Understanding the Medicaid ACO Landscape

The webinar will begin at 12:30 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

Agenda

1. Housekeeping and Speaker Introductions
2. Presentations
3. Audience Q&A and Follow-Up

Housekeeping

1. Speakers will present for around 60 minutes
2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab (not chat) on your dashboard to the right of your screen at any time during the webinar
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers

Carrie Arsenault is the vice president of operations at Northern Light Beacon Health, the population health organization, and Beacon Direct, the T.P.A. and direct to employer division, of Northern Light Health. She is responsible for leadership, plan management and operations of the Beacon Health lines of business and works with members and strategic contractors to guide transformation to a value-based model of care. Carrie joined Northern Light Beacon Health in 2012 and previously worked in directing physician practices and with Coding & Reimbursement programs. She is a graduate of Husson University's MBA and bachelor of science programs.

Pam Halvorson is the lead executive of operations for UnityPoint Accountable Care. In addition to this primary role, she serves as the executive sponsor for connecting to community resources in THE Care Model, UnityPoint Health's population health initiative. In the Next Gen ACO program, Ms. Halvorson is responsible for the development and monitoring of implementation strategies and progress, care coordination, culture change and team and community integration activities. Previously, she held positions as the COO at Trimark Physicians Group and regional vice president of clinic operations for UnityPoint Clinic. Ms. Halvorson graduated from the University of North Dakota in occupational therapy.

Speakers

Judith D. Moore is an independent health policy consultant who works part time with NAACOS on Medicaid ACO issues. She previously directed the federal Medicaid program in HCFA/CMS and worked at George Washington University. Moore was a Founding Commissioner on the Medicaid and Children's Health Payment and Access Commission (MACPAC) and is co-author of Medicaid Politics and Policy, a political history of the Medicaid program.

Kathy Parsons, MHA, MBA, serves as the vice president of population health and risk contracting for CentraCare. She also serves as the executive director of the Central Minnesota Health Network, a clinically integrated network that includes 13 regional health care partners, as well as for the Central MN ACO which is in Basic Track E and includes 7 regional healthcare organization partners.

Speakers

Patt Richesin currently leads Kootenai Care Network (KCN), a clinically integrated network including Kootenai Health and more than 500 physicians and advanced practice professionals. She also is responsible for the Medicare Shared Savings ACO, Kootenai Accountable Care. Before joining KCN, she served at the national level as vice president, physician strategies and services, Vizient, Inc. Ms. Richesin has held senior executive positions in private and public multi-specialty practices, academic centers, and management services organizations. She also has served on the MGMA Government Affairs Committee and Western Section Executive Committee. Ms. Richesin received her MBA with health care concentration from Excelsior College and is a fellow in the American College of Medical Practice Executives.

Medicaid ACOs – National Overview

- Estimated Medicaid Beneficiaries served in ACOs – 3.6 million
- Number of individual ACOs serving Medicaid Beneficiaries – Unknown
- States with Past, Present, or Potential ACO programs -22
- States with Active ACO or ACO-Like programs - 12
- Informed Observers: most states with large ACOs have at least some Medicaid beneficiaries receiving ACO services
- Many Medicaid beneficiaries receive services through AC0-Medicaid Managed Care subcontracts – no data, no guestimates
- Impetus: Improved Quality and Outcomes, Decreased Costs

Background and Evolution

- State Decision-Making and Administration in Medicaid
- Early State Interest Post-ACA
- CMS/CMMI Medicaid Waivers and Special Demonstrations
- Changes in State ACO Interest and Evolving Models
- Predominance and Continuing Expansion of Medicaid Managed Care (MMC)

Current Models Using ACO Systems

- State Contracts with ACOS to serve Medicaid Beneficiaries
- State requires or obligates MCOs to Contract with ACOs to serve Medicaid Beneficiaries
- Formal and Informal MCO Arrangements with ACOs to provide services for Medicaid beneficiaries

Significant, Sophisticated State ACO Models

- Massachusetts
  - Three-model statewide ACO program to serve all Medicaid beneficiaries began 2018
- Minnesota
  - Integrated Health Partnership, developed 2011-2015, enhanced and expanded to date
- Oregon
  - Coordinated Care Organizations began 2012 with capped funding/global budget
- Rhode Island
  - Accountable Entities Pilot began in 2016
- Vermont
  - Moving to single-payer statewide ACO for all; Medicaid ACO coverage began in 2014

