Overview of Connecticut Participation in NGA High Need, High Cost Policy Academy December 11, 2015

Connecticut Department of Social Services

Making a Difference

Agenda

- Overview of NGA Policy Academy and Connecticut application
- Historical context
- Current Connecticut Medicaid strategies
- Initial profile of high need, high cost Medicaid members

Overview of National Governor's Association Policy Academy and Connecticut Application

Overview

- In May, 2015, the National Governor's Association released a Request for Applications soliciting responses for a policy academy entitled, "**Developing State-level Capacity to Improve Health and Reduce Cost of Populations with Complex Care Needs**."

- The Policy Academy represents an 18-month technical assistance opportunity, and involves two tracks – Track 1.0 for states at an earlier point of developing data in support of analyzing needs of individuals with complex needs; Track 2.0, for states at a more advanced level of data readiness.

Overview

Within the body of the RFA, the NGA indicated that:

Governors are exploring policies and programs intended to reduce their Medicaid costs and improve the health of their residents. ***Generally, a large portion of states' Medicaid expenditures are accounted for by a small segment of the beneficiary population. Those individuals, often referred to as "super-utilizers," tend to have a history of chronic illness, multiple comorbidities, special needs, and other non-clinical complications related to unstable housing, employment, food insecurity and transportation.*** *They often rely on emergency departments and inpatient services to address a number of challenges best addressed in ambulatory and social service settings.* ***By redirecting delivery system resources to more appropriately address the social determinants of health and adopting best practices for intervening with complex care needs individuals, states might be able to reign in escalating costs and improve the quality of care delivered to high-risk and vulnerable Medicaid beneficiaries.***

Overview (cont.)

- Connecticut submitted an application for Track 2.0, and was selected to participate.

- We elected to apply for Track 2.0 because:

  - in marked contrast to the majority of states, Connecticut Medicaid already has a fully integrated set of claims data
  - Connecticut Medicaid has already implemented diverse strategies designed to support individuals with complex needs (Intensive Care Management, community care teams, health homes) and to promote their use of primary care (Person-Centered Medical Home)

Overview (cont.)

- NGA's goals for Track 2.0 states are, "to have developed and begun implementing strategic action plans for one or more of the following: 1) developing more sophisticated data analytic, data exchange, and evaluation approaches; 2) identifying and adopting strategies to incorporate behavioral health, public health and social support services into care delivery models; 3) working toward adopting more sophisticated payment models; or 4) scaling-up an existing complex care needs program."

Overview (cont.)

Connecticut's application stated the following:

Connecticut Medicaid proposes to focus its participation . . . on examining whether and how a local high utilizer intervention - Project Access New Haven's model of patient navigation - could be paired with Connecticut Medicaid's existing claims-based risk stratification and Administrative Services Organization-based Intensive Care Management (ICM) interventions to further improve outcomes, including, but not limited to, 1) rates at which Medicaid beneficiaries fail to fulfill primary care and specialty visits (no-show rates); 2) inappropriate use of the hospital emergency department; and 3) readmissions to the hospital. The PA-NH model represents great potential to augment the Connecticut Medicaid's ICM model in targeted areas of the state.

Overview (cont.)

- The Connecticut application identified a core team representing the Departments of Children & Families (DCF), Mental Health and Addiction Services (DMHAS), Correction (DOC), and Social Services (DSS), as well as the Office of Policy and Management (OPM).

- We plan to augment this core with representatives of the Medicaid Administrative Services Organizations, the Connecticut Hospital Association, the Connecticut Association for Health Care at Home, Project Access and other community partners.

Overview (cont.)

- Connecticut's current Medicaid ICM approach for high need, high cost individuals who frequently use the Emergency Department is federated within statewide ASOs, and is funded as a component of Medicaid administration.

- The team will analyze best means of supporting its desired goals of migrating ICM and other coordinative interventions to a more local level, using Medicaid State Plan or other authority.

Overview (cont.)

