

# Model Design Development

## February 7, 2012



# Health Neighborhoods: Team Participation

- Mandatory team participation to include:
  - Primary Care Practitioner
  - Core Specialists
    - Cardiology/Pulmonology
    - Neurology
    - Podiatry
    - Other?
  - LTSS
  - Hospital
  - Pharmacy/ies
  - Nursing Home
  - Behavioral Health

# Health Neighborhoods: Services

- Comprehensive assessment and planning including dementia with home visits on enrollment and annually
- Care coordination of, and support for access to:
  - Person-Centered Intensive Care Management (ICM) Services
  - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
  - Medication management
  - Use of evidence-based guidelines across the full continuum
  - Preventive and health promotion services
  - Mental health and substance abuse services
  - Chronic disease management, including self-management support to individuals and their families
  - Individual and family supports, including referral to community and social support services (e.g. transportation, specialty medical and social services and supports and waiver services)

# Health Neighborhoods: Team-based Care

- Contractually-driven purchasing standards that establish the Health Neighborhood as the accountable entity (TBD).
- Development, implementation and sharing of Individualized Care Plans across the continuum.
- Interdisciplinary care team meetings (telephonic or in-person).
- Sharing of real-time data to the extent possible (hospitalizations, ED, changes in medications, SNF admission, other “major” transitional events).

# Health Neighborhoods: Collaboration Tools

- Neighborhood participants could be required to subscribe to HIE
- HIE will allow secure care coordination and quality improvement as part of Connecticut's overall plan to transform health care
- HIE solution will provide strong support for communication across the health neighborhood.
- HITE will implement secure messaging between providers which will greatly improve the exchange of health information in the coordination of care while also improving the security and privacy of patient information.
- HITE can support the following use cases: laboratory results retrieval, clinical consults, patient referrals, coordinated care, immunization reporting, reportable health conditions, emergency care, and health care quality reporting
- Communication governed by strong patient privacy and patient data control policies

# Health Neighborhoods: Additional Requirements

- Continuous approach to quality improvement
  - Collect, report and act on data that permits an evaluation of increased coordination of care and management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

# Health Neighborhoods: Participation

- Option 1: Geographically Distinct Health Neighborhoods
  - Create, based on a competitive bids, one health neighborhood in each geographic area of the State.
- Option 2: Geographically Overlapping Health Neighborhoods
  - Create, based on competitive bids, geographically overlapping health neighborhoods across physical areas within the State.

# Health Neighborhoods: Participation

- Should geographic areas overlap or not overlap?
  - Is it possible that more than one health neighborhood could exist in a geographic area?
  - Would consumer choice between FFS and Health Neighborhoods support adequate access and options for MMEs?
- Should providers have the ability to participate in more than one health neighborhood?
  - Should PCPs have the ability to participate in more than one health neighborhood?
  - Should specialists and other providers have the ability to participate in more than one health neighborhood?
  - What about providers who practice in more than one geographic area?

# Health Neighborhoods: Anti-Trust Considerations

- Anti-trust issues to address include the need to demonstrate that:
  - Must identify the pro-competitive efficiencies that are likely to result (e.g. improved cost controls, case management and quality assurance, economies of scale and reduced administrative or transaction costs) and be able to justify why the agreements are necessary to achieve these efficiencies;
  - The initiative meets the “rule of reason” such that the arrangement does not represent such a large portion of the service that it cannot effectively exercise market power (<35%);
  - The services being purchased do not 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 (<20%).

# Health Neighborhoods: Geographic Infrastructure

## OPTION 1: Non-Overlapping Geographic Neighborhoods

Pros	Cons
<ul style="list-style-type: none"><li>• Supports numbers necessary for participation threshold (infrastructure development, ability to re-engineer practices, financial basis of participation)</li></ul>	<ul style="list-style-type: none"><li>• Less choice for MMEs (except that MMEs can, in all likelihood, select FFS providers with additional services from the ASO)</li></ul>
<ul style="list-style-type: none"><li>• Ease of administration (at least for PCPs in an enrollment-based model – TBD)</li></ul>	<ul style="list-style-type: none"><li>• May create inconsistencies with the way in which providers practice (but unclear without further research)</li></ul>
<ul style="list-style-type: none"><li>• Creates greater incentives for providers to form a functioning neighborhood that meets requirements</li></ul>	

