State Agency Response To Request For Input/Feedback On Possible Strategies and Current Context

A) Commissioner Raul Pino - DPH

We at DPH have plenty of initiatives going on that have an impact of health care cost, but for the most part they are not cost containment measures per se, they are prevention initiatives.

Million Hearts Learning Collaborative has tested a wide variety of approaches to collecting, accessing, sharing, and using data to inform hypertension identification and control efforts. They idea is to improve cardiovascular health and create a continuum of care from the primary care provider to the pharmacist, including local heath. In this effort we are partnering with the CDC, UCONN school of pharmacy, local pharmacy retailers in Bridgeport and the local Health Department. Data will be coming latter in the process, very promising.

Another area that was mentioned was Acquire Health Care Infections that could really drive cost; well we are rapidly improving in that area as well. The enclosed link will touch on the data, click on the + signs to display.

DPH's Healthy Connecticut 202 Dashboard is available at http://www.ct.gov/dph/cwp/view.asp?a=3130&q=553676.

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B) Commissioner Rod Bremby --DSS

It is interesting and provocative to consider the entire range of available strategies, but selection among these would most usefully be informed by the strengths of the present state, as well as structural and other features that may affect the feasibility of certain interventions. Two specific examples of these are as follows:

* DSS has successfully employed practice transformation through Person Centered Medical Homes and Administrative Services Organization-based Intensive Care Management to improve health and care experience outcomes for Medicaid members, and to control costs. DSS' working premise is that these features are essential building blocks of our future state under such strategies as the Medicaid Quality Improvement and Shared Savings Program.
* DSS has with the Office of the State Comptroller explored the feasibility of joint purchasing of pharmaceuticals. While this remains an area of interest, there exist significant barriers (e.g. federal law "any willing provider" requirement) to folding Medicaid into such a strategy. States such as Washington that have succeeded in joint purchasing have not, to the best of DSS' knowledge, been able to incorporate Medicaid within their approaches.

What current strategies are you undertaking to contain costs and ensure continued or improved quality for your constituents? Include collaborations with partner state agencies and private partners

Our starting premise is that enabling Medicaid members to seamlessly access, and effectively utilize and coordinate, the broad range of services that is covered under HUSKY Health will control costs. To this end, we are focusing on four key areas: a streamlined administrative Medicaid structure, access to primary, preventative care; integration of behavioral and medical care; and rebalancing of long-term services and supports.

A. Streamlined Administrative Structure

Why are we focusing here?

Historically, Connecticut Medicaid used a mix of managed care and fee-for-service arrangements to provide services to beneficiaries. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for beneficiaries. Further, this lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the

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Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services.

What are the key elements of work in this area?

Structure. By contrast to almost all other states, Connecticut no longer utilizes managed care arrangements, under which companies receive capitated payments for serving beneficiaries. Instead, Connecticut Medicaid is structured as a self-insured, managed fee-for-service model, through which the program contracts with four statewide Administrative Services Organizations (ASOs), respectively, for medical, behavioral, and dental health and for non-emergency medical transportation (NEMT) services. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction outcomes. An important feature of the ASO arrangement is that three of the ASOs provide Intensive Care Management (ICM), an intervention developed specifically to meet the diverse needs of our most socially and medically vulnerable members.

Data Analytics and Intensive Care Management. Employing a single, fully integrated set of claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk or who have complex health profiles with ASO ICM support. Risk stratification is based on medical and pharmacy claims, member/ provider records, and results from diagnostic laboratory and imaging studies. Factors used to determine risk include: 1) overall disease burden (ACGs); 2) disease markers (EDCs); 3) special markers (Hospital Dominant Conditions and Frailty); 4) medication patterns; 5) utilization patterns; and 6) age and gender.

ICM is structured as a person-centered, goal directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's 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;
* 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;
* reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and

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

Interventions through our medical ASO, CHN. CHN utilizes a stratification methodology to identify members who presently frequent the emergency department (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. 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. 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.

Interventions through our behavioral health ASO, Value Options. Under the direction of the three state agencies that manage the Connecticut Behavioral Health Partnership (the Departments of Social Services, Mental Health and Addiction Services, and Children and Families), 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. This approach includes 1) 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; 2) assigning peer specialists to members who could benefit from that support; and 3) dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social support needs of the involved individuals. 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.

Benefits of ASO structure. ASO arrangements have substantially improved beneficiary outcomes and experience through centralization and streamlining of the means of receiving support. The ASOs act as hubs for member support, location of providers, ICM, grievances and appeals. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and 'clean claims' are paid completely and promptly through a single fiscal intermediary – Hewlett Packard Enterprises. This promotes participation

and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

B. Access to Primary, Preventative Medical Care

Why are we focusing here?
Connecticut adults to not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 are receiving recommended care. [Commonwealth Fund, 2009] Further, a report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009]

What are the key elements of our work in this area?

* Person-Centered Medical Homes (PCMH). The Department implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the "glide path" toward recognition receive technical assistance from CHN CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

* Electronic Health Records (EHR). Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR supports more person-centered care and reduces duplication of effort across providers. DSS collaborates with the UConn Health Center to administer a Medicaid EHR Incentive Program. This includes review and approval of incentive payment applications from "Eligible professionals" (physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists) as well as eligible hospitals. It also includes extensive outreach and education to providers, and support of other health IT efforts.

* Health Disparities Work. DSS and its partner CHN-CT are currently examining access barriers related to gender, race and ethnicity face by Medicaid beneficiaries. This project is

focused on identifying disparities and equipping primary care practices with tools and strategies to reduce these barriers. DSS is also continuing to partner with the Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations through the development of policy and programming designed to eliminate disparities.

C. Integration of Medical, Behavioral Health, and Long-Term Services and Supports

Why are we focusing here?
Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have complex health profiles. A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient's medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions. Further, historically there has been considerable division as between medical and long-term services and supports, with little coordination or communication occurring among providers. DSS believes that the mind is part of the body, and that overcoming these boundaries is essential to responding in a person-centered manner to beneficiary needs, and to achieving better outcomes.

What are the key elements of our work in this area?

* Health Homes: DSS is working with the Department of Mental Health and Addiction Services to implement "health homes" for individuals with serious and persistent mental illness (SPMI). The federal Affordable Care Act 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 homes were implemented in Fall, 2015.

