

COMPLEX CARE SUBCOMMITTEE MODEL DESIGN COMMITTEE—FEBRUARY 7, 2012

Health Neighborhoods:

Focus on CT model and shared savings methodology at next meeting.

(insert Power Point presentation)

PCP is key and a constant in any health neighborhood. Core specialists—Who are they or should they be a demonstrated network with which health neighborhood has relationship. Critical pathways to specialists through agreements—how referrals are made, how collaborative. At times, specialist may act as PCP, depending upon person's condition. Use data to identify major conditions. Many specialists are not Medicaid providers so will be important to document available provider partners. Sheila indicated that social/housing providers have to be linked given poverty of population, and the fact that people with dual eligibility of all ages will now be covered. Home health agencies and hospice must be included, as well as home & community based services. Care management model goes beyond traditional health care management model.

Deb Polun asked what is difference between Health Neighborhoods and original concept of Integrated Care Organizations? Mark Schaeffer commented it's the definition of "organization." Will not solicit bids from new organizations for this. Kate McEvoy commented that continuum of options from care coordination agreements up to and including new legal entities, the latter not expected for this initiative. Steve Frayne—may be potential for anti-trust risk, which health neighborhoods would have to evaluate. Matt Katz—if have electronic records, may not need telephonic collaboration or meeting. Should add "end of life" care to services. Formation of teams will reflect constituency of clients, so team may vary based on person's needs. Have to assure competencies for various populations within team assessment capability and capacity. Meg Morelli asked for every "health neighborhood" must they develop capabilities for populations that they do not know serve?

- Mark Schaefer indicated state could solicit broadly defined neighborhoods that developed tailored approaches to different populations. Could also have groups that specialize in certain populations and certain disorders. For broadly defined health neighborhoods, would have to work with DDS, DMHAS, and aging groups to develop/define core competencies.
- Deb: Can consumer easily access other providers who are not in "neighborhood?"
- Can providers participate in more than one neighborhood? Many providers practice in more than one geographic area.
- Health neighborhoods could be overlapping geographically or geographically distinct.
- Kate McEvoy: CT does not have statutes to immunize providers against anti-trust. DSS will conform model to criteria that minimize anti-trust.
- What makes sense for MME needs? How is anti-trust avoided?

- Rule of Reason rule—do provider agreements mandate exclusivity? Non-exclusivity is favored by courts.
- Also must identify “pro-competitive” efficiencies which this design highlights.
- If most of PCP market goes “all in,” makes it difficult for MME not to be in neighborhood. Person can opt out of any participation in any service. DSS would not make a PMPM payment up front to providers for this group. Potential risk for MME is there may not be any real non-neighborhood choice. Can person access specialty services not under the neighborhood? Mark—person is free to go wherever they want, and DSS writes authorizations for out of state. Medicare rules apply.
- Will there be competitive bids on cost? On composition of neighborhood and meeting basic requirements? DSS would pay risk adjusted advance payment for everyone enrolled, and ability to provide additional services or contract with ASO; also get shared savings. Still get FFS for actual services rendered. Not a cost based bid—based on core competencies and ability to reach these.
 - Steve Frayne said previous discussion was that health neighborhoods were developmental and were not going to be “competitively” bid. Should designate open access model, and promote local providers to come together to provide collaborative services. Does state want more of an “ICO” or more of a developmental process supported by statewide ASO?
 - Mark Schaeffer said this open model is the CPCI model, whereas the MME initiative is really about promoting collaborative models. Must have someone to whom advance payments are made to take responsibility—is there a fiduciary or organizational model? Meryl—procuring three or four health neighborhood models—pilot structure to determine how it works. Non-exclusive—any provider can join.
 - Matt Katz—how does neighborhood work with someone who is seeing enrolled patient outside of neighborhood in terms of outcomes, especially when that neighborhood (as in a rural area) may not have many of the services?
 - For geographic areas, DMHAS believes competition is good for quality of care. Health neighborhoods might have specialized approach for certain populations such as SPMI.

SHARED SAVINGS: (insert PP)

Mercer presentation: Educational presentation on shared savings.

State’s criteria for shared savings must be transparent.

Two types of savings: Global in which cost shifting minimized, or, Targeted—e.g , reduce ER visits, but if offsetting costs aren’t measured, may be a false savings.

Sheldon commented that those additional costs that would be likely could be measured. How has CMS limited targeted shared savings? Do any of the initiatives featured used targeted shared savings? Mercer: how does one determine what the offsetting costs are from reducing

emergency room visits? Mercer not aware of any current models with targeted shared savings—all are global shared savings.

Matt Katz—how is risk calculated? Adjust for overall statewide change, e.g., trends re morbidity. Is their different risk for particular health neighborhood re profiles of members? Risk models not as prevalent for Medicaid populations.

Key decision points:

Which providers are eligible for shared savings program?

How do members get into the program? Attribution the primary method.

Most common method of state sharing is 50/50 with states. Most complicated is how shared savings actually get distributed among providers—what is structure of Health neighborhoods?

Shared savings depend upon meeting target performance outcomes.

(How are shared savings distributed—shouldn't it be based on statewide performance? How do we prevent providers from prescribing more expensive drug and/or more physical therapy? Performance outcomes could be rewarded with the shared savings only.)

Next meeting of Model Design Work Group: Thursday, Feb. 23 at 1:30 p.m. (Note new date)

Submitted by

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