August 30, 2016

DSS Responses to Bailit Health Recommendations to Health Care Cabinet

Aims of legislation:

- Framework for: monitoring of and responding to health care cost growth . . . that may include establishing . . . benchmarks or limits on health care cost growth; identification of providers that exceed such benchmarks; provision of assistance for . . . health care providers to meet such benchmarks
- Identification of mechanisms to identify and mitigate factors that contribute to health care cost growth as well as price disparity
- Authority to implement and monitor delivery system reforms
- Development and promotion of insurance contracting standards and products
- Implementation of other policies to mitigate factors that contribute to unnecessary health care growth and to promote high-quality, affordable care

Synopsis of DSS Responses:

- In lieu of proposed joint procurement with Office of State Comptroller for regional Consumer Care Organizations:
    - continue with SIM agenda in its focus on 1) quality as it contributes to cost containment; and 2) alignment around use of Medicare ACO SSP shared savings arrangements (for Medicaid, the PCMH+ initiative) and use of common quality measures, across payers;
    - examine experience with PCMH+ (e.g. member outcomes, development of provider practice transformation capabilities, costs) as well as the range of available Medicaid authorities (1115 waiver, State Plan) to plan carefully for implementation of regional health neighborhoods.

- Optimize state pharmacy purchasing across Office of the State Comptroller, Departments of Corrections and Veterans Affairs, and (if technically feasible) DSS/Medicaid.

- In lieu of Delivery System Reform Incentive Program (DSRIP)/1114 waiver proposal, build on Connecticut Medicaid's proven success in improving health and care experience and controlling per member per month costs (these have decreased by 1.9% from SFY 2012 through SFY 2016) by:

  - continuing to optimize the present care delivery reform initiatives that are typical of those included in DSRIPs, including ASO-based Intensive Care Management, Person-Centered Medical Homes (PCMH), behavioral health health homes, and long-term services and supports (LTSS) re-balancing agenda;
  - launching PCMH+ (combined care delivery and payment reform) effective January 1, 2017;
  - implementing targeted new care delivery and payment reform initiatives based on analysis of Connecticut Medicaid claims data on high cost, high need individuals (all of these are in active development):
    - initiative to optimize Medicaid claiming and care access/continuity for justice-involved individuals re-entering communities;
    - initiative to develop a health home for children with complex trauma;
    - initiative to develop a 1915(i) State Plan Amendment to cover transition and tenancy-sustaining supports under Medicaid, to address and support the need for housing stability as it contributes to improved health outcomes;
    - initiative to address the care coordination needs of children with complex medical needs (e.g. sickle cell) who present to the hospital;
    - initiative to increase use of standards-based telemedicine (teleconsult has already been implemented in FQHC settings);
    - initiative to launch a "Safe to Wait" consumer intervention around self-triage and use of the ED;
    - initiative with hospitals to address the needs of individuals presenting to ED because of pain; and
    - development of bundled payments (e.g. for obstetrics); and
  - layering on a hospital risk model based on a rigorous quality framework.

- Analyze Medicaid claims data, geo-access information on provider participation, member and provider survey data and other sources and make targeted increases to Medicaid specialty rates, to better ensure proximate access and use of community-based care in lieu of the emergency room.

- Examine appropriateness and feasibility of integrating oversight bodies related to health care reform (Health Care Cabinet, SIM Steering Committee, Certificate of Need Task Force, HIT Council, Medical Assistance Program Oversight Council, Behavioral Health Program Oversight Council) to ensure better alignment and synthesis of reform efforts. Create a single table for health policy discussions.

- Investigate the need for enabling legislation for the package of recommendations that is ultimately endorsed by the Cabinet.