* Medicaid Quality Improvement and Shared Savings Program (MQISSP): The Department of Social Services is launching a planning process to develop a new, upside-only shared savings initiative entitled the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The Department's goal with MQISSP, which is a component of the State Innovation Model (SIM) Model Test Grant initiative, is to improve health and satisfaction outcomes for Medicaid beneficiaries currently being served by Federally Qualified Health Centers (FQHCs) and "advanced networks" (e.g. Accountable Care Organizations, ACOs), which will be competitively selected by the Department via a Request for Proposals. Both FQHCs and certain ACOs are

currently providing a significant amount of primary care to Medicaid beneficiaries. MQISSP represents an opportunity for Connecticut Medicaid to build on, but not supplant, its existing and successful Person-Centered Medical Home initiative, through which over one-third of beneficiaries are being served. While PCMH will remain the foundation of 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. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions, and lack of literacy. Enabling connections to organizations that can support beneficiaries in resolving these access barriers will further the Department's interests in preventative health. Further, partnering with providers on this will begin to re-shape the paradigm for care coordination in a direction that will support 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.

D. Rebalancing of Long-Term Services and Supports

Why are we focusing here?
Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In SFY'14, a total of $1.934 billion was spent in Connecticut on LTSS. This represented 11% of the state budget and 37% of the Medicaid budget. In SFY'14, 61% of beneficiaries of Medicaid LTSS received those supports in the community, but 29% of LTSS spending was attributable to these services. Rebalancing refers to reducing reliance on institutional care and expanding access to community Long-Term Services and Supports (LTSS). A rebalanced LTSS system gives Medicaid beneficiaries greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered. Achieving a rebalanced LTSS system requires that states examine current policies, services, access, and other systemic elements that may present challenges to rebalancing goals.

What are the key elements of our work in this area?

In January, 2013, the Governor, the Office of Policy and Management and the Department of Social Services released the State's Strategic Plan to Rebalance LTSS. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive LTSS. Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Program (BIP) activities; 3) TEFT; 4) nursing home diversification; and 5) launch of a web-based hub called "My Place". The strategic plan also identifies 'hot spots' for

development of services, including medical services, by projecting demand attributed to the aging population at a town level. Consistent with the Supreme Court's decision in Olmstead, the rebalancing plan supports provision of services in the most integrated setting that is appropriate for each individual.

Collaboration with state agencies and private partners:

DSS is privileged to collaborate in a range of health care initiatives with sister agencies and private partners. Key examples of these include:

* joint management with DMHAS and DCF of the Connecticut Behavioral Health Partnership;
* partnership with DMHAS in support of development of behavioral health health homes;
* partnership with DCF on its Three Branch project on child welfare, and associated examination of a Medicaid-funded early intervention for children who have experienced complex trauma;
* partnership with DMHAS, DCF, DOC and OPM on the NGA High Need, High Cost Policy Academy;
* partnership with DMHAS, DOH, DDS, OPM, the Partnership for Strong Communities and the Corporation for Supportive Housing on the CMS Innovation Accelerator Program on Medicaid-Housing Partnerships;
* partnership with DMHAS and OPM on the CMS Certified Community Behavioral Health Clinics (CCBHC) 223 Demonstration Program; and
* partnership with DMHAS and DDS on the Balancing Incentive Program long-term services and supports universal assessment requirement.

Can you provide concrete data that describes the strategies, success in containing costs and improving quality?

Yes. We are able to describe success in containing costs using a fully integrated set of claims data that permits detailed examination of cost trends across eligibility groups, provider types and any other data point that is captured by the way in which DSS reimburses for services provided to Medicaid members. The "Financial Trends" section of the attached provides a snapshot of our experience since conversion of the program from a capitated managed care approach to a managed fee-for-service approach. We are able to describe success in improving quality through a broad range of HEDIS and hybrid measures, as well as CAHPS data. Further, we are able to compare providers that have already engaged in practice transformation under our Person-Centered Medical Home initiative to non-PCMH providers.

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In February, DSS provided extensive detail on cost and quality results to the Appropriations, Human Services, Public Health and Aging Committees. Here is a snapshot of the attached presentation:

* While HUSKY Health enrollment is increasing, per member per month costs are trending down.
* The federal share of costs of Medicaid has increased from 50% pre-ACA to 59% currently. The state share of costs of Medicaid has not increased.
* Our financial trends compare very favorably with national trends. In 2015, our per member, per month costs went down 5.9%.
* The number of Medicaid participating primary care and specialty providers has increased due to factors including, but not limited to, extension of the primary care rate increase, enhanced PCMH reimbursement and performance payments, and streamlined administrative supports through the Administrative Services Organizations.
* Diverse measures of health and care experience have improved (please see below).
* We have enabled thousands of people to avoid institutionalization with community-based supports, and have transitioned over 3,800 people from nursing facilities to independent living in the community.
* We use data to examine and address each and every barrier that inhibits choice and independence.
* We are partnering with diverse entities including nursing facilities to create the LTSS system of the future.
* We are the first Money Follows the Person project in the country to be featured in a peer-reviewed journal – Health Affairs.

Here are some of the descriptors of our success since conversion from capitated managed care arrangements:

* Eligibility expansion promotes financial security and well-being, as well as contributing to the overall economic security of the state. Connecting thousands and thousands of new people to Medicaid has given them access to a broader array of services and supports than any private health care plan, but also two important benefits that may be less obvious. Research demonstrates that having health insurance gives people more financial security from the catastrophic costs of a serious health condition. Connecticut Medicaid does not require cost sharing, and people can count on being able to access services without having to pay a deductible or co-payments up front. A great example of this is that we fully cover the cost of very expensive, much needed prescription medications. We can also observe that coverage tends to result in improved mental health. Why? Likely, because it removes a significant stressor. Finally, we provide health care to many working people who are employed by large and small Connecticut businesses. This coverage enables people to stay well and to keep working.

* Covering kids promotes security. Providing health care coverage to children helps to improve their health status, but also supports their school readiness and ability to meet, or receive assistance in meeting, developmental milestones. We provide Medicaid coverage to approximately one in five children in Connecticut.

* Coverage of preventative services and coordination of care promote well-being. Connecticut Medicaid covers a broad range of preventative services. An important example is that we cover medication and counseling in support of smoking cessation. We are also making investments in primary care practices through the Person-Centered Medical Home initiative, primary care rate bump and Electronic Health Record funding that have inspired many more primary care clinicians to enroll in Medicaid. We are also doing great work in identifying people with complex needs, and serving them through Intensive Care Management (ICM) interventions under our Administrative Services Organizations.

