

VALUE-BASED PURCHASING LEARNING COLLABORATIVE
**Integrated Care Models: Creating and
Implementing More Coordinated,
Person-Centered Care**

October 4, 2012

3:30 – 5:00 pm ET/12:30 am – 2:00 noon PT

CALL-IN NUMBER: 800-776-0816 / PASSCODE: 621935

Today's Agenda

- Welcome and Overview
- The Value-Based Purchasing MAC Collaborative: A Brief Overview
- Minnesota's Health Care Delivery System (HCDS) Demonstration: An Integrated Care Model Program
- Helping States Prepare for the Development and Implementation of an ICM Program
- Discussion

Questions?

SUBMIT ONLINE



Please click the question mark icon located in the drop-down menu of the toolbar at the top of your screen to submit online.

The Value-Based Purchasing MAC Collaborative: A Brief Overview

Medicaid and CHIP Learning Collaboratives (MAC LCs)

- Established by CMS to bring state and federal partners together to help establish a solid health insurance infrastructure
- Collaborative workgroups focusing on: early innovator information technology (IT) solutions; coverage expansion; **value-based purchasing**; data analytics; and promotion of IT efficiency and effectiveness Medicaid enterprise systems
- Coordinated by Mathematica Policy Research, the Center for Health Care Strategies, and Manatt Health Solutions

Value-Based Purchasing Integrated Care Models Learning Collaborative

- **Purpose**
 - Identify ways to improve care and lower costs in non-risk based arrangements in non-risk based care delivery arrangements
 - Provide states an opportunity to engage CMS regarding integrated care model programs
 - Provide CMS a forum to share new ideas with states and receive feedback
- **Participants:** Arkansas, Colorado, Connecticut, Illinois, Maine, Minnesota, Missouri, and Oklahoma
- **Structure:** Monthly webinars with state ‘homework’
- **Timeframe:** February – November, 2012

Impetus for Emerging Integrated Care Models

- ▶ Current payment approaches do not support or foster new primary care-focused models
- ▶ Growing recognition that payers must shift risk and rewards to the point of care, fostering greater flexibility and accountability
- ▶ Moving from volume to value is essential and must be done in a way that ensures that federal and state investments are realized
- ▶ Improving access to care and achieving better outcomes for the beneficiary

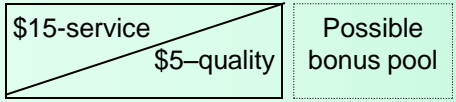
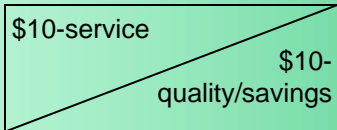
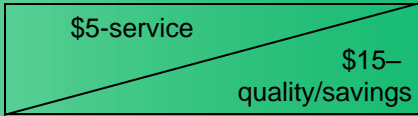
Focus on Emerging Integrated Care Models

- ▶ On July 10, 2012, CMS released two State Medicaid Director letters providing guidance on ICMs
- ▶ ICMs = integrating care across the delivery system
- ▶ ICMs = medical homes, health homes, ACOs, ACO-like models, etc.
- ▶ Multiple implementation pathways: State Plan Amendments, Medicaid demonstrations or other waivers
- ▶ State Policy Considerations
 - Provider qualifications and service definitions
 - Provider attribution
 - Comparability and freedom of choice
 - Payment for quality improvement and shared savings
 - Patient engagement

Continuum of Integrated Care Models and Features: For Illustrative and Discussion Purposes Only

