# Connecticut Medicaid 101

January 21, 2016

Connecticut Department of Social Services

*Making a Difference*

We are transforming every aspect of how we provide health services to Connecticut residents.

- We are putting systems in place to **help people qualify for services more easily and timely**.

- We have **expanded Medicaid eligibility.**

- Our partner Administrative Services Organizations are **supporting people in using their medical, behavioral health, and dental benefits well and in connecting with providers**.

- We are investing in **primary, preventative care**.
- We are working to **integrate medical and behavioral health care**.
- We are **enabling people who need long-term services and supports to receive them in the community**.

- We are **using our rich set of claims data to identify and monitor the needs of beneficiaries**, as well as to **make informed policy decisions**.

- We are moving to **shift from paying for procedures and services, to reimbursing in a way that rewards outcomes**.

- We are examining means of **addressing social determinants of health.**

# Why are we doing this?

Because, consistent with the mission of the Department of Social Services:

*Guided by shared belief in human potential, we aim to increase the security and well-being of Connecticut individuals, families, and communities.*

# Goals

- Set context (enrollment, expenditures, outcomes)
- Share core concepts of Medicaid coverage
  - Medicaid State Plan
  - Contrasting Medicaid and Medicare
  - Eligibility and coverage groups
  - Means of covering services
- Provide overview of key DSS health reform strategies

# Setting Context

# Medicaid Enrollment

- Connecticut Medicaid and CHIP, which are known as HUSKY Health, are major payers of health services and currently serve over **750,000** beneficiaries

- **4 out of 10 births in Connecticut** are to mothers who are Medicaid beneficiaries (note that this figure is much higher in many cities and “distressed” municipalities)

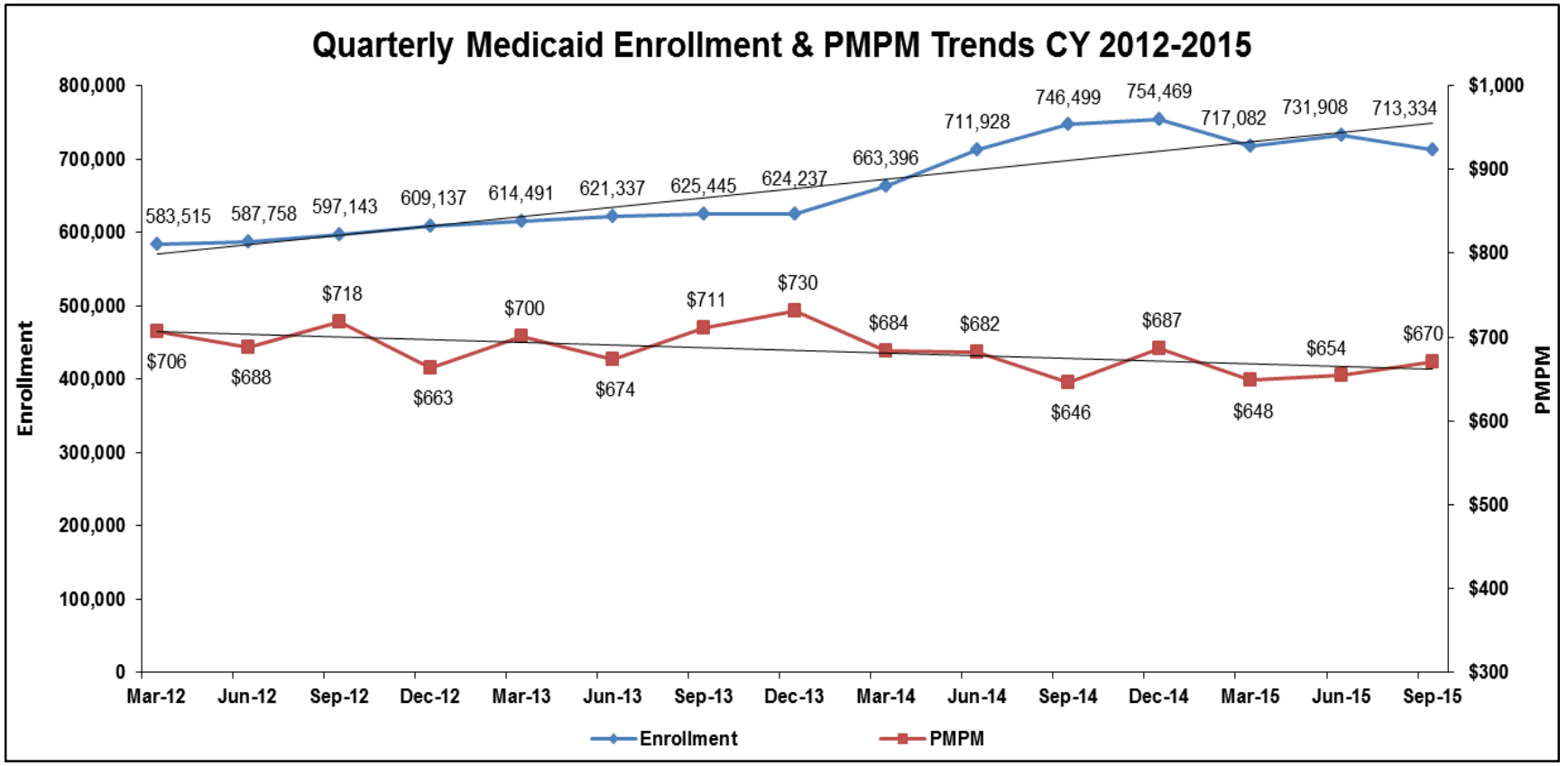
# Medicaid Enrollment (cont.)

