

ASO/Health Neighborhood Proposal
DRAFT: FOR DISCUSSION ONLY
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Introduction

The purpose of this document is to describe a program model for serving individuals who are Medicare and Medicaid Eligible (MME). Under this proposal, demonstration services would be provided to qualified MMEs who are not otherwise enrolled in an Accountable Care Organization (ACO), a CPCI demonstration or a Medicare Advantage Duals Special Needs Plan (D-SNP).

Under the demonstration, Connecticut would develop and implement statewide systemic improvements by leveraging the existing administrative service organization (ASO) infrastructure recently established to serve all Medicaid recipients as described below.

Summary Model Design and Service Enhancements

The Department is considering an infrastructure to serve participating MMEs that incorporates two key elements: an ASO and a delivery system that features health neighborhoods.

The first element entails the Department leveraging its existing statewide medical ASO infrastructure to provide a range of demonstration services. Today, all of Connecticut's MMEs are served by the ASO; however, the absence of integrated Medicare and Medicaid data within the ASO's analytic suite limits ASO services to the provision of information on benefits, referral assistance, Medicaid covered services management, and routine care coordination and customer service. The ASO infrastructure will provide a substantially higher standard of integrated person-centered care across the continuum of primary, specialty, and hospital care; long-term supports and services (LTSS) and nursing facility care than what currently exists today for MMEs.

Under the demonstration, the ASO would be required to contract for, or directly provide, MME data integration and sophisticated analytics that incorporate Medicare and Medicaid data that support health risk stratification and predictive modeling services. Such analytic services would contribute to the delivery of ICM and other demonstration services. The ASO would support the development and emergence of health neighborhoods over time as described below.

Consistent with its value purchasing strategy, the ASO would be eligible for performance payments for meeting and/or exceeding the Department's specific MME requirements.

The second key element of the demonstration would feature health neighborhoods, consisting of clusters of medical and non-medical providers that offer a team-based approach to MME service delivery. The Department would procure three to four health neighborhoods at the outset of the demonstration for implementation on December 1, 2012; however, additional health neighborhoods would be procured over time. If the health neighborhood model were successful, the Department would seek to establish statewide coverage.

The manner in which provider relationships would be structured within health neighborhoods has not yet been discussed with stakeholders. Health neighborhoods would lead the delivery of demonstration services wherever they exist, although they would continue to rely on the ASO infrastructure for data integration, data analytics, performance measurement, and the provision of other tools and services to facilitate coordination across the neighborhood and team based care. The continuum of providers that comprise health neighborhoods would include, but not be limited to, primary care practitioners, specialty physicians, independent therapists, behavioral health providers, hospitals, home health agencies, LTSS and nursing facilities.

This document includes detailed information regarding this model on the following topics:

1. Population Served
2. ASO Design and Requirements
3. Health Neighborhood Design and Requirements
4. Shared Savings

The document further includes questions that the Department may ask CMS.

1. Population Served

The demonstration would serve any MMEs age 65 years or older who are not otherwise enrolled in a Medicare Advantage Special Needs Plan (D-SNP) or assigned to an Accountable Care Organization (ACO) or a primary care practice that participates in the Comprehensive Primary Care Initiative (CPCI). Attached as Exhibit 1 is a graphic that depicts the various MME options and hypothetical numbers of participants in each option including the Department's CMMI demonstration.

The Department suggests that stakeholders consider whether to also include individuals under age 65 in the demonstration. Among providers, advocates and the state's Department of Mental Health and Addiction Services (DMHAS), there is particular interest in including individuals with Serious and Persistent Mental Illness (SPMI). For this special population, DMHAS began planning several months ago for a health home state plan amendment and is prepared to include this population in the demonstration application. There may also be interest in other populations as well, such as individuals with developmental or physical disabilities.

2. ASO

A key advantage of the Department's plan is the ability to build on its existing ASO infrastructure, which serves nearly 600,000 Medicaid eligible individuals including approximately 75,000 MMEs. With additional requirements for integrated data analytics that will result in significantly stronger ICM service delivery, the ASO offers the Department a close-to-readymade infrastructure to serve this population. At the same time, the Department recognizes that the ASO may require additional capacity to provide the needed level of integrated MME data analytics under the demonstration, as described below.

Under this proposal, the ASO would continue to provide services offered under its existing contract with the Department for nearly 600,000 Medicaid eligible individuals including, but not limited to:

- Utilization Management for customized equipment, surgery, etc.);
- Quality Management (quality initiatives, performance measurement and reporting);
- Provider relations and network development;
- Clinical support (e.g. processes to promote evidence-based medicine and patient engagement); and,
- Member services (e.g., benefit information, referral assistance, transportation assistance, patient navigation).

In addition, the ASO would provide multiple value-added services specifically for the MME population.

Acute care, behavioral health and LTSS providers are not accustomed to working together, nor have they been expected to offer integrated care in the past. The ASO could offer the "glue" needed to bring together the full continuum of providers and to support person-centered, data-driven,

evidence-based service delivery. Here, the ASO could provide network development support to help medical, behavioral and non-medical providers coalesce into health neighborhoods.

