

Health Home ASO Option Medicare and Medicaid Eligibles (MME) Model

For Consideration by the Complex Care Committee Model Design Group

December 22, 2011

OPTIONS FOR COMMENTS AND DISCUSSION ONLY

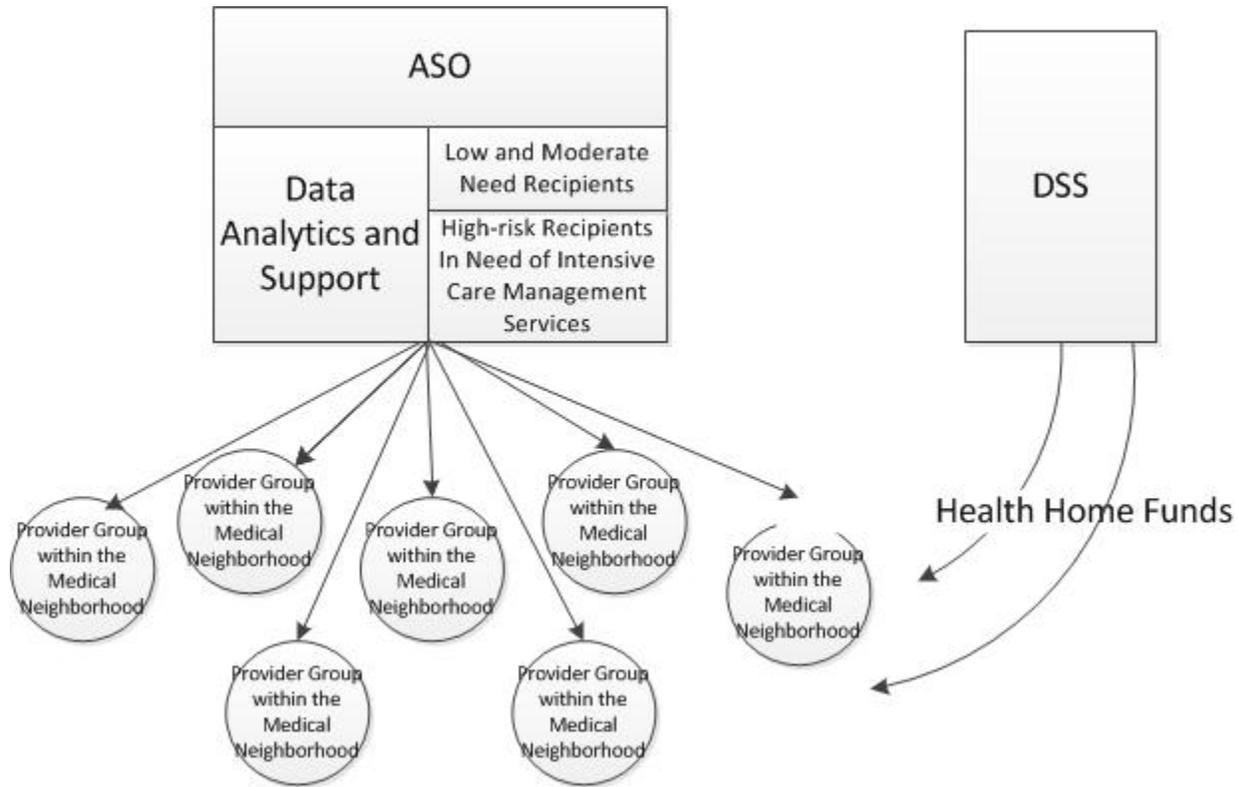
This document does not represent a proposed model by the Department of Social Services.

Model Overview: The ASO Health Home Model would rely on the infrastructure of an Administrative Services Only (ASO) organization to support and manage a person-centered, integrated approach to care delivery by the full continuum of providers.

The ASO may provide a range of supports as described below. Key elements of this model include:

- the formation of “medical neighborhoods” or multi-disciplinary clusters of providers that incorporate the full continuum of non-medical and medical services;
- support from an ASO infrastructure (TBD based on the model design)
- Health Homes that would serve individuals with SPMI and other chronic conditions, based on the definition and requirements set forth by CMS to obtain enhanced federal matching dollars
- The availability of Information Technology collaboration tools that facilitate sharing of HIPAA compliant information to support care coordination efforts
- Management of care transitions – both in the community and in institutional settings. Transition management would rely on, among other supports, real-time Emergency Department, Hospital Admission and other data to facilitate care management
- Incentives that would align services delivered across the continuum of care
- Ongoing stakeholder involvement and engagement, including consumer input, to continuously manage and improve service delivery to MMEs.

