


GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director/Medicaid Director

Transmittal # 17-10

TO: All Interested Parties

FROM: Claudia Schlosberg, J.D. 
Senior Deputy Director and State Medicaid Director

DATE: April 19, 2017

SUBJECT: Request for Information on Potential Medicaid Accountable Care Organizations

The Department of Health Care Finance (DHCF) is soliciting stakeholder responses to gauge interest and feedback on the prospect of developing Medicaid Accountable Care Organizations (ACOs) in the District. Please note that this is a Request for Information (RFI). No award will be made as a result of this RFI.

Purpose

Medicaid ACOs are groups of providers who come together to provide service and manage the quality and cost of care for a specified patient population. DHCF is interested in perspectives on the potential development of ACOs that would be charged with providing high-quality, cost-effective care to District Medicaid beneficiaries.

Submissions

DHCF will accept responses to the attached RFI by email at HealthInnovation@dc.gov by Friday May 19, 2017 at 5:00 PM (ET). All submissions should be single-spaced on 8 ½" by 11" pages. All responses must be limited to a maximum of 12 pages in total, excluding appendices.

CC: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance



Request for Information:

Accountable Care Organization (ACO) Program Design to Promote Population Health

April 19, 2017

To All Interested Parties:

The Department of Health Care Finance (DHCF) is soliciting information from interested parties regarding the potential development of a Medicaid accountable care organizations (ACO) within the District.

This Request for Information (RFI) is exploratory in nature. No award will be made as a result of this RFI. DHCF may share responses publicly in aggregate; however, individual responses will not be identified.

Submission Deadline: Friday May 19, 2017 at 5:00 PM (ET)

Submission Format: Responses to this RFI should be submitted in a Microsoft Word attachment and single-spaced on 8 ½" by 11" pages.

Respondents: DHCF is seeking feedback from the health plans, provider networks, independent providers, hospital organizations, consumers, patient advocates, and other stakeholders interested in the prospect of developing Medicaid ACOs in the District.

Questions: Questions concerning this RFI must be received via email at HealthInnovation@dc.gov no later than Friday, May 5th, at 5:00 PM (ET). Please reference the transmittal number on all correspondence. Any questions received in response to the RFI will be posted on DHCF's website as an addendum to this solicitation.

Table of Contents

1.0 Introduction3

1.1 RFI to Inform the Potential Design of Medicaid Accountable Care Organization (ACO) Program 3

1.2 Process 3

2.0 Background 3

2.1 Purpose of the Request for Information..... 3

2.2 Premise for Reform 4

2.3 Current Program Characteristics..... 5

3.0 Content of Requested Response.....6

3.1 Organization Profile 7

3.2 Principles for Value-Based Purchasing in the District 7

3.3 Potential ACO Program Requirements 8

3.4: Feedback on Key Aspects of Program Design 11

3.5: Interest in Becoming an ACO 13

1.0 Introduction

On behalf of the Government of the District of Columbia, the Department of Health Care Finance (DHCF) is soliciting responses from the provider community, health plans, and interested stakeholders to gauge interest and feedback on the prospect of developing Medicaid ACOs in the District. ACOs are one potential strategy to enable providers to play a larger role managing population health and collaborate with DHCF to enhance health care quality, improve care and outcomes, promote health equity, and ensure optimal value and efficiency of DHCF's programs.

This is a Request for Information (RFI). No award will be made as a result of this RFI.

1.1 RFI to Inform the Potential Design of Medicaid Accountable Care Organization (ACO) Program

This RFI outlines the type of information being solicited from potential respondents and includes guidelines for content and format of responses. The RFI includes a number of questions designed to solicit feedback on key aspects of a potential ACO design. Respondents need not reply to every question to participate in this process.

DHCF may share responses publicly in aggregate; however, individual responses will not be identified.

1.2 Process

Please submit responses by email to HealthInnovation@dc.gov by Friday May 19, 2017 at 5:00 PM (ET). All submissions should be single-spaced on 8 ½" by 11" pages. All responses must be limited to a maximum of 12 pages in total, excluding appendices.

2.0 Background

2.1 Purpose of the Request for Information

This Request for Information (RFI) is being issued to solicit specific information from health plans, provider networks, independent providers, hospital organizations, consumers, patient advocates, and other interested stakeholders with respect to the potential establishment of a Medicaid ACO program in the District.

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.

DHCF is interested in perspectives on the development of ACOs that would be charged with providing high-quality, cost-effective care to District Medicaid beneficiaries. DHCF will use findings generated by this RFI in conjunction with other available information to develop a proposed approach to a Medicaid ACO program design, provider eligibility standards, and potential contractual requirements for accountable entities.