Detailed Notes on Recommendations:

Slide #	Recommendation	Comments	Proposed Alternative
12	Use state levers to control costs:		
	Purchasing power: use Medicaid and state employee plans to implement payment reform and evidence-based coverage decisions	While DSS strongly supports this in concept, DSS observes that 1) Sustinet proposals to pool risk for state employees and individuals served by Medicaid were met with extensive opposition; and 2) there are structural impediments in Medicaid to joint purchasing (an applied example of this is, for purposes of proposed joint purchasing of prescription drugs, inability to reconcile Medicaid's "any willing provider" requirement with the OSC's use of a Pharmacy Benefit Manager).	Optimize pharmacy purchasing across state employee/retiree health plan and other state department purchasers (e.g. Department of Corrections).
	Provider rate setting: to promote payment equity and contain cost growth	DSS utilizes standard, statewide rate schedules for reimbursement of many Medicaid services. DSS has also modernized hospital payment by migrating to use of DRGs for inpatient services and Ambulatory Payment Classifications (APCs) for outpatient services. This has better aligned and standardized payment across hospitals. Both of these aspects contribute to payment equity <u>within</u> Medicaid.	Consider targeted rate increases for Medicaid specialty services to enable better access to needed supports for members.

		Since 2013, HUSKY Health has been reimbursing many primary care codes at 100% of Medicare rates. In years 2013 and 2014, additional costs incurred for this were fully covered by federal funds. Ongoing, the administration and legislature have elected to continue to "rate bump" over a somewhat more narrow set of codes. As a result, primary care is largely been paid at Medicare rates. This has contributed to a significant increase in participation by primary care practitioners in the program. An overall comparison of Connecticut Medicaid rates with Medicare [2014 data] yields an overall Medicaid-to-Medicare index of 0.90, which is relatively high as compared to the great majority of other states, with the exception of several with rural access challenges. See notes following this chart for more detail and a link to the cross state index. When the overall index is unpacked, however, a reality for Connecticut Medicaid that has both contributed to cost containment, and also presented challenges regarding access, is that the majority of specialty rates have for many years been set at 57% of a benchmark Medicare rate year. Access	

	Data sharing: to identify cost drivers and direct policy decisions	to certain specialty services (e.g. orthopedics, dermatology) has been limited by this. DSS has a fully integrated set of Medicaid claims data and is already using this data to 1) perform stratification of the needs of Medicaid members (through the Johns Hopkins CareAnalyzer tool); 2) inform policy making; 3) to push data to Person Centered Medical Home practices; 4) to analyze results on PCMH performance and year-over-year improvement measures; and 5) examine financial trends.	
22	1. Lack of trust among key stakeholders 2. No table at which to have meaningful policy conversations among all stakeholders 3. Cultural inclination to resist change – "land of steady habits" 4. No unified cost containment strategy among key state agencies 6. Key health care systems slow to embrace value-based payment and delivery models	Many of these items seem to relate to the parallel tracks on which the present health care reform oversight bodies (e.g. Health Care Cabinet, SIM Steering Committee, MAPOC) are operating. It would seem useful to review how re-structuring, development of unified vision and values, and communication tools/norms could contribute to improved trust basis and synthesis of reform efforts. Connecticut Medicaid embraced a pay-for-performance approach for its PCMH initiative that has yielded 1) participation by 107 practices (affiliated with 434 participating sites and 1,536 providers) that are now serving	

		320,395 Medicaid members (almost 43% of members); 2) enabled extensive practice transformation; and 3) improved health and care experience outcomes. Further, DSS will be launching PCMH+ (care delivery and shared savings initiative) effective January 1, 2017.	
28-38	Implement risk-based contracts with Consumer Care Organizations using aligned contracting and purchasing strategies for HUSKY Health and State of Connecticut Employee Health to promote efficient use of services and improve quality. • Voluntary arrangements • Built on PCMH model; capable of being formed by any willing provider • Responsible for coordinating a comprehensive set of medical, behavioral health and SUD services for attributed client population (to build in capacity to provide dental care and integrate LTSS within 3 years) • Inclusive of provider and consumer participation in governance	DSS has the following concerns about this proposal: • ACO models are relatively new and are still being evaluated for impact on quality and cost savings – while there are some early successes, there have also been examples of <u>increased</u> costs; • Connecticut Medicaid will be implementing shared savings arrangements for the first time with PCMH+, effective January 1, 2017; • assumption of even upside risk is a very new phenomenon for Medicaid-affiliated providers; • SIM research has confirmed that Connecticut has an unusually high incidence of small primary care practices, and that, in general, clinicians have been relatively slow to	In lieu of proposed joint procurement with Office of State Comptroller for regional Consumer Care Organizations: • continue with SIM agenda in its focus on 1) <u>quality</u> as it contributes to cost containment; and 2) alignment around use of Medicare ACO SSP shared savings arrangements (for Medicaid, the PCMH+ initiative) and use of common quality measures, across payers; • examine experience with PCMH+ (e.g. member outcomes, development of provider practice transformation capabilities, costs) as well as the range of available Medicaid authorities (1115, State Plan) to plan carefully for implementation of regional health neighborhoods.

