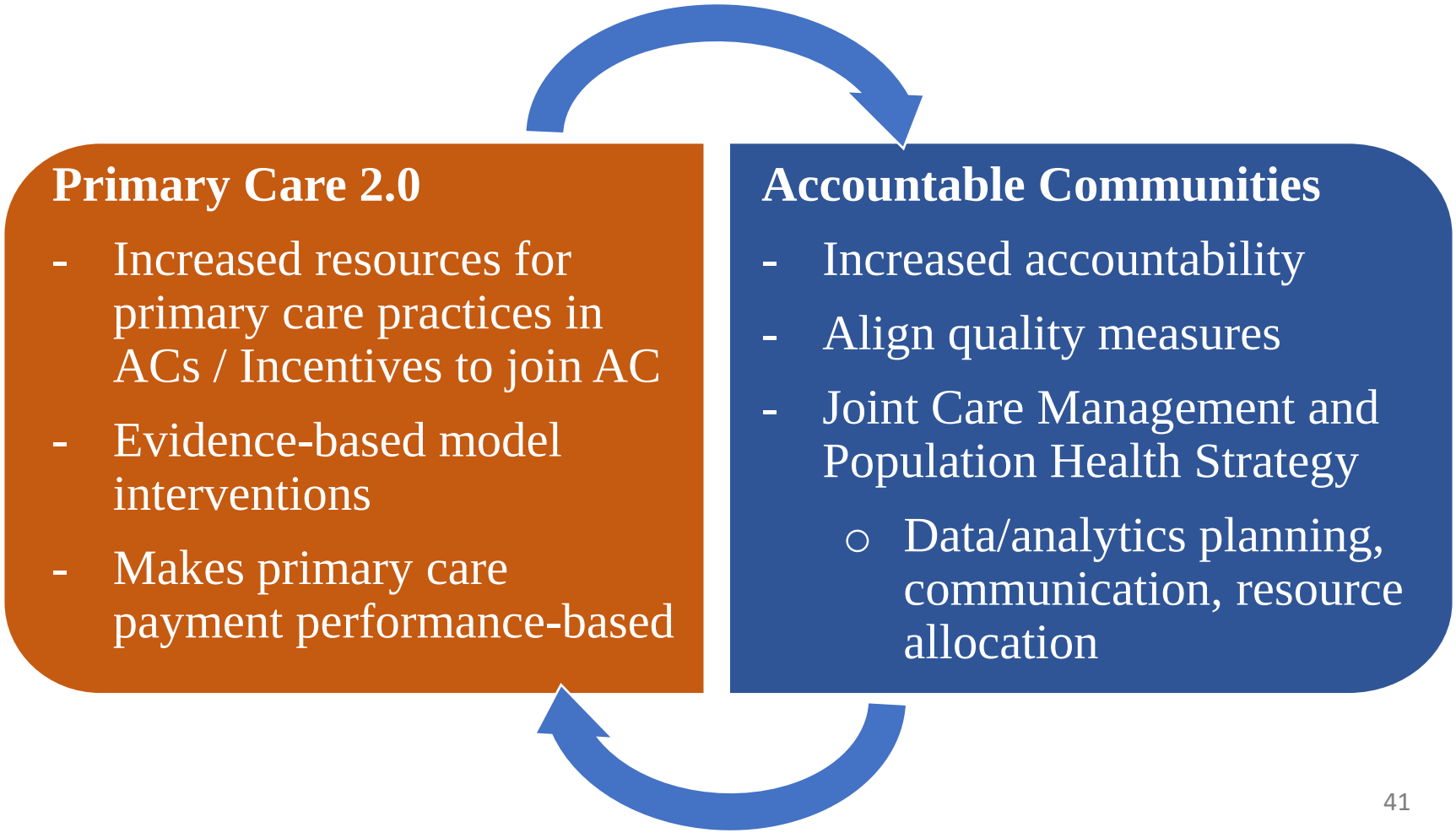
AC Program Goals: Components of the Glidepath

	PY 8 (Aug. '21)	PY 9 (Aug. '22)	PY 10 (Aug. '23)
Upside Shared Savings	*50% Cap at 10% benchmark*	55% *Cap at 10% benchmark*	65% *Cap at 15% benchmark*
Base Program Downside Risk	*No downside risk*	30% *Cap at 3% benchmark*	40% *Cap at 3% benchmark*
Downside Risk with Participation in Department-Defined Initiatives	*N/A*	20% *Cap at 3% benchmark*	30% *Cap at 3% benchmark*

Current Model

AC Program Goals: Align with MaineCare's New Primary Care Model

Goal: Increase impact of MaineCare VBP models by strengthening alignment, requirements, methodology, and incentives between models.



Next Steps

Anticipated Schedule – Subject to Change
Email MaineCare to receive sample contract *(By end of May)*
Selection of optional services/measures *(June 21, 2021)*
Practices selected *(June 30, 2021)*
Final contract sent to ACs for signing *(July 9, 2021)*
Contracts returned to OMS *(July 30, 2021)*
Performance year begins *(August 1, 2021)*

Stay informed: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities

MaineCare e-messages: https://public.govdelivery.com/accounts/MEHHS/subscriber/new?preferences

Questions?

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