This RFI is specifically seeking input on program design and standards such as:

- eligible patient populations
- scope of services and capacity
- program requirements, such as governance and analytic capabilities
- payment models
- attribution methods
- quality measurement
- oversight

2.2 Premise for Reform

DHCF is committed to transitioning the District's Medicaid system away from a fee-for-service (FFS) or volume-based payment approach and towards shared risk and population based payment approaches. The formation of ACOs is one pathway to improve the overall quality of delivered health care while reducing health care costs. Other states are implementing ACOs as a way to pair delivery system reform and payment reform in an attempt to improve quality of care and control costs.

The experience from other states suggests that several key delivery system elements need to be in place for providers to thrive within an ACO model. For example, health information exchange connectivity, care coordination infrastructure, and a robust quality measurement strategy are foundational to delivery system reforms. Many District providers have (or are working towards) developing these delivery system reforms, often with technical and/or financial support from DHCF. Coupling these emergent delivery system reforms with the District's small geographic size, high rates of Medicaid coverage, and high concentration of providers, the District may be well positioned to implement a Medicaid ACO program.

Despite the many positive attributes of the District's Medicaid program, District residents continue to have a high burden of poor health, experience fragmented care, and poor health outcomes, with substantial disparities in care and outcomes across the city. The combination of system features, the need for greater care integration and new models of accountable care suggest this may be an opportune time to design and implement a Medicaid ACO program in the District.

The District's Medicaid program is already pursuing a robust value-based purchasing (VBP) agenda. The District's current VBP programs all align around improving health outcomes with the focus on three key performance measures - that are tracked on an ongoing basis, including:

- Potentially preventable hospital admissions;
- Low acuity non-emergent visits to hospital emergency rooms; and
- Hospital readmissions within 30 days of previous admissions.

All subsequent risk-sharing approaches will maintain this focus on managing population health to promote quality outcomes and reduce potentially avoidable events.

The following sections describe key features and progress designing a Medicaid program that meets the goal of enhancing health care quality, improving care and outcomes, promoting health equity, and ensuring the value and efficiency of DHCF's programs.

2.3 Current Program Characteristics

An effective Medicaid ACO program design must consider the following characteristics of the current Medicaid program in the District. Specifically:

2.3.1: Populations Served

The District of Columbia has made a strong commitment to provide access to care through health coverage. The District's program served approximately 272,228 beneficiaries in FY 2015. The District enjoys one of the highest insured rates, 96.2% in the United States as of 2015, which is second only to Massachusetts and tied with Vermont. This high rate of insured is due to high employer coverage rates as well as Medicaid and DC Healthcare Alliance coverage (a locally funded public program for residents not eligible for Medicaid).

Forty-one percent of the District's population has coverage through Medicaid. Other major sources of coverage are employer sponsored insurance, Medicare, and the individual market. At present, there is a strong degree of competition within the large group market among several large insurers, and greater consolidation in the individual and small group market.

2.3.2: Medicaid Program Expenditures

The District's Medicaid program is a \$2.7 billion program annually. Over the past ten years, the District's annual Medicaid expenditure growth rate has varied, ranging from 5.8% to 9% annually.

2.3.3: Participating Providers

The eight hospitals/ health systems and nearly 1,910 primary care providers located in the District (of whom 57% are enrolled in Medicaid) are essential to the overall healthcare landscape. However, these providers are largely concentrated in the more affluent quadrants of the District. Residents in Wards 7 and 8 (which largely encompass the District's three Medically Underserved Areas) have particularly limited access to care. A high proportion of this population is served by our eight Federally Qualified Health Centers (FQHCs), in addition to the hospitals and primary care providers who participate in the Medicare Shared Savings program. Additionally, FQHCs currently serve 36% of Medicaid beneficiaries within the FFS program.

2.3.4: Long-term Services and Supports

Long-term services and supports, including both institutional care and home and community-based services, accounted for about 30% of Medicaid expenditures. In 2016, DHCF renewed the agency's Elderly and Persons with Disabilities (EPD) waiver, which was recently approved by CMS.

2.3.5: Managed Care

Approximately seventy-five percent of the District's Medicaid beneficiaries are enrolled in the managed care program (including individuals enrolled in the DC Health Care Alliance Program) as of FY2017. These managed care enrollees account for 44% of Medicaid expenditures.

2.3.6: High Utilizers

Within the District, the highest cost/highest need beneficiaries (top 5th percentile) make up 60% of total Medicaid spending.

The vast majority of these beneficiaries have multiple chronic conditions, including a large cohort who has three or more chronic conditions. Among these individuals (excluding the cost of long-term care and support services), annual expenditures average \$17,658 per person, more than double the average per person cost for all other Medicaid beneficiaries (\$7,241).