- As of November, 2015, HUSKY Health was serving over **750,000** beneficiaries (**~21%** of the state population)

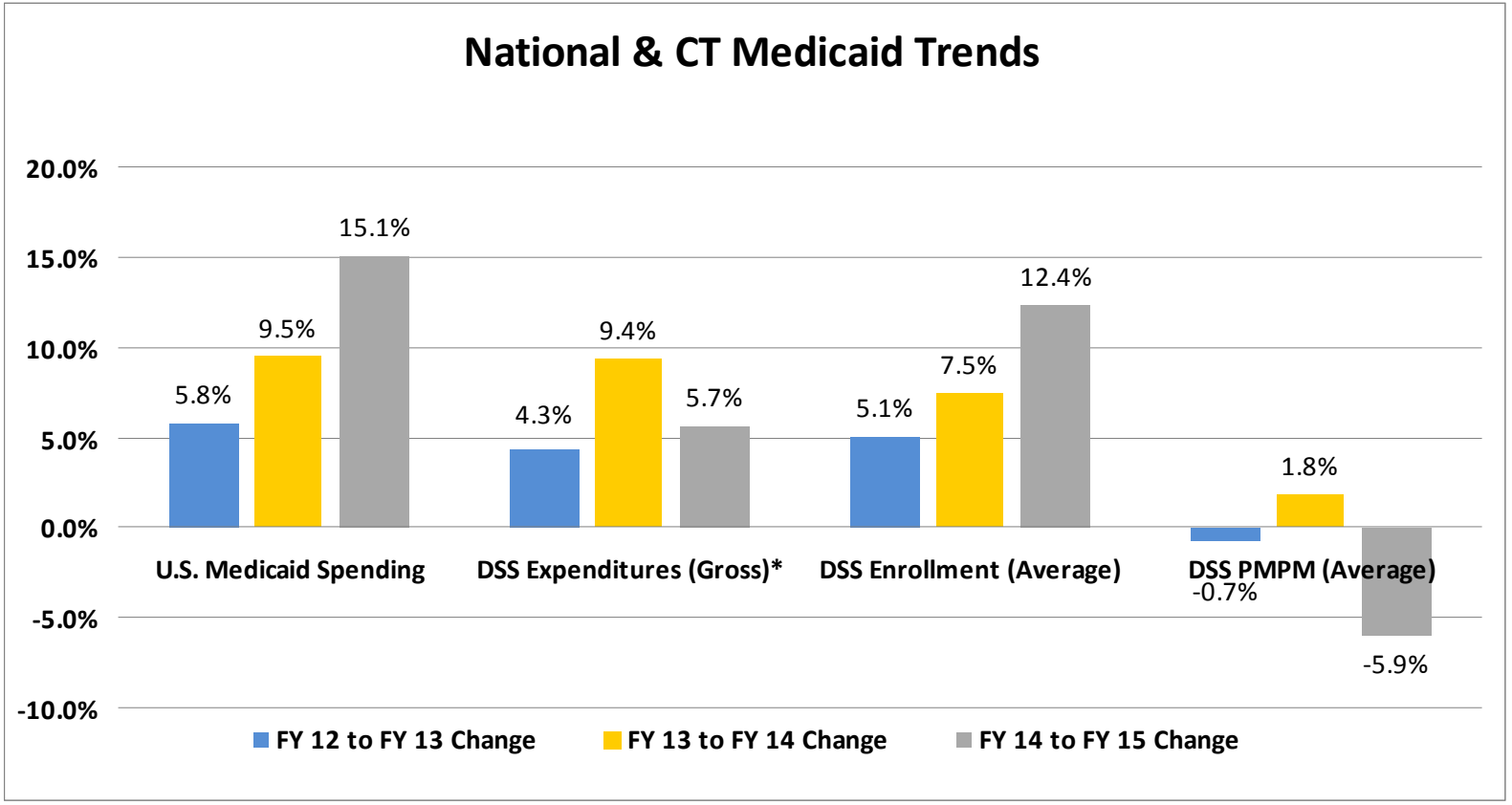
  - **442,680** HUSKY A adults and children
  - **15,362** HUSKY B children
  - **94,830** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **184,641** HUSKY D low-income adults age 19-64
  - **~ 2,500** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

