|  | **Current Care Coordination Model Examples** | **Current Alternate Payment Model Examples** |
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| **Domain/Priority** | **Health Care Homes** | **Behavioral Health Homes** | **Integrated Health Partnerships (Medicaid)** | **CMS’s Next Generation ACO Model (Medicare)** |
| **1. Health disparities** - Does it addresses health disparities, overtly or implicitly, better than current APMs? Does it mitigate health disparities directly or indirectly? | - Four payment tiers based on clinical complexity (~$10 - $60 PMPM); supplemental factors including non-English primary language, severe/persistent mental illness.- 3-year evaluation showed that HCH patients were more likely to be from populations of color, speak a primary language other than English, and have lower educational attainment. - Payments are not tied to measures of cost or quality. | - Payments are for coordination set of six health home services to specific populations of MA recipients– adults with serious mental illness (SMI), including severe and persistent mental illness (SPMI), and children with emotional disturbance (ED), including SED.- Expand the traditional medical home model to build linkages to other community and social supports, enhance coordination of medical and behavioral health care.- The inclusion of qualified health home specialist role, which may include community health workers, peer support specialists family peer support specialists, and community paramedics, is a way to better address the needs of a disparate population.  | - Compares providers with themselves on TCOC, and adjusting for any changes to risk to not provide. Quality points can be scored on both achievement and improvement. Both aim at not providing disincentive for safety net and other providers to participate; no comparison to dissimilar provider peers. - IHPs report that participation in TCOC arrangement gives them an opportunity to focus on their most complex patients, as these patients provide the greatest opportunity for shared savings.  | - Transitions away from comparisons only to an ACO’s historical expenditures - uses a one-year historic baseline trended by a regional projected trend to develop benchmark. |
| **2. Financial stability** of health care system – Does the model create an incentive to manage costs at the provider level in a sufficient manner? Does it add to costs? How does the model control cost inflation within the care system? | - Payments for care coordination services paid on a monthly basis following service delivery, in addition to current FFS payments.- Payment not directly tied to cost savings.- Cost savings: evaluation of HCH program shows savings averaging 9.2% for Medicaid patients between 2010-2012.  | - Monthly PMPM payment for delivery of six core services - inc. comprehensive care management, care coordination, health wellness promotion, comprehensive transitional care, individual and family support, referral to community and social support services. - Expectation that better managing care for people with SMI will result in better efficiencies and ultimately lower health care costs.- Not tied directly to any cost savings. - 90% Medicaid match for first 2 years. | - Additional payments to participants result only if the provider exhibits savings, and the payment is made after the close of each performance period. - Model explicitly includes cost savings incentives through shared savings/loss potential tied to TCOC measure. - Maintains current FFS structure for services delivered by participants.  | - Multiple track options ranging from shared savings to capitated arrangement (starting in 2017)- Begins to address dependency on volume based structure by offsetting reductions in FFS payment with infrastructure payment |
| **3. Patient attachment** - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider? | - All patients are part of the HCH and benefit from improved access, team-based care, etc, but only those with more complex needs receive higher-level care coordination.- For higher-level care coordination, participation is voluntary; provider discusses HCH model with patient at clinic. Agreement to participate is documented. Provider submits a claim for payment. - Patient attachment is to a primary care provider/clinic. | - Health home services are voluntary. Consumers and their identified supports need to consent to participation and play an active role as a member of the health home team. - Patient is attached to provider of their choice that is certified to provide BHH services. May be a primary care provider, mental health provider, or other integrated models. | - Patients continue to choose where they get care, under existing networks. Patients are notified at the beginning of each year they are in the demo.- Retrospective attribution based on where the patient received majority of evaluation and management claims during previous year. Health care homes and primary care providers are prioritized over specialists. - Final attribution is not known to provider until the close of a given performance period but provides receive monthly patient rosters throughout the year. | - Patients choose where they get care. They are aligned with the ACO where they have plurality of E&M services.- Beneficiaries may be eligible for a reward if a specified % of encounters are with preferred ACO affiliates. |
