CT Medicaid options for Medicare and Medicaid eligible individuals

Complex Care Committee, MAPOC
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Connecticut Health Policy Project

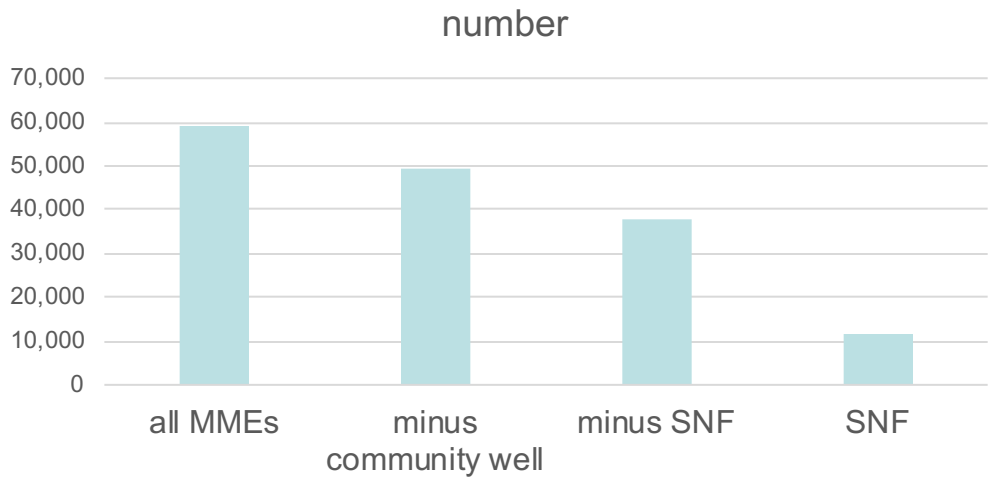
Agenda

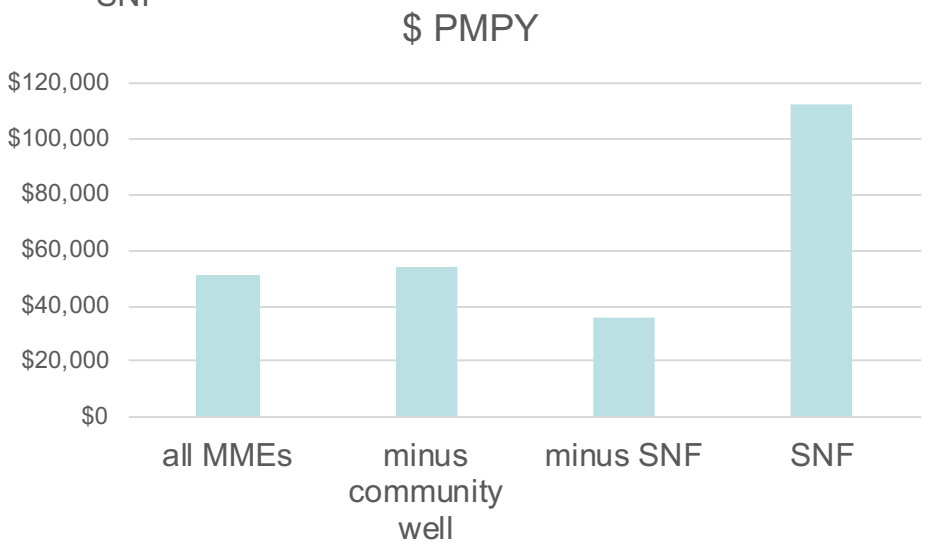
- CT dually eligible individuals' needs
- Federal options
- Other states' experience
- Health neighborhoods
- PCMH Plus
- Other resources