The ASO would also provide the following services to support care management of MMEs:

- Data integration – Ongoing integration of Medicare (A/B/D) and Medicaid paid claims data;
- Health data analytics – Health risk stratification and predictive modeling to enable providers and health neighborhoods to identify high need/high complexity individuals or gaps in care to better target their intensive care management resources;
- Comprehensive initial and annual assessments – Building on the medical and LTSS systems, the ASO would assess MMEs to identify medical, behavioral and physical support needs;
- Dissemination of real-time health use information - Distribution of real-time data on emergency department and hospital admissions and re-admissions, prescription drug use or disruptions in use and other critical events would significantly enhance care management capacity;
- Intensive Care Management (ICM) services – ICM services would be delivered based on MME-driven predictive modeling data to identify and prioritize enrollees at risk for poor health outcomes. The ASO would further be responsible for conducting outreach and engagement services to maximize the number of at-risk individuals who receive meaningful ICM services;
- Care plans – A central component of the ICM approach are person-centered care plans that would offer:
 - Integrated care planning and delivery across medical, behavioral and LTSS systems that incorporates Medicare and Medicaid benefits within larger clinics and practices and regional hubs;
 - A strong focus on education, self-care and medication management;
 - Coordination of care transitions across settings built on real-time emergency department and inpatient hospital data and care plans;
 - Medication therapy and reconciliation management; and,
 - Physical supports for individuals with disabilities who require assistance to maximize their ability to perform ADLs.
- Collaboration tools – Tools may include access to software or other systems to support team based care across the continuum of participating providers or health neighborhoods; and,
- Telehealth, remote patient monitoring, and other enabling technologies.

ASO leadership and management would provide support, including data infrastructure to manage clinical and non-clinical service delivery. Such performance data would support the efforts of health neighborhoods to continuously improve care experience, population health and cost-effectiveness. The ASO would provide performance measurement services to support the distribution of shared savings, based on the performance of the health neighborhood. Accordingly, the ASO could be responsible for using integrated data and other information (e.g., consumer care experience surveys) to calculate health neighborhood performance on the full range of performance measures (care experience, quality, outcomes, etc.). Using such data, the Department or the ASO could administer monthly PMPM payments to support intensive care management and other health neighborhood responsibilities;

Other member/clinical services may be provided to all participants or only those participants in areas without a health neighborhood including, but not limited to:

- Member services (e.g., benefit information, referral assistance, transportation assistance, patient navigation);
- Intensive Care Management; and,

- Utilization Management for Medicaid funded services (e.g., authorization for customized equipment, surgery, etc.).

3. Health Neighborhood Design Requirements

The health neighborhood would include Medicare and Medicaid providers who collaborate to deliver a full continuum of services to MMEs in an integrated manner. Health neighborhoods must include a core group of providers: primary care practitioners, physician specialists, hospital(s), behavioral health providers, LTSS providers, and nursing facilities. Provider participation and services delivered within the care continuum would likely vary based on the needs of MMEs and their families. Services would be delivered based on MME needs and preferences, not on payer source. Not all health neighborhoods would be identical; neighborhoods could vary based on the availability of providers and relationships between them in a given geographic area.

A small number of health neighborhoods would be procured at the outset of the demonstration. Additional health neighborhoods would form over time as the ASO and the Department identifies and cultivates relationships among naturally occurring clusters of providers. At the outset of the Demonstration, the ASO would reach out to providers to support care delivery across the continuum; over time, health neighborhoods would form and the ASO would provide support for these clusters of providers. The ASO could utilize historic claims data to identify clusters of providers who have a substantial number of MMEs in common. The ASO could reach out to these providers to promote the creation of health neighborhoods to support the delivery of coordinated care.

The health neighborhood would provide team-based care. The team would always include a PCP and the remainder of the teams' composition would depend on the needs of the individual MME. Each team would be led or facilitated by a dedicated ICM care manager, depending on the individual's needs. Provider responsibilities may vary depending on the MME's residential (community or institutional) and NHC/non-NHC status.

Key elements of the care management model could include, but not be limited to:

- Comprehensive assessment of individual needs including medical, behavioral and social-supports as well as functional ADL support requirements and environmental barriers to health and wellness;
- A “no wrong door” approach to requesting or identifying the need for ICM services across the entire ASO and delivery system (e.g. through ASO predictive modeling services, member services, physician or other providers, Access Agencies, consumers, families and other sources);
- Outreach and engagement services for all individuals identified at various points in the delivery system;
- Integrated care plan development with input and sign-off from individuals and caregivers/families, when appropriate. Care plans would feature strategies to promote self-care and education;
- Use of Electronic Health Records (EHRs) and care plans with HIPAA-compliant (electronic) sharing of key individual information regarding current medications, care plan goals, and advance directives among other critical information; and,
- Tracking of outcomes, including care experience.

4. Shared Savings

For all participants in the Demonstration, the Department would enter into a shared savings arrangement between CMS and the State. In Exhibit 2, attached, the Department presents three options to share savings between the State and CMS.

- Sharing of savings on Medicare Parts A and B for a limited set of Medicare covered services, net of the federal share of Medicaid expenditures. Such services might include inpatient hospital and emergency department services. This option has been raised by stakeholders; further analysis is required to understand the implications of limiting shared savings to a small set of acute care services. Under this arrangement, savings could be evenly split between CMS and the State;
- Sharing of savings on all services within Medicare Parts A and B, net of the federal share of Medicaid expenditures. Under this option, savings could be evenly split (50/50) between CMS and the State. This option is comparable to the state's existing arrangement with CMS for Medicaid services.
- Under this option, the State would propose a 70/30 shared savings arrangement in which the State would receive 70% of any savings, net of any increase in the federal share of Medicaid. It is unclear whether CMS would approve such an arrangement.