



N.C. Department of Health
and Human Services

Physical Health Services Recommendation

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Staging of reform in physical health

1. Physical health services coordination opportunity offered to accountable care organizations (ACOs)
2. ACOs expected to grow capacity/coverage and to assume increasing degrees of risk for costs and quality of care



What are ACOs?

Accountable care organizations (ACOs) are integrated groups of health care providers who

- (1) provide coordinated care across multiple health care settings and
- (2) agree with the payer to be held accountable for achieving
 - a) measured quality improvements and
 - b) reductions in the rate of spending growth.

Medicare, private payers, and a few state Medicaid programs have started using ACOs



Providers aligned, with incentives

Today	After ACO
Providers fragmented	Providers aligned in local or regional accountable care organizations
Beneficiary chooses PCP	Beneficiary selects PCP, is attributed to ACO to which PCP belongs
Fee-for-service payment	Fee-for-service payment
State is solely at risk for Medicaid overrun	Providers rewarded for savings, share risk for budget overruns
No quality incentive	Quality incentive for ACOs and participating providers



Structure and function of ACOs

- Substantial control of ACO by participating providers
- Network capacity to accept at least 5,000 Medicaid beneficiaries
 - Network to include PCPs suited to serve Medicaid population
 - Very important to include essential community providers
- Providers commit to comply with ACO's and Medicaid's rules
- Quality and care management
 - Evidence-based medicine
 - Beneficiary engagement
 - Internal reporting on quality and costs
 - Individualized care planning, coordination
- Use of data
 - Evaluate participant performance
 - Assess and improve quality of care
 - Conduct population based health improvement

Medicare Shared Savings Program ACO provisions are a point of reference but must be adapted

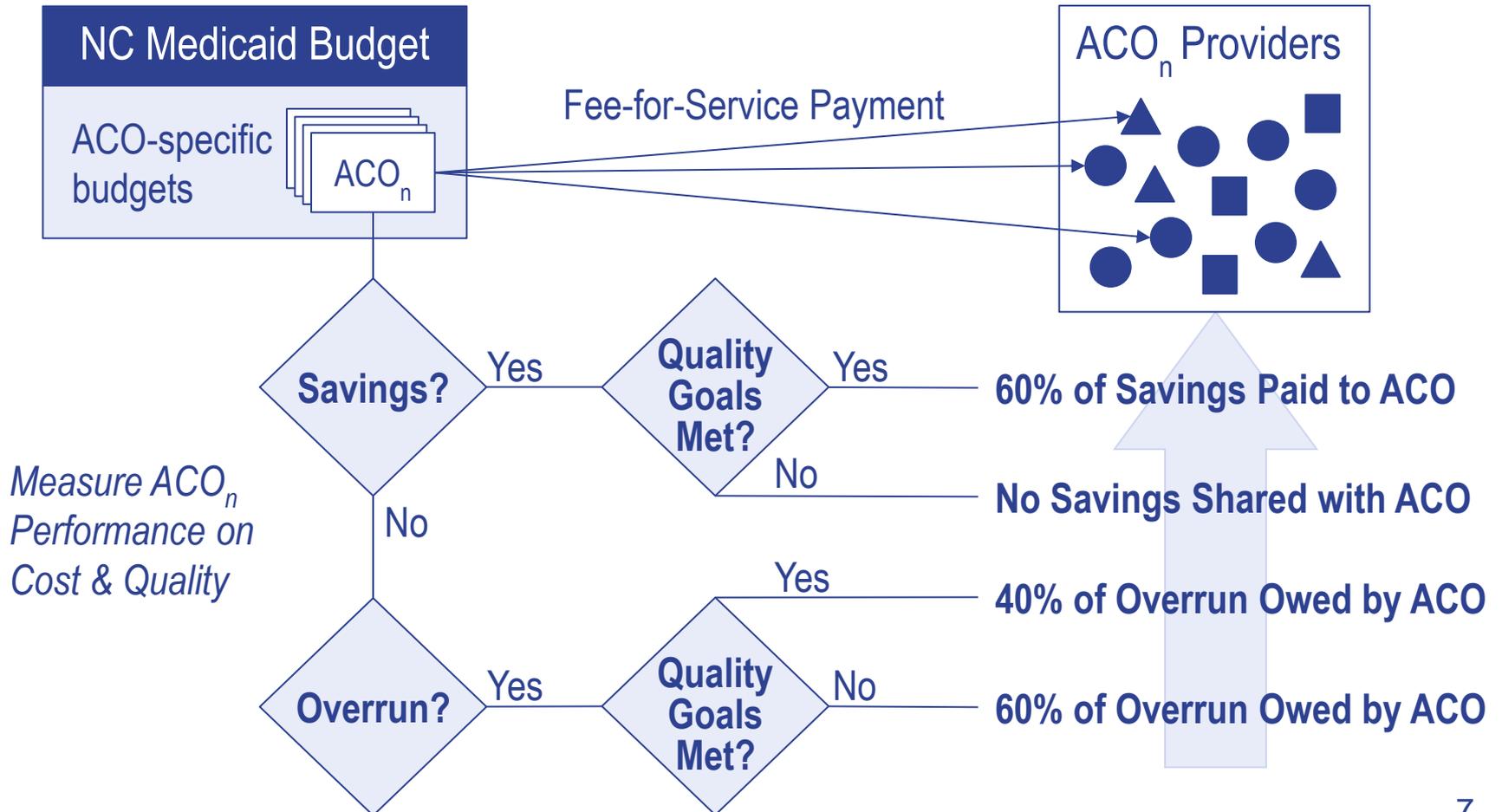


Expectations of ACOs

- Target start date for ACOs: July 2015
 - Existing and new ACOs to apply for contracts early 2015
 - Participation voluntary initially
 - Consideration of “virtual ACO” for uncovered territory
- ACOs expected to meet yearly benchmarks
 - Cost growth trend reduced materially
 - Quality scores steadily improve
 - ACOs take on higher share of risk
 - At least 80% of beneficiaries linked to ACOs in year 3