Jen analysis of CT dual eligibles

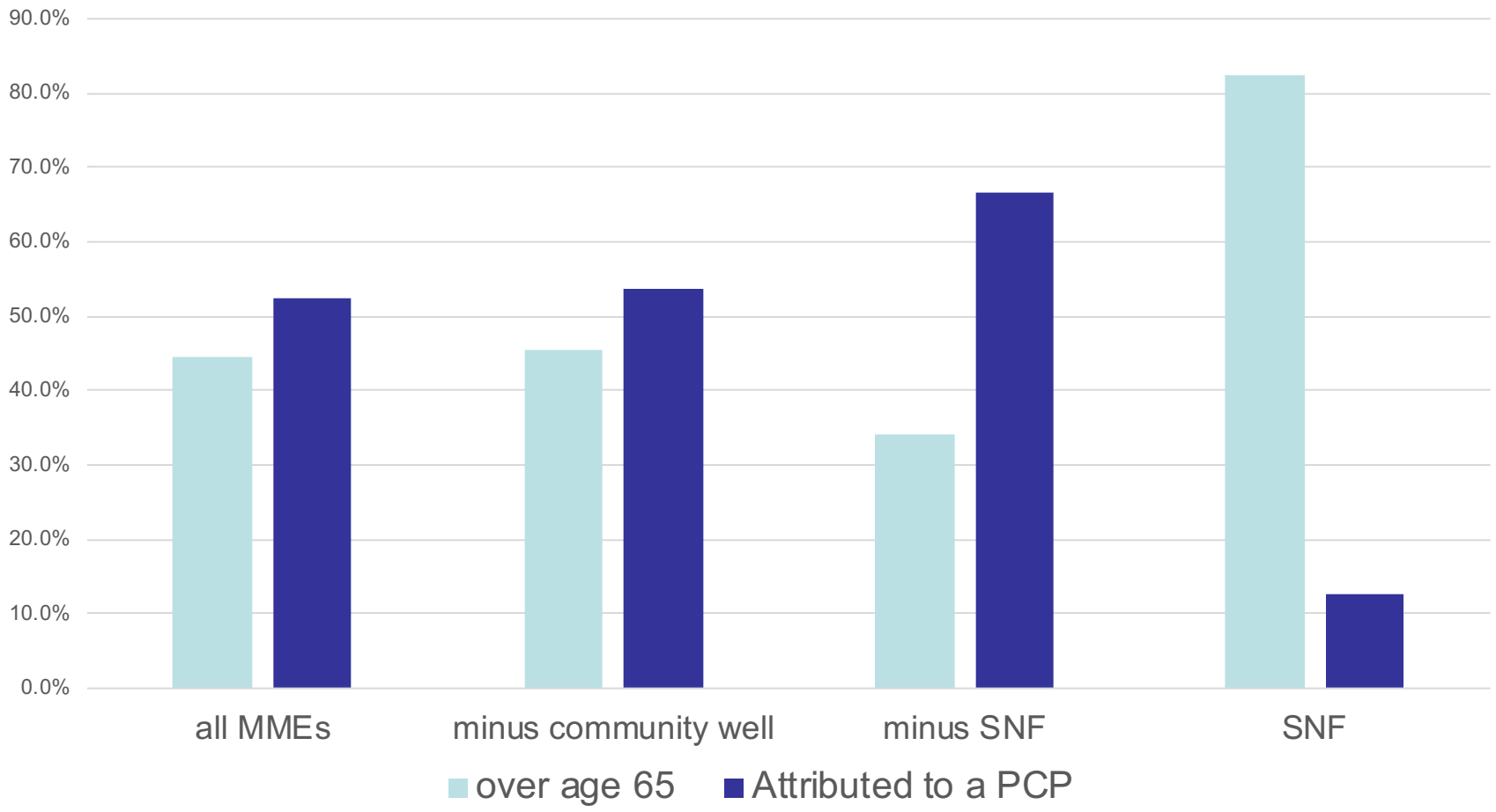
- CY 2013 data, reported to CC Comm 2015
- 58,864 individuals with full data, not excluded categories
- 4 populations
  - All dual eligibles
  - Minus community well members (84%)
  - Also minus SNF members (64%)
  - Just SNF members
- Includes both Medicare and Medicaid claims
- Includes pharmacy

