Integrated Care Demonstration for Medicare/Medicaid Eligibles

Presentation to the Behavioral Health Partnership Oversight Council

May 9, 2012

Today's Agenda

- Context
  - Centers for Medicare and Medicaid (CMS) Triple Aim
  - CMS integrated care and shared savings initiatives
  - Connecticut Medicaid reforms
- Key features of Integrated Care Demonstration
  - Goals
  - Profile of population to be served
  - Structure
- The beneficiary's perspective

Context

Centers for Medicare and Medicaid (CMS) “Triple Aim”:

- 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

Context

CMS coordinated care initiatives

- Medicare Advantage (MA) plans (capitated)
- Physician Group Practice (PGP) Demonstration

  first CMS pay-for-performance initiative that encouraged physicians to coordinate overall care delivered to Medicare beneficiaries
- 646 Demonstrations (e.g. North Carolina)

  physician/hospital integrated care and pay-for-performance initiative

Context

CMS shared savings initiatives

Model	Performance Incentives
Accountable Care Organization (ACO)	▪**Medicare** savings are shared with MDs and key partners ▪CMS defines value through performance measures ▪Mandatory enrollment (attribution)
Comprehensive Primary Care Initiative	▪**Medicare** savings are shared with MDs only ▪CMS defines value ▪Mandatory enrollment (attribution)
Connecticut's proposed model for Integrated Care Demonstration	•**Net Medicare/Medicaid** savings will be shared with MDs and broad array of providers •CT stakeholders define value •Passive enrollment with opt-out

Context

Connecticut Medicaid reforms:

- **Transition to ASO:** Effective January 1, 2012, Medicaid medical services were transitioned to an Administrative Services Organization (ASO), CHN-CT
  - Member support
  - Utilization management
  - Intensive Care Management (ICM)
  - Predictive modeling based on Medicaid data
  - Quality management

Context

Connecticut Medicaid reforms:

- **Launch of Person-Centered Medical Home (PCMH) pilot:** Effective January 1, 2012, the Department implemented a PCMH pilot to support primary care practices along a developmental curve toward certification under NCQA standards
  - Enhanced reimbursement and technical assistance to support practice transformation
  - Performance payments for achieving benchmarks on identified measures

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Goals

Through the Medicare Medicaid Eligibles (MME) Initiative, stakeholders and the Department 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
  - electronic communication tools and utilization data
- providing financial incentives to achieve identified health and client satisfaction outcomes

Profile of population to be served

- Connecticut MMEs have complex, co-occurring health conditions
  - roughly 88% of individuals age 65 and older has at least one chronic disease, and 42% has three or more chronic diseases
  - 58% of younger individuals with disabilities has at least one chronic disease
  - 38% has a serious mental illness (SMI)

Profile of population to be served (cont.)

- Connecticut MMEs use a disproportionate amount of Medicaid resources and Connecticut is spending much more than the national average on MMEs
  - the 57,568 MMEs eligible for the Demonstration represent less than 10% of Connecticut Medicaid beneficiaries yet they account for 38% of all Medicaid expenditures

Profile of population to be served (cont.)

- 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**

Profile of population to be served (cont.)

- 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

Profile of population to be served (cont.)

- MMEs have reported in 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

Profile of population to be served (cont.)

- Where MMEs with SMI get their primary care can inform decisions about model design and care coordination:
  - 62% from a general practitioner
  - 26% from an outpatient clinic
  - 7% from a psychiatrist
  - 2% from a multi-specialty clinic
  - Less than 1% from a geriatrician
  - 3% have no identified source of primary care