- The team has launched its work by inventorying existing Medicaid Intensive Care Management (ICM) and other Medicaid-funded supports for high need, high cost individuals.
- In addition, the team has developed a member profile of high need, high cost individuals, based on current data spanning the full range of Medicaid services (e.g. ED, pharmacy).
- This will support identification of gaps as well as opportunities for alignment across departments and populations.

Historical Context

Historical Context

Historically, discussions around high need, high cost individuals served by Medicaid have tended to focus upon use of the Emergency Department (ED).

Historical Context

A threshold question was, do Medicaid members use the Emergency Room inappropriately?

It may surprise you that the answer, is, in many cases, **NO**.

Historical Context (cont.)

This year, the Medicaid and CHIP Payment and Access Commission (MACPAC) released a "MACFacts" brief, entitled: "Revisiting Emergency Department Use in Medicaid". You can access the entire document here:

https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-EDuse_2014-07.pdf

This report examined some common assumptions, and illustrated what evidence and experience show.

Historical Context (cont.)

Belief: *Much of the ED use among Medicaid enrollees is unnecessary.*

Fact check: *False*

Historical Context (cont.)

- *The majority of ED visits by non-elderly Medicaid patients are for urgent symptoms and serious medical problems that require prompt medical attention (Sommers et al. 2012).*

- ***Non-urgent visits account for just 10 percent of all Medicaid-covered ED visits for non-elderly patients, a proportion comparable to that of privately insured patients*** *(Garcia et al. 2010).*

Historical Context (cont.)

- *The notion that most ED use is inappropriate may be fueled by studies that cite large percentages of ED visits paid for by Medicaid and private insurance as avoidable or preventable (Truven 2013, Weinick et al. 2010).*

- *These classifications, however, do not capture the experience of care in real time.* ***Health problems classified in research as avoidable may in fact be urgent in nature and require prompt medical attention from a physician.*** *Some problems, such as chest pain in a 50-year old or an infant's fever and rash, carry high risks for patients and are best evaluated in an ED.*

Historical Context (cont.)

- *Finally, even ED visits that ultimately are determined to be non-urgent can require a physician's assessment, and an ED visit cannot be avoided if the patient has no alternative place to seek care in a timely manner.* ***In 2012, about one in four adult Medicaid enrollees who reported a recent visit to the ED went there because of difficulty accessing another provider, not because of a serious health problem*** *(MACPAC 2014).*

Historical Context (cont.)

Belief: *Medicaid patients use the ED frequently because they have difficulty getting in to see their regular doctor.*

Fact check: *True*

Historical Context (cont.)

- *Barriers to timely care increase the chances that individuals will use the ED (Cheung et al. 2012).* ***Despite the fact that nearly all Medicaid enrollees report having a usual place of care other than the ED, approximately one-third of adult and 13 percent of child enrollees have reported barriers to finding a doctor or delays in getting needed care*** *(MACPAC 2014).*

Historical Context (cont.)

- ***Delays were more frequently reported by Medicaid enrollees than by people who are privately insured***, *and enrollees reported that these delays often occurred for several reasons, including: trouble getting through to the practice by phone or reaching a doctor after hours, difficulty getting an appointment soon enough, language barriers, and lack of transportation.*

Historical Context (cont.)

- ***For patients with disabilities*** *(who are disproportionately represented in Medicaid),* ***barriers also include facilities that lack appropriate physical access, staff who are not trained to accommodate patients with disabilities, and communication barriers****—all of which can lead to delays in care, increased ED use, and preventable hospitalizations (Drainoni et al. 2006, Neri and Kroll 2003).*

Historical Context (cont.)

- *Medicaid enrollees who report more primary care barriers are more likely to report ED use. Moreover, patients who have better after-hours access to primary care practices report lower ED use and fewer unmet medical needs than patients without after-hours access (O'Malley 2013, Cheung et al. 2012, Cheung et al. 2011, Lowe et al. 2005).9 This strong association holds regardless of insurance coverage, and also after controlling for differences in patients' illness severity, patient attitudes, characteristics of a patient's primary care practice, and community capacity.*

Historical Context (cont.)