Numbers, dollars

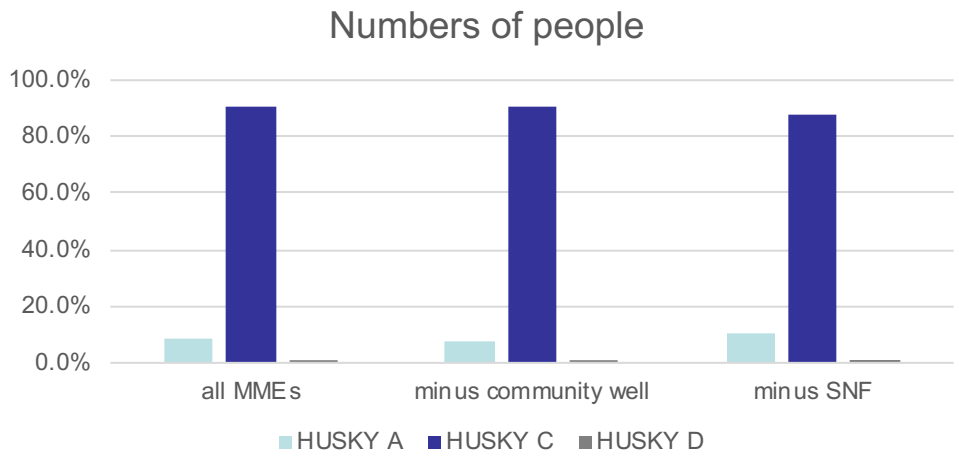


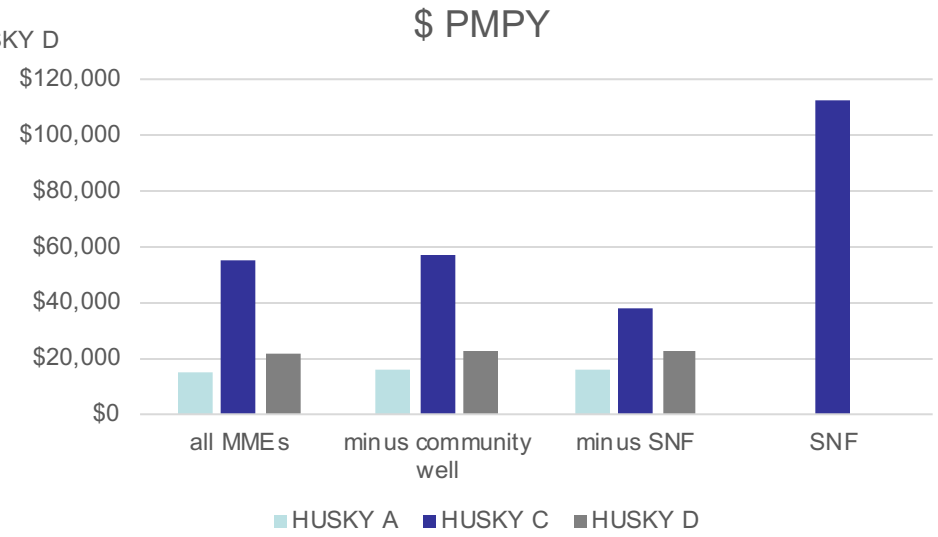


Age, PCP attribution

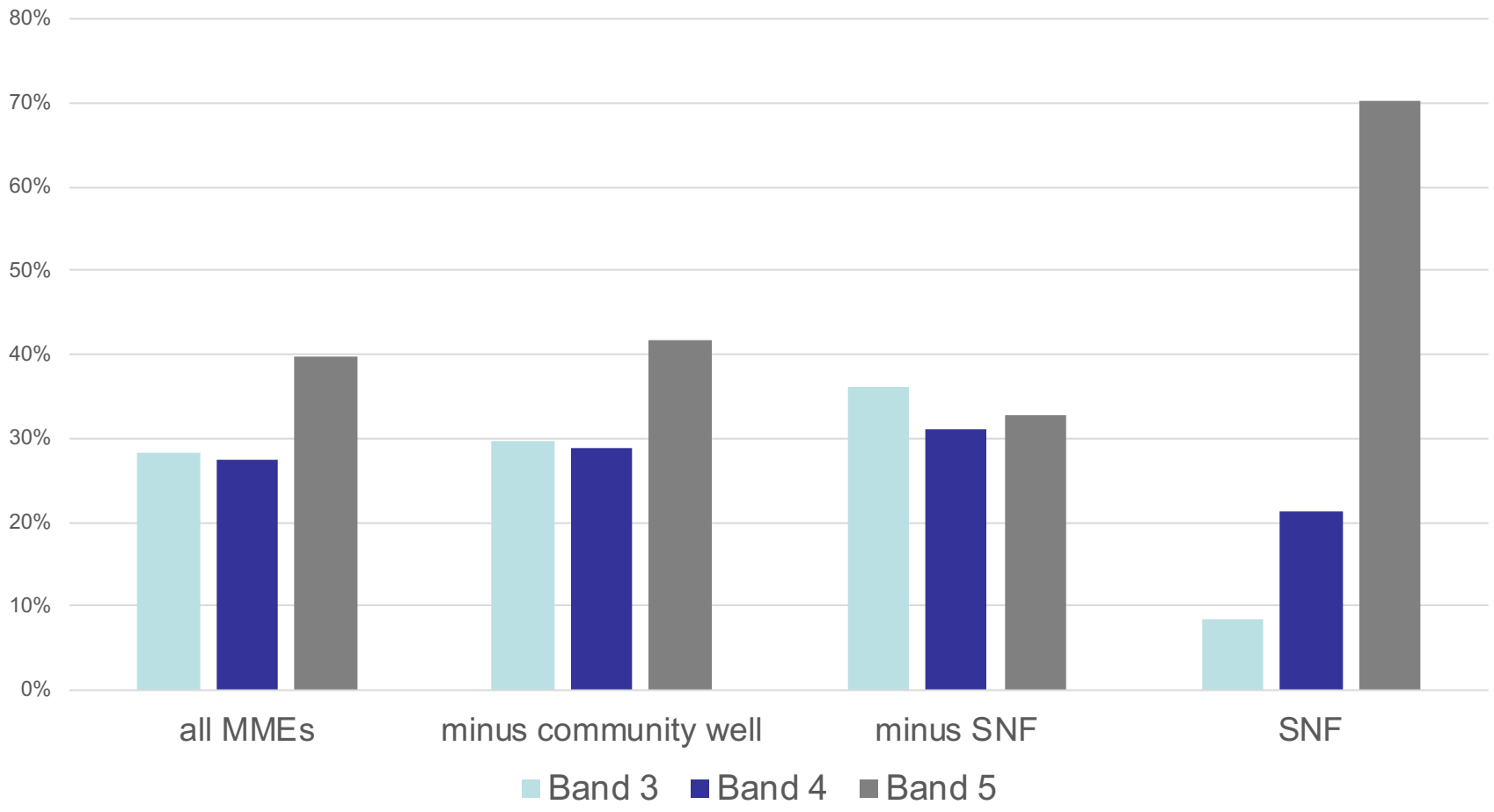


By eligibility





Percent by risk bands



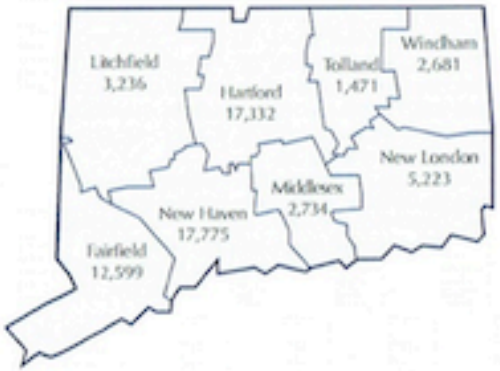
Top medical conditions

Hypertension
Musculoskeletal signs and symptoms, disorders, other
Lipid metabolism disorders
Depression
Anxiety, neuroses
Diabetes
Gastroesophageal reflux
Low back pain

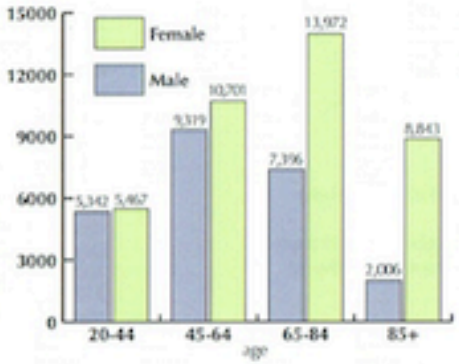
Connecticut Health Neighborhood Data
State Overview: 2013

