# Overview of the Medicaid Quality Improvement and Shared Savings Program
October 9, 2015

Connecticut Department of Social Services

*Making a Difference*

# Agenda

- Overview
- Context setting
- Model design process
- Key design features:
  - Care coordination elements
  - Quality measures
  - Provider qualifications
  - Under-service monitoring strategies
  - Shared savings methodology
  - Next steps

# Overview

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)

The Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) aims to build upon the Department of Social Services' successful Intensive Care Management (ICM) and Person-Centered Medical Home (PCMH) initiatives to further improve health outcomes and care experience of single-eligible* Medicaid beneficiaries via arrangements with competitively selected, participating providers (Federally Qualified Health Centers and "advanced networks").

* Those eligible for Medicaid only, and not Medicare

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

While PCMH will remain the foundation of Connecticut Medicaid's care delivery transformation, MQISSP will build on PCMH by incorporating new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

Typical barriers that inhibit the use of Medicaid benefits include, but are not limited to, housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions and lack of literacy

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

Enabling connections to organizations that can support beneficiaries in resolving these access barriers will further the Department's interests in population health goals for individuals who face the challenges of substance abuse and behavioral health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

MQISSP is slated to be rolled out in two waves

The first wave will serve 200,000 to 215,000 beneficiaries

Certain populations (e.g. those served by long-term services and supports “waivers”, nursing home residents) will not participate in MQISSP

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

The Department has proposed to use its current Person-Centered Medical Home attribution model to identify where beneficiaries have sought care, and to prospectively assign beneficiaries to those practices under MQISSP

Beneficiaries will continue to have the right to seek care from any Medicaid provider, and will have the right to opt out of MQISSP

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

MQISSP is an upside-only shared savings model

Upside-only refers to an arrangement under which providers are not at risk even if they experience higher costs or if they do not achieve quality performance goals

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

The Department chose an upside-only model because this is the first ever application of shared savings within Connecticut Medicaid, and it will be important to gain experience with protecting beneficiary interests and rights, and to enable providers to operate effectively within this structure

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

MQISSP participating entities will receive Medicaid-funded care coordination payments (**FQHCs only**) and, on the condition that they meet benchmarks on identified quality measures (including measures of under-service), a portion of any savings that are achieved (**FQHCs and advanced networks**).

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

The SIM Model Test Grant application originally referenced a January 1, 2016 implementation date for MQISSP

Over the course of model design development in summer, 2015, DSS formally requested that the SIM PMO seek CMMI approval of an extension of this date to accommodate full and fair stakeholder review and comment, as well as CMS review of the proposed Medicaid authority

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

- In recent weeks, the SIM PMO and the Department have also identified the need for additional time during which to synthesize and align care coordination and practice transformation efforts under the MQISSP with current Medicaid Intensive Care Management, the SIM PMO Community and Clinical Integration Program (CCIP) as well as the CMMI Transforming Clinical Practice Initiative in which the Community Health Center Association of Connecticut will be participating

# Medicaid Quality Improvement and Shared Savings Program (MQISSP)(cont.)

- The SIM PMO and the Department have therefore now agreed to seek approval from the Center for Medicare and Medicaid Innovation (CMMI) for a one year extension of the original implementation date, from January 1, 2016 to January 1, 2017

# Context Setting

# Medicaid Structure

- Connecticut Medicaid has moved entirely away from capitated, managed care arrangements
- The program is now a self-insured, managed fee-for-service program
- An hallmark of our program is that we now have a fully integrated set of claims data for all beneficiaries and all covered services
- We are using this data to risk stratify beneficiaries, to support them with ICM, and to make policy decisions

# Medicaid Structure

- The Department contracts with four Administrative Services Organizations (ASOs) to manage both:
  - **traditional features**: member services, utilization management, grievances and appeals)
  - **new features**: Intensive Care Management, Person-Centered Medical Home Initiative, Rewards to Quit (tobacco-cessation incentive program), specialized initiatives (e.g. in support of women with high-risk pregnancies and high need, high cost individuals)

# Medicaid Structure (cont.)

***The hypothesis:***

*Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, will yield improved health outcomes and beneficiary experience, and will help to control the rate of increase in Medicaid spending.*

