Behavioral Health Partnership Council
March 13, 2013

Connecticut Department of Social Services

Making a Difference

Connecticut Medicaid and Health Care Reform:

Where are we now?

Where are we going?

Where are we now?

- A snapshot of the program
- Transition to medical Administrative Services Organization (ASO)
- Projects related to primary preventative care
- Projects related to integration of care
- Rebalancing

A Snapshot of the Program: Participation

- Overall, Medicaid currently serves **615,641** beneficiaries (**20%** of the state population)
  - **428,869** HUSKY A adults and children
  - **96,423** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **87,931** HUSKY D low-income adults age 19-64
  - **2,418** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

A Snapshot of the Program: Costs in Context

Connecticut has:

- the fourth highest level of health care expenditures at $8,654 per capita, behind only the District of Columbia, Massachusetts, and Alaska
- the ninth highest level of Medicare costs at $11,086 per enrollee
- the highest level of Medicaid costs at $9,577 per enrollee

[Kaiser State Health Facts, 2009 data]

A Snapshot of the Program: Costs in Context (cont.)

- Among populations in need, the cost profile for Connecticut individuals who are dually eligible for Medicare and Medicaid is of particular concern, with per capita costs exceeding the national average by 55%

A Snapshot of the Program: Reimbursement

- Based on 2008 data, Kaiser State Health Facts indicate that Connecticut's overall Medicaid-to-Medicare fee index in 2008 was 0.99
- This is strongly influenced by favorable rates for obstetrics

	All Services	Primary Care	Obstetric Care	Other Services
U.S.	0.72	0.66	0.93	0.72
CT	0.99	0.78	1.74	0.59

Transition to Medical Administrative Services Organization (ASO)

- Member services
- Provider services
- Predictive modeling/Intensive Care Management (ICM)
- Administrative: Performance measures, reporting, rate melds

Transition to Medical ASO: Member Services

- Centralization of member services with CHN-CT has enabled streamlined support with:
  - Referral to primary care physicians
  - Referral to specialists
  - Assistance with prior authorization requirements and coverage questions

Transition to Medical ASO: Provider Services

- Centralization of provider services with CHN-CT has improved support with:
  - Prior authorization requirements
  - Coverage questions
  - Referrals

Transition to Medical ASO: Predictive Modeling/Intensive Care Management

- Predictive modeling tools and other referral means (e.g. self-report, provider referrals) enable CHN-CT to identify those beneficiaries most in need of care management support

- Through Intensive Care Management (ICM), CHN-CT nurse care managers use a specially developed care coordination tool to work with beneficiaries to set goals and address needs

Transition to Medical ASO: Administrative

- DSS' contract with CHN-CT includes a performance withhold that will be paid based on a range of measures related to health outcomes as well as beneficiary and provider satisfaction with CHN-CT
- CHN-CT is at an advanced stage of preparing a series of reports that will illustrate performance
- DSS is in process of completing the rate "melds" that were required in transition from Medicaid MCOs

Transition to Medical ASO

- Consistent with use of ASOs for behavioral health (Value Options) and dental (BeneCare)
- Furthered by transition to ASO for Non-Emergency Medical Transportation (NEMT)(Logisticare)

Projects Related to Primary Preventative Care

- Person-centered medical home (PCMH)
- Electronic Health Records (EHR)
- Rewards to Quit
- Health Disparities Grant

Projects Related to Primary Preventative Care

Why are we focusing here?

Adults do 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 receiving recommended care. [Commonwealth Fund, 2009]

Projects Related to Primary Preventative Care

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]

Person Centered Medical Home (PCMH) Defined

A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

NCQA

DSS PCMH Initiative: Overview

- implemented January 1, 2012
- an investment of financial and technical resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA)

DSS PCMH Initiative: Financial Model

- financial assistance to NCQA-recognized practices includes advance payments, enhanced fee-for-service payments and retrospective payments for meeting benchmarks on quality measures

DSS PCMH Initiative: Key Features

- key features of transformation include helping practices to:
  - enhance their medical care coordination functions
  - Increase capacity for non face-to-face and after hours support for patients
  - work towards meaningful use of interoperable electronic health records

DSS PCMH Initiative: Participation

Approved PCMH Practices	=	18
Total # of PCMH Sites	=	96
Total # of PCMH Providers	=	386

According to past claim history, these PCMH sites served over 100,000 Medicaid members.