Little/No Accountability for Quality and Cost Outcomes

Significant Accountability for Quality and Cost Outcomes

Care Models	FFS Only	PCCM	PCCM Plus P4P	PCMH	PCMH + Health Home	Network of PCMH	ACOs	Comprehensive ACOs	MCOs	Other ICMs
Services Accountable for	Who and what are closely related and this can vary significantly					Must be primary care-oriented and include hospitals, specialists				
Providers	Who and what are closely related and this can vary significantly					Must be primary care-oriented and include hospitals, specialists				
Payment	Made to individual PCP Fixed \$ amount  Individual Service-Focused			Made to individual providers or entity Upfront \$, savings & FFS  Population-Focused			Made to entity \$ based on savings  Population-Focused			
System Performance Metrics	Data capturing & sharing			Improved clinical processes			Improved outcomes (costs down, patient experience up)			
Success Indicators	Process measures indicate improved care in future, yield data collection for policy development and baseline			Clinical processes and new benchmarks informed by data collection; benchmarks adjusted for cont. improvement			Improved care outcomes, not volume; pt. experience			
Metrics/valuation	Some MU core set; some adult/child core sets measures			Practice measurement changes and process measures that will lead to outcomes improvement			Population health, functional status, total cost of care			
Accountability	What information would confirm that care is integrated and coordinated?									
Examples			Oklahoma PCMH	Missouri PCMH HH	North Carolina CCNCs	Colorado RICOs	Minnesota ACOs		Oregon CCOs	

VBP Learning Collaborative Focus Areas

- Integrated Care Model Program Features
- Shared Savings Methodologies
- Federal and State Quality Strategies
- Bundled Payments/ Episodes of Care
- Accountable Care Organizations
- Value-Based Purchasing for Hospitals



Arkansas – Health Care Payment Improvement Initiative

- **Background:** Arkansas is transitioning to a multi-payer episode-based model that rewards team-based, coordinated, high-quality care for specific conditions or procedures with financial incentives
- **Existing Delivery System:** Primary care case management (PCCM)
- **Covered Services:** Five episodes to launch October 1, 2012: (1) total hip/knee replacement; (2) perinatal (non-NICU); (3) ambulatory URI; (4) acute-, post-acute heart failure; and (5) ADHD
- **Eligible Entities:** Each episode has a Principal Accountable Provider (PAP) who is accountable for pre-specified services

Arkansas – Health Care Payment Improvement Initiative

- **Covered Patient Populations:** Medicaid beneficiaries who meet episodes of care criteria
- **Payment Methodology:** (1) Providers submit claims; (2) payers reimburse for services; (3) claims are reviewed to identify the PAP; (4) payer calculates average cost per episode for each PAP and compares to average costs; (5) based on results, the provider will either share in savings, pay part of excess cost, or see no change
- **Payment for Quality Improvement and Shared Savings:** Shared savings (contingent on performance on quality metrics) or losses are split 50/50 with the state
- **Pathway:** State Plan Amendment, approved

Maine – Accountable Communities

- **Background:** MaineCare will contract with provider organizations that manage and/or deliver services to a targeted patient population
- **Existing Delivery System:** Build on an existing PCCM system and the core expectations of Maine’s Multi-Payer PCMH pilot and Health Homes Initiative
- **Covered Services:** Must directly deliver or commit to coordinate with specialty services, including behavioral health, and must coordinate with all hospitals in the service area
- **Eligible Entities:** All Accountable Communities must include qualified PCCM providers

Maine – Accountable Communities

- **Covered Patient Populations:** All Medicaid beneficiaries, including dual eligibles
- **Payment Methodology:** FFS system will continue, along with global care coordination fees under PCCM and Health Homes. Total cost of care will be compared to a baseline PMPM
- **Payment for Quality Improvement and Shared Savings:** Accountable Communities can share in savings in one of two models when quality benchmarks are met:
 - **Model 1:** No shared or downside risk, but opportunity to share in up to 50% of savings
 - **Model 2:** Shared risk and savings model with opportunity to share in up to 60% of savings.
- **Proposed Pathway:** State Plan Amendment, in development

Minnesota's Health Care Delivery System (HCDS) Demonstration: An Integrated Care Model Program



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OCTOBER 4, 2012

health reform

MINNESOTA

A Better State of Health

Medicaid ACO Demonstration: “Health Care Delivery System and Payment Reform Demo”



“The Minnesota Department of Human Services shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.”