Using our single, fully integrated set of claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk or who have complex health profiles with ASO ICM support. ICM is structured as a person-centered, goal directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's ICM interventions:

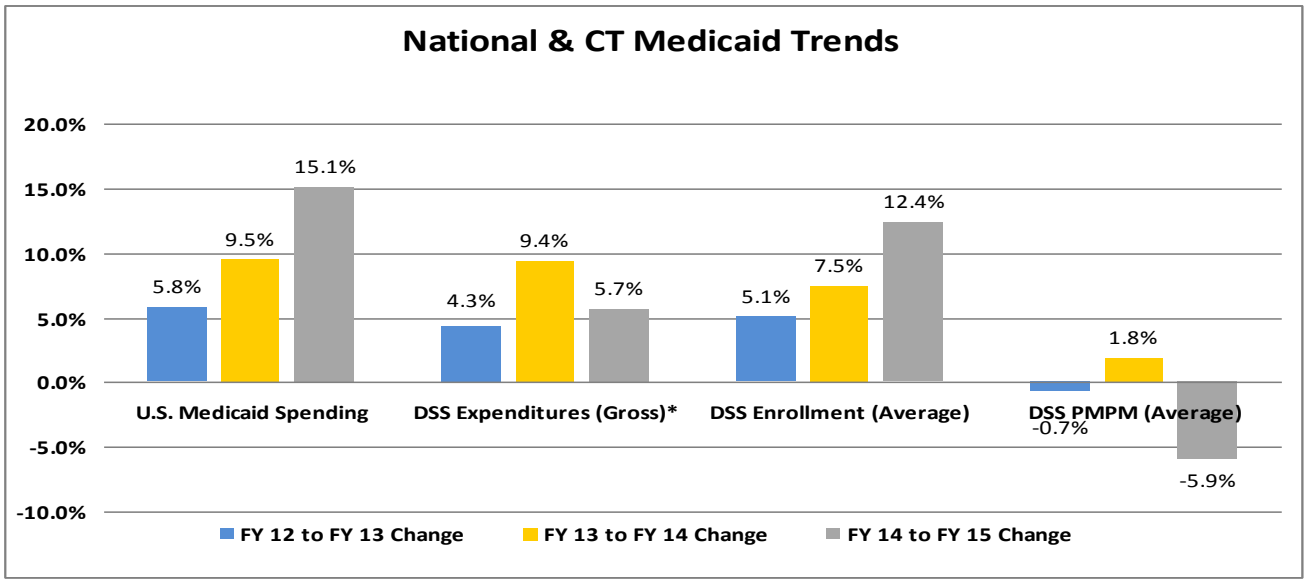
* integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;
* augment Connecticut Medicaid's Person-Centered Medical Home initiative, through which primary care practices receive financial and technical support towards practice transformation and continuous quality improvement;
* 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;
* reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
* reduce use of the emergency department for dental care, and significantly increase utilization of preventative dental services by children.

* Our long-term services and supports (LTSS) "rebalancing" initiatives promote self-sufficiency and security. Money Follows the Person has enabled over 3,800 people to transition from nursing facilities to the community and to receive Medicaid-funded home and community-based waiver services as well as housing subsidies and support in making those living situations accessible. The recently implemented Community First Choice initiative will enable people who are at risk of nursing home placement to self-direct budgets for services including personal care assistants. Our Medicaid waivers continue to serve thousands of

people (the Connecticut Home Care Program alone serves over 16,000) to remain in their homes or apartments and to receive the services that they need to maintain independence. Finally, our LTSS (and also extended duty nursing under Medicaid and CHIP) protect people from catastrophic, out-of-pocket costs and spousal impoverishment, as well as enabling caregivers to continue to work.

Here are just a few of the many specific indicators of success.

The first chart reflects trends inclusive of all hospital supplemental and retro payments. The second presents the trends with all hospital supplemental and retro payments removed from all years.



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.* ***This depiction includes all hospital supplemental and retro payments.***

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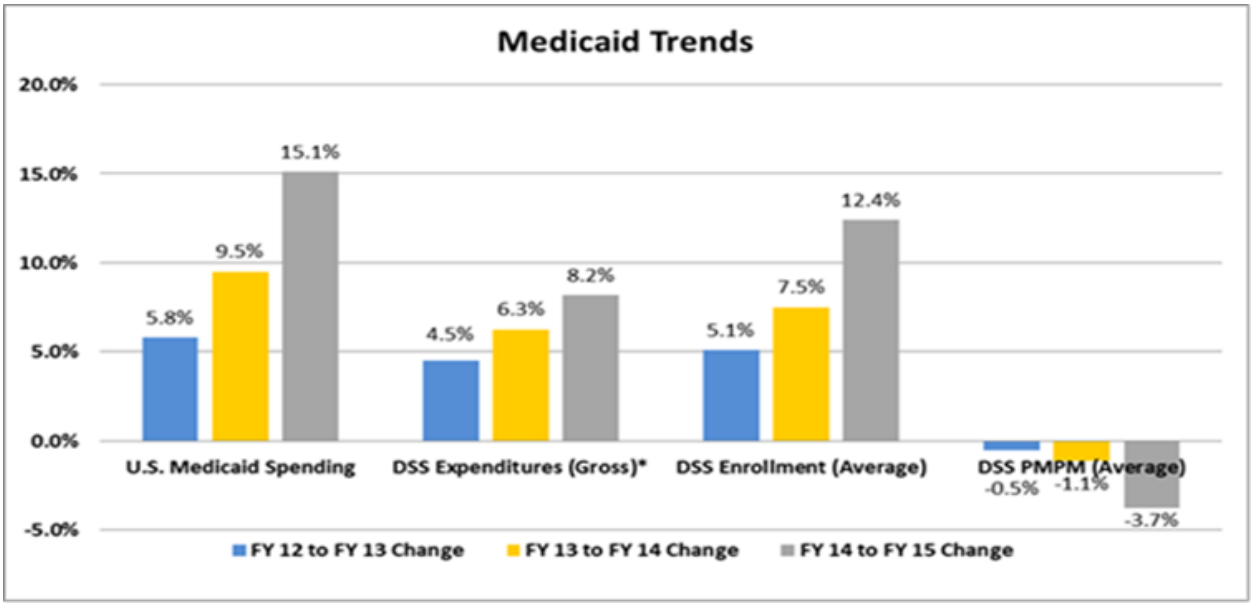

