MAPOC

March 10, 2023

CT Department of Social Services

Agenda

Medicaid eligibility overview

FQHC 101

Value based care 101

How HUSKY supports individuals with Autism Spectrum Disorder

Community Options – Innovation.

PACE

Medicaid Eligibility

FQHC 101

Overview: FQHCs

FQHCs = federally qualified health centers that receive federal Public Health Service (PHS) Act, Section 330 funds, and provide primary care services in underserved, urban and rural communities. Federal designation from the U.S. Dept. of Health & Human Services, Health Resources & Services Administration (HRSA), Bureau of Primary Health Care, and the Centers for Medicare and Medicaid Services (CMS) that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved populations.

Primary purpose *

To expand access to primary health care for uninsured and underserved populations, who experience financial, geographic or cultural barriers to care and who live in or near federally designated health professional shortage areas and medically under-served areas.

Defining characteristics *

1. Located in a federally designated **medically underserved area** or serve a federally designated **medically underserved population**
2. Provide **comprehensive primary care services**, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation
3. **Provide services to all** in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to income
4. Have **nonprofit**, public, or tax-exempt status
5. Have a **governing board, the majority of whose members are patients of the health center**

* CT Department of Public Health:
https://portal.ct.gov/DPH/Family-Health/Community-Health-Centers/Community-Health-Center-Overview

FQHCs play a key role in the HUSKY program

Scope

Connecticut residents are served by **17 in-state FQHCs** and **3 border-state** clinics in Rhode Island and Massachusetts

In Connecticut, there are over **300 different** FQHC locations ranging from stand-alone clinics to mobile clinics to school-based centers.

Statistics about our members*

Among our continuously enrolled members in 2021, **~28%** of our members visited an FQHC at least once in the 12-month period.

Of the members with a primary care attribution, **~32%** were attributed to a FQHC. During this period, FQHC total expenditure was **$1.6b**.

Among our continuously enrolled members who reported racial data, FQHC attributed members were 1.4x more likely to identify as Black non-Hispanic and 1.3x more likely to identify as Hispanic.

* Technical notes: Attribution methodology includes members enrolled at the time the report was run with a 15 month look back period attributed to an eligible PCP who the member had a plurality of visits with.

The data on the first two paragraphs is on non-dual members in 2021. The data in the third paragraph, on race and ethnicity, is an identical population, refreshed as of March 2023.

FQHCs financing – high level overview

Summary

- Federal law dictates how Medicaid programs pay FQHCs; **FQHCs are paid under a prospective payment system (PPS)**
- Under PPS, FQHCs are paid a **fixed rate** for each visit; the PPS rate is the same, regardless of the exact mix of services delivered. There are separate rates for medical, dental, and behavioral health visits
- Other than **alternative payment models (APMs)**, the state does not have discretion over the details of the PPS payment

History

- Pre-2001, FQHCs were paid based on costs
- The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L 106-554) ("BIPA") created the PPS for Medicaid FQHCs in all states and territories
- *Initial* PPS rates, back in 2001, were set based on FQHCs 1999 and 2000 cost reports in accord with BIPA
- Rates are increased annually by the **Medicare Economic Index** (MEI) – *details on future slide*
- Rates may be adjusted to account for a *change in scope* as defined in 17b-262-995. "Change in the scope of service" means a change in the type, intensity, duration or amount of services provided by an FQHC. A change in the cost of the service alone is not considered a change in the scope of service.

Backup: Additional details on FQHC payments

- Medical rates are clinic specific and range from $153.60 to $178.28 per visit
- Dental rates are clinic specific and range from $140.38 to $167.79 per visit
- Behavioral health rates are clinic specific and range from $169.49 to $218.35 per visit

Additional details on PPS rate

- Each FQHC has a **specific encounter rate for medical, dental, and behavioral health**
- In general, FQHCs can bill for **one medical, one behavioral health, and one dental visit each on the same day**. Allowance for second visit in case of emergency
- Federal law: rates may be adjusted based on **change in scope of services** provided by an FQHC. *See* 42 USC § 1396a (bb)(3)(B),
- All FQHC PPS rates are post to the Department website: https://portal.ct.gov/DSS/Health-And-Home-Care/Reimbursement-and-Certificate-of-Need/FQHC-Medicaid-Reimbursement/FQHC-Medicaid-Rates

Legal basis

- Rates are **increased annually by the Medicare Economic Index** (MEI). *See* 42 USC § 1396a (bb) (2) & (3)
- CMS approved SPA 16-015 on October 17, 2018, effective March 1, 2016; this SPA clarified that FQHCs are reimbursed an all-inclusive encounter rate per client in accordance with a prospective payment system, and delineated the process by which an FQHC may apply for an adjustment of its encounter rate based upon a change in scope of service
- Regulations were approved by the Legislative Regulation Review Committee of the Connecticut General Assembly on April 28, 2015, effective May 13, 2015