powered by JEN associates

Eligible Population by County



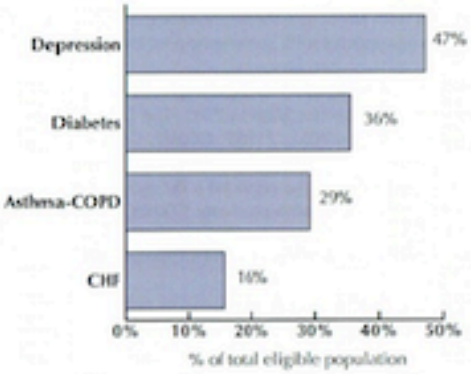
Age-Sex Distribution



Long Term Supports & Services

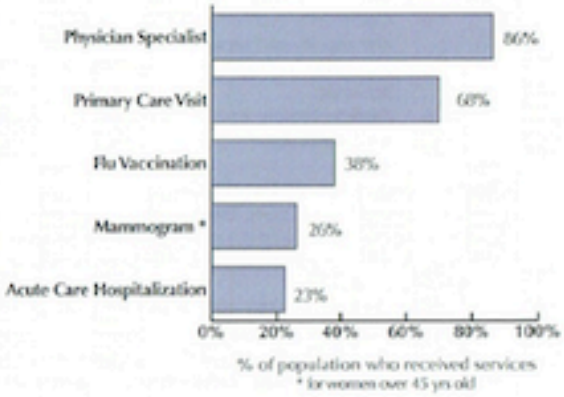
% of eligible population by use status

Select Chronic Conditions



Select Disabilities

Access to Care



Federal options

- State Medicaid Director letter April 2019
- “Today’s letter opens new ways to address [members’] complex needs, align incentives, encourage marketplace innovation through the private sector, lower costs, and reduce administrative burdens for dually eligible individuals and the providers who serve them.”
- Feds will share savings with states
- 3 options
  - Capitated Financial Alignment Model – three way contracts between state, CMS and MCOs, currently in 9 states
  - Integrating care through the managed fee-for-service model – WA, CO
  - New models for integration

Federal options

- Option 2 – Managed Fee for Service
- WA (promising) and CO (not working according to letter)
  - WA used health home authority, no state funding
  - CO added duals to existing managed fee-for-service ACO model, has ended
- Lesson learned – most effective if target highest risk members and high-intensity interventions
- CMS recognizes that retrospective shared savings may not work for state budgets that must be balanced, so want to engage with states

Federal options

- Option 3 – Test new state-developed models, come with our ideas, concept papers and/or proposals
- Can be broad or targeted, e.g. younger people with disabilities, rural areas, people using LTSS
- Important to address SDOH

Federal options

- Special interests:
  - Promote member empowerment and independence
  - Expand access to care coordination, both Medicare and Medicaid services
  - Enhance quality, especially outcomes
  - Reduce costs for both Medicare and Medicaid
  - Preserve
    - Access to all covered Medicare benefits
    - Cost sharing protections for full-benefit duals
    - Provider choice
  - Expect robust stakeholder engagement throughout design and implementation

Washington program

- Began July 2013, paused 6 months in 2015
- Built on previous Chronic Care Management program
- Used ACA health home authority – 90% match, 8 quarters
- Integrate across primary care, LTSS, behavioral health
- Based on robust analysis of duals' needs, costs
- Managed Fee-for-Service
  - Pmpm – based on intensity of encounters, not risk
  - Quality bonuses from savings pool
- Emphasis on helping members keep themselves healthy
- Health Homes create a network of CCOs (ACOs)
  - CCOs have primary care, LTSS, specialists, behavioral health
  - Must include local agencies that authorize Medicaid LTSS, behavioral health care

Washington program

- Competitive RFP – chose provider consortium, two AAAs, a mental health regional support network, and 2 MCOs (but <5%)
- Program pause 2015 due to uncertainty about federal support, whether it saved – stopped new enrollment but continued with current members -- lost care coordinators
- Coordinators – some at health home, some at CCO
  - Focus on needs of the whole person not necessarily related to one service
  - “Engage enrollees to set health action goals and increase self-management skills”
  - Nursing homes not allowing care coordinators access
  - Hard to engage members – less than half could be found, only 14% are ”actively engaged” (have a care plan and involved with a care coordinator)
  - Hard to hire and retain care coordinators

Washington program

- 21,050 enrolled out of 24,543 eligible (12/31/16)
- Members are auto-enrolled, can opt-out formally or just refuse services
- Payment is pmpm, 3 tiers based on intensity of encounters
  - 1st payment for outreach/engagement, health screening, care plan $252.93
  - Monthly after that, high intensity ($172.61) or low intensity ($67.50)
  - Most payments are for intensive care coordination
  - Rates are inadequate – health homes lose 20%
  - Sustainability question
- Overall savings 11.8% savings
  - Over 18% gross

Washington program

Quality impact	
Inpatient admissions	decreased
SNF admissions	decreased
ER visits	no change
Physician E&M visits	no change
Long-term stay SNF use	decreased
Readmissions	increased
Follow up after hospitalization for mental illness	no change
Preventable ER visits	no change
Preventable hospital admissions, all	no change
Preventable hospital admissions, chronic composite	no change

