

COMPLEX CARE SUBCOMMITTEE—APRIL 12, 2012

CMS application for dually eligible population was reviewed. After Medicaid Council review, public notice and formal comment will begin later in the month with submission of application at the end of May.

Kate McEvoy indicated that “landscape has shifted” in that Connecticut was not chosen as a participant in the Comprehensive Primary Care Initiative. Therefore, this initiative for people who are dually eligible becomes more key.

Building blocks for duals application are the new Medicaid ASO and the Person Centered Medical Homes. Also DSS will work closely with DMHAS and DDS to coordinate care and assure that beneficiary protections and program evaluation are in place related to each population group.

Also applying practice of “person centeredness” is central, including providers understanding what this means. Karyl Lee Hall asked about differences in services to ASO clients and those in Health Neighborhoods. Will those with highest risk have more individualized planning? Predictive modeling will identify individuals at highest risk with co-morbid conditions, high acuity, etc. who will need intensive care management. This will occur whether individual is associated with ASO or Health Neighborhood and will be carried out by care manager identified by individual. Kate McEvoy said that everyone who received ICM will have individualized plan of care. For people with lesser needs, can broker meetings communication with providers involved or will work with the individual based on accessing what they need. Mary Ann Cyr clarified that predictive modeling identifies people with certain diagnoses or cluster of diagnoses, use of medical system, and uses algorithms to determine risk score, and therefore interventions needed after assessment. “No Wrong Door” for assessment and interventions.

Sheila suggested future meeting devoted to elements of intensive care management, who gets what levels of care, and how person centered planning is assured at all levels of care.

Key elements include “real time” sharing of information. All current MMEs are now aligned with either of the two Medicaid ASOs, and this will continue unless they are in a Medicare Advantage Plan or aligned with ACO, which don’t yet operate in CT. Health Neighborhoods will evolve with people who have their primary care in these neighborhoods “passively enrolled” to the HN; person can opt out if they choose. DSS does not want to create a situation that would create a situation in which people would be potentially discouraged from being in the HN.

Sheldon Toubman asked how one could compare Model 1 and Model 2 because of added benefits to HN. DSS said they have been clear that aspects are not the same. Financing models are different, but never meant to identify them as comparable. Matt Katz asked why ASO would not be providing chronic illness self-management, and would like to see that and nutritional counseling under ASO also. Mark clarified that ASO cannot provide pharmacy or nutritional services based on CMS requirements. Sheila indicated that people not in HN will be

under ASO. Jill Benson said that many people with serious mental illnesses do not have primary care physicians, so how will they receive services. Paul DiLeo stated that DMHAS is working on language regarding health homes for people with serious mental illnesses, related to care management occurring at local level either through HN and LMHA or with ASO and LMHA. Paul said proposal helps bring together physiological and behavioral health and addressing high comorbidity of SPMI population. Mark Schaefer indicated that people who have received treatment at a local mental health provider or who have incidence of ER visits could be attributed to the HN so that people “off the grid” aren’t left out of care in the HN.

Mary Ann Cyr said that part of their care team are registered pharmacists, dieticians, as part of ASO staff who are available to people served.

Although CT has high level of spending, we are not getting better outcomes in terms of rehospitalization and some other outcomes. HN provides multi-disciplinary approach in integrated fashion. Beneficiary protections will encompass Medicaid requirements with open choice of providers. Learning collaborative will be used to “equip” providers re specific needs of specific populations. Matt Katz asked if person opted out of sharing information, would they be part of HN? Person can choose not to be part of HN, but if they want to be a part, must share information. Matt suggested that if person makes informed decision to opt in then they know data is shared. If someone is just assigned, may be confusing re information that will be shared. He indicated that MDs are concerned that data must be shared for care to be provided adequately. Sheldon raised the fact that most of the population is potentially compromised as well. Ellen thinks that this will be attractive model so opt in should not be a problem. Quincy raised that communication is really the issue about how to make this work.

Mark Schaefer indicated that shared savings programs to date have met quality targets. The issue is how we have enough enrollees to support model in an actuarial way. National models indicate that we would not have enough enrollees with opt in and opt in would allow active enrollment of lower risk and discouragement of higher risk.

FINANCING MODEL:

1. Start up payments to HN Lead agency, amounts to be determined to offset costs of setting up HN and acting as fiduciary.
2. Converting PCMH to bundled payment model, making payment per beneficiary.
3. Risk adjusted Advance Payments to HN (ASO not responsible for HN clients)—bundle in ICM and other supplemental services, including possibly housing case management and disease education.
4. FFS continues.

