Medicaid Accountable Care Organizations (ACO) in the District of Columbia

Summary of Stakeholder Comments in Response to DHCF Request for Information

Overview

In April 2017, the Department of Health Care Finance (DHCF) released a Request for Information (Transmittal #17-10) soliciting stakeholder responses to gauge interest and feedback on the prospect of developing Medicaid Accountable Care Organizations (ACOs) in the District. DHCF received 16 responses from respondents, including community primary care practices, Federally Qualified Health Centers, health systems, managed care organizations (MCOs), home health agencies, trade associations, and nonprofit interest groups.

Executive Summary

Overall, respondents to the DHCF Medicaid ACO RFI conveyed a considerable amount of enthusiasm for the potential of a Medicaid ACO model in the District. Respondents largely supported the notion of provider-led efforts to manage population health as well as reimbursement strategies that pay for value rather than volume of services. Notably, three respondents indicated they anticipate that they could implement ACO contracts in the next year.

Respondents did share some hesitation about near-term implementation of ACO models based on the level of practice change required to support such a model. A majority of respondents called for a robust health information technology and exchange infrastructure that many perceive is necessary to manage population health. While many commended the District's initial health information exchange work, respondents called for sustained investments to continue to advance data exchange and utilization. Finally, a few respondents cautioned that the research around ACO effectiveness is still new and developing.

DHCF synthesized responses to the ACO RFI, which are provided in the attached chart. The following is a short narrative summary of these responses, organized by the major sections of the RFI.

I. Value -Based Purchasing Principles

DHCF solicited feedback on a set of principles to guide the development of future value-based purchasing initiatives. Respondents generally agreed with the proposed principles, with a few suggested edits. Several respondents recommended amending the principles – listed below – to emphasize the importance of patient centeredness and consumer engagement.

<u>Expand Access</u>

- Ensure appropriate and adequate access to services across all eight (8) wards.
- Improve patient-centered care coordination for all Medicaid beneficiaries. This includes efforts to coordinate physical, behavioral, and long-term health care.

Improve Quality

- Enhance hospital quality and outcomes.
- Promote partnerships between DC hospitals and primary care providers to improve care delivery and outcomes.

Promote Health Equity

- Develop programs and services for the District's high-need populations, particularly for those with a high-burden of chronic illness, and homeless.
- Incorporate social determinants of health (SDOH) to improve health equity in the District.

Enhance Value and Efficiency

- Pay for value, not for volume of health care services.
- Promote efficiency, transparency, and flexibility of DHCF's programs.

II. Value -Based Purchasing Opportunities

DHCF solicited feedback on specific value-based purchasing initiatives, interventions, and/or target populations that could benefit from value-based purchasing efforts. Respondents primarily offered responses stating their organization's priorities for specific target populations, and specific goals for these programs, which are summarized below as opportunities to improve care quality and health outcomes in an ACO model.

ACO Target Populations: The most common target populations prioritized by responders include:

- The fee-for-service (FFS) population
- The Medicare-Medicaid dual-eligible population
- High-cost, high-needs populations, such as individuals with multiple chronic conditions

Opportunities for Improvement in an ACO model: The most common opportunities to improve care quality and outcomes include:

- Improving care coordination/managing populations
- Reducing inappropriate/preventable emergency department and inpatient use

III. Features of an Effective ACO Program

DHCF solicited feedback on the most critical components of an effective ACO program needed to achieve high-quality health outcomes. Most responses addressed two issues: infrastructure and day-to-day operations, and patient/population management.