Washington program

CAHPS survey item	
Doctor or other provider talked to them about specific things they could do to prevent illness	81%
Someone on their health team talked with them about specific goals for their health	79%
Satisfied with the shared decision making for their health care with their doctor or other provider	92%
Satisfied with the shared decision making for their prescriptions with their doctor or other provider	82%

Washington program

- Challenges cited
  - Hiring, training and retaining enough care managers
  - Finding and engaging members
  - Care coordination rates are not sufficient
    - Health homes have to subsidize, losing 20%
  - No separate state funding
    - Start with health home ACA funds
    - Sustain with savings
- Strengths
  - Built on prior program
  - Targeting high-need, high-cost members for care coordination
  - HH/ACO care coordinators pull everything together, consider the whole person, including SDOH

Colorado

- Sept. 2014 through Dec. 2017, phased in enrollment
- Add duals to state's Medicaid Managed Fee-for-Service (ACOs)
- Attribute to ACOs by geography/residence
- Attribute to PCP by where they get their care
- Can opt-out/disenroll anytime
- For duals, additional ACO expectations:
  - Develop individual care plans based on members' health goals
  - Support members progress toward those goals
  - Enter into agreements with LTSS, behavioral health providers to coordinate and avoid duplication
  - Facilitate transitions from hospitals
  - Assess, provide technical assistance to providers to deliver disability-competent care

Colorado

- Note: place members in risk categories at beginning of demonstration, to avoid gaming the system
- Foundation ACO program built on PCMHs, saved money, improved quality, no shared savings, modified fee-for-service, PCMH links members to social services needed, coordinate transitions
- Duals quality results – (only Medicare $$ counted yet)

Colorado

Quality, savings results

- Lowered ED visits 8% for non-disabled
- Lowered readmissions and total admissions
- Imaging down – rate varies by pop but all down
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%)
- Increased preventive services for diabetics
- Increased child well visits
- Increased follow up care after hospital discharge
- (2018) pmpm down $120 for duals (only Medicare $$ yet)

Health Neighborhoods review

- CT one of 15 states awarded CMS planning grants, much of the design work happened in Complex Care Committee and workgroups, dropped
- "Establish a person-centered multi-disciplinary provider network that will coordinate services across Medicare and Medicaid"
- "Key strategies for achieving these results include multi-disciplinary care coordination and use of a provider portal to support care planning and to share data on beneficiaries"
- Eligibility – duals over age 18 except those in Medicare Advantage, MSSP, or a health home, unless they opt-out of the health home
- Providers can be in >1 Medicaid or Medicare model, but members can only be in one

Health Neighborhoods review

- 3 to 5 pilots covering >5,000 people each, base on cluster analysis of where duals are currently getting care
- Administrative Lead Agency (ALA) responsible for:
    - “establishing an integrated service network within its geographic area, linked by care coordination contracts
    - ensuring compliance with contract requirements informed by the Department
    - distributing shared savings dollars to HN providers using a pre-determined distribution methodology
    - Each HN must also identify a Behavioral Health Partner Agency (BHPA) with expertise in serving MMEs with behavioral health conditions”
- 2 controlling agencies was a Committee concern and raised in comments

Health Neighborhoods review

- ALA and BHPA have joint responsibility for:
  - “ensuring adherence to Demonstration care coordination standards and procedures
  - developing a quality improvement program for care coordination
  - collecting and reporting Demonstration data
  - providing or contracting for and monitoring Demonstration supplemental services
  - creating forums for core curriculum learning collaborative activities for providers
  - developing client education and outreach materials and strategies”

Health Neighborhoods review

- Health Neighborhoods must provide:
  - primary care providers;
  - identified specialists
  - extender staff
  - behavioral health professionals
  - Access Agency(ies) for the Connecticut Home Care Program for Elders and LMHA or LMHA affiliates
  - occupational, physical and speech/language therapists
  - dentists
  - pharmacists
  - community-based LTSS including home health agencies, homemaker-companion agencies, and adult day care centers
  - hospitals that serve the health neighborhood's coverage area
  - nursing facilities
  - hospice providers