(Minnesota Statutes, 256B.0755)

Process and Timeline



- Spring 2011: Gather input through Request for Information.
- June 30, 2011: RFP issued.
 - 9 responses received, broadly representative of geographic and organizational structure.
- Individual negotiations started in February, 2012.
- Expectation that all 9 demos will start operation, January 2013.
- Three respondents are also Pioneer ACOs.
 - Working to align models.

HCDS Virtual and Integrated Models



- The Health Care Delivery System Demonstration (HCDS) includes two payment models to be implemented across both managed care and FFS. In the two payment models, providers are either part of an integrated provider delivery system or not:
 - Model 1: Virtual HCDS – for primary care providers who are not part of an integrated delivery system. Allows organizations to participate in one-way, upside gain sharing with the state.
 - Model 2: Integrated HCDS – for integrated provider delivery systems with both inpatient and ambulatory care. Begins with gain sharing and evolves toward symmetrical two-way risk sharing of both gains and losses.
- It is the HCDS entity itself that shares in savings or losses.

Provider Characteristics/Service Definitions



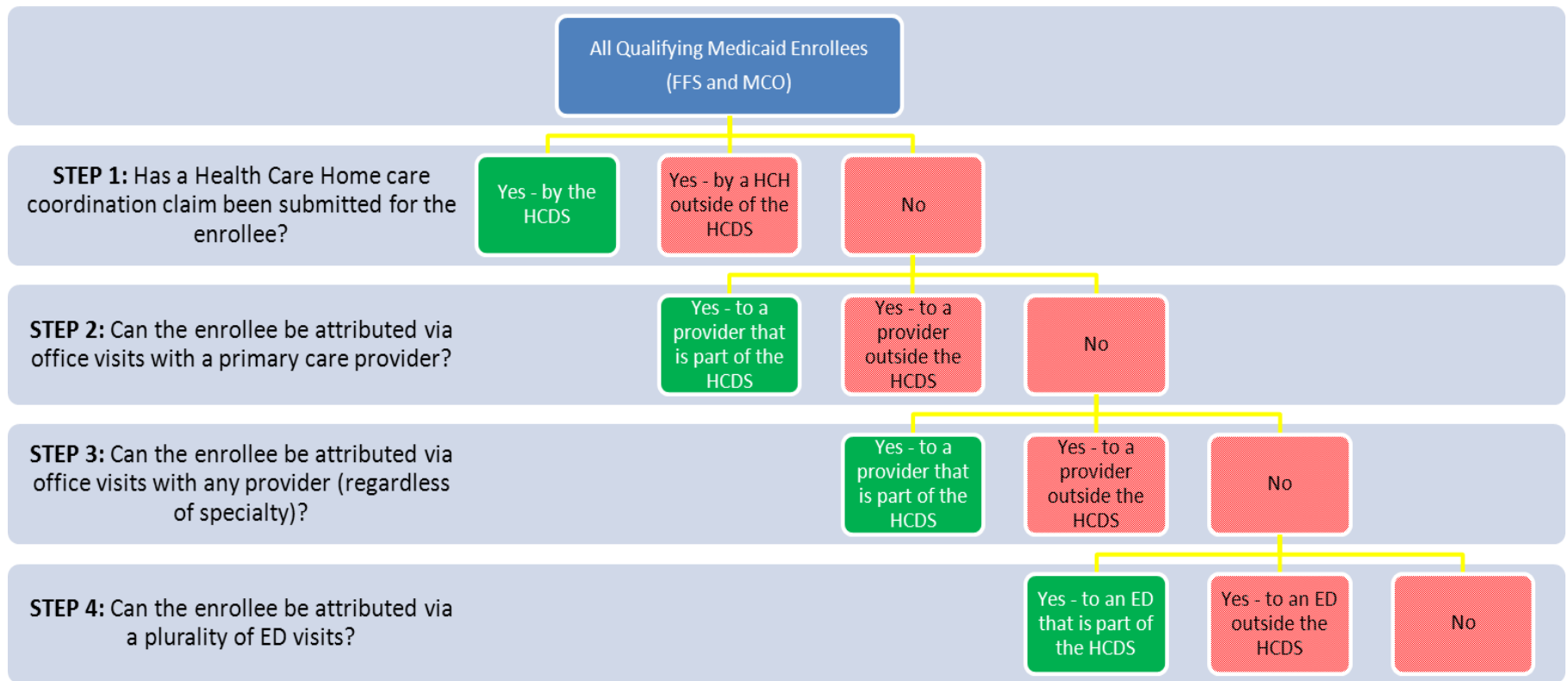
- All providers must be enrolled Minnesota Health Care Programs providers.
- HCDS providers must deliver the full scope of primary care services, defined as “overall and ongoing medical responsibility for a patient’s comprehensive care for preventive care and a full range of acute and chronic conditions.”
- Providers must also coordinate with specialty providers and hospitals.
- All providers must demonstrate how they will partner with community organizations and social service agencies and integrate them into care delivery.