# Medicaid Structure (cont.)

Use of ASOs for all Medicaid services has:

- built upon a model that had worked successfully for Medicaid behavioral health and dental services
- improved access to and use of data in support of best use of public resources and transparency
- centralized and streamlined administration, utilization management and member and provider supports

# Medicaid Structure (cont.)

We have improved provider experience with Medicaid, and have also been attentive to developing a broad and expanding network

- Providers now have the benefits of an electronic enrollment process, uniform statewide rate schedule, ASO-based utilization management support, and bi-weekly claims cycles

# Medicaid Structure (cont.)

- Rate enhancements (primary care, dental), careful network geoaccess analysis, and provider support have enabled access

- Over SFY'15, Connecticut Medicaid:
  - increased the number of Primary Care Providers (PCPs) enrolled in Medicaid by 7.49% and specialists by 19.34%
  - recruited and enrolled 22 new practices into DSS' Person-Centered Medical Home (PCMH) program

# Medicaid Structure (cont.)

- Under the Person-Centered Medical Home initiative:
  - 101 practices (affiliated with 366 sites and 1,332 providers) are participating
  - Over 274,000 beneficiaries are being served
  - In 2013, eligible practices received an average of **$121,000 in enhanced payments, $6,000 in incentive payments and $13,900 in improvement payments**

# Medicaid Structure (cont.)

- PCMH practices achieved better results than non-PCMH practices on measures including, but not limited to:
  - adolescent well care
  - ambulatory ED visits
  - asthma ED visits
  - LDL screening
  - readmissions
  - well child visits

# Medicaid Structure (cont.)

- Practices achieved an **overall member satisfaction** rating of 91.1% among adults and 96.1% on behalf of children

- **Immediate access to care increased** to 92.5% of the time, when requested by adults, and 96.7% of the time, when requested on behalf of children

- Among a number of **measures of courtesy and respect** shown to HUSKY members, communication before and during care, PCMH providers were rated overwhelmingly positively by HUSKY members

# Medicaid Enrollment

- Medicaid is a major payer of health services and currently serves over **700,000** beneficiaries

- **4.6 out of 10 births in Connecticut (6 out of 10 in Connecticut cities)** are to mothers who are Medicaid beneficiaries

- Under the ACA expansion, **Connecticut Medicaid is serving almost 100,000 new participants age 19 to 64**

# Medicaid Enrollment (cont.)

- As of the end of August, 2015 DSS was serving over **719,700** beneficiaries (**20%** of the Connecticut population) with medical coverage
  - **429,200** HUSKY A adults and children
  - **15,478** HUSKY B children
  - **95,424** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **179,696** HUSKY D low-income adults age 19-64
  - **~ 2,000** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

# Medicaid Expenditures

In the latest available comparison year, Connecticut had:

- the fourth highest level of health care expenditures at $8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska [2009 data]
- the ninth highest level of Medicare costs at $11,086 per enrollee [2009 data]
- the highest level of Medicaid costs at $7,561 per enrollee [2010 data]

[Kaiser State Health Facts]

