MODEL DESIGN WORK GROUP—APRIL 4, 2012

Attendance: Sheila Admur, Kathy Brusie DSS,
Bill Fiochetta Mercy Community Health, Mag Morelli Leading Age CT, Sheldon Toubman NHLAA,
Molly Rees Gavin CCCI, Kathy Pajor CAHCA, Ken Lalime CMSS-IPA, Stephen Frayne CMS-IPA,
Alicia Woodsby PSC, Swb Polun CHACT, Deborah Hoyt CAHCT, Ken Ferrucci CMCHS,
Colleen Harrington DMHAS, Meryl Price DSS, Julia Evan Starr COA, Sherree Swanson Mercer,
Marianne Ringel Mercer, Ernest Jaramillo Mercer, Kate Mcevoy DSS, Mark Schafer DSS,
Sam Espinosa Mercer

Main focus of agenda is on the Shared Savings model. Maria Dominiak, actuary from Mercer, presented. It is not clear on what basis Medicare will decide if there are shared savings—is it based on reducing a certain cost trend, is it based on reducing expenditures of the previous fiscal year, etc. This is unknown.

Powerpoint on Webpage.

Cautions included not creating unintended consequences, and assuring that the savings targets are just not random fluctuations in costs. CMS has required "minimum savings" for ACOs (+ or – 2% around target). CMS has not been prescriptive yet in any of the states. States submit what they want and not clear what CMS will negotiate. CMS expects savings to be small at the beginning and then ramp up over three period. CMS will use Mercer to project this.

Duals initiative competes with ACOs and CPCI (if state gets this). Need incentives to "compete" with these initiatives. Providers will have to make choices about whether to participate in these initiatives. Why would they do so?

Re what services to include, difficulty is that there is no data to inform the process. Data on duals will presumably be presented the week of April 9.

Mercer recommending attribution model for participation. Will be a challenge to determine actual attribution and how to share savings and with whom. Participant can choose any providers in or out of the Health Neighborhood. If consumers opt-in, requires 30 to 40% active choice to achieve 5,000-7,000 participants per HN in most populated areas (Hartford and New Haven). Mercer does not believe we will get to critical mass if opt-in method chosen. If this is person centered approach, Deb Polun asked if opt-in wouldn't be a good way to get the person involved? Ken Ferrucci said that "cherry picking" does not appear to be that applicable if providers can't provide the services. Sheila Amdur raised that given the higher disability and poverty of this population, it is not comparable to a healthier Medicare population in which people with complex health care needs might be more of an outlier.

How savings are allocated can be complex given that some providers may lose revenue. The distribution model for savings may impact in which initiatives providers participate. Providers could also use this process to "dissuade" consumers they do not want in HN because of costs.

Not much evidence to determine if shared savings will actually occur to any significant degree. Need requirements for the "panel". Must also determine how upfront costs can be met for Health Neighborhoods to form. State must be able to link Medicare and Medicaid data for HNs. Process takes a long time. Mercer recommending focusing on a phase-in model. How will this initiative be evaluated in relationship to other initiatives—how is right-sizing factored in? If there is a nursing home closure, how does that impact the HN? Risk adjustment—big range of costs in this population. Medicare risk adjusts for acute care costs in Medicare Advantage. State needs to be consistent. No national model for long term care supports; need data and experience to develop this.

Steve Frayne asked what if only one neighborhood had savings and met quality targets and others did not—would they still receive savings? Dr. Schaefer indicated it would be his preference that they did, dependent upon Administration budget office agreement.

Demonstration allows determining what methodologies and approaches work and could be replicated statewide. Shared savings would have to be substantial enough so that providers in HN who met standards could have distributions from the HN if it met its overall standards. No shared savings in the first year to allow implementation of quality. State may also have to get waiver(s) related to some of the requirements for HN.

Ken Ferrucci—how to get MDs to participate in this model and its cost sharing model. CSMS will be reviewing and providing comments. Kathy Pajor for CT Assoc of HC facilities: The Association and CHA wants to eliminate the hospital 3 day requirement for home care as well as for skilled nursing facility. Ken LaLime: CSMS runs shared savings programs and must depend upon data. Without data, can't measure outcomes. CPCI providers won't be able to participate in HNs.

Sheldon raised a series of questions. How will this demonstration attract providers vs ACOS and CPCI over which we have less control? Must have quality metrics specific to the population we served so we have overall value for this population—quality and costs. Why not use the PCMH model to reward quality?

Sheila Amdur proposed a phase in model. Steve Frayne said hospitals have to decide which of these initiatives will they put time and resources behind. Steve feels hospitals might not participate if saving not allocated until the third year; want to see shared savings from the start. Requirements should be set for quality and for savings. Pam Meliso raised that ACO is risk model down the road. Hospitals faced with multiple federal initiatives that are being "popped out" by CMMI. Meryl Price said CMS wants model to be and running as of December 1. Deb Polun asked what level of savings might state be expecting from Feds. NC demonstration had no savings in the first year. Mercer indicated CT will not likely have savings in the first year. Collectively there is potential.

Sheldon spoke with CMS re sharing savings with providers based on quality. His contact at CMS said shared savings not necessary for demonstrations. Also unless we do phase in of shared savings, Sheldo indicated that must have opt-in as the “number one consumer protection.” Meg Morelli said groups of providers will need up-front costs met so that care management takes place. Must measure quality and performance outcomes and costs. When data is clear, then reward HNs that are meeting requirements and saving money. Steve Frayne believes that if there are savings above and beyond the upfront costs, where do those funds go? Ken LaLime indicated for ACOs, Medicare will indicate by the end of second year if there were any savings for first year. By third year, get first payout on reconciliation of first year. Mercer believes it’s important to phase in shared savings by year 2.

Organizations have to make commitments to participate. Quality was improved in the few places in which shared savings operated. Kathy Bruni said that biggest problem is patients being diverted to ERs, and believes HN will address this. Molly Gavin said it’s difficult to understand this proposal re "savings" given that there has been no rate increase in Home Care in 5 years. Who will participants be among these 5,000-7,000? How will savings be shared with diversity of providers?

Additional issues rasied: What kind of reinvestment options for savings can be set? DD/DMHAS providers using this as learning labs. Compare the effectiveness of this to ACOs.

- Options for shared savings: return to general fund, share with providers, designate how funds should be used. Reinvestment of savings in neighborhoods. Infrastructure improvements critical to help providers improve and streamline practices. HNs get savings to improve their local structures.

Next Steps: Draft Application will be sent to full Complex Care Subcommittee on Thursday, April 5. Complex Care subcommittee will meet on April 10 to formulate their recommendation to the Medicaid Council for their April 13 meeting.

Submitted by,

Sheila Amdur