Other Impt State ACO(like) Programs

- **Colorado** – Regional Accountable Entities cover primary and behavioral health
- **Iowa** – Evolved to Managed Care Organization contracts with ACOs
- **Maine** – Accountable Communities pilot program began in 2014
- **New Jersey** – Experimental ACO programs began in 2015; state moving to population health emphasis with MCO-ACO contracts
- **New York** – Extensive MCO contracting with ACOs under statewide delivery system reform initiative
- **Utah** – State-defined ACO program began in 2011, sometimes characterized as enhanced Medicaid managed care

Notable Features of Medicaid ACOs

- Adopted as a Value Based Purchasing Strategy
- Part of Waiver/Delivery System Reforms
- Driving Data and Financial Infrastructure Development
- Need for Careful State Oversight and Administration
- Attention to Social Determinants in Leading States
- Continuing to Evolve and Change

Challenges for States and ACOs

- Need to build unique State programs reflecting local delivery system characteristics and idiosyncrasies
- Meshing ACOs and MCOs or other VBP techniques
- Financing, Data, and Reporting Infrastructure
- Oversight – State regulation and staffing
- Growing Interest in focus on Social Determinants of Health
- Federal Requirements and Opportunities

Future of Medicaid ACO Programs

- What is the fit with Medicaid Managed Care?
- Evaluation, Oversight, Monitoring – Costs and Benefits for the State and for the ACO
- Federal Waiver Policy and Funding for Delivery System Reform

For Further Information

- **National Association of ACOs (NAACOS)**
  - Website, “Policy and Advocacy – Medicaid ACOs” section
  - https://www.naacos.com/medicaid-acos

- **Judith D. Moore**

  NAACOS Medicaid Adviser
  Health Policy Consultant
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CentraCare and the Minnesota Integrated Health Partnership

PRESENTED BY Kathy Parsons

CentraCare

- 2 PPS hospitals, 6 Critical Access hospitals, 842 employed providers
- Located in West Central Minnesota – mix of city and very rural
- Being the only hospital in these communities helps us
- Entered into initial contract in 2013, in 2019 we entered another 3 year agreement in IHP 2.0
- Currently 43,000 lives covered in this contract

Minnesota Integrated Health Partnership Features

- Quality Scores impact amount of shared savings available
- Must save 2% before any shared savings
- Beginning in 2019, CD/Mental Health Costs are included
- Largely good, consistent data from the State
- DHS holds User Group meetings with all organizations to share ideas and issues
- DHS is receptive to discussions around changes needed
- Over time additional populations included
- Equity measures added this year – significant community partnership allows for reduced downside risk

Successes

- Never had a payback year – either neutral or positive results
- In 2018 CentraCare earned 11.9% of possible 12% of savings
  - Reduced ER Visits
  - Reduced IP stays
  - Increased ACG risk scores

Initiatives Leading to Success

- Integrated behavioral health in primary care clinics
- Community Health workers and Community Paramedics doing outreach
- Coordinated Care Clinic for medical patients who have significant behavioral concerns and who tend to fail in standard clinics
- Outreach nurse provides care to local homeless shelter weekly

Additional Initiatives

- Jail Medicine program with the County Jails
- Community Partnership with law enforcement, other mental health providers, probation and jails to form Community Mental Health Steering Committee and Community Action Team – reduces ER visits
- English language classes for refugees, using health literacy topics as the language lessons
- Becoming a trauma informed community with focus on impact of Adverse Childhood Events

Challenges

- Data sharing with other agencies
- Transportation and other social determinants in rural areas
- Data delays – we have no data for 2019 yet
- Utilizing data supplied by DHS – trying to get outside data to the point of care. Epic is focused on Medicare

What Next?

- State considering direct contract to the ACO
- The organization is committed to focus on this population and improve health and outcomes
- Further engaging local partners – we cannot do it all
- Continued work on capturing risk – the population moves in and out of Medicaid and we need to keep focus on this
- Push State legislature on data sharing challenges

Northern Light
Beacon Health

Maine Accountable Communities Initiative
July 16, 2019

Presented by: Carrie Arsenault, VP Operations, Northern Light Beacon Health

Accountable Communities Initiative (ACI)

- Overall Structure/Background
- Participation/Performance
- Success/Opportunities

Accountable Communities Background

MaineCare's AC program launched in 2014.