| **4. Multi-payer alignment** - Does the model incent alignment or provide an opportunity for alignment across payers? What is the role for the MCOs and commercial payers under the model? | - Medicaid and commercial payers. -Commercial payers required to pay for care coordination in a manner 'consistent with' Medicaid approach. | - Medicaid only (Fee for service and managed care) | - Medicaid programs only (MA and MinnesotaCare; FFS and managed care). - Model is based on CMS’s Medicare Shared Savings Program. Similar to some commercial arrangements.- Includes MCO and FFS enrolled Medicaid beneficiaries- Based on common “community standard” methods where available (attribution based on E&M claims, TCOC methodology) | - Medicare FFS beneficiaries only (alternative to Medicare Advantage) |
| **5. Triple aim goals** - Does it include a way to monitor the patient outcomes, cost, and quality of the care delivered? Is there any incentive to deliver towards positive patient outcomes and care quality at a sustainable cost? Does it address population health?  | - HCHs required to participate in Statewide Quality Reporting & Measurement System (SQRMS); results on select quality measures benchmarked against other HCHs for improvement. -Recertification tied to quality performance in 3rd year of certification and beyond. -3-year eval showed higher results for HCHs on most quality measures (diabetes, vascular, asthma, depression remission), and lower Medicaid costs. | - States are required to report upon a federally defined set of evaluation and quality measures. The state will conduct an evaluation on a set of state measures. - While the BHH model will capture outcomes and quality measures, the payment is not tied to outcomes. | - Shared savings payment is based on demonstrated cost savings. - Risk arrangement includes downside risk (reciprocal risk for integrated IHPs in year 3). - Portion of shared savings based on quality/patient experience measurement performance (vs. peers or improvement). Core measures are sub-set of SQRMS. | - Rewards both attainment of and improvement in efficiency based on risk adjusted benchmarked targets.- Includes graduated discount in rates that rewards quality including patient experience. |
| **6. Innovation** - Are there activities that are already taking place through other existing payment models/activities proposed in the model (e.g. through HCHs, MCO care management)? If so, how does the model differ, enhance, the existing activities? How do we reconcile for these potentially duplicative activities? | - Care management/coordination may take place at plan/payer level depending on needs of the patient. -Patients may be receiving other types of provider case management or coordination (TCM, waiver, etc.)  | - Builds upon the patient-centered medical home model, expands requirements in order to meet the needs of the Medicaid population. The BHH model is available to people with serious mental illness, including adults, youth, and children.- Payment cannot duplicate other similar care coordination/case management services (TCM, HCH).- Health homes are a set of 6 services that focus on the whole person, including behavioral, physical and social service needs. MCOs will work with BHH providers to identify the workflow for care coordination when there is a consumer under a health plan. | - Builds on existing care coordination efforts, such as HCH or BHH, by allowing for wide variety in how IHP delivers/coordinates care. - May overlap with existing health plan alternate payment arrangements. -Data sharing with IHP to support care coordination and quality improvement efforts. | - Allows Medicare payment rule waivers designed to improve care and cost savings (telehealth expansion, post-discharge home visits, 3 Day SNF rule).- Data sharing with ACO to support care coordination and quality improvement efforts. |
| **7. Social determinants** - Does the model enable a flexible way to integrate/pay for services addressing the social determinants of health (e.g. flexible payment options that enable payment for non-medical services)? | - Payment enhancement for non-English primary language.- As part of certification, have to identify/work with community-based services, public health, social services, etc to facilitate availability of resources.- HCH’s tend to serve patients that are more likely to be from populations of color, have lower educational attainment, and speak languages other than English (3-year evaluation) | - Model acknowledges the need for a whole person approach and recognizes the various needs and systems that ultimately impact a person’s health. BHH requires coordination with community and social supports, and enhances coordination of medical and behavioral health care.- Payment is tied to six services, which specifically includes individual and family support and referral to community and social support services. | - Participation requires IHP to describe how they will coordinate with community and social supports.- Shared savings payment is flexible, may be used as provider determines, including enhancing social service supports. - Non-medical supports and services are not included in the TCOC or payment model. -Provider can propose alternative quality measures | - Some payment options, i.e. prospective PMPM for infrastructure or capitation, may enable providers flexibility in service delivery.  |
