A Snapshot of the DSS Health Care Transformation Agenda July, 2015

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 access 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?

- Medicaid is a major payer of health services and currently serves almost **750,000** beneficiaries (**20.6%** of the state population)

- overall, **4 out of 10 births in Connecticut** are to mothers who are Medicaid beneficiaries; in cities and other distressed municipalities, this ratio is as high as **6 or 7 out of 10 births**

Medicaid Context (cont.)

- As of June, 2015, Medicaid was serving:
  - **460,718** HUSKY A adults and children
  - **15,057** HUSKY B children
  - **93,868** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **191,556** HUSKY D low-income adults age 19-64
  - **1,593** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

Why are we doing this?

- Key health indicators for Connecticut Medicaid beneficiaries, including hospital readmission rates and outcomes related to chronic disease, are in need of improvement

Why are we doing this?

- Connecticut's health care spending in Medicaid is high compared to other states

- The Connecticut **Medicaid budget** is **$6 billion** (reflecting both federal and state shares); this **represents 13.6% of the State budget**

Why are we doing this? (cont.)

Connecticut has:

- the fourth highest level of health care expenditures at $8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska [2009 data]
- the ninth highest level of Medicare costs at $11,086 per enrollee [2009 data]
- the highest level of Medicaid costs at $7,561 per enrollee [2010 data]

[Kaiser State Health Facts]

Why are we doing this? (cont.)

Please note the following per capita break-out of Medicaid costs by recipient group:

- $16,955 Aged
- $25,393 Disabled
- $ 3,533 Adult
- $ 3,339 Children

[Kaiser State Health Facts, 2010 data]

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 populations
- reducing the per capita cost of health care

We are also influenced by a value-based purchasing orientation. CMS defines **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.

Medicaid Context

- By contrast to most other states, Connecticut is not using any managed care arrangements

- Instead, Connecticut Medicaid is self-insured and has entered into contracts with single, statewide Administrative Services Organizations (ASOs) for each of the four major service types – medical, behavioral health, dental and Non-Emergency Medical Transportation (NEMT)

Medicaid Context (cont.)

This is our hypothesis:

Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations (ASOs), 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.

Contact Information for ASOs

Type of coverage:	Contact:	Operated by	Telephone Number/ Web Site
Medical coverage	HUSKY Health Member Services	CHNCT	1-800-859-9889 www.huskyhealthct.org
Behavioral health coverage	Connecticut Behavioral Health Partnership (CTBHP)	Value Options	1-877-552-8247 http://www.ctbhp.com/
Dental coverage	Connecticut Dental Health Partnership (CTDHP)	Benecare	866-420-2924 855-CTDENTAL (855-283-3682) www.ctdhp.com
Non-Emergency Medical Transportation (NEMT)	Logisticare	Logisticare	1-888-248-9895 https://facilityinfo.logisticare.com/LinkClick.aspx?fileticket=mbeWTZOSeN0%3D&tabid=826&mid=1857

Medicaid Vision

An effective, person-centered health care delivery system for eligible people in Connecticut that promotes:

- well-being with minimal illness and effectively managed health conditions;
- maximal independence; and
- full integration and participation in their communities.

Medicaid Strategies

Connecticut Medicaid is engaged in a broad range of strategies that are grouped in the following slides around the key features of the Triple Aim.

Improving the Patient Experience Of Care

Issues Presented	DSS Strategies	Anticipated Result
Individuals face access barriers to gaining coverage for Medicaid services	• ConneCT • MAGI income eligibility • Integrated eligibility process with Access Health CT	Streamlined eligibility process that optimizes use of public and private sources of payment
Individuals have difficulty in connecting with providers	• ASO primary care attribution process and member support • Support for primary care providers (Person Centered Medical Home, Electronic Health Record funding, primary care rate increase)	DSS will help to increase capacity of primary care network and to connect Medicaid beneficiaries with medical homes and consistent sources of specialty care
Individuals struggle to integrate and coordinate their health care	• ASO predictive modeling and Intensive Care Management (ICM) • Duals demonstration • Health home initiative	Individuals with complex health profiles and/or co-occurring medical and behavioral health conditions will have needed support

Improving the Health of Populations

Issues Presented	DSS Strategies	Anticipated Result
A significant percentage of Connecticut residents does not have health insurance	• Medicaid expansion • Integrated eligibility determination with Access Health CT	Increased incidence of individuals covered by either Medicaid or an Exchange policy
Many Connecticut residents do not regularly use preventative primary care	• Person Centered Medical Home initiative in partnership with State Employee Health Plan PCMH	Increased regular use of primary care; early identification of conditions and improved support for chronic conditions
Many health indicators for Medicaid beneficiaries are in need of improvement, and Medicaid has the opportunity to influence other payers	• Behavioral health screening for children • Rewards to Quit incentive-based tobacco cessation initiative • Obstetrics and behavioral health P4P initiatives	Improvement in key indicators for Medicaid beneficiaries; greater consistency in program design, performance metrics and payment methods among public and private payers