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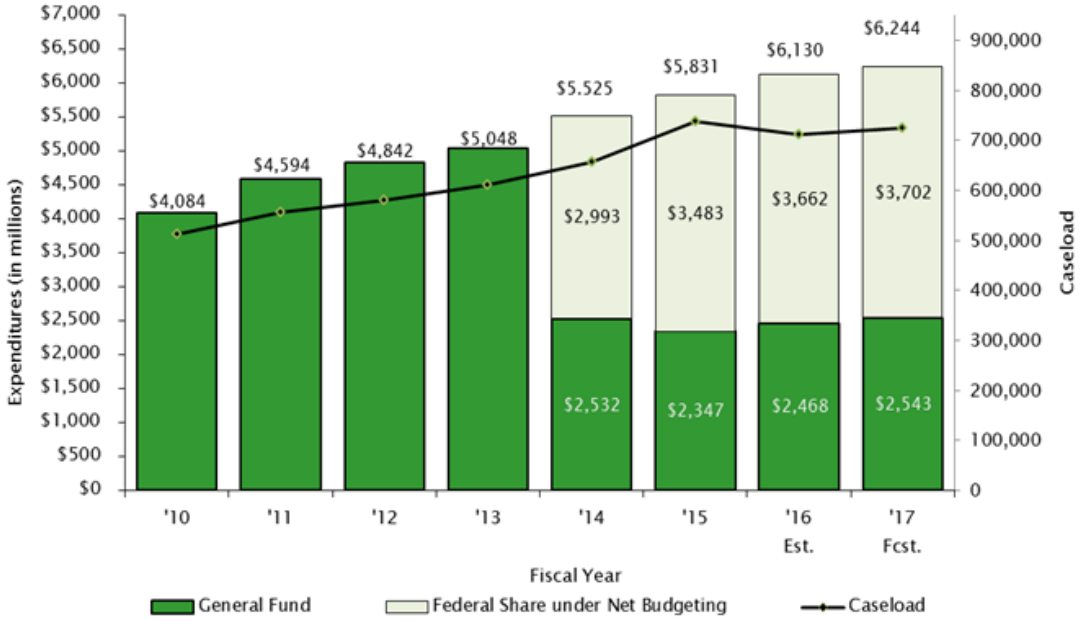
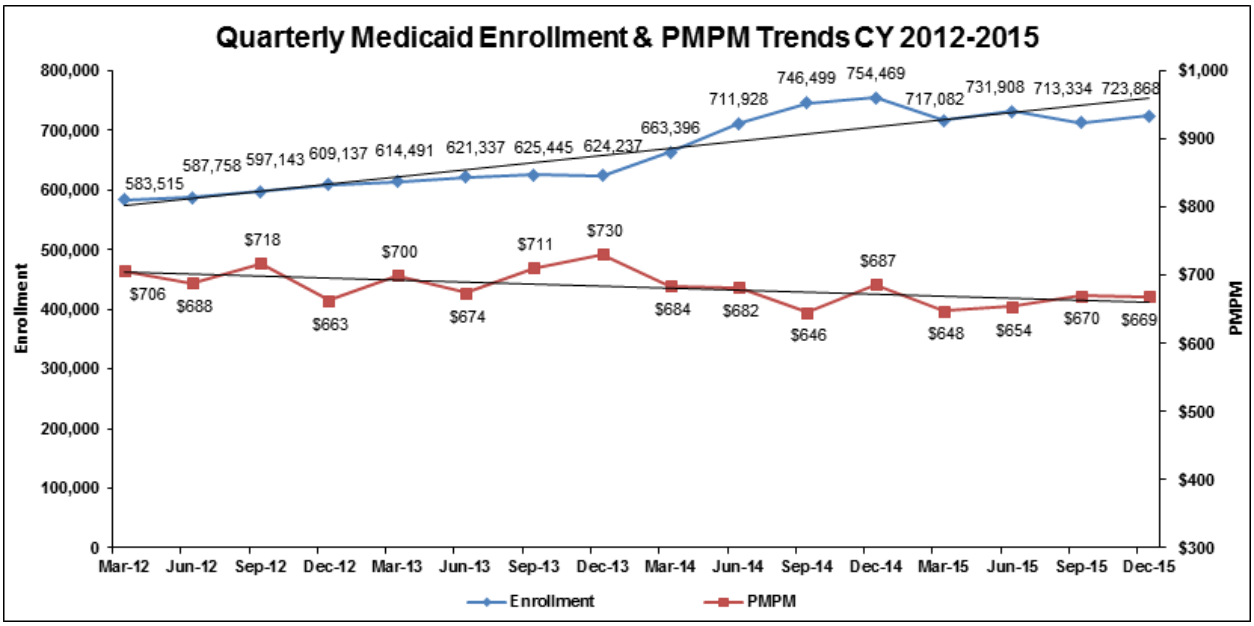


As noted above, the federal share of HUSKY Health costs has increased to 59%, up from 50% pre-ACA. This takes into account 100% federal funding for HUSKY D.



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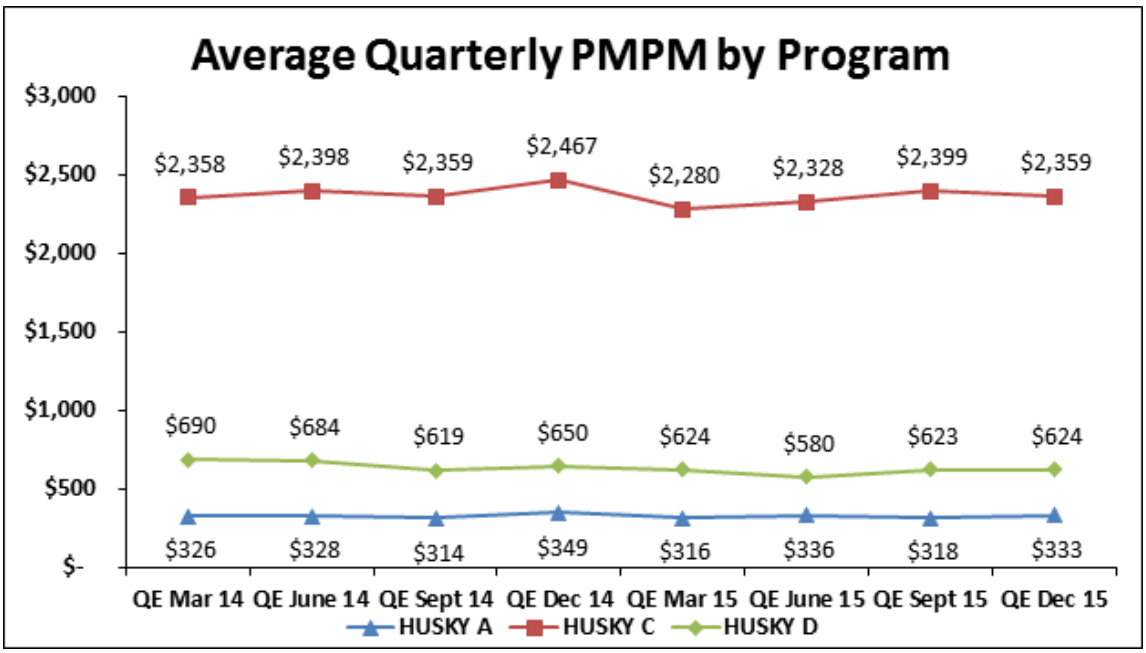