# Medicaid Expenditures

- While enrollment growth has increased over this period, PMPM's have remained steady and have actually decreased slightly.



# Medicaid Expenditures (cont.)




** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.*

# 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.)

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 Outcomes (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 Outcomes (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 Outcomes (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 Outcomes (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 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

# Core Concepts of Medicaid Coverage

# Core Concepts of Medicaid Coverage

- Medicaid State Plan
- Contrasting Medicaid and Medicare
- Eligibility and coverage groups
- Means of covering services

# Medicaid State Plan

- **Medicaid State Plan:** A written plan between a State and the Federal Government that outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services (CMS)

# Medicaid Aims

- The purpose of Medicaid is to enable states **"to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."**

- Further, the Medicaid Act requires that each state medical assistance program be administered **in the "best interests of the recipients."**

# Medicaid State Plan

- Generally, State Medicaid plans must, among other requirements:
  - ensure that services are provided in all parts of the state (the **“statewideness”** requirement)
  - provide a fair hearing process through which applicants and participants can appeal denials or failure to act on applications within the standard of promptness

# Medicaid State Plan (cont.)

- establish or designate a single State agency to administer the plan - in Connecticut this is the Department of Social Services (DSS)
- require the State health agency - in Connecticut, this is the Department of Public Health (DPH) - to establish health standards for medical providers
- provide coverage to certain categorically eligible individuals

# Medicaid State Plan (cont.)

- describe the extent to which the State is covering optional groups of individuals
- provide services for all recipients in the same amount, duration and scope (the **“comparability”** requirement)
- impose cost sharing in a manner that is consistent with federal law

# Medicaid State Plan (cont.)

- describe financial eligibility standards;
- implement estate recovery, asset transfer restrictions and evaluation of trusts in a manner that is consistent with federal law
- provide individualized plans of care for recipients