In Fiscal Year 2001, PPS rates were set in accordance with the following federal requirement:

> *Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title*

Medicare Economic Index (MEI)

Background	MEI is a federal index overseen by the Secretary of Health and Human Services under 42 U.S.C. §217a. It is updated annually and applied each year to the FQHC PPS rate at the start of the federal fiscal year (on 10/1).
Details	Designed to measure inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians' services such as physicians' time, non-physician employees' compensation, rents, medical equipment, capital costs, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies.

FQHCs and alternative payment models

Under federal law, the *only* way for Medicaid programs to pay an FQHC outside of the PPS is though an "alternative payment model" (APM) [42 USC § 1396a(bb)]

Under an APM, the state and each FQHC may enter into an agreed APM; the APM must result in a payment that is at least equal to the Medicaid PPS rate ("upside only")

Examples of Alternative Payment Models (APMs) in other states

	Oregon	Washington	Illinois	Minnesota
Program	Alternative Payment and Advanced Care Model	Alternative Payment Methodology 4	Medical Home Network ACO	FQHC Urban Health Network (FUHN)
Start Date	2013	2017	2014	2013
Participation	18 of the state's 32 health centers	16 of the state's 27 health centers	9 FQHCs	10 FQHCs with 30 health center sites
Payment Model	Health centers receive a base encounter payment from the health plan and an up-front supplemental capitated PMPM wrap payment from the state. A portion of the payment is tied to meeting five quality benchmarks.	Health centers receive an up-front PMPM payment from the health plan as well as a monthly "enhancement payment" from the state. The rate is then prospectively adjusted annually by the state to reflect the FQHC's performance on five quality targets.	Health centers receive an up-front PMPM payment from the ACO to deliver care coordination. Health centers also receive a shared savings payment from the ACO based on each center's total cost of care and its performance on quality measures.	If FUHN earns shared savings through its state contract, member health centers receive a portion of shared savings based on a total cost-of-care calculation for a core set of Medicaid services, and for achieving quality targets.

Payment Reform 101

From Feb MAPOC

HUSKY pays most* providers in one of four main ways

	(1). Provider fee schedule (most common)	(2). Cost-based (generally for institutions)	(3). Value based payments (small but growing)	(4). Grant based retrospective CPE claiming
Description	*Focus of today's presentation* HUSKY publishes a list of payments for each service and pays all providers who bill from that fee schedule accordingly	Creates provider-specific reimbursement based on a provider's costs	Pay providers based on the value (clinical and financial) they deliver to members	Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes
Example provider types	. Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.	Nursing homes	Maternity providers, starting 2023	DDS waiver providers
Advantages	. Follows Medicare . Simple . Creates incentives for providers to be financially efficient	. Matches reimbursement to costs, reducing costs . Avoids potential incentives to "cream or skim" healthier patients	. Gives providers incentives to improve quality and lower costs . Can encourage holistic treatment of disease	• Grant-based funding supports greater flexibility for providers • Agency / provider share responsibility for meeting federal claiming requirements.
Main disadvantages	. Little financial incentive to keep patients healthy . Could "overpay" some providers, paying more than costs	. Dulls incentives for providers to operate efficiently . Traditionally not linked to patient acuity	. Could potentially result in "stinting" or "cream skimming" if appropriate policies to mitigate are not in place	Delay in finalization and truing up expenditures for claiming purposes.

* There are some important provider types who are <u>not</u> paid according to these three buckets. For example, **Federally Qualified Health Centers (FQHCs)** are paid via the federally mandated prospective payment system (PPS). HUSKY pays our **hospitals** via an APR DRG system for inpatient services and an OPPS APC methodology for outpatient services.

HUSKY pays most* providers in one of four main ways

	(1). Provider fee schedule (most common)	(2). Cost-based (generally for institutions)	(3). Value based payments (small but growing)	(4). Grant based retrospective CPE claiming
Description	*Focus of today's presentation* HUSKY publishes a list of payments for each service and pays all providers who bill from that fee schedule accordingly	Creates provider-specific reimbursement based on a provider's costs	Pay providers based on the value (clinical and financial) they deliver to members	Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes
Example provider types	. Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.	Nursing homes	Maternity providers, starting 2023	DDS waiver providers
Advantages	. Follows Medicare . Simple . Creates incentives for providers to be financially efficient	. Matches reimbursement to costs, reducing costs . Avoids potential incentives to "cream or skim" healthier patients	. Gives providers incentives to improve quality and lower costs . Can encourage holistic treatment of disease	• Grant-based funding supports greater flexibility for providers • Agency / provider share responsibility for meeting federal claiming requirements.
Main disadvantages	. Little financial incentive to keep patients healthy . Could "overpay" some providers, paying more than costs	. Dulls incentives for providers to operate efficiently . Traditionally not linked to patient acuity	. Could potentially result in "stinting" or "cream skimming" if appropriate policies to mitigate are not in place	Delay in finalization and truing up expenditures for claiming purposes.

