

Model Design Work Group

May 17, 2012



Today's Agenda

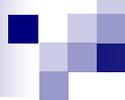
- Procedural status of application
- Questions on Draft Application
- HN Design Assumptions/Options
- Shared Savings Program Design Considerations
- Co-lead for Health Neighborhoods

Procedural Status of Application

- The draft application has been posted on both the MAPOC and DSS web sites

<http://www.ct.gov/dss/cwp/view.asp?a=2345&pm=1&Q=503056>

- A 30-day comment period commenced on Wednesday, April 25 - the Department will review and inventory comments received by close of business on May 25
- the Department plans to submit the final application on May 29, 2012



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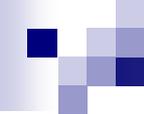
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Draft Application – Key Components

- Approximately 57,000 MMEs
- Two models (1 – ASO) and (2 – HN)
- Shared Savings in Model 2
- Consumer protections
- Neutral enrollment broker
- Performance measures
- Open issues:
 - CMS requirements for performance measures
 - CMS methodology for establishing cost benchmark

Questions on Draft Application

- Initial questions on the draft application have centered on three broad topics:
 - enrollment
 - requisites for and role of Health Neighborhood Lead Agencies
 - shared savings (featured in this presentation)



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Questions: Enrollment

- How will MMEs be affiliated with HNs?
 - an MME will be passively enrolled based on where he or she has received the plurality of his or her primary care or behavioral health services over the 12 months preceding implementation
 - definition of primary care should be expansive
 - method could to a degree parallel the ACO Rule in proceeding “step-wise” to assess:
 - initially, whether there is a source of primary care;
 - whether there is a source of behavioral health care;
 - whether there is a specialist who proxies for this function.

Questions: Enrollment (cont.)

- What beneficiary protections will be associated with the passive enrollment process?
 - MMEs will receive the following from a neutral enrollment broker:
 - confirmation of enrollment
 - disclosure of the benefits of participating
 - disclosure of shared savings mechanism
 - notice of right to opt out of participation and means of doing so
 - MMEs will retain full choice of provider, within and without the HN

Questions: Lead Agencies

- What entities will be permitted to apply as Leads?
- Should any entities have preferred status as Leads? On what basis?
- Will any entities be excluded from participating as Leads?

Questions: Lead Agencies

- What requisites will be required for Leads?
 - content expertise: e.g. care coordination (medical, BH), access to care, person-centeredness, cultural competency
 - solvency
 - ability to enlist partners

Questions: Lead Agencies

- What are the key duties of the Leads? How will duties be allocated as between medical and BH Leads?
 - Administrative functions:
 - infrastructure: operating capital, management, information technology
 - contracting
 - management/oversight of care coordination provided by the network
 - compliance with Department requirements
 - support for provider members (e.g. data sharing, use of evidence-based protocols, CQI)
 - performance reporting
 - accountability for standards (including termination of non-performing)

Questions: Lead Agencies

- What are the key duties of the Leads? How will duties be allocated as between medical and BH Leads? (cont.)
 - Fiduciary functions:
 - APM II
 - performance payments
 - Content expertise/direct service

Questions: Lead Agencies

- Will there be any limitations on the role of Leads? Will Leads be conflicted from offering care coordination, direct FFS and/or supplemental services under the Demonstration?

Questions: HN Composition

- What are the rules concerning participation?
- Who are required participants?
- Who are optional participants?
- Who are excluded participants?
- Will we allow for non-Medicaid participating providers?
(e.g., housing agencies, volunteer organizations, service organizations)

Questions: HN Composition

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- Who are excluded participants?
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Shared Savings Program Development

- Mercer developing financial modeling tools to enable state to better assess impact of various shared savings program policies and design parameters on:
 - State financial risk
 - Strength and certainty of value proposition for providers
 - Improvements in quality and economy
 - Shift in focus from volume to value
- Seeking additional post-application design dollars from CMMI

Shared Savings Program Development

- Tools will enable the state to model and evaluate:
 - Interdependence of Models 1 and 2
 - Independent Medicaid and Medicare cost and savings scenarios
 - Independent Medicaid and Medicare savings distribution and federal claiming assumptions
 - Possible distribution adjustments:
 - HN population size
 - Population risk rating
 - Cost performance
 - Quality performance (variation above minimum standard)

Factors that Influence Modeling

CMS-related factors:

- CMS has not yet established minimum standards for performance (quality and care experience) that must be met to share in savings

Factors that Influence Modeling

CMS-related factors:

- CMS has not yet issued its methodology for:
 - establishing cost targets or benchmarks against which performance will be measured
 - computing savings (e.g. minimum savings threshold, first dollar requirements)

Factors that Influence Modeling

CMS-related factors:

- uncertainty about whether a pool funded by Medicare savings:
 - can be paid to providers and
 - qualify for federal match under Medicaid

- uncertainty about whether separate shared savings program agreements can be established with CMS for each of Connecticut's two models

Factors that Influence Modeling

Structural factors:

- projecting what costs would have been in the absence of the Demonstration has elements of uncertainty
- isolating the impact of HNs will be challenging in a landscape that also includes cost-saving efforts by the ASOs, Money Follows the Person (MFP) re-balancing, and hospital discharge planning activities

Factors that Influence Modeling

Structural factors (cont.):

- cost and utilization of Medicare and Medicaid services can also be affected by random fluctuation and/or precipitating factors (e.g. flu epidemic) that do not relate to HN performance
- there are many scenarios that may result, among them the possibility that even if there are no net state shared savings the State could be responsible for making performance payments to HNs – final design may need to eliminate or mitigate this risk

Factors that Influence Modeling

HN-related factors:

- risk adjustment among HNs that serve different arrays of the MME population is challenging
- there are many ratios along which performance payments could be allocated between quality performance and cost savings

Factors that Influence Modeling

HN-related factors:

- there are different means of allocating performance payments for cost savings (e.g. based on the amount that the HN contributed to gross savings; based on the HN's percentage of net savings)
- there are also different means of allocating performance payments for quality measures (e.g. minimum overall and/or measure-specific attainment level, sliding scales of payments)

Complex Care Committee Recommendation

- **Year 1:** shared savings should be paid out to individual Health Neighborhoods from a statewide pool funded by HN savings based on quality measures solely, and not on whether the specific Health Neighborhood has achieved savings for its particular enrollees
- **“Stage 2”:** shared savings should be paid based on performance on quality measures but the amount that HNs receive will be reduced (amount or percentage to be determined) if they do not also produce savings for their particular enrollees

Shared Savings Program Models

- Simplified
 - Initial models disregard impact of Model 1
 - All models disregard Medicaid savings
 - No adjustments for population, risk, or quality
- Savings shown assume *state share* of Medicare savings – 50% of actual savings
- Assume distribution to providers with no opportunity for federal match
- All models and formulas are for illustrative purposes only....*they are not proposed formulas*

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
2a	A	\$ (1,000,000)	Y	\$ 787,500
	B	\$ (500,000)	Y	\$ 337,500
	C	\$ (750,000)	N	\$ -
	Total	\$ (2,250,000)		\$ 1,125,000

Should there be a cap on distributions? E.g., not to exceed 50% of the savings generated by the HN?

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
2b	A	\$ (1,000,000)	Y	\$ 500,000
	B	\$ (500,000)	Y	\$ 250,000
	C	\$ (750,000)	N	\$ -
	Total	\$ (2,250,000)		\$ 750,000

With 50% cap; balance remains with the state

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
2c	A	\$ (1,000,000)	N	\$ -
	B	\$ 300,000	Y	\$ 450,000
	C	\$ (200,000)	N	\$ -
Total		\$ (900,000)		\$ 450,000

Could disproportionate savings accrue to an individual HN that did not achieve cost savings?

Should there be a separate quality bonus pool that would effectively limit the size of a quality distribution when no savings were generated?

Separate Pools for Quality and Value

- Value Incentive Pool funded from a percentage of the net savings; distribution contingent on meeting quality standards and proportionate to savings
- Quality Bonus Pool funded from a percentage of the net savings; distribution could be proportionate to population and quality performance

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Value Incentive Pool	Quality Bonus Pool
2d	A	\$ (1,000,000)	N	\$ -	\$ -
	B	\$ 300,000	Y	\$ -	\$ 45,000
	C	\$ (200,000)	N	\$ -	\$ -
	Total	\$ (900,000)		\$ -	\$ 45,000

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Value Incentive Pool	Quality Bonus Pool
2d	A	\$ (1,000,000)	Y	\$ 360,000	\$ 45,000
	B	\$ 300,000	Y	\$ -	\$ 45,000
	C	\$ (200,000)	N	\$ -	\$ -
	Total	\$ (900,000)		\$ 360,000	\$ 90,000

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
2e	A	\$ (1,000,000)	Y	\$ 112,500
	B	\$ 500,000	Y	\$ 12,500
	C	\$ 250,000	N	\$ -
	Total	\$ (250,000)		\$ 125,000

A fundamental problem with the net shared savings model is uncertainty.

A demonstrated successful investment in quality and economy may not result in a significant return on investment.

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
1	N/A	\$ 2,000,000	Y	\$ -
2f	A	\$ (1,000,000)	Y	\$ -
	B	\$ (500,000)	Y	\$ -
	C	\$ (250,000)	N	\$ -
Total		\$ -		\$ -

The problem of uncertainty is amplified if one includes the Model 1 performance, either a failure of economy...

Shared Savings Program Models

Model	Health Neighborhood	Savings	Quality Performance	Distribution
1	N/A	\$ (2,000,000)	N	\$ -
2f	A	\$ (1,000,000)	Y	\$ -
	B	\$ (500,000)	Y	\$ -
	C	\$ (250,000)	N	\$ -
Total		\$ (3,750,000)	N	\$ -

Or a failure of quality.

Potential Approach for Application

- Divert a capped percentage (to be determined) of any net state shared savings that are achieved by the Demonstration to two pools:
 - a “quality bonus” pool to reward performance
 - a “value incentive” pool to reward quality and cost savings

Final SSP Model

- The final shared savings program model for the application shall be developed with consideration of the following factors:
 - extent to which proposed model will incent providers to transform service delivery culture and practice to delivery value
 - extent to which approach is likely to generate a return on the state's investment
 - preference expressed by providers and other stakeholders in Complex Care Committee, Model Design Workgroup and public comments

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Behavioral Health Co-Lead

- Supports attainment of the triple aim (improving healthcare experience, improving overall health, reducing healthcare costs)
 - 38% of MME population diagnosed with SMI
 - Co-leads allow for behavioral health and primary care integration at the highest level
- Unique knowledge base
 - BH providers bring experience in care coordination and network management
 - Learning collaboratives - technical assistance and lessons learned
- Level playing field
 - Stigma/Discrimination
 - Parity

Behavioral Health Co-Lead

- Enrollment/Attribution/Quality Control
 - BH service recipients often lack a connection to primary care
 - Existing relationships/trust between BH recipients and providers
 - BH service recipients die early due to co-morbid physiological health conditions - not SMI conditions
- Network enhancement
 - Existing relationships with non-medical/recovery support service providers (housing, employment, etc.)



Questions