COMPLEX CARE MODEL DESIGN WORK GROUP—MARCH 12, 2012

Person Centered Care: Karyl Lee Hall—core of program—definition that Karyl Lee provided is from CMS federal register. Performance measurement subcommittee has approved previous definition. Kate pointed out need to equip individual with information to make informed decisions, works with person to determine what services they need, and then works with the individual to create a care plan. Full subcommittee will decide upon the recommendation. Karyl Lee pointed out that the consumer directs the care and that the definition is explicit. Ellen pointed out that the person should sign on to care plan. Person centered definition drives the performance measures.

Performance Measurement: How do performance measures link to an incentive approach? Matt Katz asked to whom are these measures targeted—to Neighborhood or individual providers? Meryl Price indicated these are aggregate for the Neighborhood, and Neighborhood has to drill down re individual performance of providers. Matt pointed out that some of the measures are system wide. "Person-centeredness" is its own domain but cuts across other domains. Looked at national standards and standards being used for ACOs, Meaningful Use, and Health Homes, as well as other programs and areas like NCQA. Alicia raised that behavioral health as domain is very broad, and many issues have to be included. Meryl indicated she also has to compare this to DMHAS and Value measures. Housing stability and suitability of the environment apply across all groups.

Measures will be used in screening and assessment, and then whether follow-up and action was taken. Client surveys will have to be cost supported by the state. List will be narrowed from "expert group", performance measurement will review and will also be sent by Survey Monkey to full group, and then consolidated version presented to full SC. Expert group will comment on committee's "high priority and highly relevant" measures. Kate indicated that for today wanted to show types of measures: health status, consumer satisfaction, care coordination. Kate also indicated that discussion on incentives really pertinent to what is expected in terms of performance. Meryl Price will send out list of "Expert Group." Will also get broad input from Medical Society, and may do focus group with physicians. Would actually pick actual measures after application is submitted. Alicia pointed out that "expert group" is predominantly people in aging; there is limited additional representation. Complex Care stakeholder group has full range of stakeholders and some providers.

Stakeholder group has included social and environmental and integration factors—menu to "pick from." Matt pointed out there are clinical issues that should be high priority which the "experts" haven't prioritized.

SHARED SAVINGS AND INCENTIVES: Savings state realizes and also received from Medicare go into a reinvestment pool. Meryl indicates that quality measures drive payments to Health Neighborhoods, not savings. (However, must have savings to provide incentive payments.) In PCMH, DSS has developed a small pool to cover incentives. Goal for MME project is to use quality outcomes to generate savings to pay incentives. Different "pots of money" become

available to PCMH and to Health Neighborhoods; can be cumulative. Providers who are PCMH qualified can earn both.

ACO approach—members are attributed, only Medicare, and measures primarily related to savings. For MME program, can look at

- Pre-program method, usual CMS 3-year historical data, stratified by sub-population, risk adjust, and looking at national trends of spending. (can be conducive to cherry picking and can game risk adjustment tools—only looks at acute care side and not the integration of totality of care.) Or:
- Aggregate Medicaid claims and risk adjustment—a "looking forward" approach
- Not clear what CMS is planning.

Pam Meliso reviewed letter sent from advocacy and legal organizations about shared savings. Concern is how savings will be distributed. Recommendation is that savings should be paid strictly on performance, and not necessarily whether neighborhood saves money. Department may have to take an incremental approach. No payments in first year; data not available. DSS hasn't fully evaluated this. Requirements will be set for first year that Health Neighborhoods have to meet. What would state do if overall costs went up but a Health Neighborhood actually had savings? Mark indicated that savings dependent upon if individual Neighborhood has met their performance measurements and if they have generated savings. Mark did not believe this is "value based performance contracting" if Neighborhood does stellar job, saves funds, but state overall has no savings; Neighborhood should still be rewarded. Matt Katz thought payment should be based on meeting quality savings; in base year, may well be additional expenditures. Mark indicating that approach here will be similar ACO and CPCI, but broader distribution of funds. Matt asked how we "model costs", to understand where we are starting from. ACO model looks different in each state. Mark indicating that DSS at beginning of actuarial process; Matt said we have no data to compare this population to national cost so must base on CT data. Also must take into account increased costs to system to undertake this kind of system integration, nurse care management, etc.

Sheila raised the issue of whether we have accurate risk models for Medicare/Medicaid populations. Also we do not know about how much MORE care will be needed for a poorer, sicker population that MMEs represent. At what point can we reasonably assume that the system structure is in place to meet performance measures, that community infrastructure not in place is being addressed, and how long does this take? Mark indicated national risk models may be available and more information will be provided.

Sheldon Toubman presented from advocates' letter that performance measures are paramount, and that state should distribute savings from statewide pool. DSS model at this point is that Neighborhood would have to meet quality targets and generate savings also. Ellen raised concern about "cherry picking" to save funds about how doctors may encourage people to join which model. Mark agreed that enrollment methodology becomes quite important. Ellen suggested that one can do global savings approach to assess this.

Mark indicated that DSS is now looking at shared savings, enrollment attribution, and questions raised today about model.

Enrollment Options: Matt Katz, Sheldon Toubman, Pam Meliso met with Meryl Price on enrollment. Decision was made to have "opt-in". Would have to have sufficient number of MMEs to make this viable. Mercer et. al. reviewing this in terms of making this viable. Can waiver of three day rule at hospital be pursued? Beneficiaries can only be in one model, providers can cross participate in multiple initiatives. Matt raised if people "opt-in" may have higher risk clients, and must risk adjust for this. Sheldon clarified "shared savings" based on what state saves, and not what Neighborhoods saves, is directly linked to whether an "attribution" model can be used.

Submitted by,

Sheila B. Amdur
Co-Chair, MAPOC Complex Care Subcommittee