

# **State of Delaware**

## **Medicaid Accountable Care Organization**

### **Request for Information HSS 19-035**

#### **For**

## **Division of Medicaid and Medical Assistance**

Deadline to respond

March 1, 2019

11AM

**Date: 02/01/2019**

**REQUEST for INFORMATION NO. HSS 19-035**

This Request for Information (RFI) will **not** result in award of a competitively bid contract.

The State of Delaware, Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA), is seeking market information on the design and development of Medicaid Accountable Care Organizations (ACOs). The information gathered may or may not lead to the issuance of a Request for Proposals.

Responses to this RFI will remain confidential until such time as a determination is made on whether the State will move forward with a Request for Proposal for any one or more types of Medicaid ACO services. If a decision is made to move forward with a Request for Proposal, the responses to this Request for Information will remain confidential until the completion of the Request for Proposal process.

All responses to this RFI shall be submitted in a sealed envelope **clearly displaying the request for information number HSS 19-035 and responder name** by 03/01/2019 by 11 AM.

**Responses must be mailed to:**  
**Kimberly Jones**  
**Purchasing Service Administrator**  
**Department of Health and Social Services**  
**Procurement Branch**  
**Main Admin Bldg., Sullivan Street**  
**2<sup>nd</sup> floor – room #257**  
**1901 N. DuPont Hwy.**  
**Herman Holloway Campus**  
**New Castle, DE 19720**

Please review and follow the information and instructions contained in this Request for Information (RFI). Should you need additional information, please contact;

**Alexis Bryan-Dorsey**  
**Chief of Administration**  
**Division of Medicaid & Medical Assistance**  
**Herman M. Holloway Sr. Campus**  
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**I. Background**

Four years ago, the Centers for Medicare & Medicaid Services (CMS) awarded Delaware a State Innovation Model grant to achieve five state-defined objectives, one of which was to engage payers to move health care payment to a pay-for-value model based on total cost of

care budgeting. Since that time, and following considerable intensive stakeholder work, it has become apparent there are limits to the scope and pace of progress through voluntary adoption of payment and delivery reform by payers and providers. In states that have initiated or implemented reform, state government and stakeholders have collaborated to create mechanisms that bolster and accelerate system transformation.

In its 2017 *Report to the Delaware General Assembly on Establishing a Health Care Benchmark*, DHSS identified five strategies to advance the adoption of value-based payment (VBP) models, one of which was the implementation of total cost of care alternative payment models within Medicaid managed care contracts and the State Employee Benefit Contracts. In 2018, DHSS increased its focus on alternative payment strategies by adding VBP requirements to its Medicaid managed care contracts for calendar year 2018.

In an effort to improve health outcomes for Medicaid patients, lower health care costs, and increase provider accountability for quality and cost, Delaware DHSS is now considering creating a Medicaid ACO program in which ACOs would work with Medicaid managed care organizations (MCOs) as part of their network providers. ACOs (and clinically integrated networks [CINs]) are provider affiliations created to contract with payers for managing the health and cost of care for defined populations of patients, typically as determined by patient primary care provider affiliation. Delaware providers are positioned to take this step with nearly 50% of primary care providers and all health systems now participating in one or more ACOs or CINs. Based on interviews conducted in 2018 with Medicaid health care providers and stakeholders, an ACO model appears to have the greatest potential for uptake among Delaware Medicaid managed care plans and providers.

Kaiser defines ACOs as, “a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. At the heart of each patient’s care is a primary care physician. ACOs can include hospitals, specialists, post-acute providers and even private companies. The only must-have element is primary care physicians, who serve as the linchpin of the program.”<sup>1</sup> This definition provides a great deal of flexibility and DHSS supports such flexibility to develop models with new or existing organizations that meet the needs of a variety of programs and populations; however, DHSS believes that there are critical characteristics to successful Medicaid ACOs.

DHSS’ vision for a Medicaid ACO incorporates the following critical elements:

1. Governance and leadership – The governance structure and leadership features must focus on clinical systems and data sharing that support provider accountability and care management. Clinical protocols and practice support must enable providers to be effective agents in a care strategy that results in the delivery of high quality care, delivers better patient experiences including successful engagement in treatment, and emphasizes prevention resulting in lower costs of care. The

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<sup>1</sup> Jenny Gold, Kaiser Health News, “Accountable Care Organization, Explained” September 14, 2015