Access to Care

* Increased the number of Primary Care Providers (PCPs) enrolled in Medicaid by 7.49% (from 3,339 PCPs in CY 2013 to 3,589 PCPs in CY 2014). Recruited and enrolled 22 new practices into DSS' Person-Centered Medical Home (PCMH) program (from 71 PCMH practices at the end of CY 2013 to 94 practices at the end of CY 2014 (*Please Note: Two practices merged during CY 2014, resulting in a net of 22 new practices)

Utilization Management and Cost-Effectiveness

* Overall admissions per 1,000 member months (MM) decreased by 12.2% (from 124.10 in CY 2013 to 108.90 in CY 2014)
* Utilization per 1,000 MM for all other hospital outpatient services decreased by 5.3% (from 1,439.7 in CY 2013 to 1,363.2 in CY 2014)

Child and Adolescent Well Care Outcomes for HUSKY A and B

* Increased the CY 2013 Well Child Visit rate in the third, fourth, fifth and sixth year of life 3.70% to 85.00% (from 81.97% in CY 2013 to 85.00% in CY 2014)
* Increased the Adolescent Well Care Visit rate by 11.60% (from 59.66% in CY 2013 to 66.58% in CY 2014)
* Increased the Lead Screening rate by 3.95% (from 76.64% in CY 2013 to 79.67% in CY 2014)
* Increased the Immunization Rates by:

    * 11.82% for DTaP/DT (from 76.16% in CY 2013 to 85.16% in CY 2014)
    * 5.71% for Hepatitis A (from 89.54% in CY 2013 to 94.65% in CY 2014)
    * 11.59% for Hepatitis B (from 77.62% in CY 2013 to 86.62% in CY 2014)
    * 6.93% for HiB (from 87.83% in CY 2013 to 93.92% in CY 2014)
    * 7.35% for IPV (from 86.13% in CY 2013 to 92.46% in CY 2014)
    * 3.25% for MMR (from 89.78% in CY 2013 to 92.70% in CY 2014)
    * 11.90% for Pneumococcus (from 77.62% in CY 2013 to 86.86% in CY 2014)
    * 29.43% for Rotavirus (from 60.34% in CY 2013 to 78.10% in CY 2014)
    * 16.49% for HPV for females (from 20.68% in CY 2013 to 24.09% in CY 2014)
  * Increased the Immunizations for Adolescents rate by:
    * 6.87% for Meningococcus (from 80.90% in CY 2013 to 86.46% in CY 2014)
    * 7.92% for Tdap/Td (from 82.69% in CY 2013 to 89.24% in CY 2014)

Maternity Outcomes

  * Increased the Timeliness of Prenatal Care measure visit rate by 6.66% for HUSKY A and B (from 80.29% in CY 2013 to 85.64% in CY 2014)
  * Increased the Frequency of Prenatal Care measure visit rate by 26.85% for HUSKY A and B (from 48.91% in CY 2013 to 62.04% in CY 2014)
  * Increased the Postpartum Care measure visit rate by 17.00% for HUSKY A and B (from 60.10% in CY 2013 to 70.32% in CY 2014)

Diabetes Outcomes

  * Increased the HbA1c testing rate by:
    * 5.27% for HUSKY A and B (from 77.66% in CY 2013 to 81.75% in CY 2014)
    * 6.96% for HUSKY C (from 82.24% in CY 2013 to 87.96% in CY 2014)
    * 11.32% for HUSKY D (from 77.37% in CY 2013 to 86.13% in CY 2014)
  * Increased the number of members with a HbA1c result <7 by:
    * 7.22% for HUSKY A and B (from 25.35% in CY 2013 to 27.18% in CY 2014)
    * 22.85% for HUSKY D (from 22.84% in CY 2013 to 28.06% in CY 2014)
  * Increased the number of members with a HbA1c result <8 by:
    * 11.46% for HUSKY A and B (from 35.53% in CY 2013 to 39.60% in CY 2014)
    * 45.63% for HUSKY C (from 33.33% in CY 2013 to 48.54% in CY 2014)
    * 32.21% for HUSKY D (from 32.85% in CY 2013 to 43.43% in CY 2014

  * Reduced the number of members with a HbA1c in poor control by:
    * 12.94% for HUSKY A and B (from 56.59% in CY 2013 to 49.27% in CY 2014)
    * 23.43% for HUSKY C (from 57.91% in CY 2013 to 44.34% in CY 2014)
    * 21.28% for HUSKY D (from 58.88% in CY 2013 to 46.35% in CY 2014)

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* Increased the rate of retinal eye exams by:
  * 12.35% for HUSKY A and B (from 60.26% in CY 2013 to 67.70% in CY 2014)
  * 17.50% for HUSKY C (from 58.39% in CY 2013 to 68.61% in CY 2014)
  * 4.30% for HUSKY D (from 57.91% in CY 2013 to 60.40% in CY 2014)

* Increased the rate of controlling high blood pressure for diabetic members (<140/90 mm Hg) by:
  * 59.32% for HUSKY A and B (from 43.41% in CY 2013 to 69.16% in CY 2014)
  * 33.88% for HUSKY C (from 43.07% in CY 2013 to 57.66% in CY 2014)
  * 47.71% for HUSKY D (from 39.66% in CY 2013 to 58.58% in CY 2014)

Program Satisfaction

* Achieved a 97.2% overall favorable rating by members surveyed for satisfaction with the ICM program in CY 2014 as compared to a rating of 94% in CY 2013
* Among those providers that worked with the ICM department, 94.6% were satisfied with the ICM program when surveyed through the Provider Satisfaction survey in CY 2014 as compared to 85.7% in CY 2013
* Achieved a 97.03% overall favorable rating by members surveyed for satisfaction after completion of a call with the CHNCT Call Center in CY 2014 (Please Note: CY 2014 was the first year for this survey)

Person-Centered Medical Home Program Satisfaction

* Achieved an overall member satisfaction rating of 91.1% among adults in CY 2014 (as compared to 90.6% in 2013) and 96.1% on behalf of children in CY 2014 (as compared to 95.8% in CY 2013)
* Immediate access to care increased to 92.5% of the time, when requested by adults in CY 2014 (as compared to 90.7% in CY 2013), and 96.7% of the time, when requested on behalf of children in CY 2014 (as compared to 95.4% in CY 2013).

