Connecticut HUSKY Health and CAHCH: the Benefits of Public/Private Partnership

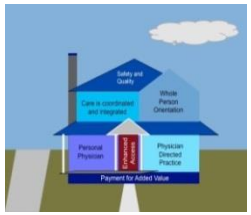
Connecticut Association for Health Care at Home

Annual Conference

November 1, 2018

HUSKY Health 2018 and Ongoing

On a foundation of



Person-Centered Medical Homes

ASO-Based Intensive Care Management (ICM)

Pay-for-Performance (PCMH, OB)

Data Analytics/ Risk Stratification

we are building in

Community-based care coordination through expanded care teams (health homes, PCMH+, rebalancing)

Supports for social determinants (transition/tenancy sustaining services, connections with community-based organizations)

Value-based payment approaches (PCMH+)

with the desired structural result of creating

Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods/health enhancement communities

What We Want, in Words

A stronger and healthier next generation that avoids preventable conditions and is economically secure, stably housed, food secure, and engaged with community.

Families that are intact, resilient, capable, and nurturing.

Choice, self-direction and integration of all individuals served by Medicaid in their chosen communities.

Empowered, local, multi-disciplinary health neighborhoods.

HUSKY HEALTH CONNECTICUT

The Why of Rebalancing

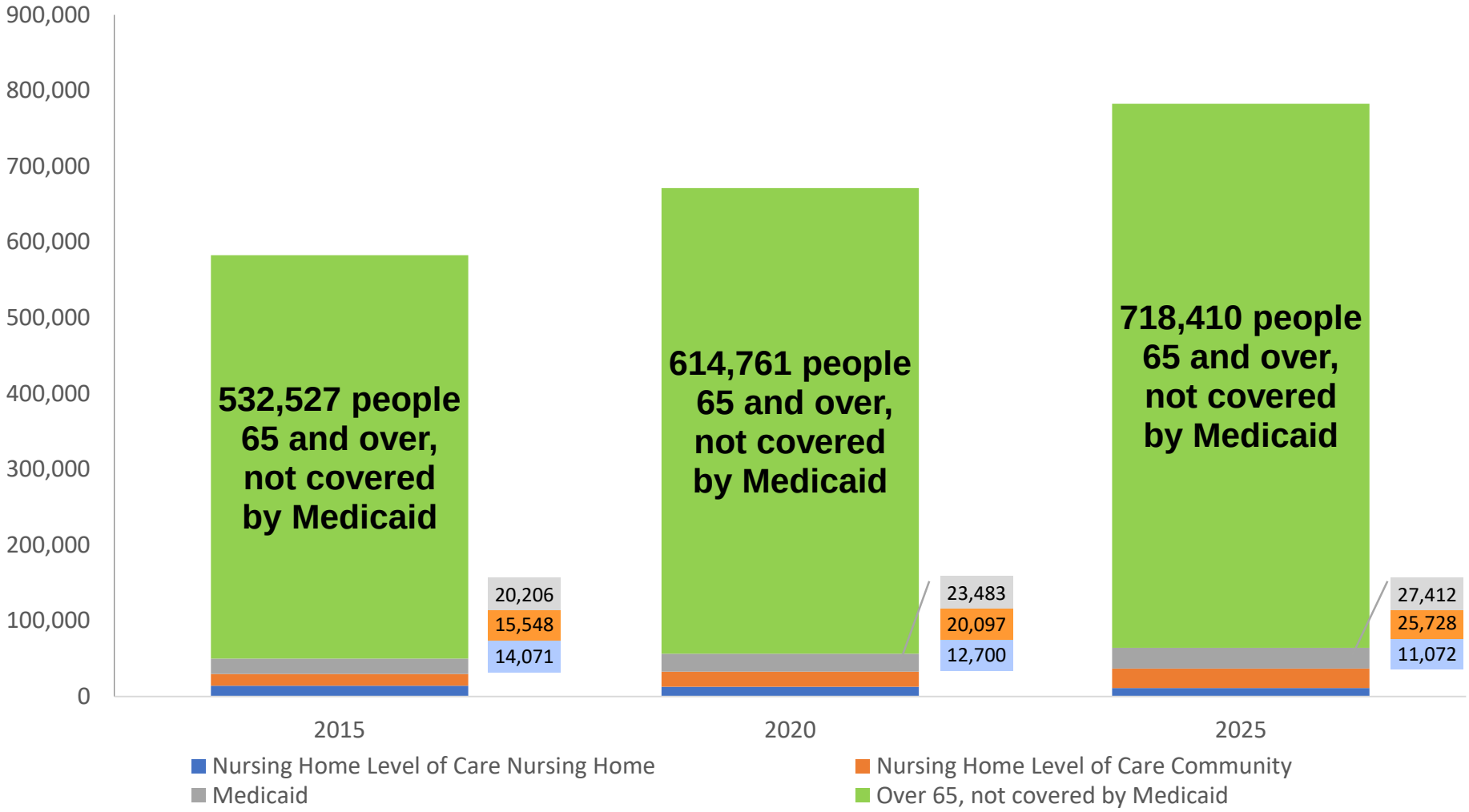
Rebalancing of long-term services and supports is a key component of our Medicaid reform strategy:

- Consumers overwhelmingly wish to have **meaningful choice** in how they receive needed long-term services and supports (LTSS).

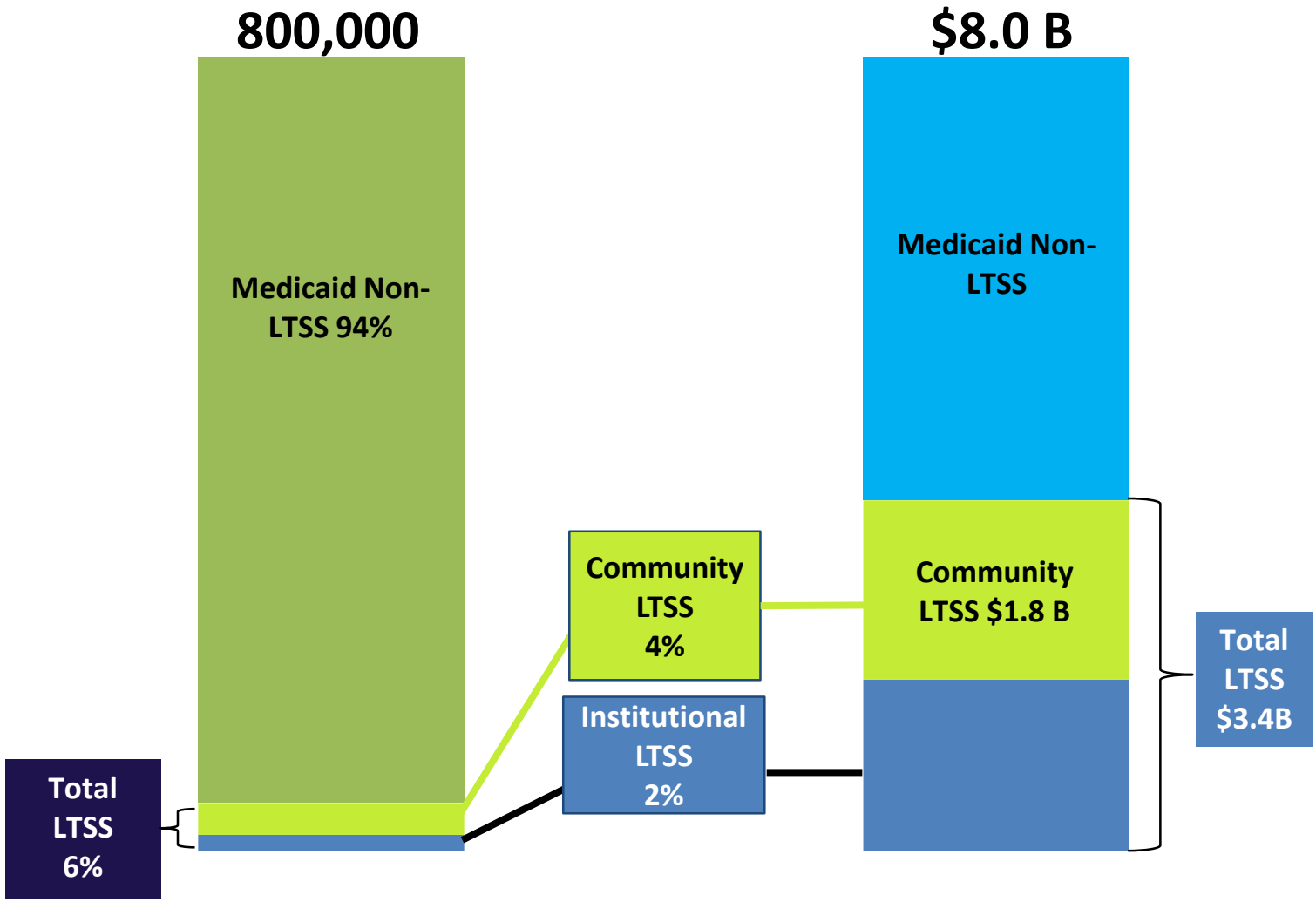
- Average per member per month **costs are less in the community**.