ACO value-based payment concept





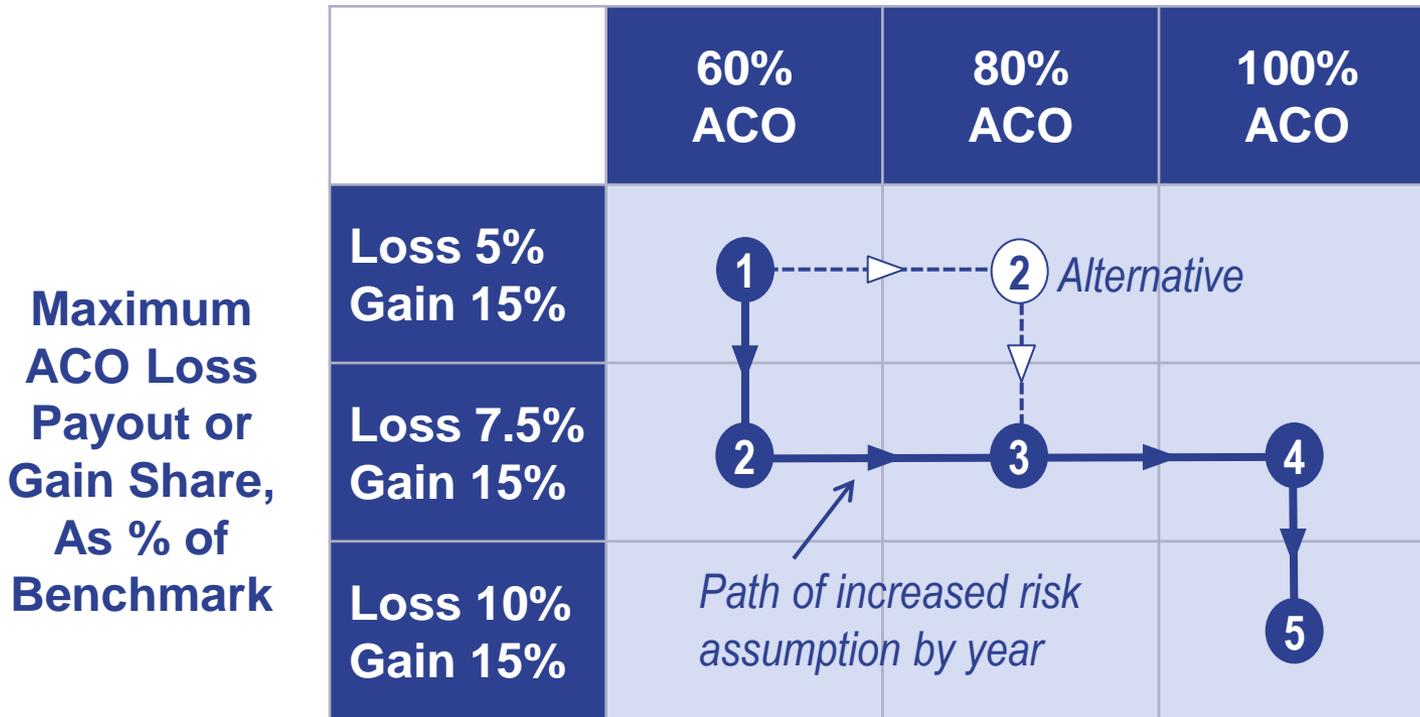
ACOs' risk of loss mitigated

- Services not controlled by ACO not factor in ACO risk
 - Mental health, substance abuse, I/DD
 - Long-term services and supports
 - Dental
 - Portion of outpatient prescription drugs (share with LME-MCOs)
- State and ACO share risk on pro rata basis
- Most of costs of individual high-cost cases excluded
 - Ex: 90% of costs above \$50,000 for a beneficiary in one year
- Total ACO risk of loss capped at % of budget



Pathway to growing ACO risk

ACO's Pro Rata Share of Loss or Gain



Pilot projects having higher risk sooner will be considered



Quality factors into rewards

Medicare Shared Savings Program Quality Measures a Starting Point

Domain	Examples
Patient/Caregiver Experience • 7 measures	<ul style="list-style-type: none">• Patient rating of provider• Timely appointments, information• Access to specialists
Preventive Health • 8 measures	<ul style="list-style-type: none">• Influenza immunization• BMI screening and follow-up• Screening for clinical depression
At-Risk Population • 12 measures	<ul style="list-style-type: none">• Diabetes: Hemoglobin A1c control• Hypertension control• Coronary artery disease: lipid control
Care Coordination/ Patient Safety/ HER • 6 measures	<ul style="list-style-type: none">• Hospital readmissions• % of PCPs who qualify for EHR incentive payments