Are there strategies in Connecticut or elsewhere that you are aware of that have not yet been featured?

DSS would welcome discussion of the RWJF Aligning Forces for Quality, long-term services and supports rebalancing strategies including Money Follows the Person, and the Rhode Island affordability standards

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Please see this document for more information –

HUSKY Health Overview - Informati

C) Commissioner Wade – CID

Please see the attached document describing the CID rate review process –

CID Rate Review Process Power Point

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D) DCF – Kristina Stevens

- What current strategies are you undertaking to contain costs and ensure continued or improved quality for your constituents? Include collaborations with partner state agencies and private partners?

  We would reference some of the material submitted by DSS as DSS and DCF were the first partners in the ASO with Value now Beacon Health Options. This partnership, inclusive now of DMHAS has yielded positive outcomes in a range of ways for children with behavioral health needs.

  For those services and supports that are not funded through Medicaid, DCF engages in a number of quality assurance measures to monitor model fidelity, utilization management, capacity and outcomes. A range of factors are included in these efforts including key demographic information including race and ethnicity. DCF has invested in a number of evidence based practice models with a long history of demonstrated positive outcomes. Our ongoing quality assurance efforts demonstrate outcomes consistent with the national literature and research further confirming the investment in these services.

  DCF has the benefit of two federal grants further supporting our work specific to children's behavioral health. Both grants combined with the Departments lead role in PA 13-178, the Children's Behavioral Health Plan calls for financial mapping and network of care analysis. These efforts are underway examining both the substance use and mental health service array. We have the benefit of representation from DMHAS, DSS, DPH, DDS, Insurance Department, OHA, OEC, SDE and School Based Health Centers actively engaged in the Children's Behavioral Health Implementation Advisory Board engaged in these activities. An Interagency Council was established per the IMPACCT grant and includes representatives from CSSD, DMHAS and SDE.

  DCF and DMHAS have a well-established partnership relative to caregivers with Substance Use where utilization and outcomes are regularly examined at the statewide and local levels to assure the right intervention for the needs of the family.

  DCF is leading an effort inclusive of DMHAS, DSS, DPH, OEC and the CT Hospital Association specific to fulfilling the CAPTA requirements for substance exposed infants. The intention is to assure screening and early intervention in addition to collaborating with partners on the notification process and assure that Plans of Safe Care are developed with families and the agencies/treaters they are working with to assure children receive the early care they need.

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- Can you provide concrete data that describes the strategies, success in containing costs and improving quality?

  Children come into care for a range of reasons and their families present with complex issues often tied to the behavioral health needs of caregivers and their children as well. Congregate placements were often relied upon as the solution for children and families with complex needs though stays in inpatient and congregate settings were at alarmingly high rates and literature clearly indicated diminishing outcomes when children stayed beyond their treatment needs. Since January 2011, key practice issues, enhanced investment in community based services and partnerships has resulted in:

  - A decrease of 15.8 percent of children in care;
  - The percentage of children in care who live in congregate (group) care dropped from 29.8% in January 2011 to 13.4%
  - There are 354 fewer children in out of state care -- a decrease of 97.8 percent.

  *As of September 1, 2015 and compared to January 2011

  The total unique youth Medicaid membership increased slightly in Q3 '15 and then decreased in Q4 '15. DCF youth continue to make up about 2.5% of the total youth membership. We would echo the importance of the performance targets established with Beacon specific to admissions, discharges and readmission rates. A review of some of these data points illustrates the following:

  - The Inpatient Average Length of Stay (ALOS) decreased for all populations (all youth, DCF and Non-DCF) from Q4 '14 to Q4 '15. The DCF population had the most significant decrease in ALOS
  - ALOS for both the DCF 3-12 year olds' and the 13 –17 year olds' decreased
  - The percent of days delayed decreased over the past year (Q4 '14 to Q4 '15). DCF was the driver of this decrease
  - Intensive Care Managers (ICMs) continue on site collaboration with DCF at each area office, inpatient facilities, PRTFS, and have added daily on site collaboration with Solnit inpatient
  - New weekly child clinical rounds began at Waterbury hospital
  - The ICM team managed 730 reported children in ED overstay in 2015
  - Monthly meetings, Rapid Response and daily rounds continue with CCMC
  - The number of Youth in ED overstay has decreased from 2014 to January, 2016 (see table below)

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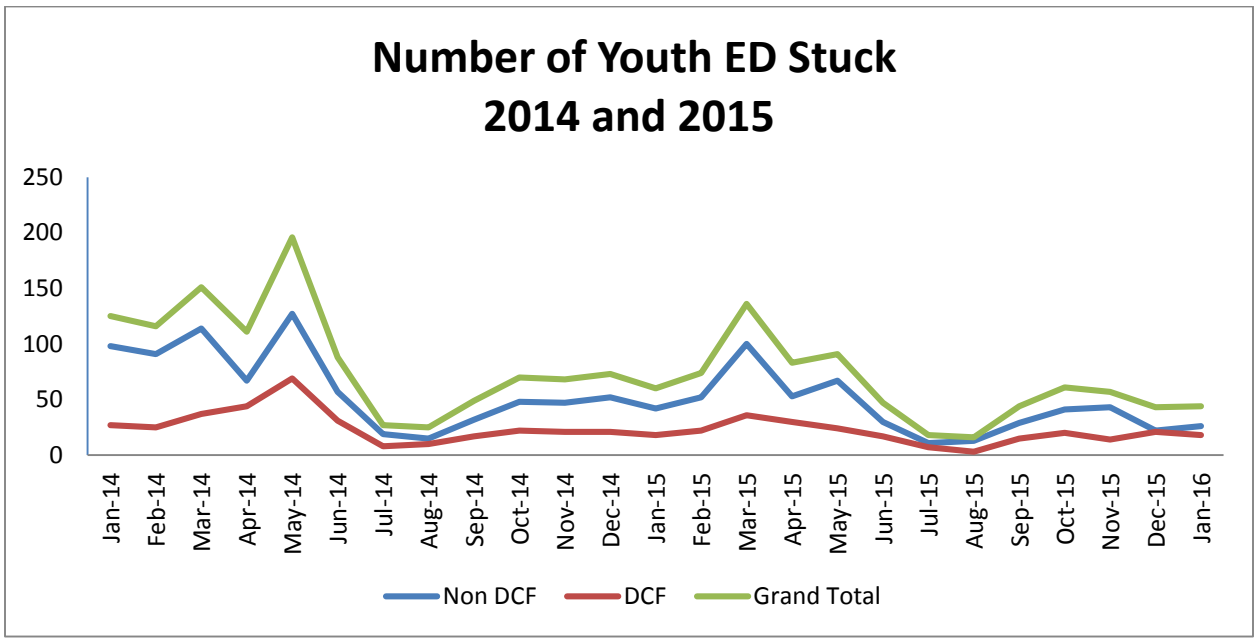