<https://khn.org/news/aco-accountable-care-organization-faq/>

- governance model should clearly align incentives and share in risks and rewards between providers, particularly primary care providers and the ACO entity.
2. Target populations – Medicaid programs often serve the most vulnerable populations including children with complex conditions, individuals with chronic conditions, medically frail, as well as aged and disabled populations. DHSS believes that care management and coordination strategies, a focus on prevention and compliance strategies at the core of a Medicaid ACO strategy can drive better outcomes and quality of life for Medicaid populations.
  3. Primary care – DHSS agrees with Kaiser that primary care is the linchpin of a successful ACO model and should be at the core of care management and patient engagement strategies.
  4. Financial models – Reimbursement models must align incentives and must fairly compensate ACO participants. To the extent ACOs and their provider members are able to successfully participate in alternative payment structures, these structures should be utilized. Provider payment structures should align with delivery system and clinical protocol goals resulting in a shared accountability and rewards throughout the organization.
  5. Data and analytic capacity – ACOs must be able to gather, analyze, and distribute data and clinical information and provide analytical support to member physicians. Care management and patient engagement is dependent on timely, accurate, and complete data. ACOs must have a strong data strategy that is shared within its provider community.
  6. MCO partnership – ACOs and MCOs bring unique skills and resources to the delivery system and those resources must be effectively leveraged to avoid duplication and provide the best information and access to enrollees. ACOs that work in collaboration with MCOs must have a strong partnership with clear delineations of responsibility and accountability.

While these attributes do not necessarily encompass every aspect of a successful Medicaid ACO, DHSS believes these elements form a strong base for what an ACO must address. DHSS envisions ACOs, together with MCO partners, would manage the total cost of care tied to quality metrics with a progression toward increased provider risk. Such accountability should accelerate delivery system reform within the State driving quality and cost management.

DHSS is releasing this RFI to solicit feedback from all stakeholders to inform a Medicaid ACO program design, including:

- Current and potential ACOs
- Health care providers, including behavioral health providers and providers of long-term services and supports
- Beneficiaries and their families
- MCOs
- Community-based organizations and social service providers

This RFI seeks stakeholder input on these critical elements and on any additional features of a successful ACO that would operate within Medicaid MCOs in Delaware.

## **II. Responses to this Request for Information:**

After reviewing the State's RFI, Respondents shall provide responses to the questions listed in Appendix A.

Each Respondent shall provide one (3) paper copy and two (3) electronic copies.

## **Appendix A Questions**

### **A. RFI respondent information**

In order to support the design of an ACO program, DHSS seeks to better understand stakeholder organization structures, affiliations, and risk arrangements.

1. For organizations that deliver services to Medicaid beneficiaries, please provide a brief description of your organization, including, as applicable:
  - The number of Medicaid beneficiaries you serve and types of services you provide.
  - Current or planned affiliations that support a fully integrated, coordinated care model serving Medicaid beneficiaries.
  - Your organization's experience with risk-based contracts.
2. For current Medicaid MCOs, please provide a brief description of your organization, including:
  - The number of Medicaid beneficiaries you serve and types of services you provide.
  - Current or planned arrangements that support a fully integrated, coordinated care model serving Medicaid beneficiaries.
  - Your organization's experience with risk-based contracts with provider organizations.

### **B. ACO definition and governance**

Governance is a critical part of Medicaid ACO program design, and shapes the priorities and investments of the participating ACOs. DHSS seeks feedback on how a Medicaid ACO program should be defined and governed in Delaware.

1. How should DHSS define "ACO" for the purposes of a Delaware Medicaid ACO program?
2. What are the most critical features of an effective ACO program?

3. What requirements should DHSS develop related to ACO governance or leadership and management structure (e.g., corporate structures allowed, governing board membership)?
4. How should DHSS ensure primary care is the foundation of the ACO program?
5. What structures or competencies are necessary for providers to take on accountability for cost and quality of care?

### **C. Beneficiary eligibility and attribution to ACOs**

ACOs serve beneficiaries that are “attributed” to the ACO through a pre-established process, and are responsible for the cost and quality of care delivered to these attributed beneficiaries. Two common attribution methods are (1) prospective attribution, where patients are attributed in advance of the year through MCO assignment, patient selection, or historical utilization; or (2) retrospective attribution, where patients are attributed after-the-fact based on their actual utilization during the year.

1. Which eligibility groups, populations, or sub-populations would mostly likely benefit from care under an ACO model?
2. Are there any eligibility groups, populations, or sub-populations that should be excluded from consideration under an ACO model? If so, please explain.
3. How should beneficiaries be attributed to ACOs (e.g., retrospectively or prospectively, based on primary care or specialty service utilization)?
4. Should DHSS require health care entities to have a minimum number of attributed beneficiaries to participate in the ACO program? What is an appropriate beneficiary threshold?

### **D. State ACO requirements and MCO contracting**

DHSS is considering an approach in which ACOs work with MCOs as part of the MCOs’ network providers. Some states with ACO programs for a managed care population have created a standardized, state-administered ACO certification process. Others have broadly-defined program requirements and administer these requirements solely through MCO contracts.