	• Joint procurement by DSS and OSC • Majority of payments, value-based; population-based payment model and shared risk – withhold 2-5% of payment to be earned based on performance on quality measures • Limit rate increases for non-participating providers Rationales are based on cost savings and quality improvements in other states' Medicaid ACO models	initiate practice transformation (the Medicaid PCMH initiative has helped to address this); • PCMH+ is designed to test experience with care delivery interventions that build upon a base of PCMH capability, and also to examine use of shared savings agreements – this will be implemented in January 1, 2017, but it will likely be at least two years before we will have sufficient data and maturation of experience to meaningfully incorporate learning into a regional network model design; • successful regional network models typically include up-front payments for care coordination, and it would be challenging to justify these new investments in the current budget landscape; • absent reimbursement for care coordination, DSS will likely be hard pressed to identify emerging networks with the financial wherewithal to support such costs pending sharing of savings at a future date; • there is no present Connecticut multi-payer structure on which	

		to effectively model joint procurement; and • among certain advocates, the Medicaid 1115 research and demonstration authority is highly controversial because it is seen as a likely means of contracting eligibility limits and/or scope of covered services – it will require intense engagement to overcome this hurdle, and this may be obviated by the use of alternative Medicaid State Plan authorities (e.g. the primary care case management (PCCM) Medicaid State Plan authority that DSS plans to use for PCMH+).	
40 42	Set requirements and limitations on the increase in health care costs, set targets for APM adoption, and create the regulatory authority and new structure to monitor target achievement Support growth cap through aligned Medicaid Advanced Networks (MAN) and Commercial Advanced Networks (CAN) Set APM targets, including down-side risk assumption and non-FFS model adoption	Medicaid cost control has already been clearly evidenced by stable/declining PMPM since the January 1, 2012 inception of a self-insured, managed fee-for-service structure and affiliated contracts with Administrative Services Organizations. In large part due to already implemented care delivery and payment reforms, Connecticut has experienced a decrease in per member, per month (PMPM) costs of -1.9% over the period from SFY 2012 through SFY 2016.	

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53-58	Pursue a Section 1115 Medicaid Waiver, and request a 5-year Delivery System Reform Incentive Payment (DSRIP) program to access new federal funds for provider infrastructure investment • This would build in reimbursement structure for CCOs	Connecticut Medicaid has already implemented many of the care delivery reforms that are typically featured in approved DSRIPs (care coordination, PCMH, health homes). Further, DSS will be launching the PCMH+ shared savings initiative effective January 1, 2017. A gap area in current efforts is that we have not entered into any value-based partnerships with hospitals to improve quality of care. It is useful to examine opportunities for optimization of federal revenue, and better synthesis of health reform efforts, but it is also important to understand requirements for such waivers – notably, that all Section 1115 research and demonstration waivers are required to be budget neutral for federal spending across a five-year period. It is also useful to examine the full range of available Medicaid authority options, including State Plan integrative authority, in light of the range of opinions in Connecticut regarding use of 1115 waivers. DSS is using State Plan PCCM authority for PCMH+. Please see below a useful excerpt from	In lieu of Delivery System Reform Incentive Program (DSRIP)/1114 waiver proposal, build on <u>Connecticut Medicaid's proven success in improving health and care experience and controlling per member per month costs by</u>: • continuing to optimize the present care delivery reform initiatives that are typical of those included in DSRIPs, including ASO-based Intensive Care Management, Person-Centered Medical Homes (PCMH), behavioral health health homes, and long-term services and supports (LTSS) re-balancing agenda; • launching PCMH+ (combined care delivery and payment reform) effective January 1, 2017; • implementing targeted new care delivery and payment reform initiatives based on analysis of Connecticut Medicaid claims data on high cost, high need individuals (all of these are in active development): 1) initiative to optimize Medicaid claiming and care access/continuity for justice-involved individuals re-entering communities; 2) initiative to develop a health home for children with complex trauma; 3) initiative to develop a 1915(i) State Plan Amendment to cover transition and

