Behavioral Health Partnership Oversight Council

Adult Quality, Access & Policy Committee

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Co-Chairs: Howard Drescher, Heather Gates, Alicia Woodsby

Meeting Summary
Tuesday May 1, 2012
2:30 – 4:30 p.m.
Value Options
500 Enterprise Drive, 4th Floor Huntington Conference Room
Rocky Hill, CT

Next Meeting: Tuesday June 5, 2012 @ 2:30 PM at Value Options, Rocky Hill

Attendees: Co-Chair Howard Drescher, Co-Chair Heather Gates, Co-Chair Alicia Woodsby, Sheila Amdur, Teodoro Anderson-Diaz, Jill Benson, Alyse Chin, Elizabeth Collins, Susan Coogan, Marilyn Cormack, Letha Deck, Kate Galambos, Terri DiPietro, Ronald Fleming, Sara Frankel, Bill Halsey, Colleen Harrington, Juan Hernandez, Charles Herrick, Jennifer Hutchinson, Colleen Kearney, Sabina Lim, Steven Moore, Marie Mormile-Mehler, Mary Anne O'Neill, Ann Phelan, Kelly Phenix, James Pisciotta, Debra Struzinski, Hillary Teed, and Laurie Van Der Heide

Opening Remarks and Introductions

Co-Chair Heather Gates commenced the meeting by welcoming everyone and introductions were made.

DSS Presentation on Medicare/Medicaid Eligibles Integrated Care Initiative


Microsoft Word Document


Microsoft PowerPoint Presentation

Kate McEvoy form DSS presented an overview on Health Neighborhoods otherwise known as the Medicare/Medicaid Eligibles (MME) Integrated Care Initiative. She said that individuals have historic barriers in accessing care and the **"Triple Aim"** of this program is to:

- Improve the health of the population
- Enhance the individual's experience of care (quality, accessibility, reliability)
- Control the rate of increase in, and where possible reduce, the per capita cost of care

There are several State models of care, most notably, North Carolina's 646 Demonstration program based on a physician/hospital integrated care and pay-for-performance initiative, which has had good success **Goals** of this Program: Through the Medicare Medicaid Eligibles (MME) Initiative, stakeholders and the Department of Social Services seek to create and reward innovative local systems of care and supports that provide better value over time by:

- Integrating medical, behavioral, and non-medical services and supports
  - Intensive care management
  - Contracts and care coordination
  - Electric communication tools and utilization data
- Providing financial incentives to achieve identified health and client satisfaction outcomes

The Profile of the CT Population to be served is based on 57,569 people who are MMEs with complex, co-occurring health conditions:

- Roughly 88% of individuals age 65 and older have at least one chronic disease, and 42% has three or more chronic diseases
- 58% of younger individuals with disabilities have at least one chronic disease
- 38% have a serious mental illness (SMI)
- Connecticut MMEs use a disproportionate amount of Medicaid resources and Connecticut is spending much more than the national average on MMEs
  - The 57,569 MMEs eligible for the Demonstration represent less than 10% of Connecticut Medicaid beneficiaries yet they account for 38% of all Medicaid expenditures
  - Per capita Connecticut Medicaid spending for the 32,583 MMEs age 65 and over and the 24,986 MMEs with disabilities under age 65 is 55% higher than the national average

- Comparatively high spending alone on MMEs has not resulted in better health outcomes, better access or improved care experience
  - Illustratively, in SFY'10 almost 29% of MMEs were re-hospitalized within 30 days following a discharge, and almost 10% were re-hospitalized within 7 days following a discharge
  - MMEs have reported Demonstration-related focus groups that they have trouble finding doctors and specialists that will accept Medicare

and Medicaid, and often do not feel that the doctor takes a holistic approach to their needs

The question was asked, where are the MME population getting primary care? Kate answered, of the 19-64 year olds, 62% from a Primary Care Physician, 22% from outpatient services, 5% from hospitals, and 11% had no identifiable source of a PCP.