# Medicaid Authorities

- Federal law:
  - 42 U.S.C. Section 1396 *et seq.*
  - 42 C.F.R. Parts 430-455
- State law:
  - Chapter 319v (Secs. 17b-220 to 17b-319), and various others
- Department of Social Services Uniform Policy Manual (UPM)

# Contrasting Medicaid and Medicare

- The **Medicaid** program is a medical welfare program based on financial and functional need
- Applicants must meet income and asset eligibility requirements, or must demonstrate a qualifying disability or functional need for services
- Generally, Medicaid has a more comprehensive array of covered services than does Medicare

# Contrasting Medicaid and Medicare

- Further, with several important exceptions, recipients of Medicaid are not typically required to participate in cost sharing (e.g. copayments or deductibles)

# Contrasting Medicaid and Medicare

- By contrast, eligibility for **Medicare** is not based on financial need

- Individuals who have met the required minimum number of “quarters” of work to qualify for Social Security retirement benefits, or have been receiving Social Security disability benefits for at least two years, automatically qualify for Medicare (children with End-Stage Renal Disease or Lou Gehrig’s Disease who meet identified criteria qualify more rapidly)

# Contrasting Medicaid and Medicare

- Medicare provides a standard benefit that provides partial coverage of hospital and nursing facility services, physician services, some preventative services, and durable medical equipment

- Medicare beneficiaries are required to pay deductibles and copayments for most services, and there are strict durational limits for certain services: notably, coverage of care in a nursing facility

# Medicaid Eligibility and Coverage Groups

- Medicaid is composed of different "**coverage groups**", each with their own eligibility requirements
- Eligibility requirements include categorical, income, asset, and other requirements
- Categorical requirements describe categories of individuals eligible for coverage, such as aged, blind and disabled individuals, children under age 19 and their parents, pregnant women and low-income childless adults

## Eligibility and Coverage Groups (cont.)

- **HUSKY A** – Provides coverage to:
  - Children under age 19 and their parents/caretaker relatives
  - Pregnant women
- **HUSKY C** – Provides coverage to:
  - Individuals age 65 and older
  - Disabled individuals
  - Blind individuals
- **HUSKY D** – Provides coverage to:
  - Low Income childless adults age 19 through 64 who do not receive Medicare

# Medicare Savings Programs (MSP)

- Qualified Medicare Beneficiary (QMB)
  - Pays Medicare Part A and Part B Premiums
  - Medicare deductibles
  - Medicare co-insurance
- Specified Low Income Medicare Beneficiary (SLMB)
  - Pays Medicare Part B Premiums
- Additional Low Income Medicare Beneficiary (ALMB)
  - Pays Medicare Part B Premiums

All MSP categories confer eligibility for the Medicare Part D Prescription Drug Program's Low Income Subsidy (also known as "Extra Help")

## Eligibility and Coverage Groups (cont.)

- Since the passage of the federal Affordable Care Act (ACA), HUSKY A and HUSKY D are one part of a health care coverage continuum that also includes:
  - The Children's Health Insurance Program (HUSKY B) Provides coverage to children in families with incomes too high to qualify for Medicaid
  - Subsidized Qualified Health Plans
  - Unsubsidized Qualified Health Plans
- Household income determined using "MAGI" tax-based rules

# Eligibility and Coverage Groups (cont.)

| Category | Connecticut Coverage Groups and income limits (% of Federal Poverty Level*) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | <=138% | <=155% | <=201% | <=254% | <=263% | <=323% | <=400% | >400% |
| Pregnant Women | Medicaid (Husky A) | Medicaid (Husky A) | Medicaid (Husky A) | Medicaid (Husky A) | Medicaid (Husky A) | Subsidized Insurance | Subsidized Insurance | Unsubsidized Insurance |
| Children < 19 | Medicaid (Husky A) | Medicaid (Husky A | Medicaid (Husky A) | CHIP Band 1 (Husky B) | CHIP Band 2 (Husky B) | CHIP Band 2 (Husky B) | Subsidized Insurance | Unsubsidized Insurance |
| | | | | | | | Subsidized Insurance | Unsubsidized Insurance |
| Primary Caretaker or Parent of Children < 19 | Medicaid (Husky A) | Medicaid (Husky A) | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Unsubsidized Insurance |
| Childless Adult 19 to 65 | Medicaid (Husky D) | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Subsidized Insurance | Unsubsidized Insurance |