Day-to-Day Operations: Respondents suggested that the following ACO features – and demonstrated track record or support for these features - is needed:

- An adequate number of primary care providers and network of specialists
- Experience, capital, and established infrastructure needed to support ACO operations
- The ability to integrate information from all possible sources, including claims, clinical, operational, utilization, and cost data
- Increased accountability standards

Patient and Panel-Level Management: Respondents prioritized the following ACO features to support patient/panel management:

- Comprehensive and person-centered care coordination activities
- An increased focus on outcomes and beneficiary satisfaction
- Culturally sensitive care
- Increased use of data analytics to manage a population

IV. ACO Scope of Services

DHCF solicited feedback on the scope of services that an ACO should provide. Most respondents suggested that ACOs should be responsible for all services. A few respondents suggested the following services should be phased into an ACO more slowly, or should be excluded, or "carved out" of an ACO:

- Phase in LTSS
- Carve out long-term services and supports (LTSS)
- Carve out mental health and substance use disorder

V. ACO Health IT and Data Analytic Needs

DHCF solicited feedback on analytic capacities needed to manage population health under an ACO model. Respondents consistently pointed to the need for effective and efficient health information exchange as a necessary component of an ACO. Respondents identified numerous resource needs, including:

Data Collection/Assessment Tools

- Care planning tools
- Collection of life circumstance data/social determinants data

Data Exchange

- Improved data sharing (especially mental health data)
- Incentives to share timely, high-quality data (especially hospital discharge data)
- Ability to merge clinical and claims data
- Ability to work with non-health agencies

<u>Analytic Tools</u>

- Business intelligence tools/analytic tools to see patterns of service use and gaps
- Ability to use data to construct financial models

<u>Tools to Promote Stakeholder Engagement</u>

- Tools to share insights with community partners
- Tools for patients to see their own data

VI. Relationship Between ACOs and MCOs

DHCF solicited feedback on the interaction between ACOs and MCOs (i.e. should ACOs participate in the MCO procurement process, should MCOs should be required to contract with ACOs, or should MCOs voluntarily contract with ACOs).

DHCF received a varied range of responses to this question, including the following:

- Most respondents agree the best near-term practical approach is to work with MCOs
- Most *providers* wanted MCO's to be mandated to contract with ACOs
- Most *payers* wanted voluntary contracting
- A *few* suggested that ACOs should contract directly with DHCF to ensure the FFS population is served by an ACO, potentially via the procurement process

Conclusion

District stakeholders who responded to DHCF's RFI on the prospect of creating a Medicaid ACO demonstrated strong interest in migrating towards value-based purchasing initiatives. There is enthusiasm for a Medicaid ACO as one vehicle to support further movement towards value-based purchasing in the District's Medicaid program.

Respondents did suggest a few specific areas of support in which DHCF could provide further support for ACOs and a sustainable approach to value-based purchasing more generally, including:

- Time to prepare for a transition
- Start-up funds to support the transition, including practice transformation technical assistance
- A payment glide path to ease the transition to significant levels of financial risk
- Improvements in HIE capabilities
- Transparency in establishing payment rates
- Stakeholder buy-in on the beneficiary attribution process

Next Steps

DHCF greatly appreciates the time and thoughtfulness provided by District stakeholders who responded to the RFI. Over the next couple of months, DHCF will schedule meetings with health care organizations that have submitted responses to the RFI to better understand stakeholders' interest in developing a Medicaid ACO in the District.

DHCF also plans to hold a public stakeholder meeting August 17th to further explore the opportunities to develop an ACO initiative. For additional information regarding this RFI, or interest in attending the stakeholder meeting on August 17, please email healthinnovation@dc.gov