# Medicaid Expenditures (cont.)

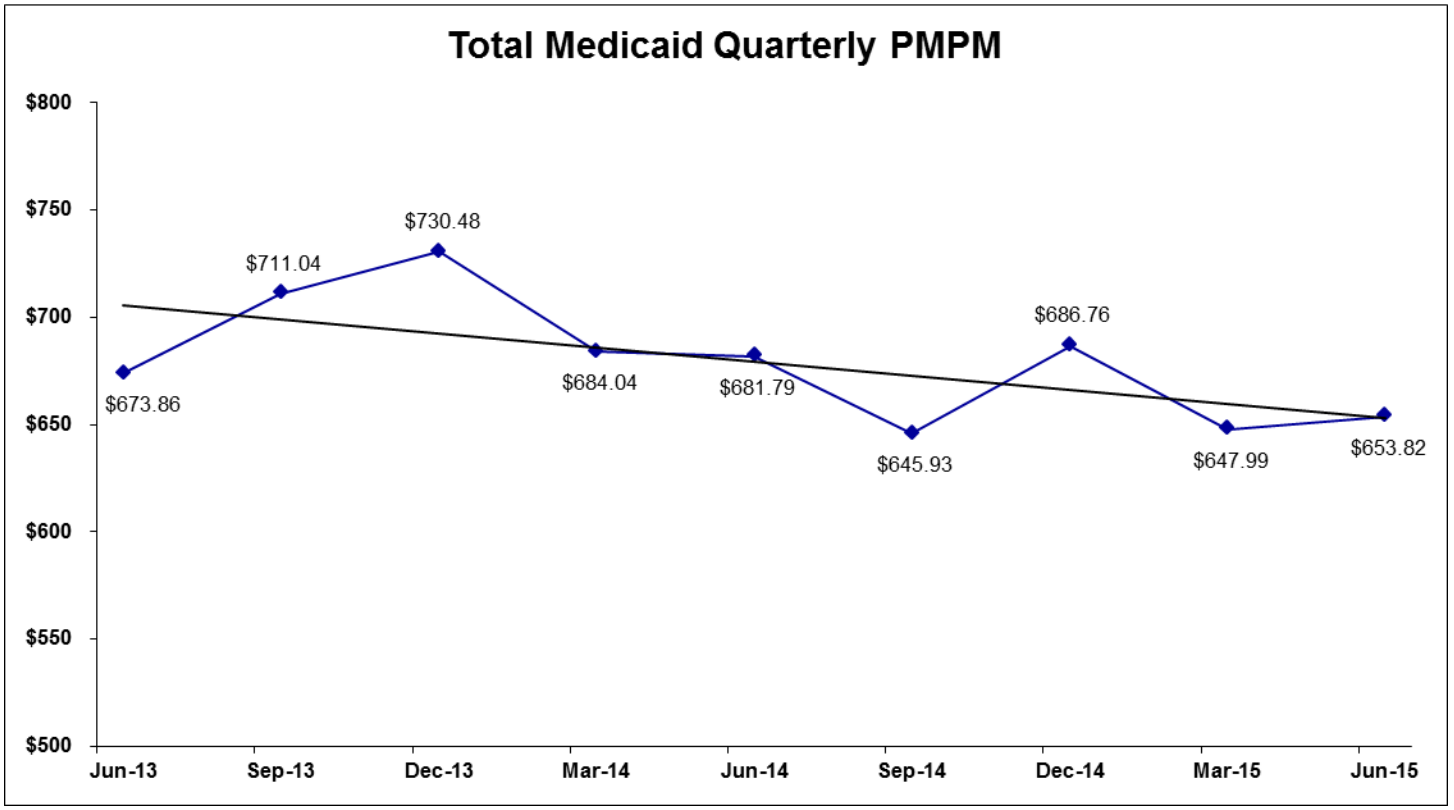
Please note the following per capita break-out of Medicaid costs by recipient group:

- $16,955 Aged
- $25,393 Disabled
- $  3,533 Adult
- $  3,339 Children

[Kaiser State Health Facts, 2010 data]