MaineCare provides:

-Quarterly quality and cost of care reports

-MaineCare's VMS Portal with monthly claims data

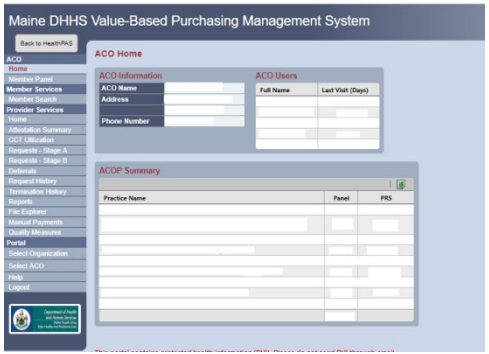
To achieve goals, the ACs initiate activities, such as:

Using received data to identify members for various interventions

Emphasizing preventative care

Integrating Behavioral Health

Increasing the investment in care management services for members with chronic conditions. (Community Care Teams)



Accountable Communities Structure

Shared Savings/Loss Model Options

Model #1	Model #2
*Requires minimum of **1,000** members*	*Requires minimum of **2,000** members*
Share in a maximum of 50% of savings, based on quality performance, with cap at 10% of benchmark TCOC	Share in a maximum of 60% of savings, based on quality performance, with cap at 15% of benchmark TCOC
No downside risk in any of the performance years	No downside risk in first performance year
	Liable for 40-60% of losses, based on quality performance, in years two and three, with cap at 5% of benchmark TCOC in second year and 10% of benchmark TCOC in third year

All ACs have chosen and stayed in Model #1

Attribution Methodology

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

35%	63%	< 2%
Health Home member 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

*Members need six months of continuous MaineCare enrollment or nine months of non-continuous MaineCare enrollment in order to be attributed to an AC.

Maine Department of Health and Human Services

Accountable Communities Enrollment

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.

Accountable Communities Total Cost of Care (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
Mental 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	

Accountable Communities Quality (performance year 5 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
Evaluation for Risk of Opioid Misuse *
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

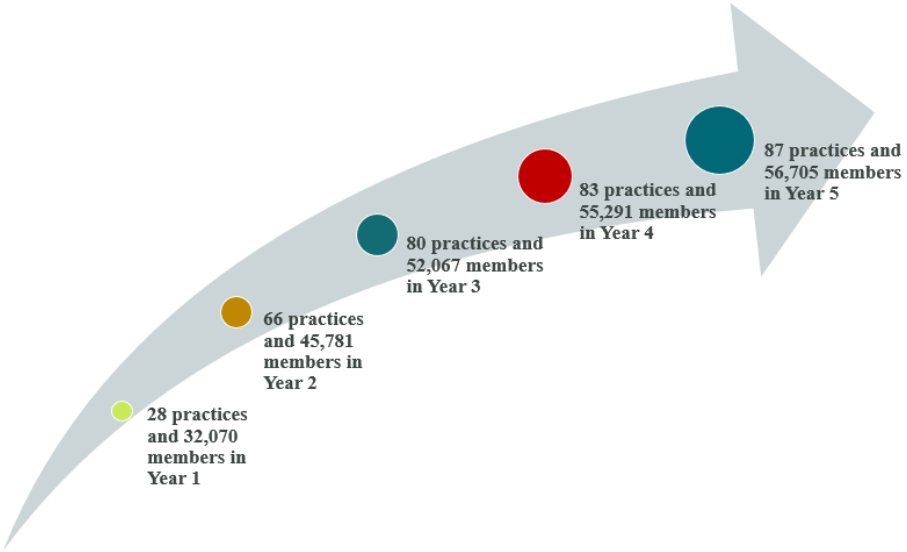
Patient Experience
Patient Experience Survey

*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 *

Success/Opportunities

Accountable Communities Participation



Maine Department of Health and Human Services

AC Specific Results – Beacon Health

	PY1	PY2	PY3
Savings (Loss)			
PMPM Benchmark Total Cost of Care	$345.22	$401.65	$479.98
Actual PMPM Total Cost of Care	$326.23	$339.81	$442.29
PMPM Savings (Loss) = Benchmark minus actual	$18.99	$61.84	$37.69
Qualification for Shared Savings Payment			
Savings as % Benchmark	5.50%	15.40%	7.85%
Attributed Members in PY1	1,519	1,542	3,180
Savings Threshold*	2.5%	2.5%	2.5%
Qualify for Shared Savings Payment?	yes	yes	yes
Payment Calculation			
Quality Score	80.88%	95.61%	80.07%
AC Total Savings (Loss) = PMPM savings x MMs	$ 327,764	$1,087,663	$1,371,629
Preliminary Gross Shared Savings Payment = AC total savings x 50% x quality score	$ 132,539	$ 519,971	$ 549,163
Care Management Fees (CMFs) to Deduct**	$ 67,574	$ 50,545	$ 122,025
Final Shared Savings Payment	$ 64,966	$ 469,426	$ 427,138

Opportunities

The Department of Health and Human Services/New Administration would like to see ACI's in track #2 (upside/downside risk) & more practices/systems participating

Dual population – opportunity to collaborate with Medicare to obtain primary claims information

Importance of local knowledge/expertise with Mainecare benefits!

Data, Data, Data!