1. How can DHSS ensure ACOs have the necessary capabilities and infrastructure to manage cost and quality of care?
2. How prescriptive should ACO program participation requirements be (e.g., should ACOs have specific provider participation requirements, should the quality measurement and payment model be flexible)?

3. Should MCOs be required to contract with ACOs in order to participate in Medicaid?  
Should ACOs be required to contract with MCOs?

#### **E. Payment model**

An ACO model aims to hold health care providers accountable for the total cost of care of attributed beneficiaries. DHSS envisions ACOs, together with MCO partners, would manage the total cost of care tied to quality metrics with a progression towards increased provider risk.

1. Which types of covered services should be included in the total cost of care for shared risk arrangements (e.g., primary care, specialty, behavioral health, pharmacy, and/or long-term services and supports)?
2. Are there any types of covered services that should be excluded from the total cost of care for shared risk arrangements?
3. Should ACO total cost of care and quality targets be based on historical performance of the ACO, market performance relative to other ACOs, or another approach?
4. How much flexibility should DHSS allow in the amount of risk an ACO takes on?  
What is a reasonable timeframe for requiring ACOs to take on downside risk?
5. What criteria should be used to evaluate the ability of an ACO to take on financial risk?
6. Should DHSS define requirements related to risk-adjustment methodology used for Value Based Purchasing (VBP) or should MCOs be responsible for risk adjustment?

#### **F. Performance measures**

To incentivize improved quality of care, ACO programs link payments to performance on quality measures across domains such as health outcomes, process, patient experience, and access to care.

1. What considerations should guide the selection of quality measures for use in the ACO program (e.g., alignment with other VBP programs, based on claims/clinical data, focus on high-needs populations)?
2. What role, if any, should DHSS have in selecting quality measures for the MCOs and ACOs to use in evaluating program performance?

#### **G. Care coordination, management, and integration**

ACO models aim to improve communication between organizations and care teams to provide coordinated, patient-centered care across the care continuum. Care management programs are an important means of supporting this goal and improving health outcomes of high risk patient

populations. DHSS is also considering how to address social determinants (e.g. socio-economic or environmental factors) that impact health outcomes.

1. What role should non-primary care providers, such as behavioral health or long-term services and supports providers, play in an ACO program?
2. How can ACOs coordinate and integrate services with social service providers (e.g., food banks, housing services, job placement services)?
3. To what extent should ACOs be expected to coordinate with community-based organizations?
4. How can MCOs and ACOs partner to effectively provide care management to beneficiaries? Are there certain capabilities that are more appropriate for one entity to lead? If so, please explain.

#### **H. Data and analytic capacity**

To effectively coordinate care, Medicaid ACOs need to be able to analyze data to track cost and quality measures and improve care delivery. This includes 1) receiving timely claims data, 2) collecting and reporting on clinical data, 3) analyzing claims and quality data to inform programs and quality improvement initiatives.

1. What data should be provided to ACOs to facilitate performance tracking, care coordination, care management, cost management, and quality improvement?
2. What is the optimal or preferred frequency of applicable data sharing with ACOs? What format should the data be in (e.g., raw data feed, reports, etc.)?
3. What data processing and analytic capabilities must ACOs have to effectively manage risk-based payment?
4. What data processing and analytic capabilities must MCOs provide to ACOs to effectively manage risk-based payment?
5. Health care providers (ONLY), please describe your organization's current data and analytic capabilities. Is your organization currently in the process of developing any additional capabilities?
6. Managed Care Organizations (ONLY), please describe how your organization could support ACOs in effectively utilizing data to improve quality and reduce cost of care.

#### **I. Alignment with other APM models**

Aligning program requirements and payment models across VBP initiatives may strengthen quality and cost incentives and minimize provider administrative burden.

1. Health care providers and MCOs (ONLY), does your organization currently participate in any VBP initiatives? What are these initiatives? Does your organization face VBP implementation challenges related to alignment across these programs?
2. How should DHSS align a Medicaid ACO program with existing VBP initiatives, such as the Medicare Shared Savings Program?

**J. Interest and ability to become an ACO (Health care providers and MCOs only)**

DHSS seeks to better understand stakeholder interest in participating in a Medicaid ACO program.

1. What is your organization's interest level in participating in a Medicaid ACO program?
2. When would your organization be ready to participate in a Medicaid ACO program?
3. Health care providers (ONLY), when do you anticipate your organization would be ready to accept downside risk? How many beneficiaries would you expect would be attributed to your ACO?
4. Please describe any barriers that may prevent your organization from participating in a Medicaid ACO program. How could DHSS help address these issues?
5. What policies or program features should DHSS consider to encourage ACO program participation?