

**Maine Department of Health and Human Services’  
Value-Based Purchasing Strategy  
Synthesis of Request for Information (RFI) Responses**

**Background**

In November 2011, Maine’s Department of Health & Human Services (the Department) released a Request for Information (RFI) seeking information from prospective providers, consumer organizations and any other interested parties regarding the proposed Accountable Communities and Health Homes Initiatives under its MaineCare (Medicaid) Value-Based Purchasing (VBP) Strategy.

The RFI sought responses regarding the following areas:

Accountable Communities Initiative	Health Homes Initiative
<ul style="list-style-type: none"> <li>• Interest of organizations</li> <li>• Accountable Communities membership, governance, and collaboration</li> <li>• Consumer advocacy and family involvement</li> <li>• Payment models</li> <li>• Assumption of risk</li> <li>• “Impactable” costs of care</li> <li>• Performance measures</li> <li>• Data sharing and analytics</li> <li>• Member attribution</li> </ul>	<ul style="list-style-type: none"> <li>• Interest of organizations</li> <li>• Capacity to provide required services</li> <li>• Capacity to coordinate primary, acute, prescription drug, behavioral health, and long-term supports and services for individuals eligible for both Medicare and Medicaid (also called “duals”).</li> </ul>

The RFI deadline was December 21, 2011. The RFI and an associated Question & Answer document are posted on the Department’s Value-Based Purchasing website, <http://www.maine.gov/dhhs/oms/vbp>.

**List of Responders (28)**

Responders were grouped into broad categories in order to assess and summarize response themes by organization type. The following are the seven categories: Health Systems, Behavioral Health Organizations, Health Plan/ Administrative Service Organizations (ASOs), Long Term and Home Care Services, Advocacy Organizations, Pharmacy and Primary Care. Three organizations were categorized under more than one organizational type; these organizations are noted below.

**Health Systems (5)**

- Eastern Maine Healthcare Systems
- MaineGeneral Health
- MaineHealth
- Mercy Health System
- St. Mary’s Regional Medical Center

**Behavioral Health Organizations (12)**

- Amistad (also included under Advocacy Organizations)
- Assistance Plus
- Aroostook Mental Health Center
- Beacon Health Strategies
- Behavioral Health Community Collaborative (Sweetser, The Opportunity Alliance, Kidspace, Catholic Charities and Oxford County Mental Health Services)
- Charlotte White Center
- Community Health and Counseling Services
- Crisis and Counseling Centers
- Merrimack River Medical Services,
- Motivational Services
- OHI
- Providence Service Corp

**Health Plans/Administrative Service Organizations (ASOs) (4)**

- Anthem
- APS
- Magellan Health Services
- Outcomes Pharmaceutical

**Long Term and Home Care Services (3)**

- Androscoggin Home Health and Hospice
- OHI (also included under Behavioral Health Organization)
- Seniors Plus

**Advocacy Groups (3)**

- Amistad (also included under Behavioral Health Organization)
- Maine Equal Justice Partners/Consumers for Affordable Health Care
- National Alliance on Mental Illness (NAMI)

**Pharmacy (2)**

- National Association Chain Drug Stores
- Outcomes Pharmaceutical (also included under Health Plans/ ASOs)

**Primary Care (2)**

- Dr. Jean Antonucci
- Maine Primary Care Association

This document is a synthesis of the responses from the 28 responders. It reflects common themes, questions and areas of concern. The synthesis focuses on responses from categories of provider, rather than on detailed individual responses. The responses from the RFI will help the Department to shape the application that will go out for Accountable Communities this spring. The RFI responses will also assist the Department as it develops Maine's Health Homes model.

## Accountable Communities

### 1. Interest in Accountable Communities Participation

RFI responses reflect a high level of interest in MaineCare's Accountable Communities Project, particularly among the state's major health systems and many behavioral health organizations (BHOs). Response was limited from unaffiliated Primary Care Providers (PCPs), community hospitals, long term care, home health and other social service providers. Among responders, health systems indicated the most interest in leading Accountable Communities, although there is some interest among provider groups in creating Accountable Communities that are not led by health systems.

Several common themes emerged from the expressions of interest in the Accountable Communities initiative. Responders strongly support the importance of integrating physical and behavioral care. Responders support including community organizations in Accountable Communities but differ in how integration within Accountable Communities should be measured or required. Responders also agree with MaineCare's approach of a gradual transition from fee for service (FFS) to shared savings and increased risk-taking by Accountable Communities. While almost all responders were reluctant to consider any risk in the initial phase of the Accountable Communities initiative, most were willing to take risk with more reliable data on utilization and costs in years two or three of the initiative.