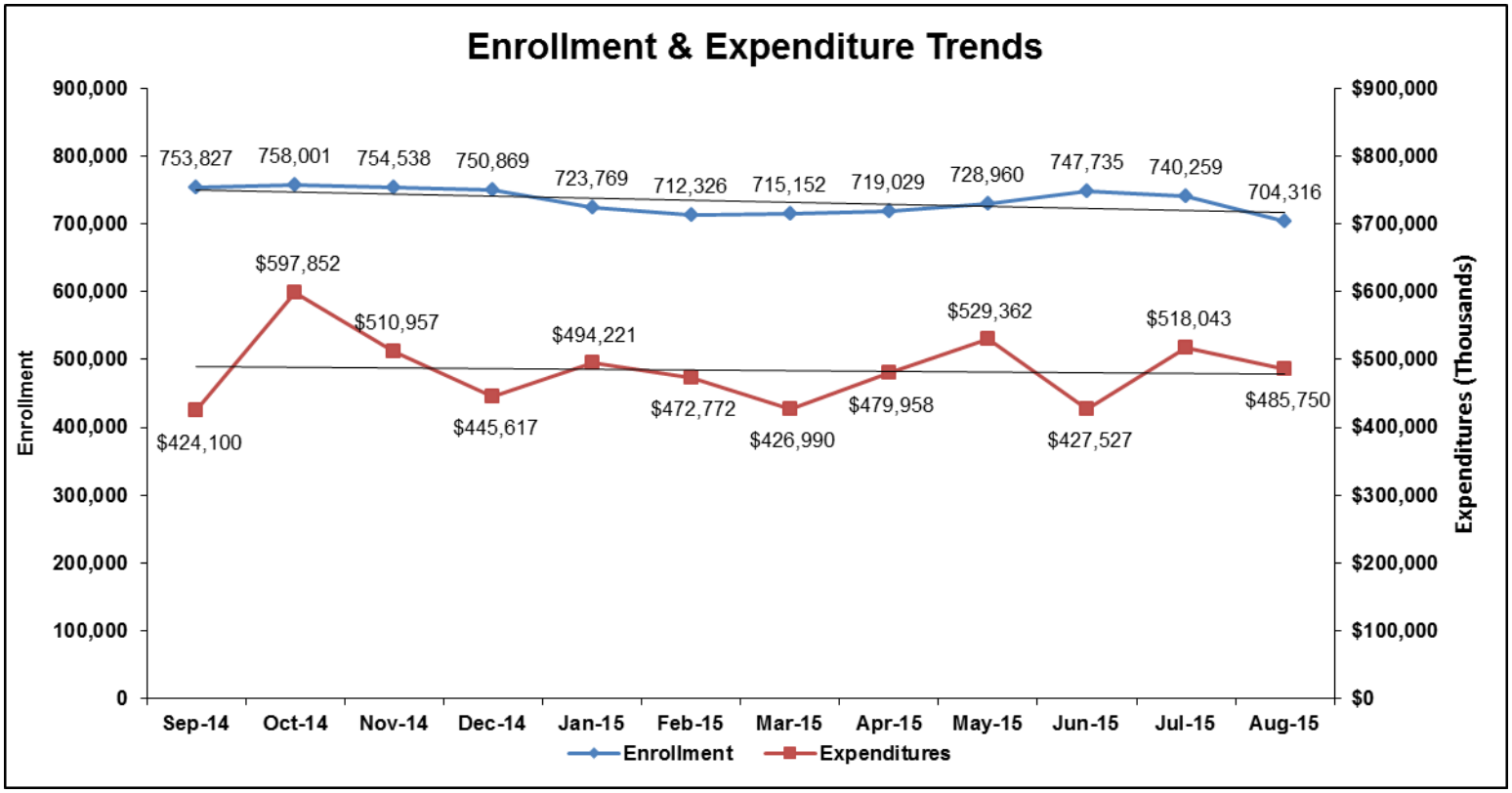
# Medicaid Expenditures (cont.)

So, how are we doing? Quarterly Medicaid per member, per month costs are trending downward.



# Medicaid Expenditures (cont.)

Overall, expenditures are holding constant.



# Medicaid Expenditures (cont.)

- The Affordable Care Act has also brought significant new revenue to Connecticut Medicaid
  - 100% federal coverage of HUSKY D
  - Coverage of Medicaid-funded preventive benefits, including smoking cessation and family planning
  - extension of the federal Money Follows the Person initiative, which enables residents of nursing facilities to transition to independent living in the community
  - $77 m. in federal funds under the Balancing Incentive Program in support for long-term services and supports
  - funding and direction for various care delivery reforms, including DMHAS health homes for individuals with serious and persistent mental illness

# Medicaid Outcomes

- Historically, key health indicators for Connecticut Medicaid beneficiaries, including hospital readmission rates and outcomes related to chronic disease, have been in need of improvement

- The Department is also deeply conscious of other indicators, such as incidence of Adverse Childhood Events (ACEs), that have bearing on coverage of and means of providing services

# Medicaid Outcomes (cont.)

How are we doing with outcomes?