		a Kaiser Foundation brief on DSRIP (see resource material following chart for more detail): ***Funding for DSRIP initiatives varies across states, but can be significant. <u>However, DSRIP funding is part of broader Section 1115 waiver programs that are required to be budget neutral for federal spending.</u> California, New York, and Texas each expect to have several billion dollars for their DSRIP initiatives over a five-year period while <u>Kansas, Massachusetts and New Jersey have smaller programs and will spend substantially less.</u>*** *The DSRIP pool is a component of larger Medicaid 1115 waivers, which must be "budget neutral" to the federal government, meaning the federal government cannot spend more under the waiver than estimated spending without the waiver. Generally, there is a lot of negotiation between states and the federal government over policy and budget neutrality for Section 1115 waivers. In concept, states will undertake initiatives expected to save Medicaid funds and then use expected savings for new investments in delivery system reform. States have also used DSRIP waivers as a means to continue receiving Medicaid funds for*	tenancy-sustaining supports under Medicaid, to address and support the need for housing stability as it contributes to improved health outcomes; 4) initiative to address the care coordination needs of children with complex medical needs who present to the hospital; 5) initiative to increase use of telemedicine (already implemented in FQHC settings); 6) initiative to launch a "Safe to Wait" consumer intervention around self-triage and use of the ED; 7) initiative with hospitals to address the needs of individuals presenting to ED because of pain; 8) development of bundled payments (e.g. for obstetrics); and • layering on a hospital risk model based on a rigorous quality framework.

		supplemental payments to hospitals as they expand their use of managed care. [Kaiser Foundation, emphasis added, available at: http://kff.org/report-section/an-overview-of-delivery-system-reform-incentive-payment-waivers-issue-brief/]	
64-70	1) Ensure a robust multi-payer, multi-provider data infrastructure through the state's APCD and the Health Information Exchange; 2) Incorporate the use of comparative effectiveness evidence to reduce overuse and misuse of health care services Medicaid currently has a robust database DSS and the Comptroller should use their purchasing powers to promote provider engagement in the HIE – hospitals and other providers that do not participate in the HIE should not be eligible to participate in the Medicaid and state-employee health CCO strategy Hospitals and other providers should receive financial support for infrastructure development for HIE	Engagement of the Health Information Technology Officer should enable identification of services in support of which multiple payers, public and private, would be willing to support robust technical functionality and development of needed state-wide infrastructure. While much of this structure can be developed using Medicaid funding, CMS will insist on a fair share allocation for non-Medicaid costs. Connectivity to the HIE infrastructure for Medicaid enrolled providers is already supported by 90/10 federal support. An appropriate allocation of costs for non-Medicaid use will be necessary.	

	participation through the DSRIP Implement a transparent process that allows for public input into determining medical necessity of medical, behavioral health and dental services		
71	Restructure existing agencies into a single state entity composed of all health-related state agencies to be responsible for aligning all state health policy and purchasing activities	Please see above comment regarding review of structure of health reform oversight bodies.	

Kaiser Foundation Medicaid-to-Medicare Fee Index

http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22connecticut%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D

Location	All Services	Primary Care	Obstetric Care	Other Services
United States	0.66	0.59	0.76	0.74
Connecticut	0.90	0.78	1.26	0.75

Notes on the Fee Index:

The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicare-to-Medicaid fee index is a computed the ratio of the Medicaid fee for each service in each state to the Medicare fee for the same services. Medicare fees are

calculated using the 2014 relative value units, geographic adjusters, and conversion factor. To aggregate fee ratios across services and states, the same weights as in the Medicaid fee index were used. This procedure was repeated for the subset of services included in the Medicaid primary care payment increase under the ACA to develop estimates of fee decreases across different state groups.