While overall interest is strong, numerous health systems and other providers raised the following significant concerns:

- **Data needs**  
In order to track utilization and costs many responders believe Accountable Communities need at least a monthly data feed from MaineCare. Several health systems question MaineCare's capacity at this point to deliver data, including unadjudicated claims, in a timely manner.
- **Multi-payer alignment**  
Many responders believe MaineCare should use the same or similar approach to payment methodology, attribution, quality measures and data sharing as have been set up for the Medicare Shared Savings Program (MSSP). Acknowledging some of the special needs of the MaineCare population, providers are concerned that creating a model with too many unique factors will hinder the ability of Accountable Communities to perform.
- **MaineCare cuts**  
Health systems are very concerned about the proposed cuts to MaineCare services and how this reduction in reimbursement will impact the Accountable Communities initiative.
- **Focus of initiative**  
Responders express that the focus should be on system redesign and transparency rather than cost-cutting. Providers are excited about the new approach but are looking for a real dialogue with MaineCare.

## **2. Models of Care – Composition of Accountable Communities**

Responders were asked in this section to focus on collaboration and partnership by and within Accountable Communities, including plans for how to include and integrate all ranges of providers within the community (home health, long term care, community social service, mental health, public health, rehab facilities). They were also asked to address such matters as governance and consumer advocacy and protection.

Below are some common themes and questions from this section:

### **Who will be included as Accountable Community provider participants?**

Most responses indicate that Accountable Communities should include physical and behavioral health provider membership and collaborate with social service, care coordinators and other community groups. Many BHOs would like MaineCare to create specific requirements (performance measures) to demonstrate full integration between physical and behavioral health care.

Pharmacy responders stressed the important role of pharmacists as members of the health team and medication treatment management as a critical service in Accountable Care Organization (ACO) models.

### **Should there be a limitation on number of Accountable Communities within a region and provider exclusivity?**

Some health systems and health plan/ ASO responders stressed the concern that too many Accountable Communities within one area and/or providers in multiple Accountable Communities will limit ability to manage care and achieve performance standards. Accountable Communities will need to have sufficient numbers of members to invest in infrastructure change and staffing to make the model work. A few responses urged a gradual approach with a limited number of Accountable Community pilots in the state.

Most BHOs and some other responders favor an “any willing provider” approach to Accountable Community membership and note that most providers work across multiple systems.

Advocacy organization responders are concerned that, in the absence of safeguards protecting member choice, potential dominance of Accountable Community-affiliated providers in an area may negatively impact member choice if providers in the Accountable Community restrict referrals to providers that are not affiliated with that Accountable Community.

## **Can any health organization or provider be the lead member of an Accountable Community?**

A number of groups independent of health systems indicated interest in establishing their own Accountable Communities for defined MaineCare populations. They asked whether there will be different criteria for non-hospital or health system-based Accountable Communities.

Responders described diverse potential governance structures. Most health system responders indicated they will rely on their employed physicians and staff to provide the majority of care. They plan for Memoranda of Understanding (MOU) relationships with outside partners. BHOs seek more formal arrangements for Accountable Community collaboration and shared decision-making. BHOs and the advocacy groups would like the state to require that peer support services play a formal role in Accountable Communities, either through a requirement that the Accountable Community offer these services or collaborate with an organization providing peer support services.

## **What are providers' plans for collaboration?**

Most health system responders state they have begun ACO development for the Medicare ACO models and/or with private payers and employers. Health Systems indicated intent to partner with retirement, behavioral health organizations, long term care, Community Care Teams and peer support organizations under their Accountable Community models.

Behavioral Health Organization (BHO) responders support a model including all physical and behavioral health providers. Several BHO responders recommend the following requirements for Accountable Communities:

- An independent advocacy organization be part of an Accountable Community.
- Evidence of strong connection between medical homes and Accountable Communities.

## **3. Payment Model & Risk Sharing**

Most responders support continuation of the FFS system with upside risk only in the form of shared savings in the initial phase of the project. Only some of the health plan/ ASO responders advocated for a managed care approach and full capitation as a first phase.

The majority of responders recommend calculating the total per member per month (PMPM) benchmark cost of care through an analysis of one or two years of historical costs, adjusted for risk through some form of health status stratification. Health systems and some other responders urged MaineCare to align its payment methodology with MSSP. Several BHOs and health plan/ ASO responders recommended an earlier move to partial or full capitation.

Virtually all responders express a strong reluctance to take on any risk in year one due to a lack of data and experience with the model. With sufficient data on utilization and costs, most responders believe they would be able to assume some downside risk in years 2 or 3 of the project. Providers strongly supported

self-selection of the level of risk they would assume. Many health systems and some smaller provider responders believe that members should be either “locked-in” to seeking care from providers within an Accountable Community or face limits on the number of times they may switch providers in a year to enable the providers to assume risk.