2.3.7: Connectivity and Analytic Capabilities to Manage Population Health

Access to electronic health data and the exchange of health information has grown substantially in the last few years. As of 2014, nearly 90% of all actively practicing District-based physicians report using an Electronic Health Record (EHR). Ensuring health information is available whenever and wherever needed is the District HIE's vision, and is a critical component of successful population health management needed for a Medicaid ACO model.

Over the last several years, health information exchange (HIE) has become more common in the District. As of 2017, all hospitals in the District are subscribed to the Chesapeake Regional Information System for our Patients (CRISP) and more than 460,000 notifications are now sent on a quarterly basis, a four-fold increase compared to 2015. These data indicate a high-level of connectivity and increasing access to real-time data provided across HIEs in the District.

In 2017, DHCF will work with CRISP and the DC Primary Care Association (DCPCA) to build four new health IT tools that will substantially expand opportunities to measure and evaluate population health. These include 1) a dynamic patient care profile tool incorporating data from healthcare providers as well as social supports and services; 2) an electronic clinical quality measurement tool and dashboard for assessing performance against key measures; 3) an analytical patient population dashboard; and 4) a OB/prenatal specialized registry. These tools will be paired with technical assistance to support use of these tools and connectivity across the HIE. Overall, the District's capacity for health information exchange is maturing at a rapid-pace and will soon be in a position to support the data analytics needed to coordinate care in real-time so that providers can benchmark performance and develop appropriate risk-bearing contracts.

3.0 Content of Requested Response

The following sections outline a set of questions for the community to guide our approach to a potential Medicaid ACO Model. The organization of the questions - and suggested page counts - is intended to minimize respondent burden and provide a structured response to facilitate analysis. The questions can

be used to guide responses, but each question need not be answered to participate. All responses must be limited to a maximum of 12 pages in total, excluding appendices. Concise responses are appreciated.

3.1 Organization Profile (2 pages)

In order to establish certification standards and better understand the health care landscape, it is helpful to understand the existing organizational structures and affiliations among provider groups in our community.

For organizations that deliver services to Medicaid beneficiaries, DHCF requests an overview of your organization.

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.

3.2 Principles for Value-Based Purchasing in the District (2 pages)

A key objective of this RFI is the desire to understand opportunities for Medicaid ACOs to expand access, improve health care quality as well as care and outcomes, promote health equity, and enhance the value and efficiency of DHCF's programs.

DHCF views the following value-based purchasing guiding principles as foundations of this effort:

- *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.

DHCF hopes to use these principles to help guide the development of future value-based purchasing initiatives, including this exploration into the potential of a Medicaid ACO.

2. Do you agree that the principles above should serve as a foundation for any future value-based purchasing initiatives? Are there others you feel should be included? Deleted?
3. What do you see as the greatest value-based purchasing opportunities in the District? Please describe specific initiatives, intervention, and/or target populations.
4. Are ACOs the right payment payment/delivery system model for achieving these goals? Why or why not?

3.3 Potential ACO Program Requirements (5 pages)

One delivery system reform approach that encompasses value-based purchasing and allows providers and other health professionals to take the lead in managing population health is the formation of ACOs. The following subsections propose requirements related to key components of an ACO.

3.3.1: Definition of an ACO

As outlined in Section 2.1, DHCF's preliminary working definition of 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.

5. Do you agree with this definition? Please suggest any edits to this working definition.
6. What do you believe are the most critical delivery system features of an effective ACO program?

3.3.2: Eligible Patient Population(s)

To ensure that ACOs target and serve beneficiaries most appropriately, DHCF seeks comments on beneficiary eligibility, assignment, and panel size criteria. DHCF is preliminarily proposing that a Medicaid ACO be required to enroll a minimum of 5,000 beneficiaries to adequately manage risk.

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).
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)?

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?

3.3.3: Required Scope of Services

Entities may be held accountable for the total cost of care for a cohort of beneficiaries. This total cost of care arrangement may require:

- Providers to be accountable for the full spectrum of services such as primary, specialty, behavioral health, dental, and long term care services, as appropriate to serve the specified population. This approach may require:
 - Participating primary care providers be qualified patient centered medical homes.
 - Integration with community organizations that can address social determinants of health (e.g. housing, employment, food security, transportation and substance use disorder recovery).

10. Which types of covered services should ACOs be responsible for delivering?

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?