***Income limits include a 5% FPL general income deduction**

# Eligibility and Coverage Groups (cont.)

## Monthly Income Limits – HUSKY A, B and D

| Family Size | HUSKY D 138% FPL | HUSKY A Parents 155% FPL | HUSKY A Children 201% FPL | HUSKY B Band 1 Children 254% FPL | HUSKY A Pregnant Women 263% FPL | HUSKY B Band 2 Children 323% FPL |
|---|---|---|---|---|---|---|
| 1 | $1,353.78 | $1,520.55 | $1,971.81 | $2,491.74 | $2,580.03 | $3,168.63 |
| 2 | $1,832.64 | $2,058.40 | $2,669.28 | $3,373.12 | $3,492.64 | $4,289.44 |
| 3 | $2,311.50 | $2,596.25 | $3,366.75 | $4,254.50 | $4,405.25 | $5,410.25 |
| 4 | $2,788.98 | $3,132.55 | $4,062.21 | $5,133.34 | $5,315.23 | $6,527.83 |

## Eligibility and Coverage Groups (cont.)

### HUSKY C

- Age 65 or older
- Disability - age 18-64 and disabled per Social Security criteria
- Blind
- Asset limit - $1,600 for one; $2,400 for married couples
  - Home is excluded (no lien on home)
  - Usually 1 car excluded (or if not $4,500 equity excluded)

## Eligibility and Coverage Groups (cont.)

# HUSKY C

# Spenddowns:

- Person is over the income limit, but meets all other requirements
- Person must ‘spend down’ the amount which is over the income limit, before Medicaid can start
- DSS uses 6 month ‘spenddown’ periods - excess for 1 mo. x 6 = spenddown amount
- must owe the 6 mo. amount on medical expenses and submit bills (paid or unpaid)
- similar to an insurance deductible

## Eligibility and Coverage Groups (cont.)

**HUSKY C**

**** Spenddown Example ****

- Monthly applied income is $960 per month
- The income limit, including disregards, is $860
- The “excess” income is $100 per month or $600 for the 6-month spenddown period
- Once client has incurred $600 in medical bills, HUSKY C will pay future medical bills for the rest of the 6-month spenddown period

# Eligibility and Coverage Groups (cont.)

| Medicare Savings Program Monthly Income Limits | | | |
|---|---|---|---|
| | **QMB** | **SLMB** | **ALMB** |
| **Single** | **$2,069.91** | **$2,266.11** | **$2,413.26** |
| **Couple** | **$2,802.08** | **$3,067.68** | **$3,266.88** |

# Means of Covering Services

- States must under their State Plans cover identified mandatory services (e.g. inpatient hospital care, FQHC services, physicians' services) and may elect to cover optional services (e.g. dental, behavioral health, medical transportation)

- Connecticut covers a broad range of optional services

# Means of Covering Services (cont.)

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid

# Means of Covering Services (cont.)

- Under EPSDT, states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines

# Means of Covering Services (cont.)

- EPSDT is made up of the following screening, diagnostic, and treatment services:
  - Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care Services
  - Diagnostic Services
  - Treatment

# Means of Covering Services (cont.)

- Another means of covering services is through “waivers”
- Waivers permit states to be excused from one or more of the Medicaid State Plan requirements – an example of this is the “statewideness” requirement
- The Affordable Care Act also provides some new options for coverage through State Plan Amendments