Structure

- CMS model alternatives:
  - CMS has permitted States to choose between two financial alignment models in support of integrating care for Medicare-Medicaid enrollees:
    - A Capitated Approach
    - A Managed Fee-For-Service (FFS) Approach
  - Connecticut has selected the FFS Approach
- Connecticut's Demonstration will feature three key elements:
  - An enhanced ASO model
  - Expansion of the Person Centered Medical Home (PCMH) pilot to serve MMEs
  - Procurement of 3-5 "Health Neighborhoods" (HNs)
- Enhanced ASO Model
  - Under the Demonstration, the ASO will address the need for more coordination in providing services and supports, through such means as:
    - Integration of Medicaid and Medicare data
    - Predictive modeling
    - Intensive Care Management (ICM)
    - Electronic tools to enable communication and use of data
- Expansion of PCMH pilot to serve MMEs
  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs (This should help divert people from going to the EDs for care.)
- Procurement of 3-5 "Health Neighborhoods" (HNs)
  - HNs will reflect local systems of care and support and will be rewarded for providing better value over time
  - HNs will be comprised of a broad array of providers, including primary care and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, and pharmacists
  - Each HN will identify a "Lead Agency" and also a "BH Lead Agency" that will provide administrative oversight, performance monitoring, coordination of provider members, identification of the means through which ICM and care coordination will be provided, and distribution of shared savings

The Beneficiary's Perspective

- Advantages of joining a Health Neighborhood (HN)

- HN will integrate Medicare and Medicaid benefits, including medical, behavioral and non-medical supports
- HN will use a person-and family centered, personalized, team-based approach that is consistent with the MME's needs and preferences
  - MME will select his/her preferred care coordinator
  - A consistent team of providers will support the MME and his or her family member/caregiver in planning and coordinating care
- HN will provide specialized supports to identified populations (e.g. individuals with serious and persistent mental illness, individuals with developmental disabilities)
- HN will provide additional benefits and services:
  - Chronic illness self-mangement education
  - Nutrition counseling
  - Falls prevention Medication therapy management

Who Will Benefit

An older adult with COPD who lives alone and who has experienced multiple unexplained falls and associated hospitalizations within the past six months will be able to work with her waiver care manger and a team of providers (e.g. primary care physician, cardiologist, pharmacist, home health nurse and OT) to examine the reasons for the falls and implement interventions that will reduce or eliminate her need to go to the hospital.

A younger individual with diabetes and bipolar disorder will be able to enlist his behavioral health care manager and a multi-disciplinary team to work on strategies for understanding his conditions and effectively manage them.

Providers that have historically had few opportunities and tools to do so will have the means and opportunity to be in direct contact and to collaborate.

The Next Steps

- The draft application has been posted on both the MAPOC and DSS website: http://www.ct.gov/dss/cwp/view.asp?a=2345&pm-1&Q503056
- A 30-day comment period commenced on Wednesday, April 25 – the Department will review and inventory comments
- The Department plans to submit the final application on or about May 29, 2012

Discussion

There was discussion on sharing net savings with providers. Sheila Amdur said no programs in the country have shown any savings in the first year. After the first year, if there are savings, they should be distributed evenly to all of the providers and after two years, bonuses should be provided based on additional factors. In order to share in the savings, providers must reach performance measures. Kate said that participants in the demonstration can go out of network for care but ultimately, the network is still responsible for care. A discussion ensued regarding the new and last minute developments in the proposal that include the addition of a behavioral health co-lead, and the intention to potentially expand the program to single-eligible Medicaid individuals and convert APM II

payments to Health Home coverage option. Implications for the Health Home planning process were discussed.

Update on Health Homes

Adobe Acrobat Document

Jennifer Hutchinson of DMHAS gave a presentation on Health Homes and passed out a chronological timeline that the Department has developed for the process (attached). She said that a lot more work needs to be done and so far, a lot of work has been done in a very short time. It is a work in progress. Sheila replied that the process has been extraordinary inclusive with regard to the Health Neighborhoods application. Sheila Amdur, Jen, and Heather all agreed that a special work group needs to convene with DMHAS, the MAPOC Complex Care Committee and the BHP OC Adult Quality, Access & Policy Committee to work discuss mutual interests in the design plan process and the recent developments in the Health Neighborhood application. After a discussion, it was decided this meeting will take place on Tuesday, May 8, 2012 at VO on the 4th Floor in the Crandall Room. Co-Chair Howard Drescher said that the Adult QAP Committee will keep up with the outcome of this new work group and will give Health Homes a high priority for its agenda. Co-Chair Alicia Woodsby wanted to clarify the apparent difference in views between DSS and DMHAS on Health Homes as simply a Financing Mechanism vs. a Quality Care Coordination Model/Program for Mediciaid clients.

New Business and Announcements

Hearing no new policy items, Co-Chair Alicia Woodsby adjourned the meeting at 4:29 PM.

Next Meeting: Tuesday June 5, 2012 @ 2:30 PM at Value Options, Rocky Hill