5. PCMH get retrospective payment against benchmarks and performance standards. HN has pool of shared savings if projected budget is “beat” along with withhold of APMII. Sheila asked why APM withhold would not be returned if they met experience and quality goals since these are the funds they need to manage this process? Mark indicated this could be discussed, whether budget targets would also be required related to the withhold. Matt Katz indicated that he has concerns about withhold—has not been discussed previously—and in commercial models this has not worked; providers have been lost. He said that the driver becomes the cost, not the quality. Need to incentivize providers to get people out of the hospital. No indication of what % of withhold is being considered. Physicians will provide more services and more risk, so why would they participate in this? What will additional costs be initially? Mag Morelli agreed in that the basis of making this work is a collaborative, intensive care management model in which providers will have to invest, and to make this work in three years is a challenge. Deb Polun said providers will get more funding above fee for service, and how much more will depend upon quality standards. Mark indicated that in PCMH 30% is withheld; remaining is paid including bonus is paid based on quality standards.

Sheldon indicated Mercer presentation at Model Design showed that the models nationally are mixed re whether there are any shared savings. Why would you have model that takes most vulnerable populations and places them in model that might cause risk of denying care (53% have neurological impairment and 38% have serious mental illness)? Also will not be competing with CPCI or potentially ASO so why then have a risk model?

Mark indicated that CMS is looking for sustainable models to control the rate of growth of spending. CMS has not seen that PCMH models lead to sustainability. Majority of state models are capitated models related to duals. Medicare believes these have the most promise. Mark sees this model as alternative to capitation. Will build in evaluation re denials of care. Matt Katz indicated we don’t have the integrated models that Massachusetts or Michigan have. He also questioned if FFS are identical rates to what is received now. He would also like to see breakdown of why our costs are higher—is it utilization or is it that we are a higher cost state? Mercer provided savings data that DSS feels must be analyzed further re our care patterns and cost related to national patterns. How does this then influence our interventions and strategies? Mark said reimbursement going forward will be what they are today and whatever changes CMS is making in future (100% of Medicare rate to primary care physicians). DSS is not committing to any payment above current rates.

Ellen Andrews indicated NC pays Medicare rates now. There are problems getting physicians to participate in Medicaid. If we believe this approach saves money, then state needs to invest in this. Sheila pointed out that we are trying to make a major change in how health care is practiced at the local level, and get a broad range of providers to change behavior patterns, If we stay totally focused on costs and not on reinvestment needed and quality standards, this will not succeed.

Mark’s point without shared savings linked to quality standards delinks “value equation.” Matt believes we really have to see data to see if we can reduce hospitalizations and other possible

unnecessary data. Kate also indicated that Department wants to review Mercer projections of cost savings to determine the basis and validity of these. Also DSS is negotiating with CMS about financial support of key data, enrollment and other aspects of program.

Ellen is very concerned about choice of lead agency for HNs. How will funds be distributed? How much does Lead Agency keep? APMII will be defined based on actuarial model of ICM utilization and other services and assuring it is being provided. Kate clarified that maps in draft do not mean hospitals are expected to be leads, but reflect clusters of providers.

Sherry asked about 1/5 of MMEs who are part of waivers. How will case management and inter-operability be addressed in implementation? Marie Smith commented that performance measures re medication are unique and innovative, and believes those measures have to be expanded.

Sheila summarized issues re opt out-opt in; APM withhold; and shared savings. Deb wanted to know what the basis for calculating shared savings would be. Matt said Medical Society is supportive of shared savings based on quality standards, and rewarding those who meet those standards. Also what is basis of calculating savings. CSMS believes that there should be performance incentives paid even if there are no savings. Sheldon indicated state must see savings before any incentives are paid, and distribution should be based on quality standards met. Mag Morelli said that there has to be relationship between quality outcomes and shared savings, and will there actually be any major savings. Invest in three year pilot providing quality in cost effective way so we can sustain system. She believes there would be inequity if HN that meets targets and achieves savings, but doesn't receive full benefit of this. Quincy Abbott said "people will do what you pay them to do", and if they meet quality targets, it should go to people who produce the savings. Quincy has concerns about how these are distributed based on who has done what in the Neighborhood. Sherry Ostrout sees no issue in this if there are shared savings distributed based on quality. Sheldon proposed:

For the first year of the demonstration, assuming there are any overall savings in the program, shared savings should be paid out to individual Health Neighborhoods from a statewide pool based on quality measures solely, and not on whether the specific Neighborhood has achieved savings for its particular enrollees. Then in stage 2, again assuming overall savings in the program, Health Neighborhoods will continue to be paid based on performance on quality measures but the amount they receive will be reduced (amount or percentage to be determined) if they do not also produce savings for their particular enrollees.

Matt Katz suggesting that there should still be some incentive payments. Tiered approach. We must know more about the data to understand how we can impact care. Second year would be linked to savings in terms of quality outcomes approved. Savings pool for first year has to be related to HN performance. Committee had consensus on the proposal Sheldon raised.

Julie complimented the Department on its work and inclusiveness.

New lists will be sent by e-mail so organizations can clarify their correct names and representation that will be reflected in the grant.

Submitted by, Sheila Amdur, co-chair