MEDICAID OVERSIGHT COUNCIL COMPLEX CARE SUBCOMMITTEE MODEL DESIGN WORK GROUP—December 22, 2011

In attendance: Steve Frayn, Molly Gavin, Tracy Woodatch, Doug Arnold, William Fiochetta, Mag Morelli, Kate McEvoy, Sheila Amdur, Mark Schaefer, Meryl Price, Deb Polun, Bob Smanik, Ken Lalime, Ken Ferrucci, Marie Allen, Ann , Tom Meehan, Jennifer Hutchinson, Michael Taylor, Pam Meliso, Sheldon Toubman

Questions from educational session on ACO/ICO/CPCI:
1. How to calculate shared savings and who receives shared savings? Does the group that serves as the "hub" distribute savings to participating providers in the "medical neighborhood?"
2. Size of dual eligible population—70,000 statewide (40,000 over 65, 30,000 under 65—in CT, dually eligible 19% of Medicaid population and consume 58% of Medicaid funds), small number with complex care needs. How do small practices carry out care coordination and carry the costs of this? Will have to think of having external group provide care coordination services and data management to small practices.
3. What are downsides of creating multiple organizations doing coordinated care for segmented populations? However, given fee schedules of Medicaid, there may be a different "universe" of providers who treat people who are dually eligible (and Medicaid only).

ASO/Health Home model: (See attachments)

1. This model aligns with serving target population and appears to be most achievable.
2. Sub-populations within dual eligibles—people in community, people in nursing homes, people with major disabilities in their own homes. Under 65, quite complex differences.
3. On individual consumer level, can be many cross sections with different providers. On system level, not much "cross pollination."
4. Ken Lalime—What are implications of changes in cost structure, utilization; cost savings will come out of someone's pocket?
5. What best suits needs of consumers?
6. Coordination with other efforts in state: Money Follows the Person, Rebalancing (Mercer contractor for these initiatives and for strategic planning for "Rebalancing" initiative). Mark will follow through to relate these initiatives.
7. This model assumes ASO accomplishing data analytics, and ICM supports, not necessarily issues re help to get to appointment, explaining care plan, etc. which is at provider level. (Needs distinctive definition of difference between "care coordination" and "intensive care management."). How do you bring together primary care practices and other services in a systematic way?
8. Expectation is that state will develop Health Home models targeted to specific chronic disease groups; state gets higher reimbursement rate for 8 quarters to pay for Health Home services. Steve Frayn suggested that physician and other services are underfunded so new reimbursement should be used to raise rates. Mark indicated that state needs to consider independently how to address rates. Health Homes increased payment from feds is for

ADDITIONAL SERVICES provided under Health Homes, not all services, and would allow state to pay PMPM to providers for these services. 90% is only for services paid to provider groups, so provider groups would have to purchase these services from ASO (from Health Home payment to provider), and 90% match then applies. Does not address fundamental underpayment to specialists (in 2013, primary care practices brought to Medicare rate.).

Incentive $ to align services across continuum: not clear to whom these payments are made and how they are calculated. It would be in the form of shared savings.

Health Homes is a state Medicaid plan amendment. Would have to file the amendment concurrently with this application being approved by CMS.

Kate McEvoy: Very necessary to know where MME's are receiving their primary and other care in terms of locus of services. Must define who does care management and what it really means in terms of choice, self-direction, health care and social needs of clients. Mark: Data is being analyzed—also linkage of Medicare and Medicaid (part A & B & Medicaid); holes related to waiver services data sets which are outside this. Will have definitive date by January for data completion.

Mag Morelli: Is the goal still to have two or three pilot areas in specific geographic areas? Mike Taylor indicated that data would inform where dual eligibles cluster. Mark Schaefer commented that state could develop relationship with CMS for state to oversee care of everyone not in a shared savings program (about 20,000) and act as a statewide "ASO." (Might also exclude people with developmental disabilities another 15,000). CMS would contract with state for shared savings and over three years, state will roll out different models with different provider groups related to size of population and types of disabilities in different areas. Steve Frayn suggested that more detail is to have any idea if this is workable. Disconnect is how to make this work when we don't know how large the population is.