Appendix - Summary of ACO RFI Responses, April - June 2017

Question	Synopsis of Responses
1. Please provide a brief description of your organization, including other organizations with whom you have formal or informal relationships. Please describe whether you currently serve Medicaid beneficiaries, including the number of beneficiaries that you serve, and what types of services you provide. Describe organizational affiliations (current and planned) that would support a fully integrated, coordinated care model serving the population of Medicaid beneficiaries.	· Payers · Providers · Trade Associations · Home Health Agencies
2. Do you agree that the principles above should serve as a foundation for any future value-based purchasing (VBP) initiatives? Are there others you feel should be included? Deleted? "Expand Access: Ensure appropriate and adequate access to services across all eight (8) wards. Improve patient-centered care coordination for all Medicaid beneficiaries. This includes efforts to coordinate physical, behavioral, and long-term health care; Improve Quality: Enhance hospital quality and outcomes. Promote partnerships between DC hospitals and primary care providers to improve care delivery and outcomes; Promote Health Equity: Develop programs and services for the District's high-need populations in the District, particularly for those with a high-burden of chronic illness, and homeless. Incorporate social determinants of health to improve health equity in the District; Enhance Value and Efficiency: Pay for value, not for volume of health care services. Promote efficiency, transparency, and flexibility of DHCF's programs."	Generally agree, supportive of move to VBP. Some comments highlighted the need for focus on person-centeredness and consumer engagement
3. What do you see as the greatest value-based purchasing opportunities in the District? Please describe specific initiatives, intervention, and/or target populations.	· Managing the FFS population · Managing the dual-eligible population · Improving care coordination/managing populations · Reducing inappropriate/preventable ED and IP utilization · Addressing the needs of high-cost, high-needs populations

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4. Are ACOs the right payment payment/delivery system model for achieving these goals? Why or why not?	• Most indicated it holds great potential, but ACOs are not the only solution/there is limited data on the efficacy of ACOs • Providers worried about having the necessary infrastructure to manage risk • Payers believe they are in the best position to build relationships needed for ACOs and that providers need a glide path towards risk; some payers thought that ACOs outside of MCO structure will struggle • One dissenter raised concern with placing beneficiaries in a capitated arrangement
5. Do you agree with this definition? Please suggest any edits to this working definition. "An ACO is a group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the total costs and quality of care for a defined population."	General agreement with the definitions; DHCF received thoughtful feedback on a few tweaks to the definitions and will take under consideration
6. What do you believe are the most critical delivery system features of an effective ACO program?	• Increased focus on care coordination and quality outcomes • Increased accountability and leadership committed to reform • Increased use of data analytics, better flow of data • Some encouraged leveraging existing standards (e.g. NCQA) to ensure alignment with the existing MCO standards
7. Which beneficiaries are most well-suited for and would most benefit from an ACO? Please describe any eligibility groups, populations, and/or sub-populations you would recommend for an ACO (e.g. dual eligible).	• High users of services/high-needs • FFS population • Dual eligibles • Entire population

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8. Please describe your preferences on determining a beneficiary's eligibility for an ACO and your recommendations on any methodologies for assigning beneficiaries to an ACO (e.g., prospectively - patients who received care by the providers in the previous year are attributed to the ACO for the current performance year, or retrospectively - patient population at the end of the year based on the patients who received care at the ACO during that performance year)?	• Majority preferred prospective, • Some suggested hybrid prospective/retrospective, including a continuous enrollment or opt-in aspect • Some suggested geographic or initial year retrospective
9. What do you think of the proposed threshold of 5,000 beneficiaries as a minimum requirement? Please provide feedback on the minimum size of a population/sub-population an ACO needs to cover in order to adequately manage population health?	• Ranged from 5,000 - 20,000 • Many suggested 5,000 was small, but the minimum acceptable number for shared savings; full risk suggestions in the 15,000-20,000+ range
10. Which types of covered services should ACOs be responsible for delivering?	• All services, some said no LTSS or to phase in LTSS
11. Are there specific services (e.g. dental, long-term care services and supports) that should not be included (e.g. "carved out")? What are the challenges of including or excluding these services?	• Some said carve out LTSS • One respondent also suggested carving out behavioral health and substance use disorder
12. DHCF welcomes feedback on the criteria outlined above, as well as additional comments on minimum data and analytical capabilities needed to support population health management. "The ability to submit claims/encounter data, the ability to receive aggregated performance data, and the ability to act upon these data (e.g. by implementing quality improvement activities to target deficient areas); Meet "stage 1 meaningful use" conditions according to the CMS EHR Incentive program; Comply with the enhanced certification standards for EHRs that require EHRs to capture clinical data necessary for quality measurement as part of care delivery, and have the ability to report electronic clinical quality for all patients treated by individual providers; Have the ability to collect standardized data on social determinants of health"	• Respondents universally agreed on the importance of a functioning HIE and the role DHCF can continue to play to improve data sharing and utilization

