CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

MassHealth Provider Input Session

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Session Agenda

- ACO Overview
- Organizational Structure Discussion
- Break
- Scope of Services Discussion
- Payment Methodology Discussion

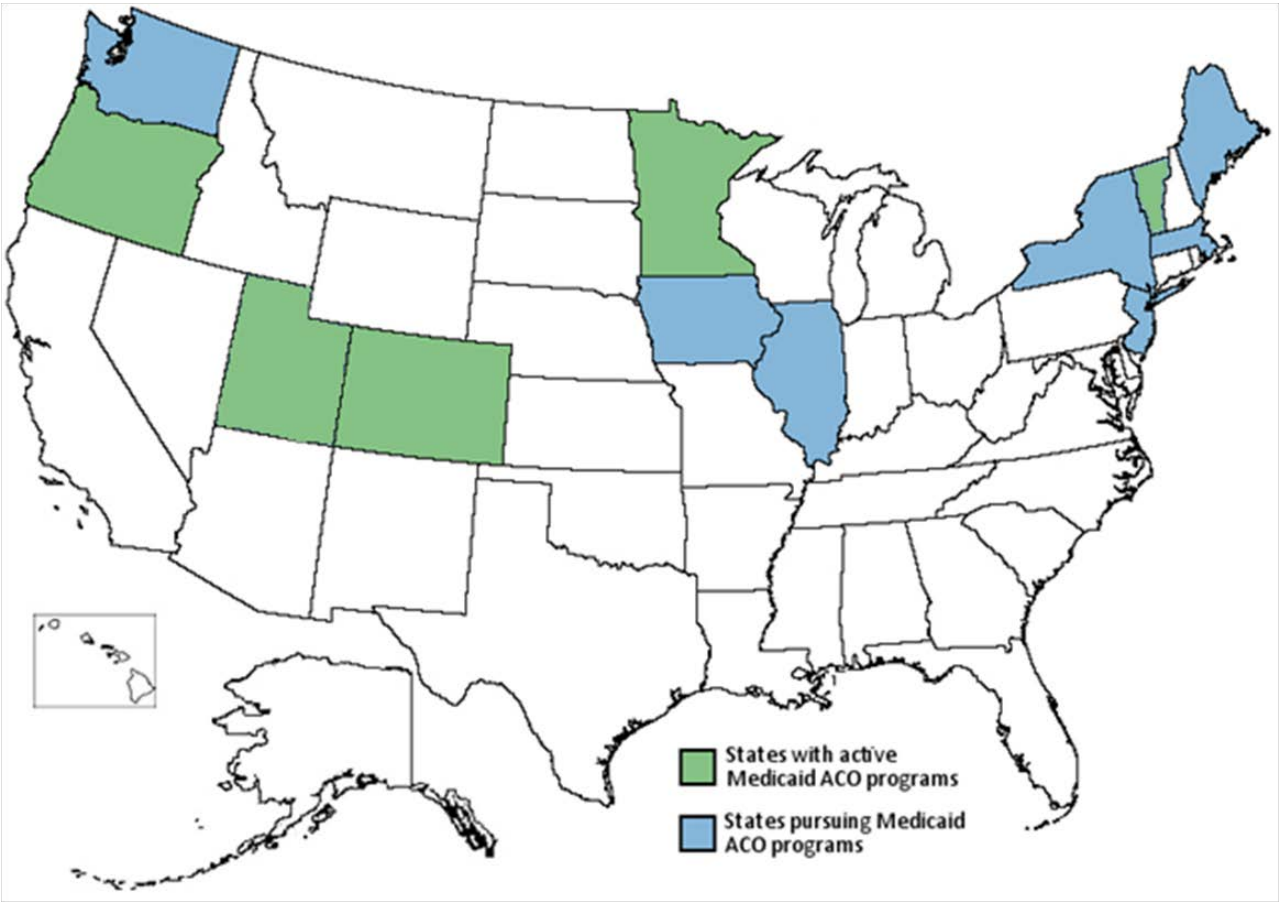
ACO Overview

- **Key ACO features include:**
  - On the ground care coordination and management
  - Payment incentives that promote value, not volume
  - Provider/community collaboration
  - Financial accountability and risk
  - Robust quality measurement
  - Data sharing and integration
  - Multi-payer opportunities

- **All of these features need to be addressed when designing an ACO model**

Medicaid ACO Models

- Twelve states have active Medicaid ACO programs in place or are pursuing ACO initiatives



Medicaid ACO Organization Structures Vary

Provider-Driven ACOs

- Providers establish collaborative networks
- Provider network assumes some level of financial risk
- Providers oversee patient stratification and care management
- State or MCO pays claims
- States: Maine, Minnesota, Vermont

MCO-Driven ACOs

- MCOs assume greater role supporting patient care management
- MCOs retain financial risk but implement new payment models
- Providers partner with the MCO to improve patient outcomes
- States: Oregon