DSS PCMH Initiative: First Steps Toward Multi-Payer Approach

- PCMH is a meaningful example of efforts in support of a multi-payer approach
- DSS PCMH uses the same core measures of success and similar payment strategies to those being used by the Office of the State Comptroller State Employee Health Plan PCMH
- This helps providers engage with private payers

Electronic Health Record (EHR)

- another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR

- DSS is also collaborating with UConn Health Center to administer the Medicaid EHR Incentive Program and to improve outreach and education to providers

Electronic Health Record (EHR)

- incentive payments disbursed to date (September, 2011 to October, 2012):
  - $18,642,346 to 929 eligible professionals

    "Eligible professionals" include physicians, physician assistants, nurse practitioners, certified nurse-midwives, dentists

  - $22,268,898 to 25 eligible hospitals

Rewards to Quit (R2Q)

- five-year federal grant of up to $10 million
- tobacco cessation program
- smokers and their providers will engage in counseling and training sessions, peer coaching and other smoking-cessation techniques
- participants will receive financial incentives for achieving various milestones toward quitting

Health Disparities

- Through generous funding from the Connecticut Health Foundation, DSS and its partner CHN-CT have the opportunity to examine access barriers related to gender, race and ethnicity faced by Medicaid beneficiaries

- This project is focusing on identifying disparities and equipping primary care practices with tools and strategies to reduce these barriers

Health Disparities

- 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

Projects Related to Integration of Care

- Demonstration to Integrate Care for Dually Eligible Individuals
- Health Home

Projects Related to Integration of Care

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.

Duals Demonstration: Overview

Through the Demonstration, 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
- providing financial incentives to achieve identified health and client satisfaction outcomes

Duals Demonstration: Overview (cont.)

- Connecticut's Demonstration will feature two models:
  - An enhanced Administrative Services Organization (ASO) model (Model 1)
  - A "health neighborhood" model (Model 2)

Duals Demonstration: Key Structural Features

- Enhanced Administrative Services Organization (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

Duals Demonstration: Key Structural Features (cont.)

- Expansion of Person-Centered Medical Homes (PCMH) pilot to serve dual eligible individuals (“MMEs”)
  - Under the Demonstration, the Department will extend the enhanced reimbursement and performance payments to primary care practices that serve MMEs

Duals Demonstration: Key Structural Features (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, long-term services and supports providers, hospitals, nursing facilities, home health providers, and pharmacists

Duals Demonstration: Past Activities

- The Department submitted the final application to CMMI on May 31, 2012
- Final submission reflected revisions related to feedback received during the thirty-day public comment period
- Application is posted on Department's web site:

http://www.ct.gov/dss/lib/dss/pdfs/mmedemo.pdf

Duals Demonstration: Past Activities (cont.)

- The Department mapped best practices associated with other integrated care initiatives and produced white papers on:
  - care coordination
  - structure of provider networks
  - performance measures

Duals Demonstration: Past Activities (cont.)

- Further, the Complex Care Committee heard presentations from Connecticut stakeholders on existing models of care coordination (medical and behavioral health ASOs, Access Agencies, behavioral health partnerships), as well as coordination of providers across disciplines

Duals Demonstration: Current Activities

- The Department and its state agency partners (DMHAS, DDS) are in process of drafting an operations plan for the proposed “health neighborhoods,” three to five of which are expected to be procured by RFP in 2013

Duals Demonstration: Current Activities (cont.)

- CMS and DSS must determine the most appropriate legal authorities under which to operate the demonstration

- CMS has forwarded questions regarding Connecticut's application and DSS has drafted responses for review by the Complex Care Committee

Duals Demonstration: Procedural Update

- CMS recently issued additional guidance for implementation funding
- Each of the 15 states that received planning grants is being asked to submit an additional application detailing plans for implementation activities
- Connecticut will submit this April 1

Duals Demonstration: Procedural Update (cont.)

- Implementation funding will be based on a reserved pool of $95 million

- Application instructions are available at this link:

http://apply07.grants.gov/apply/opportunities/instructions/oppCMS-1I1-13-001-cfda93.628-cidCMS-1I1-13-001-016200-instructions.pdf

Duals Demonstration: Procedural Update (cont.)

- Note that the Demonstration project is distinguishable from the “health home” project, planning for which is being led by the Department of Mental Health and Addiction Services (DMHAS)

Health Home: Overview

- ACA 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 Home: Eligibility

- To be eligible for the health home option, beneficiaries must have:
  - two or more chronic conditions
  - one chronic condition and risk of developing a second or
  - a serious and persistent mental health condition
- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

Health Home: Design Considerations

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify
- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

Health Home: Connecticut Activity

- DMHAS has been partnering with a work group of the CT Behavioral Health Partnership Oversight Council (BHP) since enactment of the ACA health home option to assess how this model could be implemented in support of the needs of individuals with Serious and Persistent Mental Illness (SPMI)

Health Home: Proposed Connecticut Approach

Elect health home funding outside the context of the duals demonstration and implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI)