# Means of Covering Services (cont.)

| Authority | Features |
|---|---|
| 1915(c) home and community-based waiver<br><br>(In Connecticut: CT Home Care Program for Elders, Personal Care Assistant, Acquired Brain Injury, DDS, mental health, autism) | An option through which states can cover home and community-based long-term services and supports for target populations. Services can include care management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care. Must identify a cap on participation. |
| 1115 research and demonstration waiver | An option through which states can implement demonstration projects to expand eligibility, provide services not typically covered by Medicaid, and/or use innovative service delivery systems. Must demonstrate budget neutrality and accept a cap on total expenditures over a five year period. |

# Means of Covering Services (cont.)

| Authority | Features |
| --- | --- |
| 1915(b) managed care waiver | An option under which states can implement a managed care delivery system that restricts the types of providers from which beneficiaries can receive services and use associated savings to provide other services |
| 1915i State Plan Amendment (SPA) | An option under which states can provide home and community-based services to individuals who meet identified functional criteria. In that it is a SPA, must serve all eligible individuals and cannot cap enrollment. |

# A Federal/State Partnership

- Under the federal law, states are required to pay no less than 40% of total program costs and the Federal government pays the remainder
- This remainder is called the Federal Medical Assistance Percentage (FMAP)
- Connecticut's FMAP for most Medicaid services is 50%

# A Federal/State Partnership (cont.)

- Connecticut's FMAP for CHIP services is 88%
- Connecticut’s FMAP for newly eligible (ACA expansion) individuals on HUSKY D is 100%
- Several other initiatives (e.g. administrative activities of the medical Administrative Services Organization, Electronic Health Record project, health home) are eligible for FMAP that is greater than 50%

# Means of Covering Services (cont.)

- The Affordable Care Act has provided new opportunities for Medicaid state plan coverage with enhanced FMAP

- Notable exampled of this include coverage of tobacco cessation and the health home option

# Means of Covering Services (cont.)

- ACA requires that states implement the following:
  - coverage of comprehensive tobacco cessation services (counseling, treatment, and medications including over-the-counter nicotine replacement products) for all pregnant women covered by the Medicaid Program
  - coverage of tobacco cessation products, barbituates and benzodiazapines

# Health Home: Overview

- ACA built upon existing efforts to **integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions** by permitting states to seek approval of state plan amendments to implement such coverage

- ACA "health home" amendments qualify states to receive eight quarters of **enhanced Federal Medical Assistance Payment (FMAP)** in support of this work

- By contrast to the typical Connecticut FMAP of 50% FMAP for health homes is at **90%**

# Health Home: Eligibility

- To be eligible for the health home option, beneficiaries must have at least one of the following:
  - two or more chronic conditions
  - one chronic condition and risk of developing a second or
  - a serious and persistent mental health condition
- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

# Health Home: Design Considerations

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify
- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

# Connecticut Medicaid coverage

# Connecticut Medicaid Coverage Groups

- **Husky A**: children
- **Husky B**: Children's Health Insurance Plan (CHIP)
- **Husky C**: Aged, Blind and Disabled (ABD)
- **Husky D**: Medicaid for Lowest Income Populations (MCLIP)

# Connecticut Medicaid Structure

- Historically:
  - Individuals covered under HUSKY A & B were served by multiple, at-risk, capitated Managed Care Organizations (MCOs)
  - Individuals covered under HUSKY C (coverage for older adults and individuals with disabilities) were served in an unmanaged fee-for-service arrangement

# Connecticut Medicaid Structure (cont.)

- Individuals up to 53% of the Federal Poverty Level (FPL) who were historically served by SAGA medical became eligible effective April, 2010 for new HUSKY D (Low Income Adult, LIA) group
- Connecticut was the first state in the country to gain CMS approval for an early expansion group
- This is the group for which income eligibility expanded under ACA, effective January 1, 2014

# Connecticut Medicaid Structure (cont.)

- Effective January 1, 2012, Connecticut transitioned Medicaid **medical services** for all coverage groups to a single Administrative Services Organization (ASO): CHN-CT

- This represents a “managed fee-for-service” approach, which contrasts with most other states that are moving almost exclusively to a managed care approach