- In Olmstead v. L.C., 527 U.S. 581 (1999), the Supreme Court held that title II **prohibits the unjustified segregation** of individuals with disabilities. Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Projected Growth, Age 65+, 2015-2025



Medicaid LTSS as a Proportion of Spend



Where Home Care Fits In

High quality, person-centered home care services and a robust, financially viable home care network are critically important in:

- enabling thousands of Connecticut residents who receive services under the LTSS "waivers" (Connecticut Home Care Program for Elders and others) to remain in place in the community
- furthering transition of individuals from institutional settings to the community (over 5,000 people have transitioned to date)
- supporting effective self-direction through personal care assistants (PCAs) under Community First Choice

What Gets in the Way?

That said, there are features of the landscape that can either facilitate or inhibit progress:

- adequacy of reimbursement rates
- regulatory requirements
- eligibility processing
- referral and authorization processes
- claiming processes

A New Path

In Fall, 2017, CAHCH conducted an intensive LEAN process examination to review each of these aspects, and invited DSS to take a new approach:

A public/private partnership to examine each facet of the processes for authorizing, providing, documenting and claiming for home care services to identify potential areas of improvement that would both support consumers and reduce the real costs of doing this business.

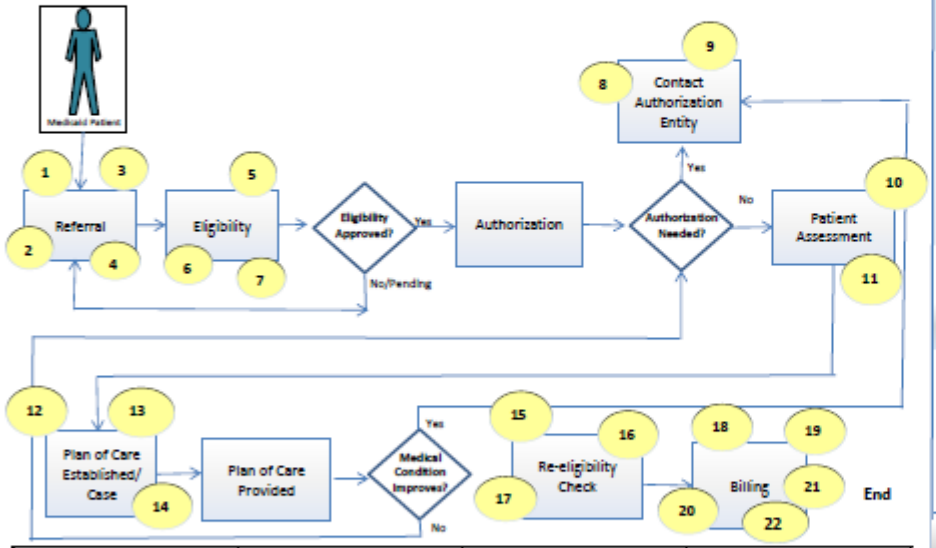
CAHCH's Analysis

CT Association for Healthcare at Home

Lean Management Process Improvement Exercise * **October 2017**

1. CURRENT STATE

The Medicaid Home Health Care Delivery Process is complicated and has many indicators pointing to root-cause problems.



1. Referral source may need to call multiple providers before referral is accepted.	6. Home health agencies deliver patient care in good faith during pending eligibility or redetermination.	11. Need for modernization of DPH regulations to align with DSS initiatives.	17. AAs and provider time and resources to find alternatives for ineligible cases.
2. Member access is a function of provider capacity.	7. Delayed eligibility issues put agencies at financial risk (spendowns and lost revenue).	12. Variation in perspective between authorizing entity and provider regarding level of care.	18. Speed of implementation without advanced stakeholder input.
3. Third party insurance limitations.	8. Behavioral Health waivers currently require duplicate authorizations (ASO & AAs).	13. DSS & DPH conflicting oversight (financial vs. regulatory).	19. EVV TPL process malfunction.