The model can graphically be depicted as follows:



	Health Home/ASO Option	Decision Points	Options t/b Considered
<p>Population Served</p>	<p>The Health Home/ASO Option would serve MMEs. The population would include a variety of sub-populations with different needs where providers could offer different care management models including, but not limited to, individuals who are:</p> <ul style="list-style-type: none"> • Community dwelling well elders, over age 65; • Community dwelling individuals, over age 65, who are Nursing Home Certifiable (NHC) that reside in the community. This may include individuals who are hospitalized but still consider a community dwelling their residence of record; • Individuals who are NHC and reside in an institutional setting. <p>Connecticut is aware that many MMEs have chronic conditions (e.g. asthma, diabetes, COPD, CHF, SPMI) and a significant number have multi-morbid conditions.</p> <p>MMEs with one or more chronic conditions or a Serious and Persistent Mental Illness (SPMI) may qualify for Health Home funding at a Federal Financial Participation (FFP) rate of 90%, assuming that the State creates such a program within their approach to serve MMEs. MMEs who qualify for Health Home services would be a key focus within this model.</p> <p>The Department is aware that Health Homes may restrict Health Homes to MMEs of particular ages (CMS is considering this); however, the Department may also have the ability to designate provider types to qualify to participate in the ASO/Health Home model (which would result in rough justice stratification regardless).</p>	<p>Will all dual eligibles over age 65 be enrolled or, will sub-sets of dual eligible individuals be excluded from the ASO/Health Home model?</p> <p>SPMI?</p>	<ul style="list-style-type: none"> • Focus initially on the >65 population as planned in the CMMI submission • Assuming that a Health Home option is incorporated, include individuals in the <65 population with specific chronic conditions based on the Health Home model • Incorporate the <65 population over time (with the exception of individuals with chronic conditions who may be served within the initial demonstration under the Health Home option)

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<p>Contracted Entities</p> <p>Providers</p>	<p>Under the Health Home/ASO option, the Department would likely contract with two different types of entities:</p> <ul style="list-style-type: none"> Providers who would be responsible for delivering services to Medicare Medicaid Eligibles (MMEs) as part of the Health Home/ASO option. Under such an arrangement, providers across a “medical neighborhood” could either be contractually or “virtually” connected. In the former example, the Department would contract with provider clusters (known in Colorado as “Regional Care Collaboratives;” in the latter, the Department would contract with primary care providers who would build and expand relationships with specialists, long term supports and services (LTSS) providers and other providers in the medical neighborhood. <p>Stakeholders may consider program design options where the state contracts with providers in various potential arrangements such as:</p> <ul style="list-style-type: none"> Primary care providers who informally link with specialists and non-medical support services within the medical neighborhood. The ASO may play a role in providing collaboration tools or otherwise helping relationships form across the medical neighborhood. Multi-specialty provider groups whose services are augmented by informal or formal relationships within the medical neighborhood. Care Collaboratives that incorporate both primary and specialty care and long-term supports and services (a la Colorado Regional Care Collaboratives) that can be characterized as contractually-based medical neighborhoods. <p>Under the Health Home/ASO option the state may</p>	<p>Which entity would the Department contract with? For what?</p> <p>How would the Department help support the creation of medical neighborhoods?</p> <p>How will the Department conduct outreach to identify, contract with and gain the participation of providers with expertise in serving individuals with disabilities, homeless individuals, persons with SPMI and other chronic conditions?</p> <p>What are the roles of various providers on the multidisciplinary team, including HCBS/LTCSS providers and medical providers?</p> <p>How can the Department facilitate the development of relationships among participants in medical neighborhoods who do not routinely collaborate with provider types across the neighborhood?</p>	<ul style="list-style-type: none"> Provider responsibilities may vary depending on the MME’s residential (community or institutional) and NHC/non-NHC status <p>Contracting options may include:</p> <ul style="list-style-type: none"> Primary care provider directly and rely on informal relationships across the continuum of providers needed (medical, HCBS/LTCSS, etc.) Medical neighborhood “clusters” that incorporate the full continuum (e.g. Colorado model) The Department could contract with different types of providers as the <i>multi-disciplinary team lead(s)</i> (e.g. the PCP would play a major role in caring for well individuals in the community (non-NHC); AAAs/HCBS providers would play a major role in managing the care of Nursing Home Certified individuals who reside in the community; and, nursing homes would play a major role in managing the care of MMEs who reside within their institution).

