Complex Care Committee

May 25, 2012

Today's Agenda

- Summary of comments received
- Review of financial model
- Next steps on design:
  - ICM/Care coordination
  - Performance measures
  - Health Neighborhood structure and design

Comments on Draft Application

- Initial comments 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)

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:
      - intially, 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 requisites will be required for Leads?
  - content expertise: e.g. care coordination (medical, BH), access to care, person-centeredness, cultural competency
  - solvency
  - generative capability (membership)

- Should any entities have preferred status as Leads? On what basis?
- Will any entities be excluded from participating as Leads?

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?

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Shared Savings Program Development

- Mercer has begun to develop financial modeling tools to enable the state to better assess the impact of various shared savings program policies or 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
  - Distribution adjustments:
    - HN population size
    - Participant risk
    - Cost performance
    - Quality performance (variation above minimum standard)

Prevailing Uncertainties

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

- 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)

Prevailing Uncertainties

- uncertainty about whether CMS will permit a pool funded by Medicare savings:
  - can be paid to providers
  - can 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

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
- Assume distribution with no opportunity for federal match
- All models and formulas are for illustrative purposes only….*they are not proposed options*

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

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

Should 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 proportionate to savings
- Quality Bonus Pool funded from a percentage of the net savings; distribution 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	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.

Shared Savings Program Design

- DSS is reviewing final shared savings program model for the application, based on a variety of 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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ICM/Care Coordination

- Develop models for both ASO and HN:
  - Assess existing CHN-CT and Value Options ICM and care coordination models, including review of assessment tools and process
  - Research and draft white paper on best practices, especially vis-à-vis the needs of individuals with disabilities
  - Engage stakeholders (e.g. waivers, LMHA, MFP) in applied work group to comment on and refine models

Performance Measures

- Refine list of measures based on criteria including relevance to Demonstration goals and realizability through such means as:
  - Clinical review by physician representatives (e.g., CSMS or PCMH workgroup)
  - Comparison with recognized sets (e.g. CMS Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults)
  - CMMI required demonstration measurement set

Health Neighborhood Structure

- Continue to work with Complex Care Committee and Model Design Work Group to:
  - Define the roles of and allocate responsibilities as between co-Lead Agencies
  - Define the minimum required provider array and incidence of providers proportionate to number of MMEs served
  - Define the means by which APM II payments and performance payments will be distributed