Payment Models: Accountability for Total Cost of Care (TCOC) & Calculating Shared Savings



- Shared gain and risk are based on a risk-adjusted Total Cost of Care (TCOC) calculation.
- TCOC is defined as a subset of Medicaid services that health care organizations can reasonably be expected to impact in their current state.
 - Generally includes inpatient, ambulatory, mental health, and chemical health services; generally excludes long-term and continuing care.
- Medicaid Recipients Attributed to HCDS for Inclusion in TCOC Calculations.
 - Both FFS and managed care recipients attributed using past provider encounters .
- Savings/losses are derived from the difference between the actual spend for the attributed patients and the projected Total Cost of Care.

Provider/Enrollee Attribution: Framework



Provider/Enrollee Attribution: Steps



- Minimum threshold of enrollment during the year for inclusion in 6 months of continuous enrollment or 9 months on non-continuous enrollment.
- Attribution occurs at the treating provider level but aggregated at HCDS entity
- Dual eligible population excluded from attribution as well as other populations with less than full claims or benefits.

Payment for Quality Improvement and Shared Program Savings



- Year 1: 25% of gain-sharing based on pay for reporting
- Year 2: 25% of gain-sharing based on quality performance
- Year 3: 50% of gain-sharing based on quality performance
- 2 Measure Categories
 - 8 clinical quality measures (5 clinic measures & 3 hospital measures) - 75% of total scoring
 - 2 patient experience measures – 25% of total scoring

Role of the MCOs



- MCOs to participate in HCDS through their contract with the state.
- Each MCO will pay (or receive) a gain/risk-sharing payment based on their members attributed to each HCDS.
- DHS performs the attribution and TCOC calculations with an actuarial vendor.

A few lessons learned so far



- Work on the foundational elements needed for providers to take on risk:
 - Better data to manage total costs;
 - Actuarial expertise; and
 - Free up provider resources to reform care delivery.
- Iterative Change and Testing; flexibility key.
- Medicaid populations less stable than Medicare.
- Risk adjustment and social complexity.
- Quality measures, while on a relative scale robust in Minnesota, still need additional work on functional status.

Moving Forward



- Expansion to additional populations/providers
- Strong emphasis on integration of acute care and other care settings and HCBS/social services
- More global community responsibility
- Patient choice versus provider interest in assignment
- Working to align purchasing with state employee group and with large self-insured Minnesota purchasers
- Examining the CMMI State Innovations Opportunity
- Learning lessons from the Hennepin Health demo

The Process of Working with CMS



- Discussion with CMS began with MSTAT calls during the development of the model (Spring/Summer 2011); included Central Office and CMMI staff
- Continued dialogue of model development through submission of SPA (December 2011)
- Began SPA process with Central Office and Region V, originally submitted as physician rate change
- Resubmitted SPA using PCCM authority, continued to work with Central Office (coverage, finance, actuaries) & Region V through SPA approval (August 2012)

