

# Complex Care Committee Model Design Workgroup

January 24<sup>th</sup>, 2012



# Agenda

- Introductions and Meeting Purpose
- Key Discussion Items
  - ASO Services and Supports Today
  - Potential ASO Value-added Demonstration Services
  - Shared Savings Model between CMS and State
  - Re-visiting the Demonstration Population
  - Participation in the Demonstration: Assignment or Enrollment
  - Health Neighborhoods
  - Relationships Between Providers in the Health Neighborhood

# ASO/Health Neighborhood – Draft Model 1-24-12

## ASO

Medicare Shared Savings Program (SSP)  
Medicare/Medicaid Data Integration  
Data Analytics  
Intensive Care Management (ICM)  
Member Services  
20-40,000?

### Health Neighborhood

Local Accountability  
State/Provider SSP  
Team Based Care  
Intensive Care Management  
Other Demonstration Services  
5,000

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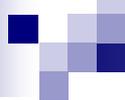
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# ASO Services and Supports

# ASO Services and Supports Today

- Currently ASO serves 500,000 single Medicaid eligibles and 75,000 MMEs
- These ASO services would continue under the demonstration:
  - Member services;
  - Utilization management (Medicaid only);
  - Limited Quality management;
  - Provider relations and network development; and,
  - Clinical support (processes to support evidence-based medicine).



# Potential Value-added ASO Demonstration Services for MMEs

- Demonstration offers the potential to contract for additional value-added services, beyond what the ASO enterprise offers to 75,000 MMEs today

# Potential Value-added ASO Demonstration Services for MMEs

- Value-added services could include:
  - Data integration (Medicare A/B/D and Medicaid);
  - Advanced data analytics (health risk stratification, predictive modeling, decisional data management);
  - Intensive Care Management (ICM) services to promote Medicare/Medicaid coordination and integration across the health care continuum;
  - Other consultative services (pharmacist, disease educators, nutritionists)

# Potential Value-added ASO Demonstration Services for MMEs

- Value-added services could include:
  - Outreach and engagement services
  - Enhanced Quality Management (performance measurement, decisional data management and reporting); and
  - Network development to help health neighborhoods coalesce and develop.

# Potential Value-added ASO

## Demonstration Services for MMEs

- Integrated Intensive Care Management (ICM) services across the health care continuum
  - Person centered assessments;
  - Integrated person-centered care plans;
  - (Near) real-time data on hospital/ED use;
  - Collaboration tools (software, systems to support team-based care);
  - Identification of high need/high complexity individuals to support local care management
  - Others?



# Shared Savings CMS/State

## Shared Savings Options Between CMS and State

**Option 1: Partial Medicare Shared Savings Only**

**Option 2: Global Medicare Shared Savings**

**Option 3: Medicare Shared Savings with a 70%/30% split**

Shared Savings is limited to a portion of Medicare Parts A and B service related savings (e.g., inpatient hospital and ED).

50%/50% sharing of Medicare savings between CMS and the State net of federal share of Medicaid expenditures consistent with SMDL letter.

This approach is a modification of the "pre-approved" under State Medicaid Director's Letter (SMDL) 11-008 and may require further Office of Management and Budget (OMB) approval.

- Medicare Part D Drugs\*
- Medicare Part A Inpatient Hospital Only
- Medicare Part B Physician
- All Medicaid cost share payments for Medicare services; all state plan (e.g., medical equipment, home health and LTSS services)
- Skilled Nursing Facility and other Institutional Services

Shared Savings focus includes all Medicare Part A and Part B service related savings.

50%/50% sharing of Medicare savings between CMS and the State net of federal share of Medicaid expenditures consistent with SMDL letter.

This approach is "pre-approved" under State Medicaid Director's Letter (SMDL) 11-008 and would not require Office of Management and Budget (OMB) approval

- Medicare Part D Drugs\*
- Medicare Part A Hospital
- Medicare Part B Physician
- All Medicaid cost share payments for Medicare services; all state plan (e.g., medical equipment, home health and LTSS services)
- Skilled Nursing Facility and other Institutional Services

Shared Savings focus includes targeted or global Medicare Part A and Part B services, consistent with Options 1 or 2.