Community pharmacist responders note that unlike other health service providers, they do not have control over their patient population and services. They are unwilling to engage in a risk sharing arrangement with MaineCare.

#### **4. Scope of “core” services for which Accountable Communities will be responsible (“impactable” costs)**

Most health systems that responded to the RFI would include all physical and behavioral health services in the core services. Some suggest an initial exclusion of long term care, developmental disabilities, and substance abuse services. Most BHOs would include all physical and behavioral services including home-based services but some suggest initially excluding emergency, crisis and inpatient services. One hospital system and some BHO and long term care responders would like to include long term care as core services.

Responses about selection of core services tend to reflect two different philosophical approaches:

- 1) Focus on predictable services initially to gain experience with the new Accountable Communities model before adding in more complex populations.
- 2) Address the highest risk and cost categories immediately (including long term care, substance abuse and behavioral health) to obtain greatest impact from the Accountable Communities.

A few responders suggested a more cautious approach to Accountable Communities, which might include setting up a few pilot Accountable Communities in the state and monitoring their progress.

#### **5. Consumer Protections**

Most responders who addressed this issue suggest making consumer protections consistent with the MSSP model. Several recommended requiring Accountable Communities to establish an internal complaint structure within the Accountable Communities with appeal rights to an outside independent entity. Responders from advocacy organizations urge an independent “one stop” system for consumers to submit complaints. They suggest that the Medicaid managed care rules regarding consumer protections be applied to the Accountable Community structure. Many stressed the importance of ensuring member choice of provider as the primary consumer protection issue.

#### **6. Data Sharing and Analytics**

Most of the health systems and a number of other responders identified the need for a monthly feed of utilization and claims data (non-adjudicated) from MaineCare to be able to manage patient care and costs.

Strong concerns were expressed, primarily by the health systems, regarding MaineCare’s capacity to provide timely data and about the statistical stability of the MaineCare population.

A number of BHOs indicate they are still ramping up on electronic health record (EHR) capacity, often working collaboratively with each other to build an EHR network. Smaller BHO responders indicated they may need financial support to upgrade their data-sharing capacity.

## **7. Performance Measures**

Most responders suggest aligning performance measures with MSSP and the Children’s Health Insurance Program Reauthorization Act (CHIPRA), and the method for tying measures to shared savings payments with MSSP as well. The responders also referenced a range of different national performance standards with which they are most familiar:

Health systems recommend:

- » Quality – MSSP and Pathways to Excellence (PTE)
- » Access – National Committee for Quality Assurance (NCQA)
- » Patient Experience of Care – Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- » Improved health of population – America’s Health Rankings, Public Health District reports

Behavioral health organizations recommend:

- » Substance Abuse and Mental Health Services Administration (SAMHSA) national outcome measures domains
- » National Council on Accreditation in Behavioral Health
- » Quality – Provider count on number times seen, metrics that point to integration of care (ER visits, acute hospital admissions for patients with certain mental health diagnoses)
- » Access – Number of no shows, same day status

Advocacy Organizations recommend:

- » Follow core quality measures developed for Medicaid managed care
- » Family Assessment Clinician-rated Interview (FACI) and Peer Support Outcomes Protocol (POP) assessments by peer and family service organizations.
- » Outside independent entity to measure patient experience and make results public

Health Plans recommend:

- » Centers for Medicare and Medicaid Services (CMS) star rating system
- » HealthCare Effectiveness Data and Information Set (HEDIS) monitoring
- » CAHPS
- » End-stage Renal Disease Quality Incentive Program (ESRD QIP)

Pharmacy recommends:

- » Medication Therapy Management Pharmacy Quality Alliance (MTMPQA) metrics for medication adherence

## **8. Attribution – Basis of assignment of members to Accountable Community**

Most responders agree that attribution should be first based on members' current Primary Care Case Management (PCCM) or, for those without a PCCM, PCP. Several health systems recommended that all members in an Accountable Community should be attributed through a PCP. The Emergency Department (ED) and specialists were not recommended as sources for attribution. One health system noted that the ED did not have the capacity and resources to provide accountable care, and that attribution by specialist care may also favor Accountable Communities within large health systems. Several responders express the importance of enforcing the PCP relationship as key to Accountable Community success, and recommended incentivizing members to stay with their PCP and limit ED use.

If a member does not have a PCCM provider or PCP, responders offered the following bases for attribution:

- » Member choice
- » Geographic location
- » Assignment to a behavioral health provider or community mental health center for members with significant mental health diagnosis
- » Provider of majority of services over the past year
- » High performing Accountable Communities
- » Avoid auto-assignment

Several health system responders suggested MaineCare follow the MSSP model for attribution which includes preliminary assignment at the beginning of the performance year and final assignment at the end of the performance year. One health system advocated that the number of members within an Accountable Community be negotiated with MaineCare.