ICM CMS Approval Process



- **Freedom of Choice**
 - Retrospective attribution allows enrollee “opt out” and free choice of provider
- **Beneficiary protections**
 - Model provides incentives/controls for provider to improve care and quality, not just reducing cost
 - Enrollees are notified based on provisional attribution
- **Comparability**
 - HCDS’ must have same core capabilities/characteristic to be eligible, but model allows flexibility in care delivery models to meet local needs

ICM CMS Approval Process



- Patient Engagement/Care Coordination
 - HCDS' utilize HCH model and are required to demonstrate that patient and their families are engaged in their care and in quality improvement & leadership roles in the organization
 - HCDS' are required to demonstrate how formal community partnerships (counties, social service, etc.) are integrated into the delivery model
 - HCDS' must have the capability to accept and utilize monthly data feedback reports from the state to improve care management and coordination
- Health care homes foundational to HCDS/ACO model – but ensure no overlap or duplication of services/payment

Continued Dialogue/Development with CMS



- Balance inclusion of model detail in SPA and need for flexibility and iterative change throughout the demonstration
- Monitoring quality and patient experience critical under models that incentivize reducing cost
- Need for continued development of MCO interactions, even though SPA is FFS
- Continuing to evaluate model design and operations (and need for SPA modifications) for inclusion of different provider types in future RFPs



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Helping States Prepare for the Development and Implementation of an ICM Program

Helping States Prepare for the Development and Implementation of an ICM Program

- The VBP MAC LC and CMS discussed ways to help states:
 - Conceptualize and articulate key concepts for proposed ICM programs.
 - Initiate discussions with CMS policy experts regarding proposed ICM programs.
- Additional guidance and technical assistance tools will continue to be issued on this topic.

ICM Concept Paper: Proposed Overview

- Overview
 - ✓ Description
 - ✓ Programmatic goals
 - ✓ Current Medicaid program/delivery system and how it will be changed
 - ✓ Existing SPAs/Waivers
- Programmatic Considerations
 - ✓ Eligible population
 - ✓ Eligible providers
 - ✓ Payment methodology
- Facilitating Circumstances, Gaps and Barriers
 - ✓ Existing building blocks
 - ✓ Gaps in existing infrastructure
 - ✓ Potential barriers or obstacles

ICM Concept Paper: Proposed Components

- Program Design
 - ✓ Eligible population
 - ✓ Eligible provider entities & provider characteristics
 - ✓ Covered services
 - ✓ Stakeholder input
 - ✓ Oversight and monitoring
- Quality Strategy
 - ✓ Goals and objectives
 - ✓ Types and uses of performance metrics
 - ✓ Description of how state will assess quality at the point of care
 - ✓ Alignment with other quality strategies in the state
 - ✓ Linkage to payments/incentives

ICM Concept Paper: Proposed Components

- Payment Methodology
 - ✓ Overview of payment methodology
 - ✓ Overview of shared savings methodology
 - ✓ Total cost of care/base line cost calculations
 - ✓ Trend rate calculations
 - ✓ Risk adjustment & risk sharing
 - ✓ Calculating savings and losses
 - ✓ Rebasing
 - ✓ Avoiding cost shifting

VBP MAC Learning Collaborative: Medicaid Managed Care Innovations

- **Goal:** Help state participants design the next generation of MCO contracting requirements and be more sophisticated purchasers of risk-based managed care
- **Focus**
 - Innovative state purchasing strategies
 - Medicaid managed care for complex populations , including managed long-term supports and services
 - Oversight and monitoring, data infrastructure, program integrity, quality strategy
- **Interested/Participating States**
 - Hawaii , Maryland, Massachusetts, New Jersey, New Mexico, New York, Oregon, Rhode Island, Tennessee and Washington

Medicaid.gov and the MAC LC Toolbox

- Visit www.medicaid.gov for information on the Value-Based Purchasing Learning Collaborative as well as for the other LCs.
- Keep an eye out for the MAC LC Toolbox.
 - A repository of tools, briefs and documents related to the MAC Learning Collaboratives.
 - There are a number of value-based purchasing tools that will be released in the near future.

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For more information, visit:

www.Medicaid.gov