

HEALTH NEIGHBORHOOD DESIGN – WHAT CAN WE LEARN FROM THE EXPERIENCE OF OTHERS?

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Under the Affordable Care Act, the Department of Health and Human Services has provided flexibility to states to develop new models featuring care coordination and financial alignment to serve the disproportionately complex and costly medical needs of dual eligibles (i.e., those individuals eligible for both Medicare and Medicaid). These demonstrations seek ways to improve quality and experience of care, while lowering costs. It is important to remember that these are demonstrations, and, as such, will be testing new models with a difficult population, with new opportunities for integration. While the body of knowledge about serving this population is limited, there is some experience and evidence base on which the State can build.

Most of the dual integration models are using a more traditional managed care model. Connecticut is pursuing an alternate route. It is testing two models, one where some of the population across the state will be managed, to the extent appropriate, by medical homes supported by an administrative services organization (ASO). The second will use new, geographically-based provider networks known as “health neighborhoods (HN),” each with an array of providers that will work together to provide team care management to those with complex needs. The basis for reimbursement will be fee-for-service and incentive payments. This paper examines what we can learn from more academic research, and from the practical experience of a few states who have been leaders in the field of team care management, with respect to the design of such health neighborhoods. It is a companion piece to a paper regarding lessons learned with respect to the care management function, and follows a white paper related to potential payment methodologies, focusing on shared savings.

What do we include in the term design? Following are some of the questions we think it is important to answer. We have a better evidence base for some areas than others:

- How are providers affiliated with one another?
- Who leads the organization (administrative and content criteria)?
- What are the functions of the lead (administrative and content)?
- What type and how many providers need to be included in the neighborhood? Or otherwise available?
- What providers can participate?
- Financial considerations: solvency, fiscal intermediaries, performance payments?
- Data sharing/Health Information Exchange requirements?
- How do HNs get formed?
- Enrollment and member services function?
- Supplemental service offerings?

More research has focused on the attributes of an organization’s care management than on its structural elements, but some findings have emerged. While some may seem obvious – e.g., sharing data – they are often difficult goals to achieve, and it is worth repeating that they are

important and deserve attention. The following findings regarding the characteristics of effective networks were cited by one or more researchers. We follow them with some state case studies, where you will also see many of these same themes echoed, particularly in North Carolina's recommendations:

- Communication and data sharing – this theme came up over and over again in many forms:
 - Sharing patient information using centralized data and electronic health records
 - Other communication among providers and between providers and beneficiaries
 - Giving feedback to providers on their outcomes and costs
- Have the “right” practitioners, doing the “right” things in the most efficient way:
 - Using comprehensive networks
 - Using evidence-based practice
 - Practitioners should practice to the top of their scope
- Make sure everyone is looking in the same direction – financial alignment of provider and network incentives – as discussed in the shared savings paper:
 - These need to address quality and cost to ensure value
 - These need to be sufficiently disaggregated so that they provide incentives to those making decisions
- Understand that this is hard to do and will take time, focus and money:
 - Allow enough time for implementation, understanding that new entities, and support structures for those entities, will need to be created or modified
 - Help new entities at start up and throughout the process, financially and technically
 - Have a project “champion”
- Ensure sufficient population with the right characteristics to maximize impact:
 - Use an opt-out model to ensure sufficient enrollment
 - Don't assume all duals are alike. Even among high cost, duals only, 1% were high cost for both Medicare and Medicaid – a group that may be where some of the greatest benefits of integration lie

State Experience

Minnesota – Minnesota is in the midst of implementing community care teams. As reflected in the RFP it issued for potential community care teams (CCT) to apply for start up grants, it has left the specifications for its teams flexible with respect to staff design, scheduling and site of operation. They allow nonprofit, for profit, government, Tribal government, clinics, hospitals, public health departments, institutes of higher education to house teams. Each CCT must include at least one certified or soon to be certified health care home (the state uses its own standards, not NCQA) and have staff with chronic condition care management and prevention expertise. There must be a local oversight structure which includes consumers. Other agencies may participate, but such participation is not mandated. There must also be a component addressing transition support for hospital discharges.

Vermont – Community health teams (CHTs) support the medical home model in Vermont, offering care coordination, health and wellness coaching, behavioral health counseling, and connecting patients to social and economic support services. They also perform community outreach to support public health initiatives. Each team is led by a registered nurse, who performs clinical

duties and supervises the team. Other nurses, behavioral health counselors, dieticians and others work with practices and individuals. There is an overarching grantee (need to verify) that supports the care teams. This group houses an advisory group and a clinical operations group. Vermont is in the enviable position of having an all-payer funding source – all payers in Vermont are required to contribute to support the state's Blueprint for Health that governs the CHTs, as well as the medical home model, more broadly. No formal evaluation has been completed.