Over SFY'15:

- Overall admissions per 1,000 member months (MM) **decreased by 13.2%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 5.4%**
- Utilization per 1,000 MM for all other hospital outpatient services **decreased by 5.3%**

# Medicaid Outcomes (cont.)

- Over SFY'15, through a range of strategies (Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced** by:
  - 4.70% for HUSKY A and B
  - 2.16% for HUSKY C
  - 23.51% for HUSKY D

# Medicaid Outcomes (cont.)

- Connecticut Medicaid's medical ASO, CHNCT, has:
  - for those members who received ICM, **reduced emergency department (ED) usage** by **22.72%** and **reduced inpatient admissions by 43.87%**
  - for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 28.08%**

# Medicaid Outcomes (cont.)

- We have also seen improvement in a range of other measures, including, but not limited to:
  - the rate for Controlling High Blood Pressure
  - the rate of Spirometry Testing in the Assessment and Diagnosis of COPD
  - Well Child Visit rate in the third, fourth, fifth and sixth year of life
  - Adolescent Well Care Visit rate
  - Lead Screening rate
  - Immunization rates
  - Timeliness and frequency of Prenatal and Postpartum Care Visits
  - Use of Preventative Dental services by children

# Medicaid Outcomes (cont.)

- All of that said, there remain diverse opportunities to continue to improve quality and care experience, to enable access, to ensure health equity and to support progress toward value-based payment

- Our next frontier in Medicaid will be to focus upon the range of social determinants that affect access to and utilization of Medicaid benefits

# Reform Orientation

We are shifting from traditional disease management and paying for procedures and services, **to supporting beneficiaries through goal-based, person-centered care coordination and reimbursing providers in a way that rewards outcomes**

Examples of current efforts include our ASO-based Intensive Care Management (ICM), Person-Centered Medical Home initiative, and obstetrics pay-for-performance program

# Reform Orientation (cont.)

What is our conceptual framework?

DSS is motivated and guided by the Centers for Medicare and Medicaid Services (CMS) “Triple Aim”:

- improving the patient experience of care (including quality and satisfaction)
- improving the health of the population
- reducing the per capita cost of health care

# Reform Orientation (cont.)

Please see the Appendix for more detail on the full range of our reform strategies

# A Next Stage of Reform Efforts . . .

While PCMH will remain the foundation of Connecticut Medicaid's care delivery transformation, MQISSP will build on PCMH by incorporating new requirements related to integration of primary care and behavioral health care, as well as linkages to the types of community supports that can assist beneficiaries in utilizing their Medicaid benefits

# A Next Stage of Reform Efforts . . . (cont.)

MQISSP will also enable progress on the payment reform curve toward cross-payer value-based payment by encouraging providers to:

- focus less on billed volume
- invest in expanding care teams to include health coaches and navigators
- universalize their approaches across all patients, irrespective of payer

# Model Design Process

# Model Design Process

- The Department worked in conjunction with Mercer consulting to propose MQISSP model design features to its lead stakeholder body: the Care Management Committee (the Committee) of the Medical Assistance Program Oversight Council (MAPOC)

# Model Design Process

- At the inception of the project, the Department worked with the Committee and the SIM PMO to develop and finalize an MQISSP “primer” document – this resource is available at this link:

https://www.cga.ct.gov/med/committees/med1/2015/0513/20150513ATTACH_A%20Brief%20Primer%20on%20MQISSP%20revised%205-10-15.pdf

# Model Design Process

- The Department also worked with the Committee and the SIM PMO to articulate a protocol for interaction with, as well as review and comment by, SIM-affiliated councils – this document is available on the MAPOC web site under the 2/20/15 meeting materials section ("MAPOC Care Management Committee SIM Work – FINAL") at this link:

https://www.cga.ct.gov/med/comm1.asp?sYear=2015

# Model Design Process

- The Department and Mercer presented material at and supported discussion at nine regularly scheduled monthly meetings of the Committee, as well as via three webinars on a proposed quality set, a webinar on the proposed care coordination elements, and a work session on the elements of the shared savings methodology and proposed framework for under service monitoring

# Model Design Process

- All of the materials that have been presented to the Committee are posted at the link below, and are also featured on the face page of the MAPOC web site:

https://www.cga.ct.gov/med/comm1.asp?sYear=2015

# Model Design Process

- The Department has also directly participated in the SIM Equity & Access (Medicaid Director), Quality (Medicaid Medical Director), and Practice Transformation (Medicaid Director and Medical Director) Councils
- Further, the Department has presented a webinar on Medicaid integration projects to members of the Practice Transformation Council and has reviewed proposed MQISSP quality measures with members of the Quality Council

# Model Design Process

- Two summative documents on MQISSP model design are posted at the following links:

Model design flow chart:

https://www.cga.ct.gov/med/committees/med1/2015/0930/20150930ATTACH_MQISSP%20Model%20Design%202015%2009%2030.pdf

MQISSP elements overview (with links to all major design documents):

https://www.cga.ct.gov/med/committees/MQ/%28MQISSP%20Elements%20September%209,%202015%29.pdf

# Key Design Features

# Care Coordination Elements

- The premise of the MQISSP care coordination elements proposed by the Department is that they will build on existing standards for FQHCs under the Health Resource and Standards Administration (HRSA) as well as Patient Centered Medical Home Standards for ambulatory entities established by the National Committee for Quality Assurance (NCQA) or The Joint Commission (TJC)

# Care Coordination Elements

- On the Department's behalf, Mercer scanned each of those standards, and also examined national best practices as well as model design and experience in many states (Alabama, Maine, Ohio, Rhode Island, Wisconsin, and Washington) that have incorporated PCMH or health home-based care delivery model designs within Medicaid reform efforts

# Care Coordination Elements (cont.)

- As noted previously, the Department sought feedback on proposed care coordination elements from the Committee through a webinar format as well as soliciting written comments

- The proposed care coordination elements are available at this link:

https://www.cga.ct.gov/med/committees/MQ/Proposed%20Care%20Coord%20%20Activities%20-%20Discussion%20Draft;%20September%204,%202015%20.pdf

# Care Coordination Elements (cont.)

- The proposed MQISSP care coordination elements focus upon the following:
  - Behavioral and physical health integration:
    - Care coordinator training and experience
    - Use of screening tools
    - Use of psychiatric advance directives
    - Use of Wellness Recovery Action Plans (WRAPs)

# Care Coordination Elements (cont.)

- Culturally competent services
  - Training
  - Expansion of the current use of CAHPS to include the Cultural Competency Item Set
  - Incorporation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards
- Care coordinator availability and education

# Care Coordination Elements (cont.)

- Supports for children and youth with special health care needs
  - Training
  - Expansion of the current use of CAHPS to include the Cultural Competency Item Set
  - Incorporation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards

# Care Coordination Elements (cont.)

- Competence in providing services to individuals with disabilities
  - Assessment of individual preferences and need for accommodation
  - Training in disability competence
  - Accessible equipment and communication strategies
  - Resource connections with community-based entities
- Provider report cards

# Care Coordination Elements (cont.)

- An important next stage in the discussion of MQISSP care coordination will be to examine and synthesize MQISSP, existing Intensive Care Management strategies overseen by the Medicaid Administrative Services Organizations, the SIM Community and Clinical Integration Program (CCIP), and the CMMI Transforming Clinical Practice Initiative in which the Community Health Center Association of Connecticut will be participating

# Quality Measures

- The MQISSP quality measures proposed by the Department were selected with a lens toward:
  - leveraging the current DSS Patient Centered Medical Home reporting
  - measures that are primarily claims based
  - measures that are nationally recognized
  - measures that use common CPT and HCPCS billing codes

# Quality Measures

- measures that do not have extended look-back periods
- measures that are relevant to Medicaid population:
  - advance DSS' emphasis on preventative and primary care
  - focus on conditions highly prevalent in Medicaid populations
- State Innovation Model proposed measures, where aligned with MQISSP goals
- measures that support identification and elimination of under-service

# Quality Measures (cont.)

- As noted previously, the Department sought feedback on proposed quality measures from the Committee through three webinar formats as well as soliciting written comments

- The proposed quality measure set is available at this link:

https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Proposed%20Quality%20Measure%20List_DRAFT%20.pdf

# Quality Measures (cont.)

- The Medicaid Medical Director presented the proposed quality measures to the SIM Quality Council
- There was strong alignment between the proposed MQISSP quality measures and those proposed by the SIM Quality Council

# Quality Measures (cont.)

- Subsequently, the Department has proposed, and received comments from the Committee on, proposed rankings of the quality measures

- This material is available at this link:

https://www.cga.ct.gov/med/committees/med1/2015/0930/20150930ATTACH_MQISSP%20Quality%20Measure%20Rankings%202015%2009%2030.pdf

# Provider Qualifications

- The Department has proposed and sought review and comment from the Committee on a list of provider qualifications for MQISSP participating entities