Regional/Community Partnership ACOs

- Community orgs partner to develop care teams and manage patients
- Regional/community org receives payment, shares in savings
- Providers partner with regional/community orgs and form part of the care team
- MCOs/states retain financial risk
- States: Colorado, New Jersey

ACO Organizational Structure

ACO Governance Requirements

- **Some states require specific governance structures**
  - New Jersey requires ACOs to form a nonprofit corporation
  - Vermont requires 75% of ACO board members to be ACO provider participants
  - Maine requires ACOs to develop partnerships with public health entities
- **Many states require member and community participation**
  - Oregon and Vermont require establishment of a Community Advisory Board
  - Maine, New Jersey, and Vermont require community and/or member representation on ACO Board of Directors

The Role of Managed Care Organizations

- **States with managed care have different approaches to the ACO-MCO relationship**
  - Oregon's CCOs are run by MCOs
  - Minnesota requires MCOs to participate in shared savings arrangements with ACOs
- **Some states require data sharing and value-based purchasing participation requirements of MCOs in their contract language**

Attribution Methodology

- **States use a variety of attribution methods**
  - Minnesota uses a modified version of the Medicare Shared Savings Program model, attributing to 1) a health home; 2) a PCP; 3) a specialist with a preponderance of care
  - In Colorado, members select a PCP and are attributed to the PCP's Regional Care Collaborative Organization (RCCO)
  - Oregon and New Jersey attribute members purely through geographic means

Communication

- **Communication with providers and members is a priority for states**
  - States and/or providers notify members when they are attributed to an ACO and explain what this means
  - Participation in Colorado's RCCO system is completely voluntary. Medicaid beneficiaries are sent an opt-out form to decide whether to participate in the RCCO
- **All states track patient experience through HEDIS measures as well as other metrics**

Key Organizational Structure Decision Points

- What should ACO governance requirements be?
- How should managed care organizations be involved?
- How should patients be assigned to ACOs or ACO providers?
- How should members be notified and communicate with ACOs?

ACO Scope of Services

Services Included

- **Many states include services beyond physical health in their total cost of care calculations**
  - Maine, Minnesota, and Oregon include behavioral health and long term supports and services in their total cost of care calculation
  - Oregon includes dental services
  - Minnesota includes pharmacy services
  - In Vermont, ACOs have the option to expand to BH, LTSS, Pharmacy, and Dental services in year two

Integration of Social Services

- **States are also considering ways to include social services (such as housing and transportation) into ACO structures**
  - Hennepin Health (a county-based ACO pilot in MN) integrates social services into their total cost of care through a braided payment stream
  - Washington State's PRISM system aggregates and shares data from multiple state agencies and uses a predictive modeling algorithm to develop future programs and target patient interventions

Key Scope of Services Decision Points

- What services should be included in ACO total cost of care (TCOC)?
  - Behavioral Health?
  - Long Term Supports and Services?
- How should Social Services be integrated?

ACO Payment Methodology

ACO Payment Structure

- **Capitation**
  - Oregon pays a global capitated payment to its Coordinated Care Organizations (CCOs)
- **Episodes of Care**
  - Arkansas has instituted an Episodes of Care model for specific encounters (e.g., knee replacement)
    - A Principal Accountable Provider (PAP) is assigned, and can share in savings if cost of the episode is less than a pre-determined benchmark

ACO Payment Structure *(Continued)*

- **Fee For Service with Shared Savings**
  - Maine, Minnesota, New Jersey, and Vermont operate shared savings programs based largely on the Medicare Shared Savings Program (MSSP)
- **Fee for Service with Global Capitation**
  - Fee for service payments are reconciled with global capitated rate at end of year

Provider Risk

- **Oregon's CCOs assume full risk immediately**
  - CCOs receive a prospective PMPM payment for covered services for attributed patients
- **Minnesota, Maine, and Vermont's shared savings programs have two options:**
  - Assume risk immediately for greater upside shared savings
  - Phase in risk over three years

Data Sharing

- **Data sharing among ACOs, Providers, MCOs, and the state is a crucial part of ACO care coordination**
  - This includes sharing of patient electronic health records (EHRs), member level reports, and claims data
  - Washington State's PRISM model also shares social service and public health data
- **Some states provide ACOs with data to assist providers with care coordination**

Key ACO Payment Decision Points

- How should ACO payment be structured?
- How should provider risk be incorporated?
- What data is necessary to support provider risk?

For more information…

For more information on these concepts, please download:

CHCS post on Commonwealth Fund Blog about multi-payer alignment in Medicaid ACOs

http://www.commonwealthfund.org/publications/blog/2014/jun/accountable-care-medicare-medicaid

CHCS issue brief on interaction between ACOs and MCOs

http://www.chcs.org/resource/the-balancing-act-integrating-medicaid-accountable-care-organizations-into-a-managed-care-environment/