Question	Synopsis of Responses
13. For organizations delivering services to Medicaid beneficiaries, please describe your current and future data and analytical capacity?	N/A
14. DHCF would appreciate comments on the importance of the specific standards outlined. "Corporate Structure: The flexibility for an ACO to be a single corporate structure or a network of providers organized through contractual relationships; Governing Board: An ACO may be required to establish and maintain a governing board with adequate authority to execute the required services and functions of a certified ACO. These responsibilities may include: • A conflict of interest policy calling for disclosure of relevant financial interests, process for determining whether conflicts exist, and an appropriate process to resolve conflicts; • Inclusion of representatives from key stakeholder groups such as: - Diverse practitioners types (e.g., primary care, specialties, behavioral health, waiver services) and a mix of health care providers in active practice; - Community members to ensure priorities and decision-making are consistent with the values of the members and the community, goals of patient-centered care. At least one of these members should be a Medicaid beneficiary."	• Important to have flexibility for governance • Consumer representation also critical
15. What impact would these governance requirements have on the existing structures already in place or under development in the District?	N/A (Limited responses)
16. DHCF seeks comments as to the advantages and risks of each of these three approaches. Which strategy, these or others, should the District consider if an ACO model is pursued?	Mixed responses from stakeholders; • Providers largely suggested mandatory MCO contracting • Payers largely suggested voluntary contracting • Some suggested that ACOs should contract directly with DHCF to ensure the FFS population was also covered via an ACO, potentially as part of the MCO procurement process
17. What do you think of the proposed payment principles? What should DHCF's approach be to address the additional payment considerations listed below?	• Most respondents indicated a gradual move towards risk - (e.g. first start with upside risk only, then move to 2-sided, and then offer an opportunity for full risk); this approach allows providers to come in at different levels • One respondent said ACOs should be paid like MCOs

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18. Which performance metrics are most critical to achieving the goals stated above?	• Two respondents said adopt CMS ACO measures (~30) • Balance of respondents recommended 10-20 measures, with some suggesting exclusively focusing measures related on top public health issues in the District
19. What principles should guide the selection of the quality measures used to evaluate outcomes of an ACO program (e.g. alignment with other measurement sets, based on claims/clinical data, ability to reflect variation within the District and address high need populations, etc.)?	• Strong focus on key public health issues specific to the District; with a preference for outcome measures
20. Should measures that incorporate social determinants of health data be included? If so, has your organization identified effective measures that you would propose?	• Two respondents suggested need to better collect SDOH and research SDOH before including it as a risk adjuster; at least one respondent was skeptical about using SDOH as a risk adjuster at all
21. In which quality measure reporting programs is your organization currently participating?	N/A
22. In what specific ways should DHCF seek to align its ACO model with other programs being implemented in the District, such as the Medicare Shared Savings Program (e.g., quality measures, attribution methodologies, payment and shared savings/risk models) and the QPP?	• Align with DC-specific programs • If aligning with Medicare, be sure to customize to Medicaid population
23. Are there any other value-based purchasing models that DHCF should pursue in the future?	• Some providers indicated that there are limited VBP payments flowing from the MCOs to providers and DHCF needs formal policy changes to drive value • Some payers indicated that the LAN Category 3 or 4 VBP requirements in the MCO contract can also drive innovation
24. Please describe your organization's level of interest in becoming a DC Medicaid ACO.	Much interest from respondents, many suggested they need: 1) time to prepare; 2) startup funds; 3) Better HIE; 4) transparency in financing; and 5) certainty around assigned populations