- This material is posted at this link:

https://www.cga.ct.gov/med/committees/MQ/Participating%20Entity%20Qualifications;%20August%2026,%202015..pdf

# Provider Qualifications

- Key features of these proposed qualifications include the following:
  - Participating entities must have a minimum of 2,500 attributed Medicaid beneficiaries
  - All practices that participate in MQISSP shared savings arrangements must already be recognized as person-centered medical homes by either NCQA or The Joint Commission
  - Participating entities must be enrolled as Medicaid providers

# Provider Qualifications (cont.)

- Participating entities can be:
  - A Federally Qualified Health Center, or
  - An “advanced network”, defined as:
    - A single DSS PCMH program participant
    - A DSS PCMH program participant plus specialists
    - A DSS PCMH program participant plus specialists and hospital(s) or
    - A Medicare Accountable Care Organization

# Provider Qualifications (cont.)

- DSS has also sought review and comment on proposed features of leadership and advisory structure (with a particular emphasis on consumer representation), as well as requirements for connections with a range of community providers

# Under-Service Monitoring Strategies

- The most recent aspect of model design that has been discussed with the Committee is a multi-pronged framework for monitoring for under-service to beneficiaries

- These materials are posted at this link:

https://www.cga.ct.gov/med/committees/new/MQISSP%20Under-Service%20Utilization%20Strategy%2009-30-2015.pdf

# Under-Service Monitoring Strategies

- These aspects of model design will be discussed and refined more extensively over Fall, 2015, but presently include the following prongs:
  - **Preventative and Access to Care Measures** – 22 of the proposed MQISSP quality measures track preventative care rates and monitor appropriate clinical care for specific health conditions

# Under-Service Monitoring Strategies

- **Member Surveys** – use of the CAHPS Person-Centered Medical Home survey and consideration of the use of the CAHPS Cultural Competency Supplemental Item Set

- **Member Education and Grievance Process –** specific, affirmative education for beneficiaries on MQISSP as well as their grievance and appeal rights

# Under-Service Monitoring Strategies

- **Secret Shopper** – expansion of the Department's current secret shopper approach to gauge access to care as well as experience in seeking care

- **Elements of Shared Savings Model Design –** various elements of the shared savings model for MQISSP (use of a savings cap, decision not to include a minimum savings rate, upside-only approach, high cost claims truncation, and concurrent risk adjustment claims methodology) were selected with a lens toward protecting beneficiary rights

# Shared Savings Methodology

- The Department and Mercer developed, and sought comment from the Committee on, characteristics of the shared savings methodology that will be used under MQISSP

- This material is posted at this link:

https://www.cga.ct.gov/med/committees/med1/2015/0826/20150826ATTACH_MQISSP%20Shared%20Savings%20Payment%20Principles.pdf

# Shared Savings Methodology (cont.)

- In proposing these aspects of model design, the Department and Mercer were guided by these values:
  - Only participating entities that meet identified benchmarks on quality standards and measures of under-service will be eligible to participate in shared savings
  - Quality improvement (not just absolute quality ranking) will factor into the calculation of shared savings

# Shared Savings Methodology (cont.)

- Higher quality scores will allow a Participating Entity to receive more shared savings
- Participating Entities that demonstrate losses will not be required to share in losses
- Participating Entities will be benchmarked for quality and cost against a comparison group devised from in-State, non-participating Entities as well as national benchmarks

# Shared Savings Methodology (cont.)

- Important features of the proposed shared savings methodology include the following:
  - Calculation of shared savings for a Participating Entity will be separate for each entity and will be based on quality measurement thresholds and scores, including measures of under-service
  - Quality measures used to determine savings distribution in the first performance year will be limited to claims-based measures that are currently being reported

# Shared Savings Methodology (cont.)

- DSS has proposed to create a hybrid savings pool consisting of both:
  - an **individual savings pool** (where savings are pooled separately and accessible individually for each Participating Entity); and
  - **a secondary savings pool** that will aggregate all savings not realized individually due to failing to meet identified benchmarks on quality standards and measures of under-service

# Next Steps

- Next steps for model design include:
  - Review and synthesis of how MQISSP, Medicaid ASO-based Intensive Care Management, the SIM Community and Clinical Integration Program (CCIP), and the CMMI Transforming Clinical Practice Initiative in which the Community Health Center Association of Connecticut will be participating, will align
  - Finalization of model design in support of drafting the MQISSP RFP
  - Further articulation of, and review and comment on, MQISSP under-service monitoring strategies
  - Development of MQISSP consumer education materials and strategies

# In conclusion . . .

- DSS and Mercer have used best efforts to propose and to seek review and comment from the MAPOC Care Management Committee on all aspects of model design for MQISSP. We now seek comment from the SIM Steering Committee on key features of that work.