70%/30% sharing of Medicare savings between State and CMS, respectively, net of increase in federal share of Medicaid expenditures.

This option is not consistent with State Medicaid Directors' Letter 11-008 and would likely require OMB approval. Such approval would be difficult to obtain for a December 2012 implementation date.

\* Part D savings are not included in federal savings calculation in Option 1, 2, or 3

# “Shared Savings” in Medicaid Today

- Under Medicaid, the BHP ASO and the Medical ASO
  - serve 500,000 single Medicaid eligibles; and,
  - achieve “savings that are shared” 50/50 between CMS and the State.
- Because the State has a stake saving Medicaid dollars, the State is willing to make the considerable investment in ASO services.
- A Medicare global shared savings program would have the same effect by rewarding the State for investing in better care for MMEs.

# Shared Savings Options Between CMS and the State

- Under shared savings demonstration options, CMS would share Medicare savings that result from providing demonstration services to MMEs
  - SMDL 11-008 calls for 50/50 sharing of savings with CMS
  - Option 2 has pre-approval from OMB
- Under Option 2, global savings would be shared 50/50 between CMS and the State, which is nearly identical to the current arrangement under Medicaid
- The State would have a stake in saving Medicare dollars. This would encourage the State to make the investments in ASO services and other service delivery reforms to improve care experience and outcomes

# Shared Savings Options Between CMS and the State

- 50/50 is probably the safest bet for the application
- However, may be some willingness at CMS to consider greater than 50/50 split
  - No such requests have been made by other states
  - Will require additional processing and OMB approval
- State could request 70/30 and negotiate to 50/50 if approval is not forthcoming
- Primary rationale for pursuing 70/30 is to enhance the pool of savings that might be available to share with providers
  - The method for sharing savings between State and providers will be discussed at a future Model Design meeting



# Demonstration Population

# Re-visiting the Demonstration Population

- Initial proposal focused on individuals over 65
- Recommend considering whether to expand proposal to include all individuals regardless of age, health status or disability
- Would make ASO demonstration services and other enhancements available to all MMEs
  
- Pros?
  
- Cons?

# Re-visiting the Demonstration Population

- Would not include individuals who are otherwise assigned to or enrolled with:
  - Accountable Care Organization (ACO),
  - Comprehensive Primary Care Initiative (CPCI), or
  - Medicare Advantage – Duals Special Needs Plan (D-SNP)
- MMEs could participate in the demonstration and receive ASO demonstration services (without participating in a health neighborhood shared savings program)



# Participation

Level I: ASO

# Participation in the Demonstration: Assignment or Enrollment

- Participation in the demonstration and the ability to receive ASO services could be based on an assignment or enrollment model
  - What is assignment?
  - What is enrollment?

# Assignment

- Assign MMEs to demonstration if they are not otherwise aligned with ACO, CPCI or D-SNP
  
- Could permit MMEs to “Opt out” for:
  - Data sharing
  - Participation in individual demonstration services (e.g. ICM)
  
- Issues:
  - Protections? Is there harm that could befall an MME as a result of participating?

# Enrollment

- Could solicit enrollment of MMEs if they are not otherwise aligned with ACO, CPCI or D-SNP or
- Could conduct default enrollment MMEs if not otherwise aligned with ACO, CPCI or D-SNP, with option to “Opt Out”
- Issues for Discussion:
  - Dual (or dueling) enrollments...PCMH, health home, health neighborhood
  - May not have a critical mass of participants for meaningful demonstration and to support state’s investment



# Health Neighborhoods

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# Health Neighborhoods

- As already discussed:
  - Would include Medicare and Medicaid providers who collaborate to deliver integrated continuum of services to MMEs:
    - Team-based care;
    - Access to all Medicare and Medicaid services
  - Core participants on the team:
    - Primary care practitioners;
    - Physician specialists (TBD with stakeholders);
    - Hospitals;
    - Behavioral health providers;
    - LTSS providers; and
    - Nursing facilities.