North Carolina – North Carolina is generally considered to be at the forefront of states implementing a medical home model, supported by a broader network of providers. They provide a good case study for Connecticut to look at in more detail, given that they use a fee-for-service, network-based model.

One lesson North Carolina stresses is that the planning and implementation processes can be as important as designing the right model. They strongly suggest pilot implementation, understanding that a network system will not be developed quickly or easily, that such a system requires strong physician and other champions, and that it is critical for physicians to feel they have ownership in the system in order to assure acceptance. They suggest an advisory board of health care leaders who would address the same questions as Connecticut in designing their system: characteristics of the network (size, providers, structure, etc.), network functions and services, enrollment, performance measurement, partner agreements, information infrastructure, etc. They also focus on the need to support the planning and fledgling network development efforts – financially, technically, with communications, with training, with feedback.

Enrollment – North Carolina started with less complex populations and added more complex groups over time. North Carolina recommends mandatory enrollment, if allowed. This has resulted in 70-75% participation for Medicaid-only enrollees. They have only achieved about 12% enrollment for dual eligibles, where enrollment is voluntary.

Building Networks – Initially, North Carolina asked all 37 large primary care case management (PCCM) practices (i.e., at least 2,000 Medicaid enrollees) to participate and got a high rate of positive response. At first, most networks were composed of only primary care practices, but as aged, blind and disabled (ABD) enrollees were added to the program, requiring more complex services and supports, other network models were used. There are 14 geographic networks.

At start up, approximately \$30,000 was provided to each network. This was accompanied by technical support and various cross network groups. North Carolina sees the role of the state as supportive, not prescriptive, beyond setting broad ground rules; for example, each network must serve at least 30,000 enrollees to ensure adequate resources. Typically, networks are built around urban medical centers and fan out from that central point.

While there is flexibility, all networks include care managers (RNs and social workers), medical management committees, an administrator, a medical director, a pharmacist and a psychiatrist. Some specialists, such as psychiatrists, may not be full time.

Central Office – North Carolina uses a central office to ensure consistency, learning and coordination among networks. A nonprofit runs the program, but with strong ties to and coordination with, the state. Approximately 70% of the central office staff is dedicated to

developing North Carolina's Informatics Center and providing data and analytic support to the networks, including a Case Management Information System, in addition to the more traditional claims data.

Funding – PCPs receive \$2.50 PMPM for the “easier” populations – typically families – and \$5 PMPM for the ABD population. This builds upon higher than average Medicaid compensation – 95% of the Medicare rate. The networks are funded similarly – through “enhanced care management payments,” paid as PMPMs by the fiscal intermediary. These rates are \$3.72 for family populations and \$13.72 for ABDs. Networks support the central office by paying \$2 PMPM for each ABD enrollee from their enhanced care payments.

Integrating Physical and Mental Health Care Management – Mental health services were not originally integrated into North Carolina's networks because the mental health system in North Carolina was undergoing a major restructuring at that time. North Carolina is working to now close that gap; the goal being to help PCPs identify mental health issues, treat to the extent of their expertise and comfort, refer when appropriate, and to improve information sharing. Network psychiatrists will serve as behavioral health leads.

Adding Dual Eligibles – North Carolina began a unique Medicare 646 demonstration in January 2010, retaining its focus on acute, rather than long-term care. They built this model on the one they had used to provide services to the ABD population. They also had a shared savings arrangement with Medicare. They did very well on quality measures, but have not, to date, accrued savings to share, potentially due to start up issues. The state has now proposed using duals demo authority and suspending its 646 demonstration. They hope to:

- Continue and expand the use of the medical home model for duals in the community and extend medical home offerings to duals in nursing homes and other residential settings (not including the mental health population)
- Develop an integrated functional needs assessment and resource allocation system, regardless of setting
- Improve communications for beneficiaries and providers

Conclusion

To assess the relevance of North Carolina's experience for Connecticut, it is worthwhile to briefly compare and contrast the experience and plans of the two states. North Carolina had the opportunity to build its system much more slowly – it added populations and services incrementally, starting with medical services for parents and children, and eventually adding the aged, blind and disabled and a broader array of services and providers. They have still not fully integrated management of behavioral health services, although they recommend that other states do so; their exclusion is largely based on historical reasons specific to North Carolina. They also built on relatively high rates paid to primary care providers. In contrast, Connecticut will be including all dual eligibles and will be focusing on the more difficult populations, aiming to provide a strong team approach that manages medical, behavioral and long-term services.

Despite these differences and despite the lack of rigorous evaluation of specific model components, there appear to be lessons to be learned from North Carolina's experience. These

include recognizing the importance of initial and ongoing technical and financial assistance to support formation of networks; emphasis on the sharing of data and on data analytics, including clinical feedback; communication and learning within and across networks, supported by a strong central office; strong health care champions, and supporting providers in taking ownership of their networks.