Reducing the Per Capita Cost of Care

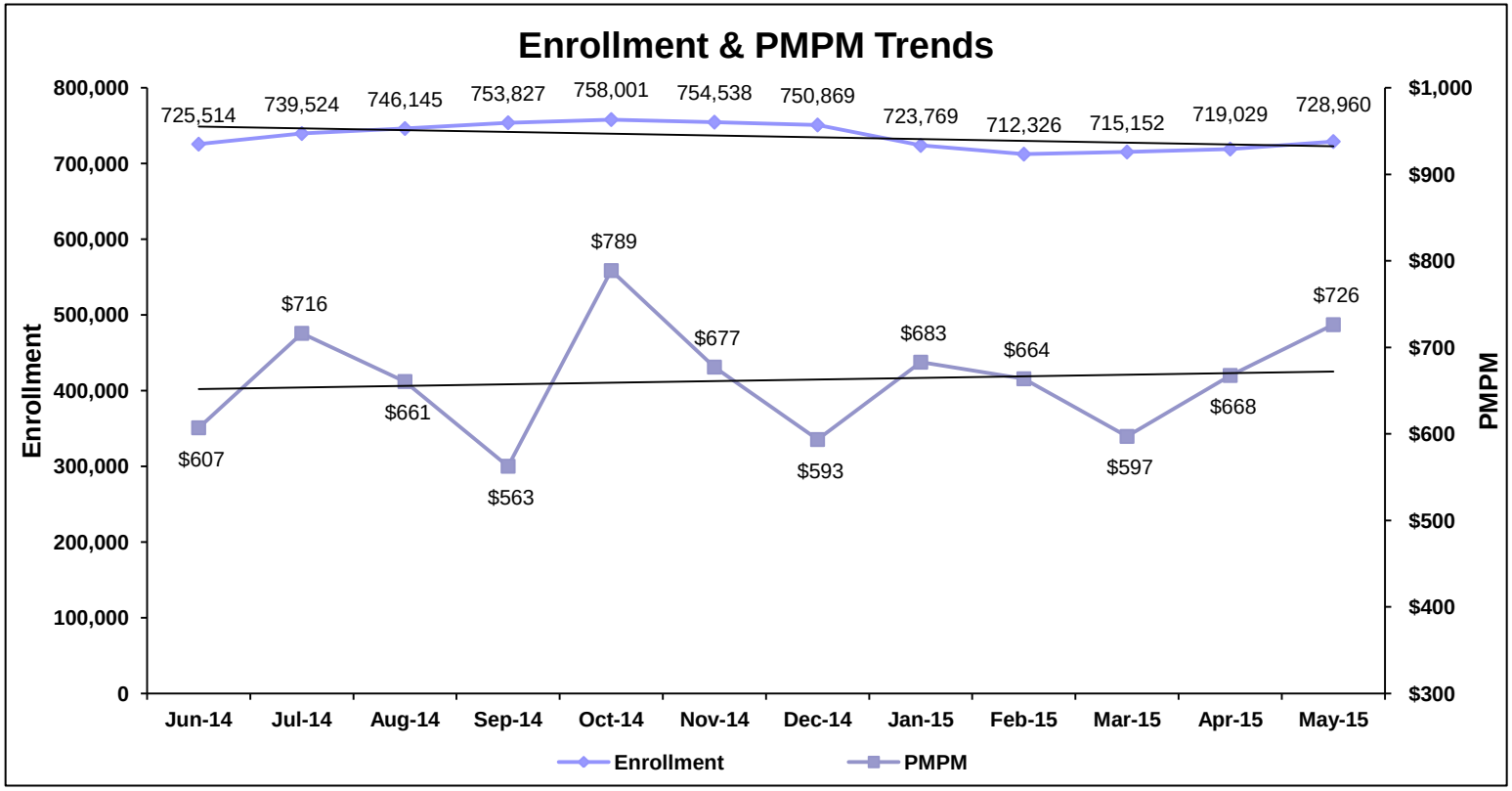
Issues Presented	DSS Strategies	Anticipated Result
Connecticut's historical experience with managed care did not yield the cost savings that were anticipated	• Conversion to managed fee-for-service approach using ASOs • Administrative fee withhold and performance metrics	DSS and OPM will have immediate access to data with which to assess cost trends and align strategies and performance metrics in support of these
Connecticut Medicaid's fee-for-service reimbursement structure promotes volume over value	• PCMH performance incentives • Duals demonstration/ MQISSP performance incentives and shared savings	Evolution toward value-based reimbursement that relies on performance against established metrics
Connecticut Medicaid's means of paying for hospital care is outmoded and imprecise	• Conversion of means of making inpatient payments to DRGs and making outpatient payments to APCs	DSS will be more equipped to assess the adequacy of hospital payments and will be able to move toward consideration of episode-based approaches

Reducing the Per Capita Cost of Care (cont.)