4. Limited specialty services (ie: IV) limit access.	9. Variation and inconsistences with authorizing entities' processes.	14. If waiver with cost cap, frequent communications required.	20. Duplicative DSS EVV mandate process.
5. Delayed access = decreased health outcomes and potential for higher costs.	10. Complicated and untimely TPL process.	15. Lack of notification of eligibility termination to AAs and providers.	21. Technical denials and delays in AA and provider payment.
		16. AAs and provider financial liability.	22. Signed physician orders and Medicaid Face to Face.

2. ROOT CAUSE

Three major themes emerged from the process mapping exercise:

1 MEDICAID MEMBER	2 ELIGIBILITY AND AUTHORIZATION	3 BILLING
Why is home health access a problem for Medicaid members ?	*Why is member eligibility and authorization a problem in the home health Medicaid*	*Why is provider billing a problem in the home*
Duplicate, burdensome and costly process requirements on providers which result in reduced capacity.	Pre and post eligibility processes have increasingly complex, inconsistent rules with multiple required touch points.	Provider payments are contingent upon multiple authorization processes, uploads to the portal, system limitations and delays.
Why?	*Why ?*	*Why?*

Root Cause: *Increased complexity in the CT Medicaid Home and Community-Based Care Delivery Process compounded by frequent system updates, mandated requirements and limited opportunity for advanced provider input.*

3. RECOMMENDATION

Create stakeholder workgroup(s) to examine existing care delivery processes within the CT Medicaid Home and Community Based Care System to streamline costly duplication and re-work, specifically around eligibility, authorization and billing.

4. FUTURE STATE

To be determinied but achieved together as committed partners through working groups.

* Identify areas within the CT Medicaid Home and Community-Based Care Delivery Process that slow or hamper cost-efficiency. Include all stakeholders in discussions to work towards creating an efficient member-centered system that avoids non-value added activities, duplication, re-work and costs to the overall system.

Action Steps Taken

DSS and CAHCH have:

- been successful in gaining authorization from OPM for an increase in companion and non-nursing home health rates

- set up sub-committees:

  - with DPH to review regulations for the purpose of aligning federal and state requirements and reducing duplication of effort
  - to examine means of improving information sharing and timeliness of eligibility processing
  - to increase timeliness in referrals and reduce duplication of work in the authorization processes
  - to examine means of smoothing the claiming process