# Health Neighborhoods

- Provide local accountability for care experience, quality and outcomes, and cost
- Would require methods for measuring performance of the neighborhood for individuals aligned with a health neighborhood
- Might include a State/Provider shared savings program

# Health Neighborhoods

- Not all health neighborhoods would be identical; neighborhoods could vary based on the availability of providers and relationships among providers in a given geographic area;
- Primary care providers could join one health neighborhood; however, specialists and other providers might join multiple neighborhoods

# Health Neighborhoods

- Options for service delivery include:
  - A “no wrong door” approach to ICM service delivery access could occur across the entire ASO and delivery system;
  - Use of predictive modeling data to identify and prioritize those with greatest need and to focus outreach and engagement services;
  - Comprehensive assessment of MME needs including medical, behavioral and social-supports as well as functional ADL support requirements and environmental barriers to health and wellness;

# Health Neighborhoods

- Integrated care plan development with significant input and sign-off from MMEs and caregivers/families, when appropriate. Care plans would feature strategies to promote MME self-care and education;
- Use of Electronic Health Records (EHRs) and care plans with HIPAA-compliant (electronic) sharing of key MME information regarding current medications, care plan goals, and advance directives among other critical information; and
- ASO supports for key functions

# Health Neighborhoods

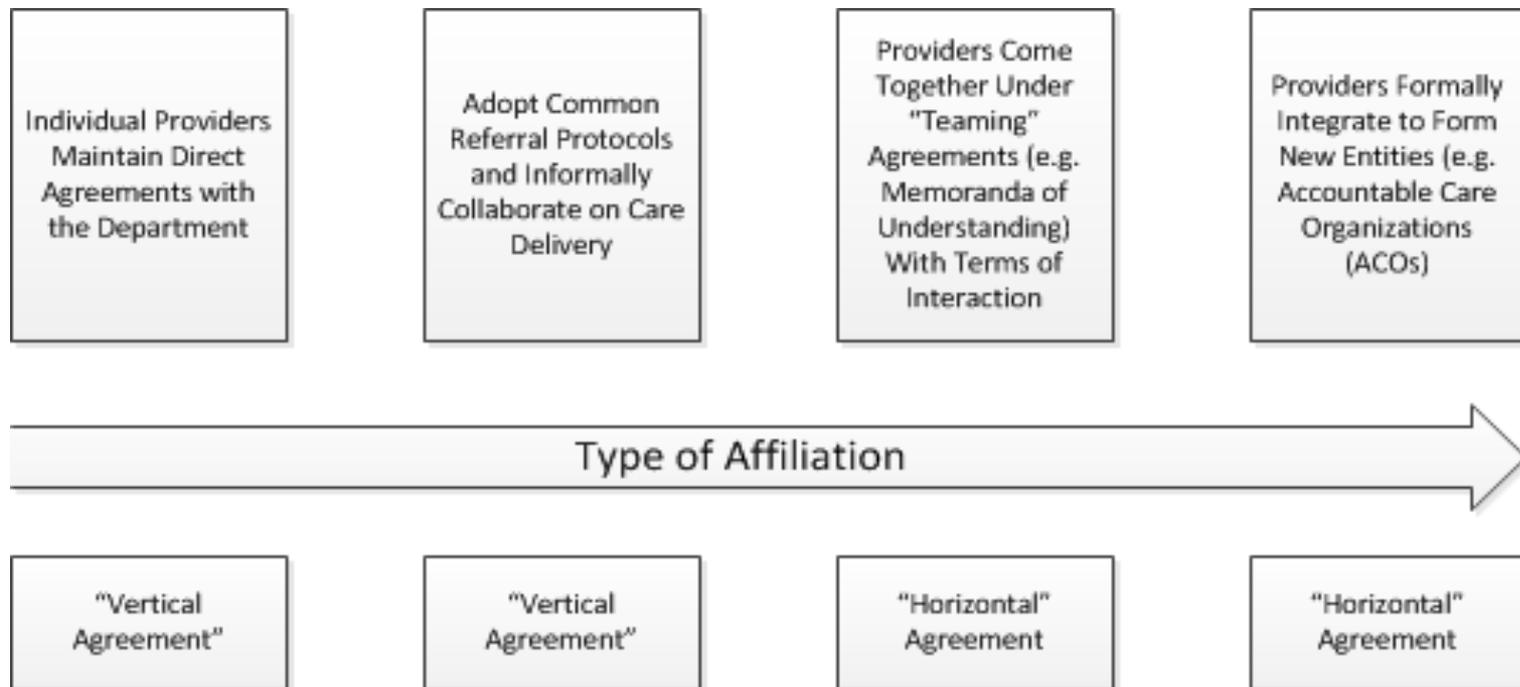
## Some Key Questions

- How would individuals be aligned? Attribution? Enrollment? Opt in? Opt out?
- Can more than one health neighborhood exist in a given geography?
- Should more than one health neighborhood exist in a given geography?
- Should there be non-neighborhood options?
- What consumer protections would be required?
- Should they receive advance PMPM payments?
- What is the role and relationship of PCMH providers to health neighborhoods?



# Anti-trust

# Anti-Trust Concerns: Degree of Provider Affiliation and Structure?



# Anti-Trust Concerns

Few anti-trust concerns where:

- Multiple providers adopt common referral protocols; or,
- Where individual providers enter into memoranda of understanding with DSS

Anti-trust concerns can arise where:

- Providers enter into agreements with other providers, especially where they do so on an exclusive basis where the agreements are lateral
- Providers enter into agreements for the purpose of joint purchasing

# Anti-Trust Concerns: Agreements Among Providers

- Issues related to providers entering into horizontal agreements with other providers:
  - No perfect fit among the models anticipated by the Agencies,
  - Most likely guidance is the Agencies' Statement of the Department of Justice and Federal Trade Commission Enforcement Policy on Multi-provider Networks:
    - “ventures among providers that jointly market their health care services to health plans and other purchasers”
- Steps of “rule of reason” analysis:
  - Evaluation of the competitive effects of the network in the market(s) with attention to whether providers:
    - have agreed to offer their services exclusively through the network; and/or
    - membership in the network excludes providers or classes
  - Evaluation of efficiencies that are likely to result from substantial financial risk sharing or clinical integration (e.g. improved cost controls, case management and quality assurance, economies of scale and reduced administrative or transaction costs)



# Anti-Trust Concerns: Implications for Agreements Among Providers

- Must identify the pro-competitive efficiencies that are likely to result:
  - Improved cost controls
  - Case management and quality assurance
  - Economies of scale and reduced administrative or transaction costs)
- Must be able to justify why the agreements are necessary to achieve these efficiencies
- NOTE: Non-exclusivity is preferable to exclusivity

# Anti-Trust Concerns: Joint Purchasing

- Issues related to joint purchasing:
  - The most applicable guidance on this issue is the Agencies' Statement on Joint Purchasing Arrangements Among Health Care Providers
  - Illustrative examples include: laundry, food service, computer and data processing services, and prescription drugs

# Anti-Trust Concerns: Joint Purchasing

- Generally, “most purchasing arrangements among hospitals or other health care providers do not raise anti-trust concerns” unless:
  - the arrangement represents such a large portion of the purchases of the product or service that it can effectively exercise market power; or
  - the products or services being purchased jointly account for such a large proportion of the total cost of services being sold by the participants that the arrangement facilitates price fixing or otherwise reduces competition.
- Statement provides guidelines for an anti-trust “safety zone”

# Anti-Trust Concerns: Implications for Joint Purchasing

- Must stay within parameters for anti-trust “safety zone”  
absent extraordinary circumstances, a joint purchasing agreement among health care providers will not be challenged if:
  - The purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and
  - The cost of the products and services purchased jointly account for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing agreement

# Anti-Trust Sources

- “Coordinating Care in the Medical Neighborhood”  
[Mathematica, June 2011]  
[http://pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483/ahrq\\_commissioned\\_research](http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/ahrq_commissioned_research)
- Statements of the Department of Justice and Federal Trade Commission Enforcement Policy on:
  - Multiprovider Networks; and
  - Joint Purchasing Arrangements Among Health Care Providers