The lack of findings that can guide the development of health neighborhoods that are derived from rigorous evaluation, and that can be definitively supported, carries over to the rest of the related literature. However, there are certain key attributes that most sources agree should be built into the model – improved communication, strong provider networks, sufficient enrollment, strong data analytics, shared records, etc. In this context of uncertainty, it is critical to remember that Connecticut is engaged in developing a demonstration project that will be used to test important design elements.

Annotated Bibliography

Bella and Palmer. Encouraging Integrated Care for Dual Eligibles, Center for Health Care Strategies, Inc., July 2009.

The authors recommend components that should be common to integrated care models. They also provide brief overviews of New York, Minnesota and North Carolina integrated care programs.

Bielaska-DuVernay. Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost, Health Affairs, March 2011.

This article contains a description of the Vermont Blueprint for Health Initiative that describes its medical home initiative and the related community health teams.

Community Care of North Carolina. The Community Care of North Carolina Toolkit, May 2011, Supported by the Commonwealth Fund.

Numerous modules provide information for states and others who are interested in understanding and/or replicating North Carolina's approach to medical homes and the community care networks that support them.

Coughlin, Waidmann and Phadera. Among Dual Eligibles, Identifying The Highest-Cost Individuals Could Help In Crafting More Targeted And Effective Responses, Health Affairs, May 2012.

Using linked Medicare and Medicaid Data the authors "drill down" into cost data for dual populations to look more closely at who constitutes the highest cost users, for what programs and what services.

Gold, Jacobson and Garfield. There Is Little Experience And Limited Data To Support Policy Making On Integrated Care For Dual Eligibles, Health Affairs, June 2012.

The authors note that states have little experience in integrated care for duals and that there are important data gaps in the area, which they believe indicates there should be caution about moving too quickly on care programs related to dual eligibles.

MedPAC. Report to the Congress, Medicare and the Health Care Delivery System, Chapter 5, Coordinating Care for Dual-Eligible Beneficiaries, June 2011.

As part of its annual report to Congress, MedPAC reported on various programs integrating care for dual eligibles. They found that integrated programs vary considerably and the lack of comparable outcomes research on most approaches leaves open the question of which models are more effective. However, they found all of the programs were similar in a number of key care coordination activities, including care transitions, medication reconciliation, patient education, and patient assessment with respect to risk for hospitalization or nursing home placement.

MedPAC. Report to the Congress, Medicare and the Health Care Delivery System, Chapter 2, Care Coordination in Fee-for-Service Medicare and, Chapter 3, Care Coordination Programs for Dual-Eligible Beneficiaries, June 2012.

Minnesota Department of Health Request for Proposals, Health Care Homes: Community Care Team Grants, April 2011.

Neuman, Lyons, Rentas and Rowland. Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans, Health Affairs, June 2012.

This commentary underscores the importance of pursuing new initiatives to address care coordination and spending concerns for duals, but urges taking time for implementation, noting the complexity of the task.

North Carolina Department of Health and Human Services, Division of Medical Assistance. North Carolina State Demonstration to Integrate Care for Dual Eligible Individuals, May 2, 2012.

This is North Carolina's proposal to CMS to integrate care for dual eligible individuals under the financial alignment demonstration.

Sebelius. Report to Congress: Physician Group Practice Demonstration Evaluation Report, 2009.

This report provides findings from the first two years of an early Medicare shared savings involving 10 physician group practices.

Thorpe. Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles, America's Health Insurance Plans, September 2011.

This article includes a list of key design features of effective care models identified in the literature: Team based care coordination, capitated payment, whole person focus, 24/7 availability, assessment and care plan, medication management, transitional care, regular contact with enrollees, centralized health records, and close integration of care coordination with PCPs.

Verdier, Au and Gillooly. Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans, Mathematica Policy Research, MedPAC, June 2011.

The states reviewed were Arizona, Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Oklahoma, Vermont, and Virginia. The authors note: "There are substantial commonalities in how integrated programs coordinate care for dual eligibles, but the programs' overall structure varies, reflecting differences in the structure of the state Medicaid programs on which they are based."

State of Vermont. Standard Grant Agreement, United Health Alliance, October 21, 2011, <http://dvha.vermont.gov/administration/203410-6118-12-final-web.pdf>.

This contract outlines the responsibilities of United Health Alliance with respect to supporting Community Care Teams.

Vijayaraghavan. Disruptive Innovation in Integrated Care Delivery Systems, Innosight, October 2011.

The authors tried to determine what defines a high-performing health system. They did seven case studies of diverse health systems, focused on “integrated, fixed-fee providers” that combine the functions of both payor and provider. While they found that a handful of integrated health systems were decisively outpacing their peers across nearly all quality and cost measures, generally the range of performance varied widely, some were lagging far behind, despite possessing what seemed to be the key ingredients for success.