3.3.4: Data/Analytics Capacity

Expert guidance suggests that ACOs need access to real time or near real time data and should have the analytic capacity to effectively use that data to improve individuals’ care and manage population health. As such, DHCF may require that ACOs demonstrate the following minimal data and analytic capacity:

- 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.
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.
13. For organizations delivering services to Medicaid beneficiaries, please describe your current and future data and analytical capacity, including:
- What data and analytical capacities are currently available to your organization?
 - What data and analytical capacities is your organization pursuing?
 - What data and analytical capacities are needed at your organization in order to participate in a Medicaid ACO program?
 - What data and infrastructure capabilities could DHCF provide to ACOs to help facilitate improved quality and care coordination?

3.3.5: Governance

DHCF acknowledges the importance of developing an effective governance model and a need to ensure that key community participants are included in the leadership team of an ACO. These community members should have the ability to influence or direct clinical practice to improve outcomes.

Draft Governance standards for certified ACOs would likely include both a corporate structure and governing board, as outlined below:

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.

14. DHCF would appreciate comments on the importance of the specific standards outlined above.

15. What impact would these governance requirements have on the existing structures already in place or under development in the District?

3.4: Feedback on Key Aspects of Program Design: (2 pages)

The following subsections outline key program design considerations for your feedback, including questions related to managed care organizations (MCOs), payment, quality measurement, and alignment with other programs.

3.4.1: Interaction with MCOs

Many states that implement a Medicaid ACO program continue to contract with their MCOs to provide care to Medicaid beneficiaries under a capitated arrangement. States have generally employed one of three approaches:

- States allow MCOs to voluntarily contract with ACOs that have been certified by the state
- States require the MCOs to contract with ACOs that have been certified by the state
- States allow ACOs that meet MCO requirements to participate in the MCO procurement process

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?

3.4.2: Payment Model

Considering the interaction of MCO questions in 3.4.1, DHCF welcomes feedback on the following principles guiding DHCF's potential approach to payment:

- All parties have financial incentives to manage care – MCOs, ACOs, District
- Partnerships are encouraged to create common priorities
- Risk potential must be adjusted over time in response to an entity's demonstrated ability to meet performance standards/quality metrics

Moving toward an “equal partnership” model is intended to allow for both the ACO and the MCO to have appropriate incentives to manage the total cost of care.

DHCF seeks comments on potential payment approaches.

17. What do you think of the proposed payment principles? What should DHCF’s approach be to address the additional payment considerations listed below?

- Should ACOs be paid using shared savings; shared savings/shared risk; partial or full capitation payment; or other mechanisms? Should all ACOs have to come in at the same payment level?
- How much flexibility should there be in an ACO model when it comes to risk? Should there be a minimum level of (upside and/or downside) risk that all ACOs bear, and if so, what should it look like? Should there be a maximum limit on risk that falls short of an ACO being at full risk for all covered services for its members?
- What parameters, if any, should DHCF have for how funds flow from the ACO to network providers within the ACO?
- How should social determinants of health be factored into payment models? What risk adjustment tools or variables are key to this type of risk adjustment?

3.4.3 Performance Metrics

The state recognizes that the incentive for ACOs to focus on total cost of care must be balanced with specific, detailed performance metrics that are ultimately centered on population health outcome measures.

As such, DHCF intends to establish performance metrics for ACOs that include both overall delivery system transformation metrics, as well as provider-specific metrics of transformation. Access to care, quality of care, satisfaction with care, and health outcomes would be tracked at both the population and provider specific level.

Please refer to the proposed programmatic principles in Section 3.2 and provide recommendations and comments on the characteristics of performance metrics that can help ensure Medicaid ACOs are achieving the District’s desired aims.

18. Which performance metrics are most critical to achieving the goals stated above?

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.)?
20. Should measures that incorporate social determinants of health data be included? If so, has your organization identified effective measures that you would propose?
21. In which quality measure reporting programs is your organization currently participating?

3.4.4: Alignment with other District, Federal, or Private Programs

Currently, several organizations in the District participate in other federal programs such as the Medicare Shared Savings program. With the advent of the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP), DHCF seeks specific recommendations and comments on how best to align with these or other value-based purchasing program.

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?
23. Are there any other value-based purchasing models that DHCF should pursue in the future?

3.5: Interest in Becoming an ACO (1 page)

DHCF seeks to learn more about stakeholder's level of interest in becoming a DC Medicaid ACO.

24. Please describe your organization's level of interest in becoming a DC Medicaid ACO.
 - If interested, please indicate the population(s) that your organization would seek to serve.
 - The timeline by which your organization would be prepared to participate as an ACO.
 - List any challenges and limiting factors that would prevent your organization from being able to meet the criteria proposed in this RFI and suggest potential methods of addressing them.
 - Please suggest specific actions or incentives DHCF might take or provide that might encourage additional participation in the program, or accelerate the timeline needed to participate.