Issues Presented	DSS Strategies	Anticipated Result
Connecticut expends a high percentage of its Medicaid budget on a small percentage of individuals who require long-term services and supports; historically, this has primarily been in institutional settings Consumers strongly prefer to receive these services at home	• Strategic Rebalancing Initiative (State Balancing Incentive Payments Program, Money Follows the Person, nursing home diversification funding, workforce analysis, My Place campaign) • Duals demonstration payments for care coordination	Connecticut will achieve the stated policy goal of making more than half of its expenditures for long-term services and supports at lower cost in home and community-based settings

How are we doing?

Per member, per month costs are stable



How are we doing? (cont.)

There is strong participation in the ASO Intensive Care Management Program.

Members Outreached for ICM in 2014	**58,902**
Members Who Enrolled in ICM in 2014	**11,883**
% Members Outreached Who Enrolled in ICM*	**20.17%**

*Medical literature typically cites enrollment rates in care management and disease management programs that range between 7% and 13%

How are we doing? (cont.)

The ICM function is diverting individuals from inappropriate use of the ED and hospital, and yielding savings.

2014 ICM								
	6 months Prior to ICM		6 months Post ICM		Pre vs Post-ICM Difference		% Difference	
	Utilization	Paid	Utilization	Paid	Utilization	Paid	Utilization	Paid
ED Visits	10,195	$5,696,689.67	6,875	$3,949,814.52	-3,320	-$1,746,875.15	-32.56%	-30.66%
Inpatient Admissions	3,423	$24,952,935.05	1,672	$14,562,066.15	-1,751	-$10,390,868.90	-51.15%	-41.64%

Medicaid Integration Initiatives

In support of integrating medical, behavioral health, dental and long-term services and supports, Connecticut Medicaid is implementing several key integration initiatives that are profiled on the following slides.

Medicaid Integration Initiatives (cont.)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
Overall statement of purpose	Seeks to enable person-centered, multi-disciplinary care coordination that will impact both Medicare and Medicaid services and programs by reducing unnecessary areas of over-treatment and/or duplication, addressing areas of unmet need, *and* integrating medical, behavioral, supplemental and social services in a person-centered manner to promote a healthier population of Medicare-Medicaid Enrollees (MMEs)	Seeks, through a care team model based in Local Mental Health Authorities (LMHA) and their affiliates, to integrate the beneficiary's behavioral health, medical and community services and supports through a person-centered care plan, leading to better patient experience and improved health outcomes	Seeks to improve health outcomes and care experience of single-eligible Medicaid beneficiaries through arrangements with competitively selected, participating providers (FQHCs and "advanced networks") that will receive care coordination payments (FQHCs only) and a portion of any savings that are achieved (FQHCs and advanced networks), on the condition that they meet benchmarks on identified quality measures.

Medicaid Integration Initiatives (cont.)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
Population served	Individuals who are dually eligible for Medicare and Medicaid	Individuals with an identified serious and persistent mental illness (SPMI) who are served by Local Mental Health Authorities and have annual Medicaid claims in excess of $10,000	Individuals are served by Federally Qualified Health Centers and “advanced networks”
Method of affiliation	Enrollment with provider from whom the individual has received services, with opt-out provision; all others are served by medical ASO	Enrollment with provider from whom the individual has received services, with opt-out provision	Retrospective attribution to provider from whom the individual has received services

Medicaid Integration Initiatives (cont.)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports providers	15 statewide Local Mental Health Authorities (LMHA) and contracted LMHA affiliate providers	FQHCs and "advanced networks" (e.g. Accountable Care Organizations, advanced physician practices) - composition of the care team is to be determined
Care coordination model	Lead Care Manager working with multi-disciplinary team	Multi-disciplinary team	Care Coordinator
Quality measures	A range of claims-based measures as well as CAHPS	A range of claims-based measures	A range of claims-based measures

Medicaid Integration Initiatives (cont.)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
Means of paying for care coordination	Per member, per month (PMPM) payment	PMPM payment	Supplemental payment to Federally Qualified Health Centers only
Shared savings model?	Yes	No	Yes
State departments involved	DSS DMHAS DDS	DMHAS DCF DSS	DSS

Medicaid Integration Initiatives (cont.)

Feature	Duals Demonstration Health Neighborhood (HN) Model	DMHAS Behavioral Health Home	Medicaid Quality Improvement Shared Savings Program (MQISSP)
Stakeholder group	Medical Assistance Program Oversight Council (MAPOC) Complex Care Committee	Behavioral Health Partnership Oversight Council Health Home Workgroup	MAPOC Care Management Committee
Procedural status	In context of action taken in the biennial budget to eliminate the state share of the care coordination payments that would have been made to providers in health neighborhoods, DSS has resumed negotiation with CMS on an ASO-only approach	Pending approval of State Plan Amendment	Planning process was launched in Spring, 2015 toward 7/1/16 implementation

In conclusion . . .

- DSS is utilizing diverse strategies to enable access to services, expand eligibility, connect people to primary care, enhance utilization of health care services, integrate medical and behavioral health care, enable services and supports in the community, and shift towards paying for value