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	<p>contract with provider entities to create medical neighborhoods that include practitioners from across the care continuum. These naturally occurring clusters of providers would collaborate to offer the full continuum of services to MMEs. Under such an arrangement, the ASO would provide data and analytic support and care coordination/care management to MMEs served by the provider clusters.</p>		
<p>Contracted Entities: ASO</p>	<ul style="list-style-type: none"> An ASO vendor that would be responsible for providing data analytics, Intensive Care Management and other supports to MMEs and providers. Such services might include, but not be limited to, utilization management, prior authorization, customer services, provider services, and quality management. 	<p>Which entity would the Department contract with? For what?</p> <p>How would the Department help support the creation of medical neighborhoods?</p> <p>How will the Department conduct outreach to identify, contract with and gain the participation of providers with expertise in serving individuals with disabilities, homeless individuals, persons with SPMI and other chronic conditions?</p> <p>What are the roles of various providers on the multidisciplinary team, including HCBS/LTCSS providers and medical providers?</p> <p>How can the Department facilitate the development of relationships among participants in medical neighborhoods who do not routinely collaborate with provider types across the neighborhood?</p>	<p>An ASO could be responsible for bringing together medical neighborhoods, given the different skills and focus of the individual provider types under the provider options, described above</p>

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Provider Participation Criteria	<p>Provider participation criteria may build on Person-Centered Medical Home (PCMH) participation requirements, with additional standards that ensure that providers meet the needs of Health Home consumers across the medical neighborhood.</p> <p>One approach stakeholders may wish to consider could requirements to convene a core team for individuals with significant needs including the following provider types and service Enhancements: <u>Core Team to Possibly Include:</u></p> <ul style="list-style-type: none"> • Primary care physicians (PCPs) • ICM staff • Care coordinators • LTSS/waiver case managers • Pharmacist • Behavioral health practitioners <p><u>Service Enhancements to Possibly Include:</u></p> <ul style="list-style-type: none"> • Comprehensive initial and annual assessments (including in-home)\including dementia assessments • Onsite level of care assessments with linkage to state funded or waiver HCBS • Intensive care management services with Person-centered care plans • Coordination linking non-medical and medical services • Transition coordination • Medication management services • Nutritional counseling • Preferred specialty care networks • Electronic records and care plans • Access to a MME ombudsman to be 	<p>What are appropriate criteria for provider participation?</p> <p>Are a specific set of standards applicable for all potential MMEs? Or, should provider criteria vary for each sub-population?</p> <p>How can the Department reasonably administer standards that vary for different sub-populations (should stakeholders decide that is desirable)?</p> <p>Should criteria build on PCMH standards or, on something else?</p> <p>Are there specific services or provider types that must be accessible? Who should be part of the medical neighborhood?</p> <p>Would neighborhoods be overlapping? Could they be non-overlapping? Within a region, how important is choice and competition?</p>	<ul style="list-style-type: none"> • Develop standards as appropriate for leads for individual sub-populations as suggested above e.g. nursing homes would play a major role in managing the care of their patients; AAAs/HCBS providers would play a major role in managing the care of their patients; and, the PCP would play a major role in caring for well individuals in the community (non-NHC) Utilize PCMH “Plus” standards to qualify providers • PCMH+ (note that stakeholders must consider whether, and which, sub-populations this option might work well) • Develop standards for the ASO to bring together medical neighborhoods (e.g. which provider types, what standards must they meet). Standards would vary based on the nature of the medical neighborhood team.

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	established by the State		
ASO responsibilities	<p>For the ASO contract, the ASO vendor would maintain responsibilities including, but not limited to the following:</p> <ul style="list-style-type: none"> • Ongoing integration of Medicare Part A, B, D and Medicaid data to support the provision of ICM by providers; • Offering data and analytic support to providers across the network to support health risk stratification and predictive modeling, performance measurement, profiling and reporting, cost-effectiveness and overall care delivery to MMEs; • Providing ICM services to Health Home/ASO practices on a purchase of services basis; • Maintaining a leadership and management structure that supports quality across all clinical and non-clinical aspects of service delivery; and, • Supporting processes to promote evidence-based medicine and patient engagement, and offering tools to coordinate care, such as telehealth, remote patient monitoring, and other enabling technologies. • Monitoring performance and improvement as the basis for shared savings distribution. <p>Contractual requirements with providers would include language that mandates them to:</p> <ul style="list-style-type: none"> • Meet participation requirements as described above • Deliver evidence-based, integrated care that incorporates preventive, primary, acute, LTSS and other services as needed, in a person-centered manner with an emphasis on self-care. 	<p>What would the ASO be required to provide to support the model selected?</p> <p>What services should the provider network offer vs. what services would the ASO offer?</p> <p>Should ICM be provided by the ASO or, directly by the network? Or purchased from the ASO by the network?</p> <p>What qualifications would the Department require of the ASO in order to participate?</p> <ul style="list-style-type: none"> • Data and analytic support • ICM support • Other ? 	<p>The ASO could potentially provide infrastructure for MMEs. Among services that the ASO might provide are the following:</p> <ul style="list-style-type: none"> • Maintaining linkages within the medical neighborhood • Network development and management • Providing data and analytic support • Providing Intensive Care Management support (see below) • Quality improvement and Incentive Management • Utilization management/decisions regarding medical necessity • Information Technology infrastructure support • Customer Service • Provider Service • Management and calculation of incentive payments to providers

