COMPLEX CARE SUBCOMMITTEE—MARCH 16, 2012

Kate McEvoy presented for the Department: (PowerPoint link)

- Areas of agreement
    - Target Population (Who in DDS population will be included—only those without current medical coordination? How will those with medical coordination be included or not included?)
    - Basic Model design structure—ASO with Health Neighborhood—Providers and agencies in the Neighborhood—DSS will define groups of providers who will be required, and standards about who should be involved. Also need to clarify legal structure of structure.
    - Shared savings between CMS and State
- Three to five Health Neighborhoods—For individuals in Health Neighborhoods, ASOs will still oversee accountability of HN and data integration. Deb Polun suggesting that ASO(s) exact role should be clarified. Same prior authorization requirements will be in place. Ellen wanted to know if providers will be required to be part of HITE-CT. Kate indicated this is still very early and not clear what outcome will be. DSS will be contracting with data analytics firm. Mark also clarified that many of the details will have to be clarified in the implementation phase. Sheldon pointed out that a care coordination model for PCMH has been worked out that is excellent.
    - Health Neighborhoods: Providers contractually linked to lead agency; MME chooses their preferred source of care coordination with RFP spelling out what the requirements are for care coordination. Alicia asked about non-Medicaid providers participating, e. g., housing providers. Mark indicated no need to preclude this since they may have key supports and expertise. Molly Gavin indicated there may be some "rogue" groups who want to participate who aren't necessarily up to the quality standards. (How will HN screen?) Mark indicated they would have to become Medicaid providers and meet requirements. Sheila gave examples of non-Medicaid providers such as psychosocial clubhouses with members with people with psychiatric disabilities. Alicia pointed out other behavioral health providers who provide major community services. Quincy Abbott indicating housing was the most serious impediment for people trying to get out of nursing homes. Ellen raised if by broadening participation would we be broadening the Medicaid budget? Mark indicated that there would be different levels of shared savings based on priority services, but this would not make a non-Medicaid provider eligible for Medicaid billable services.
- Agreement that state and CMS would share savings: 50% of Medicare, and state saves its own 50% of Medicaid.
- Focus groups completed with people over 65. Now going forward with 5 groups of people under 65. Preliminary findings with people with intellectual disabilities are concerns about losing primary care physicians and some of their specialists are even out of state; also transition from pediatric to adult care. Sheldon pointed out reports of MDs unwilling to take people with Medicaid as co-pay.

Performance Measurements:

Kate McEvoy presented prioritization of key measures by Complex Care subcommittee members who completed the survey and the "expert group." Kate indicated over 35 people completed the survey. Also CT state medical society will be commenting further. Measures will continue to be refined even after application submitted. Performance measures from MFP and PCMH also being examined. Pam Meliso asked how we incorporate other CMS priorities, e.g., racial and ethnic health disparities which was given lowest priority by people taking the survey. DSS will have to address this. Sheldon pointed out that performance measures not geared to areas that help save money. How do we reflect that in Performance measures, particularly if we want performance incentives to be the preferred method of "rewarding" providers? Sheila agreed that areas of over utilization should be monitored with focus on quality health outcomes.

- Person-Centered Care—strengthened language re MME's direction of process. Also "integrated setting" means least restrictive but with integrated services.
    - Individualized plan of care "when appropriate"—this refers to people needing intensive care management, not people needing general support services. Alicia raised that everyone should have an individual plan of care. Need to clarify who will NOT have individualized care plan. Sheila suggested that two levels of "care plans", one related to the relationship with one's primary care provider or treater, and one related to people receiving intensive care management (high, medium, low risk). Alicia also noted that people must receive their plan of care—Kate noted this would be in RFP stage.
    - Quincy Abbott—who will be reading this definition and understand it? How is it explained to real people?

Sheila noted that we have to discuss how we work with DSS after RFP completed and with development of final performance measures.

Model Design:

- Enrollment—Sheldon, Pam Meliso, Matt Katz met and agreed on Opt-in. Have to address risk selection bias, address "cherry-picking". Also how will enrollment be impacted by ACO and CPCI (if state selected), and D-SNP.
- Shared Savings—(see PP for issues raised)—Will Shared Savings be phased in? Sheldon suggested that performance measures be linked to areas where we would expect to achieve cost savings. Jill Benson asked how payments could be made if there are no savings? Mark—have to cost out where there will be return on investment; must be high upfront expenditures for ASO, ICM, e.g. Jill also raised that CMS did give incentives to providers to implement electronic health records, so advance payments for care management also important. Sheila raised the issue of what investments have to made in community support and health care services to reduce expensive and inappropriate utilization of higher levels of care? Kate will share GAO report related to this issue.

What period of time does it take to actually receive savings? DSS is making changes on CNH model of ICM based on more person-centered care and deeper involvement with person's physician based on some national findings.

- Sheldon suggesting looking at performance measures that will result in saving $. Also requiring global shared savings by Health Neighborhood—will this incentivize reduction of appropriate care.

NEXT MEETING OF FULL SUBCOMMITTEE WILL BE ON APRIL 10 TO REVIEW FINAL DRAFT APPLICATION. (MARCH 30 MEETING CANCELLED). ON APRIL 4 WILL HAVE SPECIAL MEETING OF MODEL DESIGN GROUP WITH MERCER AND OTHERS TO CONSIDER AND DECIDE UPON SHARED SAVINGS.

Submitted by

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