State of Connecticut

GENERAL ASSEMBLY

Medical Assistance Program Oversight Council

Complex Care Committee

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Co-Chairs: Rep. Anne Hughes & Rep. Susan Johnson

MAPOC Complex Care Committee met **Nov 19, 2020 01:00 PM** to discuss:
OHS'S Cost Cap Plan
COVID-19 and its Impact on Nursing Homes
Duals (Medicaid/Medicare) and Intensive Care Management (ICM)

The CHNCT presentation that raised people's radar is
at https://www.cga.ct.gov/ph/med/related/20190106_Council Meetings & Presentations/20200910/COVID-19 Impact and CHNCT Support.pdf

Somewhat buried is the very low numbers of members served by ICM over age 65
I understand that DSS argues that they don't have all the data for them, but that shouldn't be a barrier to getting intensive care management services under Medicaid. It doesn't interfere with getting other services and treatment.

Ellen Andrews talked about the Cost Cap plan

From Susan Johnson: I have been contacted a few times by Medicare beneficiaries or their families whose relatives have contracted COVID-19 in nursing facilities and have exhausted their 100 days of Medicare coverage while they were in a nursing facility. These Medicare beneficiaries were more often than not admitted to the nursing facility after a qualifying stay in a hospital and were eligible for Medicare nursing facility coverage based on their reasons for admission to the hospital.

Ordinarily they might have only used a few weeks of Medicare coverage and been well enough to go home and end the need for Medicare covered services. However due to COVID-19 they exhausted their 100 days of skilled nursing facility coverage for that "Spell of Illness." Once coverage is exhausted in a particular Medicare "Spell of Illness" there must be a 60 day break in the need for covered hospital, nursing facility or home care coverage by the Medicare program. The consequence to the individual and or the state is if they need additional care the cost will be shifted to the Medicaid program or out of their own pockets until they spend down what they have. This is a constituent issue and a state issue. I have contacted Congressman Courtney's office and they are working on legislation to address this loss to the patients and the cost shift to the states.

It might be a good idea to have our MAPOC members give the vote of confidence for this issue and make these Medicare beneficiaries whole again. I will see if I can get a copy of the draft language. Can we add this to our executive committee agenda? Susan Johnson

The numbers of Medicaid members over age 65 served by the Intensive Care Management program is low.
I find this unusual as seniors/duals are some of the most complex patients in the program and could benefit from ICM. Duals are also among the most expensive members, so the potential to coordinate care and save money could help both the tight budget and the quality of members' lives.
From DSS, I understand that they are not included because the dept. doesn't have all the Medicare claims data (although they have some of it), but CHNCT said in their presentation that claims is only one way of being referred to ICM. Can we find other way to reach out to duals and providers to get appropriate referrals to the people who need ICM?
It would be good to make this a discussion at a future Complex Care Committee meeting. We could explore other ways to ensure duals are benefitting from the ICM program, which has had a lot of success in managing care and preventing at-risk patients from getting worse.
I'm not sure when the next meeting is scheduled, but can we add this to the agenda?
Thanks
Ellen Andrews, PhD
CT Health Policy Project
To inform your policymaking about OHS's Cost Cap plan, I've attached an analysis of Massachusetts' cost cap. It's also online (https://cthealthpolicy.org/index.php/2020/11/04/has-mas-cost-cap-worked-should-ct-copy-it/). Massachusetts is the only state that has implemented a cost cap so far and OHS is largely copying their plan for their proposal. In summary, since it was implemented in 2013, Massachusetts's cap agency admits that it has not made healthcare affordable for residents. Premiums, employee share of premiums, and deductibles are similar between Connecticut and Massachusetts. Also, the share of premiums going to administration and profit is growing in Massachusetts.