Note that in 2014, the Legislative Program Review and Investigations Committee conducted a study entitled, “Hospital Emergency Department Use and Its Impact on the State Medicaid Budget”. Please see relevant excerpts below:

- **While the study found that emergency department care is not a huge cost driver for overall Medicaid costs**, continued efforts are underway through the Affordable Care Act to ensure Medicaid clients receive coordinated health care in the most appropriate setting.

Historical Context (cont.)

- Although Connecticut's utilization rate is higher than the national average, it has the lowest utilization rate among the other six New England states.

- In Connecticut, Medicaid clients had the greatest percentage of ED visits (36 percent), followed by individuals with commercial insurance (31 percent).

- Medicaid clients are the biggest users of the emergency department, but that population also had the largest drop in rate of use from 2010 to 2012, while rates for individuals who self-pay for ED services saw the greatest increase.

Historical Context (cont.)

So, what is instrumental in intercepting non-urgent use of the ED?

Historical Context (cont.)

- A systematic review of what strategies best help reduce non-urgent use of the ED, conducted by Sofie Rahman Morgan, Anna Marie Chang, Mahfood Alqatari and Jesse M. Pines, examined the following interventions:
  - patient education programs (e.g. booklets, in-person educational sessions)
  - increased primary care capacity (e.g. new community clinics, expanded hours for primary care offices)
  - pre hospital diversion ("paramedicine" programs under which EMTs transport people with non-urgent conditions to settings other than the ED)
  - managed care gate keeping
  - cost sharing/financial incentives
  - intensive care management programs

Historical Context (cont.)

So what did they find? With respect to **increased primary care capacity**, the researchers found the following:

Of 10 studies, three examined interventions that expanded capacity through new community clinics, while the remainder involved existing physician practices expanding appointments and/or hours of care. Four studies found significant decreases in the use of the ED after increases in non-ED capacity, with reductions ranging from 9% to 54%, while five were nonsignificant and one found an increase of 21% . . . Three studies reported cost data showing 10% to 20% savings with the intervention.

Historical Context (cont.)

Connecticut has invested considerable resources in primary care. These include:

- PCMH initiative financial incentives
- continuation of the Affordable Care Act "rate bump" for primary care clinicians
- Electronic Health Record payments

Historical Context (cont.)

What relevant results do we see in Connecticut, related to our PCMH initiative?

- PCMH practices achieved better results than non-PCMH practices on measures including, but not limited to ambulatory ED visits and asthma ED visits

- 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

Historical Context (cont.)

What relevant results do we see in Connecticut, related to our ICM initiatives?

- Over SFY'15. 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%**

Historical Context (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

Historical Context (cont.)

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%**

Historical Context (cont.)

In summary, historically, there has been a great deal of interest and attention focused on ED utilization.

In light of the results of present day interventions, however, DSS and its agency partners will be reviewing available data to test whether this focus remains appropriate or should be expanded.

Current Connecticut Medicaid Strategies to Support Individuals with High Needs and High Costs

Current Connecticut Strategies

Connecticut's current strategies include:

- Intensive Care Management (ICM) through the medical, behavioral health and dental Administrative Services Organizations (ASOs)
- Behavioral health community care teams
- Behavioral health peer supports
- Money Follows the Person transition activities and enhancement of service array

Current Connecticut Strategies

- Connecticut's current Medicaid ICM interventions:
  - integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs
  - augment Connecticut Medicaid's Person-Centered Medical Home initiative, through which primary care practices receive financial and technical support towards practice transformation and continuous quality improvement

Current Connecticut Strategies (cont.)

- are directly embedded in the discharge processes of a number of Connecticut hospitals
- sustain the reduction of emergency department usage, inpatient hospital admissions and readmission rates

Current Connecticut Strategies (cont.)

- reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions

- reduce use of the emergency department for dental care, and significantly increase utilization of preventative dental services by children

Current Connecticut Strategies

Brief overview of CHN ICM:

- CHN utilizes a stratification methodology to identify members who presently frequent the ED for primary care and non-urgent conditions as well as those at risk of future use of acute care services

- High risk members are defined as those who have claims data of seven (7) or more ED visits in a rolling year; members with twenty (20) or more ED visits in a rolling year are defined as ED Super Users and are considered highest risk

Current Connecticut Strategies

Brief overview of CHN ICM (cont.):

- CHN ICM focuses on high risk members with multiple co-morbid, advanced, interrelated, chronic and/or behavioral (psychiatric and/or substance abuse) conditions

- These members frequently exhibit instability in health status due to fragmented care among multiple providers, episodes or exacerbations and/or complications and impaired social, economic and material resources and tend to have higher ED utilization

Current Connecticut Strategies

Brief overview of CHN ICM (cont.):

- Many of these members are homeless and are in need of coordinated housing and access to health homes. Individuals with multiple chronic conditions benefit from an integrated plan of care that incorporates behavioral and non-medical supportive services

Current Connecticut Strategies

Brief overview of Value Options ICM and community care team strategies:

- Value Options used claims and other data to identify the five Connecticut hospitals that were associated with the greatest number of Medicaid high utilizers.

- ValueOptions then designed and implemented a multi-pronged approach to reduce the inappropriate use of the emergency department for individuals with behavioral health conditions.

Current Connecticut Strategies

Brief overview of Value Options ICM and community care team strategies (cont.):

- This approach includes:
  - assigning ICM care managers to individuals who have visited the ED, with a primary or secondary behavioral health diagnosis, seven or more times in the six months prior to participation in ICM
  - assigning peer specialists to members who could benefit from that support
  - dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social support needs of the involved individuals

Current Connecticut Strategies

Brief overview of Value Options ICM and community care team strategies (cont.):

- These provider meetings are multi-disciplinary and include, but are not limited to representatives from housing organizations, substance abuse and mental health providers, shelters, Federally Qualified Health Centers, and staff from the respective EDs.

Current Connecticut Strategies

Brief overview of Benecare ICM strategies:

- Care Coordination and Case Management services are provided through a team of seven Dental Health Care Specialists (DHCS) that are unique to Connecticut; six who cover specific regions and one who works with clients who have Special Health Care Needs (SCSHCN)

- Professionals or community agencies can refer identified clients to the CTDHP for care coordination services

Current Connecticut Strategies

Brief overview of Benecare ICM strategies (cont.):

- Services include management of care and coordination of services between dental and medical specialties as well as the coordination of other Medicaid benefits

- Special outreach initiatives are focused on educating the population about oral health care and include prenatal clients, children who do not have routine care, clients with special health care needs, sealant placement to prevent future decay and improved dietary choices including encouraging responsible behaviors

Current Connecticut Strategies

Brief overview of Money Follows the Person (MFP) strategies:

- MFP provides transition supports, home and community-based services and state-funded housing vouchers to individuals with need for LTSS who have received care in a hospital or nursing home for three or more months

- In partnership with the UConn Center on Aging, MFP tracks and analyzes a broad range of data points that help to illustrate and enable remedies of barriers to effective care transitions and retention of independence in the community

Initial Profile of High Need, High Cost Medicaid Members

High Cost, High Need Medicaid Members – CY2014 – Method Stratification

The Administrative Services Organizations were asked to provide the department the following information:

1. Using dates of service in CY 2014 and stratifying by child (0-20) and adult (21 +), the members who represent:
    a. Highest 10% members by cost, excluding nursing home (NH) residents
    b. Highest 10% of members with hospital admissions
    c. Highest 10 % of members with ED utilization
    d. Total unduplicated members from a, b, & c

High Cost, High Need Medicaid Members – CY2014 – Data & Demographics

- Number of members, adult & child
- Total spend, adult & child
- Gender
- Mean age, adult & child
- Race/ethnicity, adult & child
- HUSKY coverage group
- County
- Primary conditions for inpatient admissions

Profile of High Cost, High Need Medicaid Members – CY2014

High Cost/High Need Members	Number of Members	
	Adults	Children
High Cost Members	1,837	295
High Need Members - ED Utilizers (Medical & BH Combined)	2,113	3,044
High Need Members – Inpatient Utilizers (Medical & BH Combined)	894	806
Total Unduplicated Members	4,385	3,913