Comparison of Health Neighborhood and Health Home Models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports	Teams will be based at behavioral health care providers and will include staff with primary care expertise
Population served	Minimum of 5,000 dually-eligible individuals	Smaller scale, targeted for individuals with Serious and Persistent Mental Illness (SPMI), both dually-eligible and single-eligible individuals
Care Coordination	Multi-disciplinary care team, PMPM to support costs of care coordination and supplemental services	Health home care team, PMPM to support costs of care coordination

Rebalancing

- Money Follows the Person (MFP)
- Nursing Home Transformation/Workforce Initiative
- “My Place” campaign
- State Balancing Incentive Payments Program (BIPP)

Projects Related to Rebalancing

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 2011:
  - 54% of long-term care clients received care in the community
  - 40% of spending supported home and community-based care

Projects Related to Rebalancing

Why are we focusing here (cont.)?

- Further, only 7% of the Medicaid population receives long-term services and supports (LTSS) but 61% ($2.863 billion) of the SFY'12 Medicaid expenditures ($4.714 billion) were made on the behalf of these beneficiaries

Money Follows the Person: Overview

- a partnership with the federal government under which federal grant funds are used to assist individuals in transitioning from institutional settings back to community-based living

- implemented in December, 2008 and significantly expanded over time

Money Follows the Person: Overview (cont.)

- intended to increase use of home and community-based services, eliminate barriers to flexible use of Medicaid dollars, and assure continued access to services once transition is complete

- enhanced federal support to assist individuals with costs of transition (e.g. security deposits, assistive technology)

Money Follows the Person: Overview (cont.)

- not intended to be a long-term source of payment
- after one year of transition support, participants must be served, ongoing, through the Medicaid LTSS system
- over 1,200 individuals have been successfully transitioned to date

Nursing Home Transformation/Workforce Development

- strategic rebalancing plan
- $21 million in grants over a five-year period to nursing facilities in support of diversifying their services to include home and community-based services
- must be based on local needs and must be done in collaboration with local governments

“My Place” Campaign

- My home
- My role in person-centered care planning
- My role as a caregiver

State Balancing Incentive Payments Program (BIPP): Overview

- effective October 1, 2011 through September 30, 2015, CMS will offer enhanced Federal Medical Assistance Payments (FMAP) to states that agree to increase the proportion of Medicaid spending on home and community-based services (HCBS)

State Balancing Incentive Payments Program (BIPP): Overview

- Connecticut submitted application October 31, 2012
- Connecticut's award will be $72.7 million

State Balancing Incentive Payments Program (BIPP): Requirements

- BIPP requires that states:
  - in which 25% or greater of Medicaid spending is on HCBS (as opposed to institutionally-based long-term care) commit to increase that percentage to a target of 50% by September 14, 2015; and

State Balancing Incentive Payments Program (BIPP): Requirements (cont.)

- within six month of applying, have implemented the following:
  - a “no-wrong door single entry point system” to facilitate consumer access to information on LTC services and to assess their financial and functional eligibility for available programs

State Balancing Incentive Payments Program (BIPP): Requirements (cont.)

- "conflict-free" case management (e.g. of the kind provided by the Access Agencies for the Connecticut Home Care Program for Elders; neutral in relationship to providers)
- a core, statewide, standardized assessment instrument

Where are we going, 2013?

- 2013 Affordable Care Act (ACA) mandatory provisions:
  - Primary care rate increases
  - Reduction in Disproportionate Share Payments (DSH)
- 2013 ACA optional provisions:
  - Medicaid preventative services

2013 ACA Mandatory Provisions: Primary Care Rate Increases

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)

- Final federal rule issued November 2, 2012

2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine

- certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment

2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician

2013 ACA Mandatory Provisions: Reduction in DSH Payments

- Effective October 1, 2013, ACA reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires CMS to develop a methodology for distributing the DSH reductions

2013 ACA Optional Provisions: Medicaid Preventative Services

- Effective January 1, 2013, ACA provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations

2013 ACA Optional Provisions: Medicaid Preventative Services

- Connecticut already the bulk of the listed preventative services and will be seeking the enhanced federal match for these

Where are we going, 2014?