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

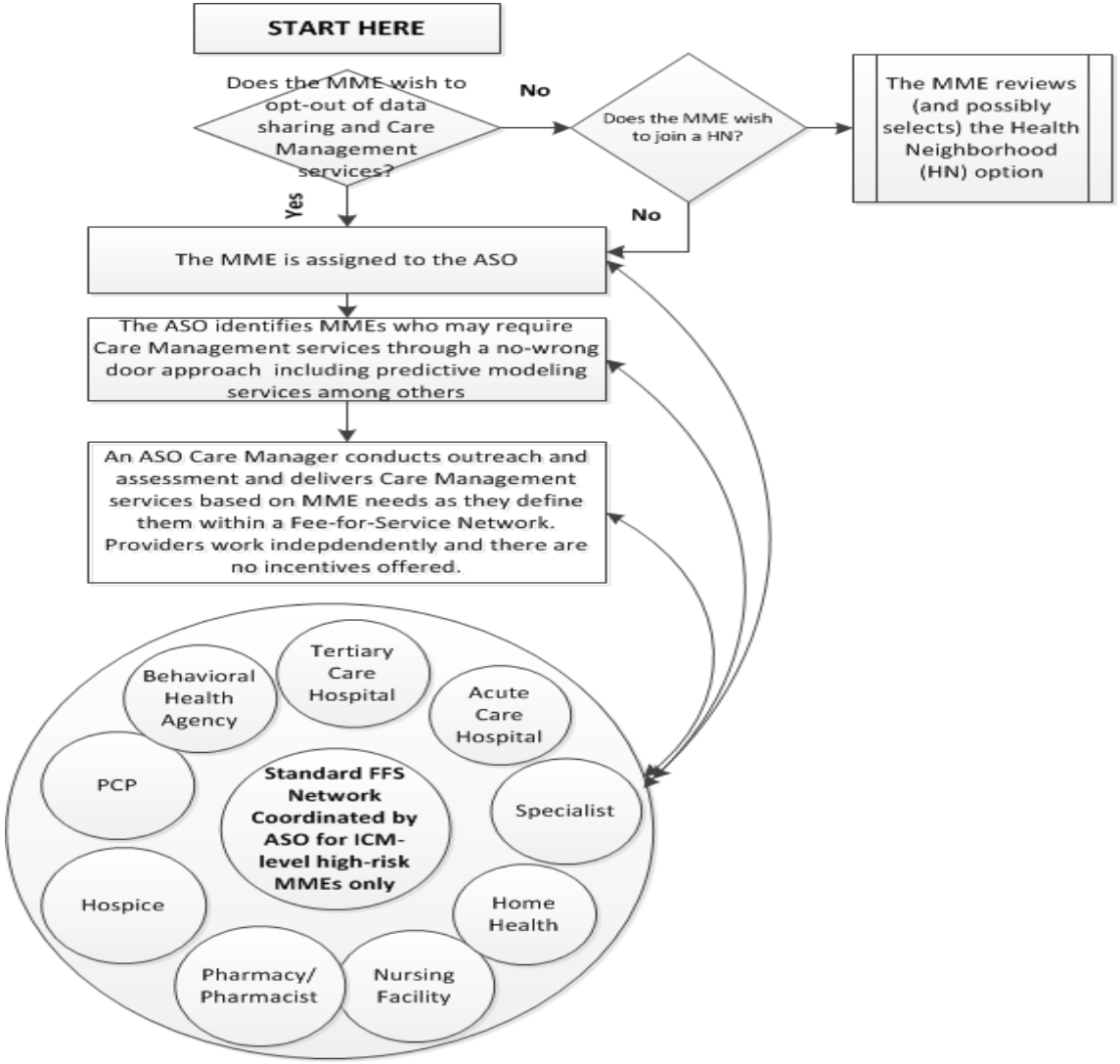
Structure (cont.)

- 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)

Structure (cont.)

- Enhanced ASO Model
  - Under the Demonstration, the ASO will address the need for more coordination in providing services and supports, through such means as:
    - Member services
    - ~~Utilization management~~
    - Predictive modeling based on Medicare data
    - Intensive Care Management (ICM)
    - Quality management
    - Integration of Medicaid and Medicare data
    - Electronic tools to enable communication and use of data

ASO Option


START HERE
Does the MME wish to opt-out of data sharing and Care Management services?
No
Does the MME wish to join a HN?
The MME reviews (and possibly selects) the Health Neighborhood (HN) option
Yes
No
The MME is assigned to the ASO
The ASO identifies MMEs who may require Care Management services through a no-wrong door approach including predictive modeling services among others
An ASO Care Manager conducts outreach and assessment and delivers Care Management services based on MME needs as they define them within a Fee-for-Service Network. Providers work indepdendently and there are no incentives offered.
Behavioral Health Agency
Tertiary Care Hospital
Acute Care Hospital
PCP
Standard FFS Network Coordinated by ASO for ICM-level high-risk MMEs only
Specialist
Hospice
Home Health
Pharmacy/ Pharmacist
Nursing Facility

Structure (cont.)

- 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

Structure (cont.)

- 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

Health Neighborhood Option

Health Neighborhood (HN) Option

The MME reviews (and possibly selects) the ASO option

No

Does the MME wish to select a HN?

Yes

The MME selects a HN to receive integrated Medicaid and Medicare services as well as Care Management and other value-added demonstration services

The MME selects a Care Manager from the HN Team. The Team assesses the MME and provides appropriate Care Management* services based on MME needs, as they define them, across the entire continuum of Medicaid and Medicare services including medical, behavioral and support services.

* Care Management includes periodic assistance (low-risk), intermittent support (moderate risk) and intensive support for individuals at high-risk.
** LTC Care Coordinator must have

Structure (cont.)

- Each HN will identify a “Lead Agency” and 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
- Clients will be attributed to the HN based upon previous medical and behavioral health service usage and their preferences (choice)
- HN can begin to build infrastructure for a future Health Home Model for all Medicaid eligibles including those living outside the HN geography

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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

The Beneficiary's Perspective

Advantages of joining a HN (cont.)

- HN will provide specialized supports to identified populations (e.g. individuals with serious and persistent mental illness, individuals with developmental disabilities)
- HNs may provide additional benefits and services:
  - Care Coordination in the community
  - Chronic illness self-management education
  - Nutrition counseling
  - Falls prevention
  - Medication therapy management
  - Recovery Assistance
  - Peer support/health navigation

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 manager 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.

Who will benefit?

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 managing them.

Who will benefit?

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

Next steps . . .

- The draft application has been posted on both the MAPOC and DSS web sites

  http://www.ct.gov/dss/cwp/view.asp?a=2345&pm=1&Q=503056

- 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