	Health Home/ASO Option	Decision Points	Options t/b Considered
Attribution/Assignment/Enrollment Methodology	<p>Attribution/Assignment/Enrollment:</p> <ul style="list-style-type: none"> MMEs assigned quarterly with a final reconciliation after each performance year based on service history Two-step assignment process: <p>Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians.</p> <p>Step 2: for beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ASO professional (defined as an ASO practitioner in the Rule).</p> <p>ASO will provide each practice with a list of its claims-based aligned patients prior to the start of the initiative each performance year. In addition, the beneficiary alignment algorithm will be run every 3 months, adjusting corresponding PBPM amounts, with reports provided to the practice within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.</p>	<p>Should the attribution methodology utilize existing methods (e.g. ACO) or something else?</p> <p>Using the chosen methodology, how would additional additional be addressed:</p> <ul style="list-style-type: none"> Logistics Data availability and reliability Other factors? <p>Should attribution assignment/enrollment be prospective, retrospective?</p> <p>If state intends to convert PCMH to monthly PMPM, and assuming that PMPM requires enrollment rather than attribution, should enrollment be considered as an alternative? With lock-in? How do we deal with enrollment of individuals who are ultimately attributed to ACO or CPCI?</p>	<p>Attribution methodologies that the Department may consider include, but may not be limited to:</p> <ul style="list-style-type: none"> ACO methodology In-house methodology based on plurality of total claims, services, or dollars Option that builds on the Department's PCMH methodology <p>Once a methodology is chosen, Additional options include:</p> <ul style="list-style-type: none"> Prospective or retrospective attribution and periodic updates Review of data availability and reliability which will drive, to some extent, attribution calculation
PMPM Payments	<p>Risk Adjusted Care Management Fee – To cover special requirements for care coordination, intensive care management and other advancements in practice such as the service enhancements described earlier in this document.</p>	<p>What risk adjustment methodology would be most appropriate for duals?</p> <p>For the care management fee to be appropriate, what special service requirements will we have? What covered services?</p> <p>At what level will we vary the rate structure? What cells are we going to use to pay the care management fee?</p>	<p>Risk adjustment models that the Department and stakeholders can select among include:</p> <ul style="list-style-type: none"> Medicare HCC, CDPS, Medicaid RX, and CDPS+RX <p>Care Management Services might include, but may not be limited to:</p>

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		<p>What services will be required as reimbursement for care management fees?</p> <p>What variables should be examined to determine the rate structure?</p> <p>Would the Department purchase Care Management centrally from an ASO or, from providers directly?</p>	<ul style="list-style-type: none"> • Targeted Outreach • Care Coordination • Intensive Care Management • Other? <p>Factors to inform the rate structure might include, but not be limited to:</p> <ul style="list-style-type: none"> • COA • Setting • Age and/or Gender and/or • Enrollment duration
Computation of Shared Savings	Given the small numbers of patients associated with individual practices, shared savings will be calculated at the market level– not the individual practice level— based on all Medicare expenditures and Medicaid expenditures.	<p>How should Shared Savings be calculated?</p> <ul style="list-style-type: none"> • timing of calculation, • data source(s), • definition of market. <p>What data source(s) are the most reliable and accurate for claims and eligibility and can be consistently matched for the duals population</p> <p>What allocation methodology is appropriate to determine how to share savings where causation for improved care exists?</p> <p>How should the allocation methodology be constructed with regard to:</p> <ul style="list-style-type: none"> • Purpose and goals of the methodology • approach by services, volume, dollars, members, member months <p>What should trend, program changes are re: reimbursement rates and shared savings?</p>	<p>NOTE: Conduct a Counter-factual analysis (CFA) to estimate savings e.g. what expenditures would have been in the absence of the interventions.</p> <p>Calculations can be done: 120/180/270 days from year-end</p> <p>Options to define the market include:</p> <ul style="list-style-type: none"> • Zip code, • Towns, MSA’s, or • Pre-defined medical neighborhood based on data analysis over time <p>Additional options to be identified after a model is selected</p>
CMS and the State	If the state follows SMDL# 11-008 “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees,” the state would share	<p>How should Shared Savings be calculated?</p> <ul style="list-style-type: none"> • timing of calculation, • data source(s), 	What data source(s) are the most reliable and accurate for claims and eligibility and can be consistently matched for the

