CHCS Center for Health Care Strategies, Inc.

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

MassHealth Member Experience Input Session

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Steve Somers
Rob Houston
Center for Health Care Strategies

Session Agenda

- ACO Overview
- Organizational Structure Discussion
- Break
- Member Experience Discussion
- Data Sharing Discussion

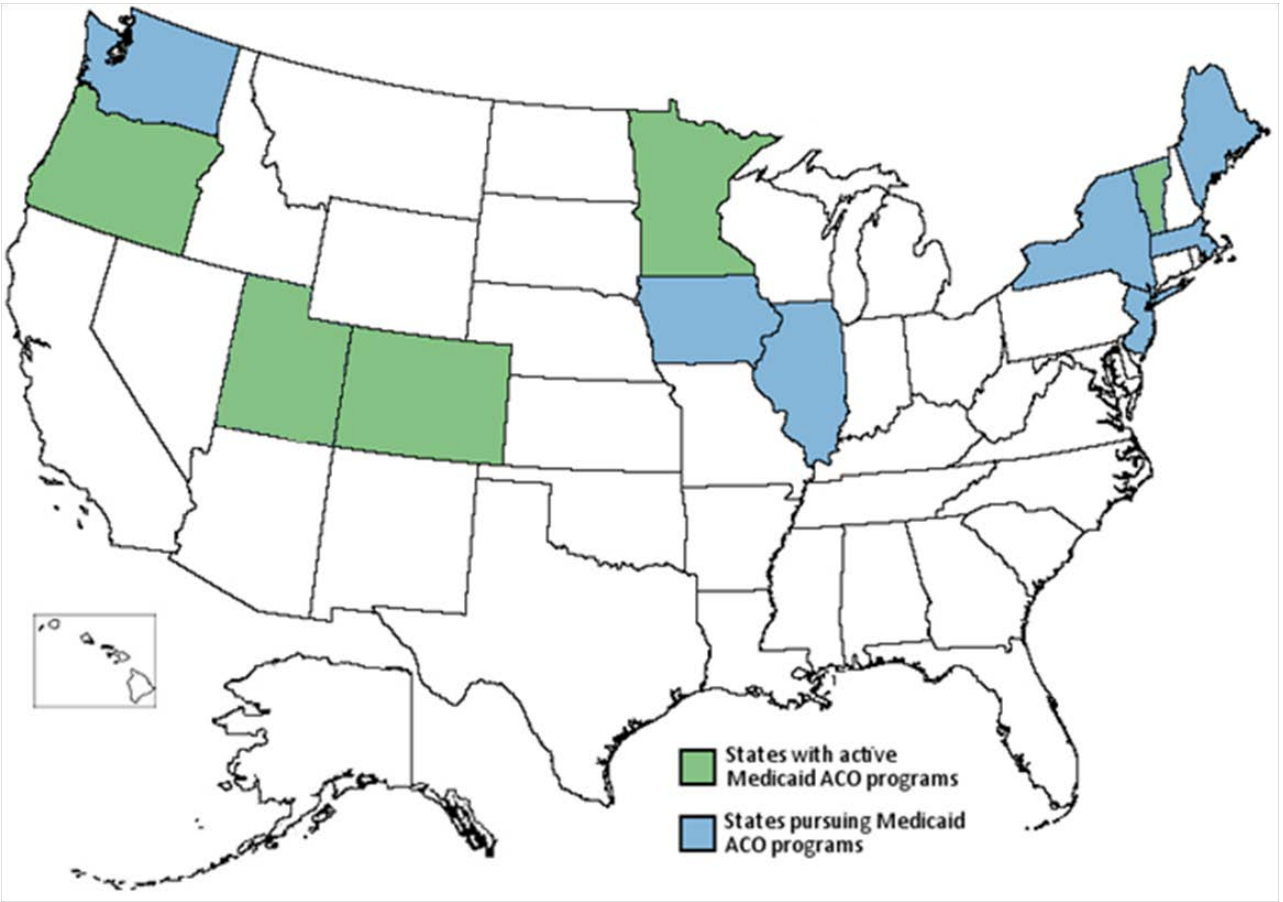
ACO Overview

- **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 Structures

- **Some states require specific ACO 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

Member and Community Engagement

- **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

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

Key Organizational Structure Decision Points

- What should ACO governance requirements be?
- How should members be involved in ACO governance?
- How should members be attributed to ACOs or ACO providers? What protections should be in place to prevent underutilization?

ACO Member Experience

Scope of Services

- **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

Care Coordination

- **Many states encourage certain forms of communication between providers**
  - Use of Electronic Health Records (EHRs)
  - Notification of hospital discharges
- **Some states also encourage new forms of patient engagement**
  - Use of non-traditional health care workers such as community health workers
  - Peer support programs
  - Face-to-face care management

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 Member Experience Decision Points

- What services will be included in ACO total cost of care (TCOC)?
  - Behavioral Health?
  - Long Term Supports and Services?
- How should Social Services be integrated?
- What care coordination requirements should be in place?
- How should members be notified and communicate with ACO providers? How should patient feedback be ensured?

ACO Data Sharing

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

Data Privacy and Protections

- **States have taken steps to ensure member privacy**
  - All ACOs are bound to comply with federal HIPAA regulations
  - States give members the option to participate in ACO data sharing arrangements
    - Most states use opt-out forms, Colorado uses an opt-in
  - States with statewide Health Information Exchanges (HIEs) share much of this information already

Transparency and Member Access to Data

- **Many programs are allowing increased member access to health data**
  - Medicare has recently released a database that allows public access to provider-level information on service provision and Medicare billing
  - Some states have encouraged the use of patient portals so members can view their medical records online, as well as limited information on providers

Key ACO Data Sharing Decision Points

- How should ACOs share data with providers, MCOs, and MassHealth?
- How should ACOs ensure member privacy? How will member information be protected?
- What data would members find helpful to help manage their care?

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/