# Health Neighborhoods: Geographic Infrastructure

## OPTION 2: Overlapping Geographic Neighborhoods

### Pros

- Possibly more choice for MMEs (except that MMEs can, in all likelihood, select FFS providers with additional services from the ASO)
- May support provider relationships and overlap in practices/use of services across geographic areas
- Avoidance of anti-trust issues to the extent that they exist

### Cons

- May or may not support numbers necessary for participation threshold (infrastructure development, ability to re-engineer practices, financial basis of participation)
- May create inconsistencies with the way in which providers practice (but unclear without further research)
- Could be more difficult to administer given overlap among providers
- Could decrease incentive for providers to form a functioning neighborhood that meets requirements

# Health Neighborhoods: Structure

- New York State Model Design – equivalent to a Health Neighborhood
  - In NYS, providers signed an MOU to bind them in a Health Home arrangement for planning purposes
  - MOU partners developed a contract to create a permanent structure to bind the providers with the State's key requirements for (Health Home) participation
    - The State has not yet asked the Health Home leads to sign a contract with the State; however, such a contract is anticipated
  - NOTE: Anti-trust issues were not raised as a part of this discussion, at least among the lead participants in Health Homes

# Health Neighborhoods: Agreements

- What types of agreements would support the creation of Health Neighborhoods?
  - All individual providers and provider organizations and the State (e.g. standard agreement with no lead organization)?
  - A lead provider and the State (e.g. New York)?
    - And between the lead provider and all other providers in the neighborhood?
  - An administrative organization that would contract with individual providers or neighborhoods?

# Health Neighborhoods: Agreements

	Pros	Cons
Contracts between DSS and individual providers/organizations	<ul style="list-style-type: none"><li>• Network and contracts are already in place – minimal work required to amend with requirements</li><li>• Less chance of raising anti-trust concerns</li></ul>	<ul style="list-style-type: none"><li>• Does not promote Health Neighborhood accountability and improvements in quality</li><li>• Does not create ties or incentives to overcome lack of system coordination</li></ul>
Contract between DSS and a lead organization with sub-contracts to the lead to meet requirements	<ul style="list-style-type: none"><li>• Promotes accountability between partners in the health neighborhood with an accountable entity to manage the neighborhood</li><li>• Creates an administrative entity to work with DSS (and potentially distribute funds) including referrals, care planning, shared resources, coordination of care, communication, team management, and APM II</li></ul>	<ul style="list-style-type: none"><li>• Creates a new type of structure that does not currently exist</li><li>• Neighborhood participants don't all current understand roles well</li><li>• Who would be the "lead"? And how would that work for providers across the neighborhood?</li></ul>

# Health Neighborhoods: Agreements

	Pros	Cons
Contracts among partner organizations; no lead agency; DSS contracts with individual providers for APM II or shared savings	<ul style="list-style-type: none"><li>• Loosely affiliated network of providers that agree to protocols re: referral, transition coordination, care coordination and team based care</li></ul>	<ul style="list-style-type: none"><li>• Will this loose affiliation work effectively without lead agency and fiduciary</li><li>• No entity responsible for receiving and possibly re-investing shared savings;</li><li>• Greater burden on states to develop individual contracts to support APM II payments and shared savings.</li></ul>

# Health Neighborhoods: Payments

## ASO Payment

- ASO Payment for Administration of Value-Added Services (e.g. Data Analytics and ICM Services in FFS and, support for Health Neighborhoods): Paid to the ASO

## APM I

- Advanced Payment Method (APM) to support the delivery of Advanced Primary Care to the PCMH practice: *Paid by the State to the PCMH*

## APM II

- APM II to support risk adjusted monthly or quarterly advance payments to support ICM or other demonstration services to MMEs who require this level of care based on risk status: *Paid to either the provider directly, a fiduciary or the Health Neighborhood "Lead"*

# Health Neighborhoods: Shared Savings

- What policies would create incentives to provide person-centered care delivery at the right time, in the right place, in the right amount?
- How would shared savings be calculated?
  - Global or targeted?
  - Sources of savings?
- How do MMEs join?
  - Attribution vs. enrollment

# Health Neighborhoods: Shared Savings (cont'd)

- Who would receive savings?
- How would savings be distributed?
- Which providers would be eligible to receive savings?
- Does the State:
  - Distribute the savings directly?
  - Distribute the savings to the “lead” (assuming there is one)?
  - Specify the level of savings to be received by each provider type in the neighborhood?
- How much savings would be shared? (Medicare, Medicaid or both?)