UnityPoint Accountable Care

Medicaid ACO Challenges

UnityPoint Accountable Care

JUNE 16,2019

Iowa's Past and Current state

- State Innovation Model Selection 2013
- Expanded Medicaid 2014
- January 2015 - Governor Branstad announced privatization of Medicaid to MCOs. All populations were included (no carve outs). Bid, process, plans and other activity slowed all other initiatives for a year – expected to decrease spending by $60M
- January 2016 – Three companies enrolled Medicaid Members – One company exited in 9 months, all members reassigned
- March 2019 – largest MCO exits (60%), new potential with another national plan,
- July 2019 – 2 Plans remain, one is new to the state,

Iowa's Current state

- 2019 SIM funding ending
- July 1, all Enrollees reassigned for the 3rd time in three years to the two MCOs
- Friday July 12th - Director Randol announced $386 Million increase in payment to MCOs
- Value-based requirements remain the same

The List Serve Question:

- UnityPoint Accountable Care is interested in learning more about the components that Medicaid ACOs have put in place to manage the population. As we move toward restructuring delivery systems for additional populations, we need to estimate what other care management, UM services, compliance, community-based staffing or other human resources are needed. If other large ACOs would be willing to share their estimated resource per aligned life or some other measure we would welcome some discussion at UnityPoint

UnityPoint (Iowa) Challenges

- New systems of Iowa Total Care (MCO) unknown
- Quality System/financial data is late or not available, difficult to interpret and missing key attributes (social determinants)
- Each MCO has different onboarding for patients
- Investments to manage this population do not fit together in the same manner as adult chronic disease – 60% - 70% of spend in in Long Term services and supports, a large portion of this is intellectually disabled.

KootenaiCareNetwork

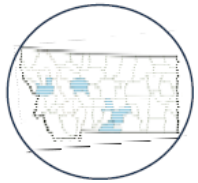
Idaho Medicaid Update
July 2019

Patt Richesin
President
Kootenai Care Network
Kootenai Accountable Care

Idaho: Medicaid Expansion State January 2020

27 Critical Access Hospitals
$2.2 billion spend prior to expansion
9% trending annual increase in Medicaid spend

Characteristics of Mountain West States

	 Utah	 Idaho	 Wyoming	 Colorado	 Montana
Average Population Density (# People/Sq. Mile for Rural Counties)	6.9	14.9	4.7	10.2	5.4
% Pop (Rural Counties)	11%	35%	70%	14%	65%
Avg. Sq Miles (Rural Counties)	3.1k	1.9k	4.3k	1.7k	2.7k
PCP/100k Population and State Rank (All Counties)	64.7 (49th)	73.1 (46th)	77.4 (43rd)	94.2 (21st)	86.6 (29th)

KootenaiCareNetwork

*Source: Rural ACO Convening Session 2019

Risk Path Evolution

- Current Medicaid spend trend at 9% - not sustainable
- Annual Healthy Connections Primary Care Case Management Payment: $18 million per year not reducing spend as anticipated
- Accountable Primary Care Organization risk path:
  - Moving Healthy Connections Case Management program to a performance based model
  - In event of loss, % HC Case Management fee at risk
- Accountable Hospital Care Organization risk path: ▪
- In event of loss, held accountable for a % of actual loss
- Share of symmetrical share/loss TBD and loss share will increase each year of the contract

Healthy Connections Value Care

Proposed Beginning 1/1/2020

Independent Accountable Primary Care Organization

- 1,000 enrollees
- Accountable for total cost of care
- Shared savings
- At risk = % chronic care management funding ($2.50 - $10.00 PMPM)

Network Accountable Primary Care Organization

- 1,000 – 10,000 enrollees
- Accountable for total cost of care
- Shared savings
- At risk = % chronic care management funding ($2.50 - $10.00 PMPM)

Accountable Hospital Care Organization

- 10,000 enrollees
- Hospital, primary care, and others as selected for AHCO
- Accountable for total cost of care
- At risk
- Hospitals enrolling as AHCO no longer have a cost settlement or UPL payment for services provided to HCVC patients

To Be Determined

- DHW/Medicaid resource management for implementation of at risk program aligned with Medicaid expansion
  - Expanded Medicaid enrollees not included for 2020 and 2021 HCVC program
  - Questions regarding adoption of HCVC outside of population centers
- Information and data
  - The intersection of information and data for actionable analytics
    - Source
    - Push/pull data
    - Analytics resources by community and provider type
- Impact in rural/frontier communities
  - Providers
  - Resources
  - Critical Access Hospitals
- Outcomes management

Q&A

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- Use the raise hand feature on your dashboard to ask a live question. You must be dialed in on a phone with the audio pin in order to be unmuted

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Thank you for participating in today's webinar