Responders offered varied opinions about the creation of policies regarding members "opting out" of Accountable Communities. Many smaller providers and advocacy organization responders stress the importance of ensuring member access to Accountable Community providers whether or not the member opts out of participation in the Accountable Community.

Several responders recommended that "opting out" be viewed more as a measure of consumer engagement for which Accountable Communities should be accountable. Several health systems and behavioral health organizations are skeptical about their ability to control quality and costs for a population of members if there are no limitations or disincentives for members to opt out, particularly if they are held accountable for costs and performance for patients who have opted out during the year. Larger health system responders suggest that allowing members to receive care from multiple PCPs and to have free range of access to specialists threatens the ability of the Accountable Community to influence outcomes.

## **9. Other**

### **Health Plans and Administrative Services Organizations (ASOs)**

The Health Plans/ ASOs who expressed interest in the Accountable Communities offered a different perspective from the other responders on many of the issues discussed. Most believe that the Accountable Communities and Health Homes will need coordinating and administrative services that their organizations can provide, either as a Managed Care Organization (MCO) or as an Administrative Services Organization (ASO). They can provide an information technology and analytics platform for Accountable Communities and also staffing for care coordination and 24/7 access for members. More than other categories of providers, the Health Plans/ASOs suggest a more expedient move to full risk and capitation.

Some Health Plan responders question whether the any willing provider Accountable Community model will limit savings and the economies of scale needed to invest in the infrastructure and staff.

### **Advocacy Organizations**

These responders focused on the concern about preserving member choice within the creation of Accountable Communities. Most had strong interest in ensuring that peer and family support services be acknowledged as an integral part of the services provided under an Accountable Community. These organizations are also interested in contracting with both Accountable Communities and Health Homes to offer nonclinical peer and support services and acting as independent entities within the Accountable Community responsible for monitoring member complaints and grievances and to measuring patient satisfaction.

## **Health Homes**

The proposed Health Home model relies on a medical home foundation that is more familiar to health providers and organizations than Accountable Communities are. The responses in this section summarize responders' interest, experience, and capacity to participate as Health Homes.

CMS requires Health Homes to provide the following services:

- » Comprehensive care management
- » Care coordination and health promotion
- » Comprehensive transitional care from inpatient to other settings
- » Individual and family support
- » Health promotion
- » Referral to community and social support services
- » Use of health information technology

## **1. Interest in Health Homes**

All categories of responders, with the exception of Health Plans/ ASOs, expressed a high level of interest and enthusiasm for Health Homes.

Some common themes emerged from respondents:

- Health systems have experience with Maine’s multi-payer Patient Centered Medical Home Pilot, and appear to be on track to expand their efforts to include the Health Home model. Most health systems express that the Health Home model, focusing on coordination of care and chronic disease management, is ideal for many MaineCare members.
- Many BHOs as well as some of the hospital systems believe that a BHO is the most appropriate Health Home for members with a primary mental health diagnosis or serious and persistent mental illness (SPMI).
- Pharmacy organization responders express interested in working with Health Homes to improve medication adherence and management. They stressed the important role of pharmacists as members of the health team and medication treatment management as a critical service in medical home and Health Homes models.

## **2. Capacity and Ability**

### **Health Systems**

All of the health system responders have created or are working to establish Medical Homes within their PCP practices. Health systems have sought and achieved national certifications for their medical homes. All health systems indicated they are either in the process of creating their own Community Care Teams (CCTs) or coordinating with CCTs staffed by other organizations. One hospital described its team approach using multiple community outreach organizations and the Peer/Patient Navigator model. This system would be a Health Home for individuals with substance abuse for multiple Accountable Communities. Health systems have limited experience in working with dual Medicaid-Medicare enrollees in medical homes but are interested in improving coordination of care management and integrating with pharmacy and long term supports and services.

### **Behavioral Health Organizations**

A number of BHO responders are interested in becoming Health Homes to serve the MaineCare members who have physical and behavioral co-morbidities. Several approaches were suggested, including creating Health Homes based in BHOs for the SPMI population, embedding primary medical care within community mental health centers, and creating a Health Home within a Methadone Maintenance Treatment Program. Most BHO respondents indicate they have the capacity to provide required Health Home functions and some will need financial assistance to develop electronic health records.

**Advocacy Groups**

The advocacy organization responders indicate they would like to contract with Health Homes for peer/patient support services. They recommend incenting Health Homes to contract with community partners and requiring contracts with peer/patient support services, particularly for members with SPMI.

**Long Term Care and Home Health Agencies**

These responders noted their capacity to provide CCT services to the current PCMH practices and their interest in expanding that role under Health Homes.

**Health Plans/ASOs**

One plan indicated it is interested in providing wraparound services to Health Homes (provider engagement, member outreach, and provider feedback).