In partnership with DSS and Beacon, DCF together with CHDI has conducted a number of analysis related to the use and outcomes associated with EMPS. Many positive findings were made including with respect to inpatient admissions, 7% of EMPS episodes experienced an inpatient admission, which was 2% lower than the rate (9%) that was observed in FY2014

In addition, the group also conducted a study to understand the predictive factors that related to children and families receiving EMPS service more frequently during a single six-month (July to December) index period in FY2014. The results of this study found the following predictive factors correlated with an increase in the frequency of EMPS use: socioeconomic indicators (e.g., TANF eligible, Medicaid insurance); diagnosis on a major Axis 1 category (e.g., Major Depressive Disorder ranked highest); self/family referral; presence of severe emotional disturbance (SED) status; DCF-involved status, and a trauma history of witnessing violence. Economic indicators of poverty were the strongest predictors of the frequency of EMPS use, including when compared with other predictors, such as severity in behavioral/emotional challenges and other social identity dimensions.

In regards to the investment in evidence based treatment approaches to successfully keep children at home and safely with their families, the following outcomes have been achieved:

- For MST in
    - 87% complete treatment
    - 79% experience a reduction in substance use
    - therapist adherence measures to assess fidelity was .76 in 2015 exceeding the MST threshold of .61
- For MDFT in 2015

  - 72% met tx goals, exceeding benchmark of 70%
  - 77% did not have new arrests during the course of treatment
  - 85% maintained or increased their rate of school attendance during the course of treatment
- ACRA
  - SFY15 77% of Youth were attending School 3 Months Prior to Discharge

- FFT
  - 2012-2015
  - 99% of those who complete remain at home
  - 98% remain in school or employed
  - 92% no further arrests

With the success of Care Coordination, DCF has continued to invest in this important service specifically identifying those with the most complex needs to return them to their families and communities and reduce the need for a higher level of care.

DCF implemented ACCESS MH in response to the shortage of child and adolescent psychiatrists and the hope of families to assure issues are identified early to allow for early intervention and treatment. Three psychiatric hubs were established to outreach directly with pediatric practitioners and provide consultation, training and support to build the capacity of those who know these children well and are already treating them with the tools to provide a more holistic response to better meet their needs. In the first 18 months of implementation the hubs have:

- Provided consultation for 1,732 unique youth presenting with mental health concerns
- Provided 7,588 consultative activities supporting pediatric practitioners within their medical home

On the healthcare side, all children entering care receive a multidisciplinary evaluation within 30 days of placement. Such an evaluation is inclusive of a comprehensive set of screening instruments to inform recommendations for ongoing care examining the child's physical, dental and mental health needs.

- Are there strategies in Connecticut or elsewhere that you are aware of that have not yet been featured?

Through DPH, the State Level Care Coordination Collaborative Leadership Team has been established to serve as a conduit for bringing gaps and barriers identified on the regional level to state level agencies and organizations that directly affect children and their families. This level of the infrastructure and its formalized link to regional efforts is unique and offers

the opportunity to address documented systems' level policy and programmatic challenges confronting CT's children and families. This team has cross agency representation.

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E) DMHAS - Commissioner Miriam Delphin-Rittmon and Michael Michaud°

- ***What current strategies are you undertaking to contain costs and ensure continued or improved quality for your constituents? Include collaborations with partner state agencies and private partners? And***
- ***Can you provide concrete data that describes the strategies, success in containing costs and improving quality?***

The DMHAS **Evaluation, Quality Management Improvement Division** (EQMI) has developed quality reports that are posted online. Providers and stakeholders are able to access the reports which detail outcomes by agency and provide statewide benchmarks.
http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=489554

DMHAS is a member of the **CT Behavioral Health Partnership**-extensive data available at http://www.ctbhp.com/reports.html

In partnership with DSS and DCF, DMHAS is leading Connecticut's **Behavioral Health Home (BHH)** initiative. BHH is a recovery-oriented and person and family centered delivery model. Integration is realized by infusing physical healthcare expertise into the behavioral health system for a subset of individuals with a diagnosis of serious mental illness (SMI). BHH provide an opportunity for mental health professionals to impact life expectancy, prevent suicides, discourage risky behavior, encourage a healthy lifestyle, and improve access to general primary medical care for enrolled individuals through the use of BHH services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to community support services

It has been argued that for those individuals who have relationships with behavioral health organizations, care may be best delivered by bringing primary care, prevention, and wellness activities onsite into behavioral health settings. BHH care coordination services are designed to provide better patient experiences and outcomes than those achieved in traditional services.
Goal 1: Improve Quality by Reducing Unnecessary Hospital Admissions And Readmissions
GOAL 2: Reduce Substance use
GOAL 3: Improve transitions of care
GOAL 4: Improve the percent of individuals with mental illness who receive preventive care

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GOAL 5: Improve chronic care delivery for individuals with SMI
Asthma, diabetes, hypertension
GOAL 6: Increase person-centeredness and satisfaction with care delivery
GOAL 7: Increase connection to recovery support services

The **HCBS Waiver** is operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid. The Mental Health Waiver Program works in collaboration with Connecticut's Money Follows the Person Rebalancing Demonstration, resulting in a decrease in institutional care.