# Appendix:

# Connecticut Medicaid Reform Agenda Within Context of CMS Triple Aim

# Improving the Patient Experience Of Care

| Issues Presented | DSS Strategies | Anticipated Result |
|---|---|---|
| Individuals face access barriers to gaining coverage for Medicaid services | • ConneCT, ImpaCT<br>• MAGI income eligibility<br>• Integrated eligibility process with Access Health CT | Streamlined eligibility process that optimizes use of public and private sources of payment |
| Individuals have difficulty in connecting with providers | • ASO primary care attribution process and member support with provider referrals<br>• Support for primary care providers (Person-Centered Medical Home, Electronic Health Record funding, ACA rate increase) | DSS will help to increase capacity of primary care network and to connect Medicaid beneficiaries with medical homes and consistent sources of specialty care |
| Individuals struggle to integrate and coordinate their health care | • ASO predictive modeling and Intensive Care Management (ICM)<br>• Duals demonstration<br>• Health home initiative | Individuals with complex health profiles and/or co-occurring medical and behavioral health conditions will have needed support |

# Improving the Health of Populations

| Issues Presented | DSS Strategies | Anticipated Result |
|---|---|---|
| A significant percentage of Connecticut residents does not have health insurance | • Medicaid expansion<br>• Integrated eligibility determination with Access Health CT | Increased incidence of individuals covered by either Medicaid or an Exchange policy |
| Many Connecticut residents do not regularly use preventative primary care | • PCMH initiative in partnership with State Employee Health Plan PCMH | Increased regular use of primary care; early identification of conditions and improved support for chronic conditions |
| Many health indicators for Medicaid beneficiaries are in need of improvement, and Medicaid has the opportunity to influence other payers | • Behavioral health screening for children<br>• Rewards to Quit incentive-based tobacco cessation initiative<br>• Obstetrics and behavioral health P4P initiatives | Improvement in key indicators for Medicaid beneficiaries; greater consistency in program design, performance metrics and payment methods among public and private payers |

# Reducing the Per Capita Cost of Care

| Issues Presented | DSS Strategies | Anticipated Result |
|---|---|---|
| Connecticut's historical experience with managed care did not yield the cost savings that were anticipated | • Conversion to managed fee-for-service approach using ASOs<br>• Administrative fee withhold and performance metrics | DSS and OPM will have immediate access to data with which to assess cost trends and align strategies and performance metrics in support of these |
| Connecticut Medicaid's fee-for-service reimbursement structure promotes volume over value | • PCMH performance incentives<br>• Obstetrics pay-for-performance initiative<br>• MQISSP shared savings arrangement | Evolution toward value-based reimbursement that relies on performance against established metrics |
| Connecticut Medicaid's means of paying for hospital care is outmoded and imprecise | • Conversion of means of making inpatient payments to DRGs and making outpatient payments to APCs | DSS will be more equipped to assess the adequacy of hospital payments and will be able to move toward consideration of episode-based approaches |

# Reducing the Per Capita Cost of Care (cont.)

| Issues Presented | DSS Strategies | Anticipated Result |
|---|---|---|
| Connecticut expends a high percentage of its Medicaid budget on a small percentage of individuals who require long-term services and supports; historically, this has primarily been in institutional settings<br><br>Consumers strongly prefer to receive these services at home | • Strategic Rebalancing Initiative (State Balancing Incentive Program, Money Follows the Person, nursing home diversification funding, workforce analysis, My Place campaign)<br>• Duals demonstration payments for care coordination | Connecticut will achieve the stated policy goal of making more than half of its expenditures for long-term services and supports at lower cost in home and community-based settings |

# Questions or comments?