| **8. Complexity of patients** – Does the model sufficiently account for variation in the complexity of patients across providers?  | - Payment tiers are based on clinical complexity and supplemental factors including non-English primary language, severe/persistent mental illness | - Payment model takes into account the range of complexity of consumers, completion of the health home services, and the team members needed to conduct those services. - Because the BHH payment can’t duplicate TCM, the majority of the population is assumed to be SMI or ED, which may have less complexity than SED or SPMI. | - TCOC is based on provider’s own prior experience, risk adjusted to accommodate changes in population’s risk between performance periods.  | - Next Generation ACOs may elect to participate in some, none, or all of the following benefit enhancements: * SNF 3-Day Rule waiver
* Telehealth originating site expansion

Post-Discharge Home Visits- TCOC benchmark is risk adjusted using the CMS-HCC model to compare average risk between the baseline and performance year with a 3% cap on average risk score increases or decreases. |
| **9. Other considerations –** How is the model operationalized? Who does what within the model (e.g. who oversees and/or makes payments? Who delivers the care coordination services, and what do those services look like?) What infrastructure would need to be in place for the model to be implemented? | - Includes certification process (MDH) to receive payment, inc. wide range of requirements in areas of patient access/communication; patient electronic registry to improve care for individuals & population; care coordination & patient/family centered care; care plans; patient engagement; quality improvement; measurement and evaluation. - Providers bill for service that may or may not be associated with an office visit (impacts deductibles, etc. depending on the payer). | - DHS does certification of providers. - Team- based model of care. - DHS or MCOs pays certified behavioral health home a PMPM rate. BHH must have monthly contact with the consumer and complete activities under at least 2 of the six health home services for each consumer. Some services, such as communication with a consumer’s other care providers, may not need to directly involve the consumer. | - DHS directly contracts with providers to participate.- Model allows flexibility by providers in how they lower cost, improve quality, and in how they utilize any shared savings payments. - Providers apply to participate through an RFP process; no certification occurs, but staff evaluates proposals based on established requirements.  |  |

| **Domain/Priority** | **Proposed components** |
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| **1. Health disparities**  | - Use of community standard risk adjustment models, with continued development of risk adjustment models for predicting cost and measuring quality that reflect complexity and social determinants. - Ensure that participant’s performance, for cost and quality purposes, is based on both performance vs. peer group and/or improvement vs. prior year.- Ensure payments are flexible enough to allow providers to effectively meet needs of patient population. - Require partnership and care coordination with broad range of community organizations.- Encourage or require participation of diverse patients in leadership or advisory teams. |
| **2. Financial stability** of health care system  | - Prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for patients with complex medical and non-medical needs and tied to TCOC savings/performance. - Incent right care, right place instead of service volume. |
| **3. Patient attachment**  | - Prospective, enrollment based attachment – Patient selects principle care management provider/clinic; if choice isn’t made, patient gets attributed to provider via alternate mechanism (e.g. regionally, prior year’s history, etc.). |
| **4. Multi-payer alignment** | - Require participation across Medicaid and commercial payers in arrangements that meet the proposed standards/recommendation.- Require providers to have X% of revenue in alternative delivery/payment arrangement across contracts.- Align payment approaches for care coordination across all payers. |
| **5. Triple aim goals** | - Tie alternate payments to cost measure – either reduction vs. provider’s previous year, and/or performance vs peer group. Ensure that measure is risk adjusted. - Tie alternate payment to quality and patient experience performance vs. peer group and/or improvement vs. prior year. - Measures should include broader set of population health measures.- Use system wide utilization measures (such as preventable ED visits, admissions, or readmissions) to assess impact of care coordination. |
| **6. Innovation** |  |
| **7. Social determinants** | - Flexible prospective payment that can be used for medical or non-medical services, tied to TCOC savings/performance. - Integration of non-medical services into TCOC calculation.- Requirement to coordinate care with broad range of non-medical/community providers within care coordination models. |
| **8. Complexity of patients**  | - Ensure that measures include risk adjustment methodology that reflects medical and social complexity.- Ensure that tiering and billing processes do not pose a barrier to reimbursement, and payment sufficient for patients with complex medical and non-medical needs. |
| **9. Other consideration**  | - Workforce challenges |