Dr. Schaefer indicated that it will take time to design sophisticated programs in the medical neighborhood that work for these complex populations. ASO structure to provide data management and intensive care management for folks who do not have this, and also contract at the local level where data supports this. Ask CMS to contract with state to use tools already developed (ASO for Medicaid, PCMH). Health Homes for state to achieve savings MUST be targeted to broader Medicaid population. Or we could do Pilot.

Molly Gavin stated that CT has funded the CT Home Care program for 30 years. Currently, about 15,000 dually eligible people are in the CT Home Care program, people at highest risk of nursing home placement. Providers have strict contract deliverables. Each of these organizations is required to have a resilient provider network, but is not connected to physician groups and hospitals on a formal contractual basis. Should we consider building on this? The Home Care programs major deficit is that it does not bridge medical community.

Initial proposal to CMS was targeted to over 65; CMS does not allow phasing in of population. Data analysis includes all populations, and Health Home definitions will focus on chronic disease conditions. Pending decision is if we include people with SMI, given DMHAS work on developing specialized Health Homes related to people with SMI. With MME, do we define it as anyone eligible over 65 and/or anyone with certain chronic conditions under 65? If CMS allows Health Homes to be limited by age, then would have everyone over 65 targeted under a specific Health Home model.

Contracted Entities/Providers:

1. Contract with PCP who develops relationship with medical neighborhood. Difficult for small practices to manage this. Mike pointed out this might be true for small private practices, not FQHCs. Do elderly seek care in FQHCS? Must see data. Ken Lalime indicates that there will be small practices that could do this management (data help inform where there are natural medical neighborhoods).
2. Contract with cluster of providers that incorporates range of providers across continuum, e.g., Regional Care Collaboratives in Colorado. (Kate McEvoy will provide background on this—anti-trust issues).
3. ASO: Responsible for facilitating and promoting relationships within medical neighborhoods, to bring groups together in "naturally occurring" clusters. No one currently can say "How well are we doing across the continuum" with these populations which ASO can answer. Can also compare across medical neighborhoods. Might also disburse incentives. Not clear who these entities are. Kate—This shifts to new model requiring performance metrics around how practices are improving measurable health outcomes of chronically ill populations, preferably using evidence based models broadly defined.
4. Who determines what appropriate, efficient, effective care is? Client should have informed choice about their care plan. UM may be done by ASO, or providers do this directly. DSS ultimately accountable.
5. Shared savings: DSS with ASO could "draw circles" around a market and share savings within that market, disbursing savings with broader range of players who have to work together to achieve better health outcomes. Different rewards for ASO and providers, so ASO also incentivized to meet performance outcomes. Question re global vs. targeted shared savings.
6. Ability of Dept. to make advance payments outside of Health Homes limited unless defined enrollments.
7. Difficult to decide model when we don't know size of population, costs, where people get care. Steve Frayn suggested looking at "CPCI" model, a medical neighborhood model, (with ASO). General support for doing management of MMEs on wider basis, and working with medical neighborhoods with ASO. How does any of this result in positive difference for people impacted? ASO/HEALTH HOME approach—shared savings distributed by ASO. (Define medical neighborhood; numbers served and where they are geographically)

(**IF ANY DIFFERENT MODEL PROPOSED, SEND DIRECTLY TO Dr. Schaefer/Meryl Price**)

- Minimum requirements for each type of participant
- Might have to phase in—milestones to achieve, e.g,, electronic health records.
- Must also be assured that requirements are justified by rewards.
- All providers form an integrated approach so there will be requirements in common.

- Neighborhood “formed” when core groups commit.

Kate McEvoy suggesting that there are Provider standards/ASO responsibilities/enrollment/Financing that we have to address. Meryl believes she can take discussion and develop more detail around the ASO/Health Homes model.

Next two meetings of Model Design Work Group:

Monday, Jan. 9-- 1 to 3
Monday, Jan 24-- 1 to 3

Submitted by,

Sheila Amdur