- 2014 ACA mandatory provisions:
  - Coverage
  - Plan requirements
  - Health exchange related activities: web site, Navigator program, integrated eligibility determination
- 2014 ACA optional provisions:
  - Eligibility expansion

2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA:
  - Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions)

2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA (cont.):
  - Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals
    - Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges
    - Cost sharing subsidies are available to those with incomes up to 250% of the poverty level

2014 ACA Mandatory Provisions: Plan Requirements

- Effective January 1, 2014, ACA :
  - Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges
  - Prohibits annual limits on the dollar value of coverage

2014 ACA Mandatory Provisions: Exchange-related activities

- Effective January 1, 2014, ACA :
  - Requires states to operate an Internet website that links the Exchange, Medicaid, and Childrens Health Insurance Plan (CHIP) and permits individuals to compare available health subsidy programs and apply for or renew such coverage

2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires CMS to develop a single, streamlined form (paper and online application) that states can use for all those applying on the basis of income to applicable State health subsidy programs (e.g. premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and state qualified basic health plans)

2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires state Exchanges to establish "Navigator" and "In-Person Assistor" supports to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints

2014 ACA Mandatory Provisions: Eligibility Determination

- Effective January 1, 2014, ACA requires states to remove asset tests and to use modified adjusted gross income (MAGI) for purposes of Medicaid/CHIP eligibility determination for parents, pregnant women and other non-elderly adults as well as children

2014 ACA Mandatory Provisions: Connecticut Plans

- A “no wrong door” approach to the citizen web portal that will provide access to Health Insurance Exchange services as well as to non-MAGI Medicaid, SNAP, and Temporary Assistance to Needy Families (TANF)-related services and data

2014 ACA Mandatory Provisions: Connecticut Plans (cont.)

- A single shared eligibility service that will be used by both the Exchange and DSS to determine eligibility for Medicaid, CHIP, Advance Premium Tax Credits & Cost Sharing Reductions (APTC/CSR), as well as non-health public assistance programs such as SNAP and TANF

2014 ACA Optional Provisions: Medicaid Expansion

- Effective January 1, 2014, ACA as enacted required states to expand Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL

2014 ACA Optional Provisions: Medicaid Expansion

- Note that Connecticut currently meets or exceeds this requirement through HUSKY A and B for all of these groups with the exception of childless adults

- Childless adults age 19-64 are currently covered under HUSKY D (the Medicaid for Low-Income Adults (MLIA) program) up to an income limit of 55% of FPL*

- 87,931 beneficiaries are currently being served by MLIA

* for regions B & C; 67% of FPL for region A

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- This expansion in coverage will be associated with enhanced federal match funds:
  - 100% match for calendar years 2014 through 2016
  - 95% match for calendar year 2017
  - 94% match for calendar year 2018
  - 93% match for calendar year 2019
  - 90% match for calendar years 2020 and ongoing

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

On June 28, 2012, the Supreme Court issued a decision in a challenge to the constitutionality of the ACA: National Federation of Independent Business, *et al* v. Sebelius, Secretary of Health and Human Services, *et al*

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

The Court:

- generally upheld the constitutionality of the law
- with respect to the mandate that States expand Medicaid coverage as described above held:

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- that while Congress acted constitutionally in offering federal match funds to states to expand coverage

- the provision that requires states to either expand coverage of forego all federal match funds for their Medicaid programs exceeded Congress' scope of authority under the Spending Clause of the Constitution

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- but, that this can be corrected by narrowly tailoring the expansion requirement to give states two options:
  - to accept federal match funds for expansion in compliance with the conditions associated with those funds; or
  - to refuse federal match funds for expansion and continue to operate their Medicaid programs as they do currently

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

How many individuals are likely to be eligible under the expansion?

- approximately 129,786 uninsured Connecticut residents have incomes of less than 139% FPL (note that the 87,931 MLIA beneficiaries are a subset of this figure)

[Kaiser Commission on Key Facts: How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage, July 2012]

And, planning ahead . . .

Planning Ahead: Connecticut State Innovation Model (SIM) Application

- Under the leadership of the Office of Health Care Reform and Innovation (OHRI), DSS joined a broad range of state agency partners and other stakeholders in mutually drafting an application seeking funding from CMS for formal health care reform planning efforts

- This application was submitted in September, 2012

State Innovation Model (SIM) Update

- On February 22nd, Lieutenant Governor Wyman announced that Connecticut has received notice from the Centers for Medicare and Medicaid Innovation (CMMI) of an award of up to **$2,852,335** to develop a State Health Care Innovation Plan.

State Innovation Model (SIM) Update (cont.)

- Connecticut will collaborate with public and private stakeholders to design a transformed health care delivery system that incorporates:
  - promotion of integrated care models
  - use of the Health Insurance Exchange to inform and connect consumers to coverage
  - expanded supply of primary care physicians and other professionals
  - increased engagement among regulators, providers and consumers

State Innovation Model (SIM) Update (cont.)

- The resulting payment and delivery system model will advance greater alignment across multiple payers on contracting and payment strategies that promote value over volume, greater consistency in quality and other performance metrics, and expanded primary care.

In conclusion . . .

- Connecticut Medicaid is already utilizing diverse strategies to support use of primary preventative care, integration of care, and rebalancing of long-term services and supports

- In collaboration with a broad range of state agency partners, DSS is partnering to plan for both mandatory and optional aspects of ACA implementation

Questions or comments?