# Connecticut Medicaid Structure (cont.)

- Medicaid **behavioral health services** have since January 1, 2006 been overseen by the Connecticut Behavioral Health Partnership, and managed by a behavioral health ASO (Value Options)

- Medicaid **dental services** have since September 1, 2008 been managed by a dental ASO (BeneCare)

- Medicaid **Non-Emergency Medical Transportation services** have since Spring, 2013 been managed by a transportation ASO (Logisticare)

# Context (cont.)

- By contrast, Medicaid **pharmacy** benefits are administered by the Department through contractor HP

- HP also serves many other key functions, including provider credentialing and enrollment, claims processing, provider communications and management of a data warehouse

# Rationales for Use of ASOs

Use of ASOs for all Medicaid services will:

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

# The Central 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.*

# Comparison of Past and Present Models

| | MCO | ASO |
|---|---|---|
| Structure | Multiple managed care entities | One managed fee-for-service entity |
| Contract | Administrative | Department withholds 7.5% of each quarterly administrative payment contingent upon ASO's success in meeting performance targets related to beneficiary health outcomes and experience of care, as well as provider satisfaction |
| Payment model | Capitated payment | Managed fee-for-service |

# Contrast with MCO Arrangement (cont.)

| | MCO | ASO |
|---|---|---|
| Care delivery model | Each MCO handled utilization management (e.g. prior authorization) on its own terms | Utilization management has been standardized for all Medicaid beneficiaries, Intensive Care Management (ICM) is available to all Medicaid beneficiaries |
| Data | Multiple data sets, inconsistent/non-standard reporting of data to Department | One integrated data set is immediately available to Department, provides much greater level of detail and transparency |

# Contrast with MCO Arrangement (cont.)

| | MCO | ASO |
|---|---|---|
| Provider enrollment | Providers enrolled in one or many MCOs | Enrollment is handled through an online process by the Department's contractor, HP |
| Provider rates | Established by each MCO (non-standard) | Department uses a standard rate schedule and common service definitions for all services |
| Provider payment | Each MCO was responsible for payment | Payment is made by HP on a twice per month |

# The Results of the ASO Approach

- Transition of all Medicaid services to a streamlined ASO platform has improved member and provider support; has through predictive modeling, ICM and data sharing enabled tailored responses to members' needs; and created a partnership between DSS and its ASOs that is mission-driven toward improving the health outcomes and satisfaction of those served by Medicaid

# Current Medicaid State Plan-Covered Services

- For a summary of covered services under HUSKY A (children and parents/relative caregivers), C (older adults and people with disabilities) and D (single childless adults age 19-64), please use this link:

http://www.huskyhealthct.org/members/member_postings/member_benefits/HUSKY_A-C-D-Handbook_9-15.pdf

# Current Medicaid State Plan-Covered Services (cont.)

- For a summary of covered services for HUSKY B (Children's Health Insurance Plan/CHIP, uninsured children under age 19), please use this link:

http://www.huskyhealthct.org/members/member_postings/member_benefits/HUSKY%20B%20Handbook_9-15.pdf

# Coverage Exclusions

- Medicaid does not cover:
  - pilot projects
  - out of state care with providers who refuse to enroll in Connecticut Medicaid
  - experimental care
  - research

# Process for Seeking New Medicaid Coverage

- Discuss in concept with DSS
- Develop service definition, coverage parameters, provider credentials and synopsis of fiscal impact
- Pursue OPM review and approval
- Partner with DSS on development of State Plan Amendment (SPA) or waiver
- Support DSS in responding to CMS Requests for Additional Information (RAI)

# For reference:
# Connecticut Medicaid reform strategies

# 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

We are also influenced by a value-based purchasing orientation. The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

*Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.*

# 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>• Health home initiative<br>• MQISSP 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) | 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 |

# In conclusion . . .

Connecticut Medicaid is utilizing diverse strategies to enable access to services, expand eligibility, connect Medicaid beneficiaries to primary care, enhance utilization of health care services, integrate medical and behavioral health care, and shift towards paying for value.