Total Spending CY2014 - High Cost, High Need Medicaid Members

High Cost/High Need Members	Total Spending in Millions	
	Adults	Children
High Cost Members	$352	$122
High Need Members - ED Utilizers (Medical & BH Combined)	$18	$7
High Need Members – Inpatient Utilizers (Medical & BH Combined)	$65	$34
Total Cost	$435	$163

High Cost, High Need Member Demographics – Total Adults 4,385

- Male: 2,156 (49%)
- Female: 2,229 (51%)
- Male mean age: 47
- Female mean age: 43

Race/Ethnicity	High Cost/High Need Adults	HUSKY Adults
White	2,463 (56%)	251,085 (54%)
Black	869 (20%)	78,944 (17%)
Hispanic	1,003 (23%)	115,135 (25%)
Asian & other	50 (1%)	16,712 (4%)
TOTAL	4,385 (100%)	461,876 (100%)

High Cost, High Need Member Demographics – Total Children 3,913

- Male: 1,694 (43%)
- Female: 2,219 (57%)
- Male mean age: 9
- Female mean age: 13

Race/Ethnicity	High Cost/High Need Adults	HUSKY Adults
White	1,564 (40%)	149,177 (44%)
Black	630 (16%)	55,509 (17%)
Hispanic	1,676 (43%)	116,205 (34%)
Asian & other	43 (1%)	17,610 (5%)
TOTAL	3,913 (100%)	338,501 (100%)

High Cost, High Need Member by HUSKY Program – Adults & Children

By HUSKY Program	Number of Members	
	Total Adults 4,385	Total Children: 3,913
HUSKY A	765	3,360
HUSKY B	0	45
HUSKY C	1,880	83
HUSKY D	1,740	425
TOTAL	4,385	3,913

High Cost, High Need Member by County – Adults & Children

County	Total HC-HN Adults: 4,385	HUSKY Adults: 463,883	Total HC-HN Children: 3,913	HUSKY Children: 336,236
Hartford	1,398 (32%)	131,950 (30%)	1,237 (32%)	92,050 (27%)
New Haven	1,234 (28%)	131,125 (28%)	1,151 (28%)	94,157 (28%)
Fairfield	805 (19%)	98,935 (21%)	725 (19%)	81,487 (25%)
New London	323 (7%)	35,765 (8%)	335 (9%)	25,041 (7%)
Windham	227 (5%)	18,125 (4%)	173 (4%)	12,230 (4%)
Middlesex	138 (3%)	16,205 (3%)	117 (3%)	9,871 (3%)
Tolland	103 (2%)	11,435 (2%)	75 (2%)	7,975 (2%)
Litchfield	157 (4%)	20,343 (4%)	100 (3%)	13,425 (4%)

High Cost, High Need Member – Hospital Inpatient Conditions Adults & Children

Inpatient Conditions	Total Adults admits: 7,457	Total Children admits: 3,315
Infectious/Neoplasms/Nutritional/ Diseases of Blood	1,459 (20%)	419 (13%)
Mental Disorder	1,413 (19%)	669 (20%)
Diseases of Nervous/ Circulatory/ Genitourinary System	1,251 (17%)	264 (8%)
Diseases of Respiratory/Digestive	1,627 (22%)	654 (20%)
Pregnancy	100 (1%)	453 (14%)
Disease of Skin/Musculoskeletal	351 (5%)	154 (5%)
Ill defined conditions/Injury & Poisoning	1,259 (17%)	702 (21%)

In conclusion . . .

The Connecticut team will further examine the data on high need, high cost members served by Medicaid and make recommendations about strategies to support them, including, but not limited to, use of community health workers.

Questions or comments?

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 • MAGI income eligibility • 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 • 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) • Duals demonstration • 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 • 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 • Rewards to Quit incentive-based tobacco cessation initiative • 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 • 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 • Obstetrics pay-for-performance initiative • 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 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) • 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