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	<p>in Medicare Part A and B savings with the federal government, net of any increase in the federal share of Medicaid expenditures. The Medicare savings would be split 50/50. Actuarial methods would be used to develop projected expenditures based on assigned beneficiaries, and to compute the difference between projected expenditures and actual expenditures (i.e., savings). With respect to Medicaid expenditures, because CT's FMAP rate is 50%, the federal share of every additional dollar spent in Medicaid would be 50 cents. Consequently, the Medicare savings would be offset by 50% of any increase in Medicaid expenditures. It is likely that CMS make shared savings contingent on meeting quality targets.</p> <p>* It is not clear what financial flexibility CMS would allow in the model established in SMDL# 11-008. The model in SMDL# 11-008 has already been approved by OMB, so this financial alignment model offers the best hope of meeting the December 2012 implementation deadline. Ideally, this model would incorporate shared savings from Medicare expenditures in such a way that all three groups; Medicare, Medicaid, and providers could benefit. In addition, the State would like this model to retain not only the enhanced match associated with Health Homes at 90% but also the ability to make ICM payments. Such a Global Approach to payment, that incorporates all of the current flexibility allowed across the various programs, provides the best opportunity to align this model's financial incentives.</p>	<ul style="list-style-type: none"> • definition of market. <p>What allocation methodology is appropriate to determine how to share savings where causation for improved care exists?</p> <p>What qualifying criteria apply for the distribution of shared savings? Which providers would be eligible? Ineligible?</p>	<p>duals population</p> <p>What is the most appropriate market for provider sphere of influence:</p> <ul style="list-style-type: none"> • Zip code, • Towns, MSA's, or • Pre-defined medical neighborhood <p>Key CFA decision points include:</p> <ul style="list-style-type: none"> • Trend • Program Change <p>For the quality targets, the Department requires input on:</p> <ul style="list-style-type: none"> • Purpose and goals of targets. • Existing quality targets already in place for MMEs, consistent with program goals • Data availability and reliability to report quality targets • Method for choosing targets – focus groups, provider input, etc. • Appropriate weighting of quality targets – e.g., purpose and goals of weighting (dollars, services, population, etc.)
The State and providers	<p>It is anticipated that the amount of shared savings earned by primary care providers will be allocated based on quality measures reported by the practice, which will include both Medicare and Medicaid</p>	<p>Who pays out savings and when? (ASO or State) and when paid (quarterly, semi-annually, or annually)</p>	<p>Savings could potentially be distrusted by:</p> <ul style="list-style-type: none"> - The State - The ASO

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	<p>Program measures*.</p>	<p>Subject to negotiation with CMS, there are several decision points relative to amount of savings to be shared and logistics around the savings payment.</p> <p>Savings by practice will be allocated based on performance on quality measures. It is important to identify those quality measures that are easily reported, not subject to manipulation or reporting bias, readily verifiable, and lead to savings. Ideally, there would be overlap with existing programs such as PCMH to allow for cross-program comparisons.</p> <p>Questions regarding quality measures include, but are not limited to:</p> <ul style="list-style-type: none"> • Purpose and goals of measures? • Review existing quality measures already in place for duals population? • Examine data availability and reliability to report quality measures? • Identify those measures most consistent with program goals? • Method for choosing measures – focus groups, provider input, etc. and then negotiation with CMS? 	<p>Savings could be distributed:</p> <ul style="list-style-type: none"> - Quarterly - Semi-annually - Annually <p>Savings could be distributed to a range of providers based on model design</p> <p>Assuming multiple targets are chosen, we will need to determine weighting of quality measures:</p> <ul style="list-style-type: none"> • purpose and goals of weighting • options for weighting (dollars, services, population, etc.)