Sources

Stephen Zuckerman, Laura Skopec, and Kristen McCormack, "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?," Urban Institute, December 2014.

What is a Delivery System Reform Incentive Payment (DSRIP) Program?

- a type of Section 1115 research and demonstration "waiver"
- 1115 waivers permit states to:
  - expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
  - provide services not typically covered by Medicaid; or
  - use innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- 1115 waivers must meet the following criteria:
  - increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state
  - improve health outcomes for Medicaid and other low-income populations in the state;
  - increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
  - increase and strengthen overall coverage of low-income individuals in the state
- 1115 waivers must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver
- 1115 demonstrations are approved for an initial five-year period and can be extended for an additional three years - states commonly request and receive additional 3-year extension approvals

[Source: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html]

Here is a useful narrative overview by the Kaiser Foundation (see this link for more detail:

http://kff.org/report-section/an-overview-of-delivery-system-reform-incentive-payment-waivers-issue-brief/):

"Delivery System Reform Incentive Payment" or DSRIP programs are another piece of the dynamic and evolving Medicaid delivery system reform landscape. DSRIP initiatives are part of broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals and often grew out of negotiations between states and HHS over the appropriate way to finance hospital care. Now, however, they increasingly are being used to promote a far more sweeping set of payment and delivery system reforms. The first DSRIP initiatives were approved and implemented in California, Texas, and Massachusetts in 2010 and 2011, followed by New Jersey, Kansas and Massachusetts in 2012, and most recently New York which was approved in 2014 and will be implemented in 2015. Key components of DSRIP waivers include the following:

Under DSRIP initiatives, funds to providers are tied to meeting performance metrics. *To obtain DSRIP funds, eligible entities (hospitals, and other providers, including provider coalitions) must meet certain milestones or metrics. While the exact structure and requirements of each DSRIP initiative differ, there is a focus on meeting process type metrics in the early years of the waiver, such as system redesign or infrastructure development, and then meeting more outcome based metrics in later years, such as clinical health or population based improvements. In support of these milestones and metrics, the DSRIP waivers impose robust data collection and reporting requirements on providers. Most recently, in the approval of the New York DSRIP plan, state DSRIP funds are also tied to meeting performance metrics beginning in year 3 of the waiver.*

Funding for DSRIP initiatives varies across states, but can be significant. However, DSRIP funding is part of broader Section 1115 waiver programs that are required to be budget neutral for federal spending. *California, New York, and Texas each expect to have several billion dollars for their DSRIP initiatives over a five-year period while Kansas, Massachusetts and New Jersey have smaller programs and will spend substantially less. The DSRIP pool is a component of larger Medicaid 1115 waivers, which must be "budget neutral" to the federal government, meaning the federal government cannot spend more under the waiver than estimated spending without the waiver. Generally, there is a lot of negotiation between states and the federal government over policy and budget neutrality for Section 1115 waivers. In concept, states will undertake initiatives expected to save Medicaid funds and then use expected savings for new investments in delivery system reform. States have also used DSRIP waivers as a means to continue receiving Medicaid funds for supplemental payments to hospitals as they expand their use of managed care.*

The role of DSRIP waivers in delivery system reform is evolving. *Recent DSRIP approvals highlight the evolution of DSRIP waivers, which increasingly include more accountability and involve a broader set of providers. For example, the New York DSRIP waiver approved at the end of 2013 includes funding for a broad set of providers, a more specific set of metrics and projects, and new requirements for the state to meet statewide goals as a condition of continuing to receive DSRIP funding (in addition to requirements for providers to meet specific metrics to access funding). Looking ahead, it will be important to evaluate the longer term outcomes of these initiatives and the extent to which they are making*

changes in care delivery, clinical outcomes, and population health. If they are successful, policymakers may want to see how these programs can be scaled and replicated across a larger number of states.