The HCBS waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by the Department of Mental Health and Addiction Services (DMHAS), but also signals new directions in the community treatment of people with serious psychiatric disabilities because of its emphasis on:

- Intensive psychiatric rehabilitation provided in the participant's home, and in other community settings;
- Attention to both psychiatric and medical needs;
- Emphasis on wellness and recovery;
- Person-Centered Planning leading to development of an individualized Recovery Plan; and
- Use of peer supports provided by people trained and certified in rehabilitative care, who know from first-hand experience about recovery from mental illness.

The HCBS waiver program, authorized in §1915(c) of the Social Security Act, allows the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. The State had broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs as well as natural supports that families and communities provide.
Cost containment is maintained through hard cost cap on the individual plan of care. The cost of a plan of care cannot exceed 125% of the average cost of nursing facility level of care for the past three (3) years. For the current Waiver year, the maximum allowable cost of annual services cannot exceed $87,000. If a client's level of need changes while enrolled in the MH Waiver, the plan must be altered to accommodate these needs. If the needs cannot be met safely within the cost allotment, the client will be referred to a higher level of care.


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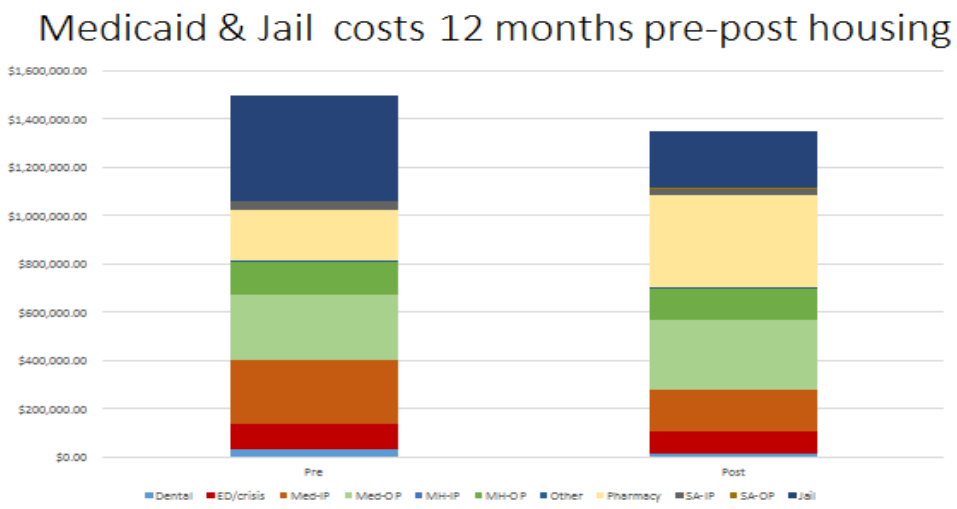
FUSE Initiative- Frequent Users Systems Engagement or Connecticut Collaborative on Re-Entry (CCR) is a framework which combines data driven targeting, stakeholder engagement, and quality supportive housing. It targets the most vulnerable frequent users of public systems, improves life outcomes for the tenants, increases efficient utilization of public resources and creates cost avoidance in crisis systems like jails, hospitals and shelter. Through a data match (jail and shelter systems), the initial 30 individuals housed in CCR accrued more than $12 million in lifetime jail and shelter costs alone. These individuals have complex unmet needs, histories of long-term homelessness, chronic health conditions, untreated mental illness and addictions.

Results have shown: Improvements over time in housing status, living satisfaction, substance use, jail days, and ER/Hospital use.



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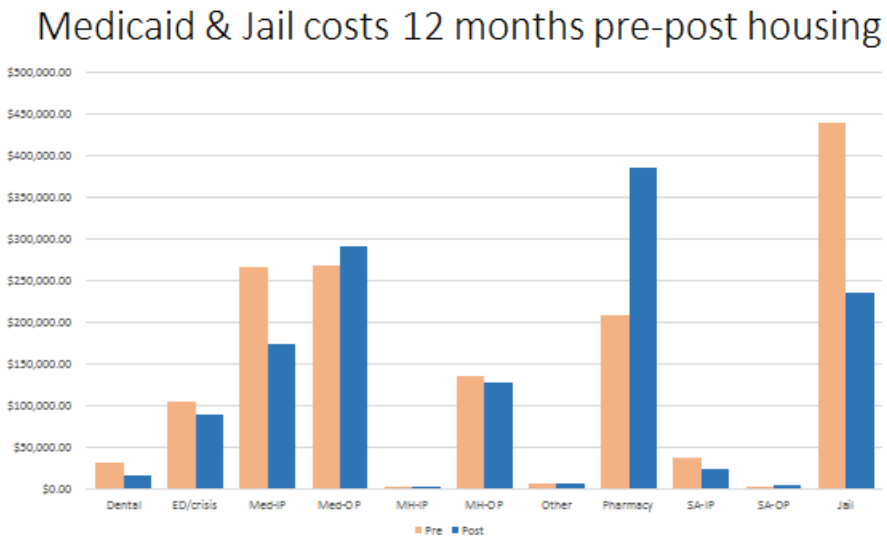

Social Innovation Fund- CT Integrated Health and Housing Neighborhoods (SIF-CIHHN) is one of four sites in CSH's five year, national initiative that is demonstrating supportive housing's role in improving health care access and health outcomes for Medicaid's highest cost, highest need beneficiaries who also experience homelessness.

For these beneficiaries, who often have multiple chronic health conditions and are at risk for long term homelessness, housing is a crucial piece of the health care delivery puzzle and without it; people can become caught in a cycle of relying on crisis health services for care, such as emergency rooms and hospitals with overall poor health outcomes. In Connecticut and nationally, the SIF initiative is proving that supportive housing can be the foundation to a better health care delivery system, helping people access much needed services, regain their health and stability and rebuild their live, while at the same time lowering public costs.

More than 580 individuals have been housed nationwide, with 163 housed in CT alone.
The work in CT has received national recognition and become a national example on how to utilize HMIS and Medicaid data to target scarce resources to the most vulnerable and to design integrated programs that achieve the greatest impact

We are seeing decreases in the use of ED's as the main source of care:

- 90% are actively connected to a primary health care provider
- 91% actively connected to MH care and
- 89% to specialty care

Service utilization patterns are trending in a positive direction:

- Overnight hospitalizations dropped from 8.5 before housing to 2.7 in the 12 months post housing placements and

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- ED visits decreased from 13 pre to 5 in the 12 months post housing