Health Neighborhoods review

- Health Neighborhoods may include:
  - “Durable Medical Equipment (DME) providers
  - Emergency Response System (ERS) providers
  - hearing aid providers
  - ophthalmologists

Health Neighborhoods review

- HN required information and assistance affiliates:
  - “Infoline
  - the CHOICES program that serves the health neighborhood’s coverage area
  - the Aging & Disability Resource Center that serves the health neighborhood’s coverage area”
- May also include social services affiliates, for example:
  - “housing organizations
  - home renovation/accessibility contractors
  - bill payment/budgeting services
  - employment services
  - local organizations serving minority, non-English speaking, and underserved populations”

Health Neighborhoods review

- Care managers
  - "Under the Demonstration, **Lead Care Managers (LCMs)**, employed by **Lead Care Management Agencies (LCMAs),** will be responsible for acting as single points of contact for MMEs [duals] who participate in HNs.
  - An **LCM** must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration training.
  - **LCMs** will be responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services.
  - The Department will make risk-adjusted PMPM care coordination payments directly to **LCMAs** (the **APM II** payment)."

Health Neighborhoods review

- State receives Medicare and Medicaid savings above a minimum floor of savings to CMS
  - Start up payments to support HN formation, proposed $250,000 each
  - APM I payment: pmpm to PCMHs, replaces current add-on rate payment
  - APM II payment: risk-adjusted pmpm to Lead Care Agencies for care coordination
  - Supplemental service payments: to ALAs for extra services such as nutrition counseling, falls prevention, medication management, peer support and recovery assistant
- Year 1 – savings into a pool, shared with HNs based on quality measures
- Years 2, 3 – savings into 2 pools – pay HNs based on savings from one, quality from the other

PCMH Plus so far

- SIM initiative taken up/accepted by Medicaid
- Promise from DSS and OPM that there would be no shared savings in Medicaid until it was prevalent in the rest of CT, with a proper evaluation of the impact, and problems addressed
  - Current state budget calls for PCMH Plus for duals
- Shared savings, with upfront payments
- Payments also for quality performance and improvement
- In Wave 2 now, evidence only for first year
- Were 9 ACOs in Wave 1, expanded to 14 for Years 2 and 3, RFP out soon for Years 4 and 5
  - FQHCs, other ACOs – slightly different services, very different upfront money
- Deep concerns about underservice, cherrypicking
  - Literature growing that cherrypicking common in shared savings

PCMH Plus so far

- Shared savings has not worked to either save money or improve quality in other states, other programs, incl. Medicare ACOs in CT
- PCMH Plus Year 1 evaluation
  - Five of nine ACOs did not save but got payments
  - PCMH+ ACOs had much higher pmpm total costs, both before and at Year 1 end
  - All but one ACO had higher ER visit rates than comparison group, both before and at Year 1 end
  - Highest and lowest quality ACO received equal payments/member
  - Indications of underservice in DME, dental – no follow up
  - Biggest ACO winner by far saw **higher** risk scores at end of Year 1

PCMH Plus so far

- Problems –
  - Promise to wait until more is known disregarded
  - Expanded program before any evaluation done
  - Consensus consumer notices eroded late in process, no language that ACOs benefit by reducing costs of care
  - Then lack of complaints/opt-outs used as evidence of consumer satisfaction
  - Consumer input includes three interviews/ACO of consumers chosen by ACOs
  - Cost the state at least $1.3 million MORE in Year 1
  - No underservice or cherrypicking monitoring, insist that it can't happen
  - Ignored/reversed on 100% PCMH requirement
  - Double paying for ICM

PCMH Plus going forward

- Independent advocates' recommendations to improve:
  - Require ACOs to have 100% PCMHs in their system
  - Fix notices so they explain risks and are understandable
  - Reject post-hoc changes to comparison group
  - Enforce no direct PCP compensation based on savings from their panels
  - Expand minimum # members/ACO from 2,500 to 5,000
  - Ensure access to ICM as appropriate, exclude those savings from payments to ACOs as they are fully state funded
  - Do not expand to any new populations – especially duals – until the impact on the current population is better understood, concerns are addressed

Other resources

- Underservice metrics, data sources for health neighborhoods
  - Complex Care Committee workgroup
- Care plan standards
  - Complex Care Committee
- Underservice/adverse selection prevention policies
  - SIM Equity and Access committee
- Palliative care needs, Advanced analytics and information management
  - UConn
- NGA high-need member project