Today's focus

What is Value-Based Payment (VBP)?

Value-Based Payment (VBP): *"*Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers."[1]

A VBP model might be referred to as an ***Alternative Payment Model (APM):*** *"*A payment approach that gives added incentive payments to provide high-quality and cost-efficient care."[2]

[1]HealthCare.Gov. Glossary. 2023. https://www.healthcare.gov/glossary/value-based-purchasing-vbp/
[2]CMS, APMs Overview, 2023. https://qpp.cms.gov/apms/overview

Value-based payments are now integral to public payor's strategy to improve outcomes and reduce inequality

CMS Innovation Center Strategic Priorities

Presidential COVID-19 Health Equity Task Force

Health Care Access and Quality

Everyone has equitable access to high-quality health care.

Improve health equity through measurement and incentives.

By:

- Developing a health equity framework, inclusive of formal metrics, equity impact statements and process to monitor […]
- Supporting the development of reimbursement models that encourage data- and community-driven approaches focused on improving equity-centered health care delivery for communities of color and other underserved populations where they live and work.
- Providing payment incentives to providers that improve metrics of health care quality and patient experience in communities of color and other underserved populations.

(Left) CMS, *Innovation Center Strategy Refresh*, 2021
(Right) Presidential COVID-19 Health Equity Task Force, *Final Report and Recommendations,* October 2021

Value-based payment has been adopted in Medicare and Medicaid, and continually advanced by the CMS Innovation Center

CMS Innovation Center: established in 2010. Goal: transition health system to value-based care by developing, testing, and evaluating new payment and service delivery models. Over the last decade, the CMS Innovation Center has launched over 50 model tests.[1]

APMs in Medicare[2]

Examples include:

- End-Stage Renal Disease Quality Incentive Program
- Hospital Value-Based Purchasing Program
- Hospital Readmission Reduction Program - *details next slide*
- Hospital Acquired Conditions Reduction Program
- Skilled Nursing Facility Value-Based Purchasing Home Health Value-Based Purchasing

APMs in Medicaid[3]

State Medicaid programs are increasingly implementing a variety of VBP models that aim to drive system change towards greater efficiency and improved health outcomes.

States have implemented a variety of approaches, using various authorities and strategies.

[1] CMS, *Innovation Center Strategy Refresh*, 2021. https://innovation.cms.gov/strategic-direction-whitepaper
[2] CMS, Medicare Value-Based Programs. *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs*
[3] MACPAC, Value-based payment. https://www.macpac.gov/subtopic/value-based-purchasing/

A non-HUSKY Example: Medicare's Hospital Readmissions Reduction Program (HRRP)

Context

Why discuss Medi**care** at MAPOC?

1. One of the largest "pay for performance" systems in US healthcare history
2. Well studied
3. We have fewer HUSKY specific examples
4. Program may have implications for HUSKY members (dual eligible + non-Medicare HUSKY members via spillovers)

Here, we are not proposing any policy changes in Medicaid; just describing a Medicare program for illustration

Readmission rates are important. Pre-Affordable Care Act, ~20% of Medicare hospitalizations had a readmission within 30 days;[1] in 2013, 30-day readmissions across all payors cost more than $50b.[2]

HRRP: If a hospital has higher a risk-adjusted payment than a benchmark, hospital receives a penalty. Penalties up to 3% of hospital's base Medicare inpatient payments;[3] current fines estimated ~$520m[4]

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9113654/#cit0007
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710454/
3. kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/
4. https://khn.org/news/article/hospital-readmission-rates-medicare-penalties/

Evidence

Key result:

- **Program substantially reduced Medicare admissions for targeted conditions**; results varied across studies, but typically show on the order of ~5 – 10% reduction in readmissions; other papers find a reduction in one-year mortality
- While there is some evidence of "gaming" on the part of hospitals, there appears to be no evidence that this harmed patient care and, in fact, evidence points to a **reduction in one-year mortality**[a]

How we know:

- Method #1. Compare hospitals that, due to the patients they serve, would likely be subject to the penalty to other, similar, hospitals unlikely to be subject to the penalty…before and after
- Method #2. Exploit a policy discontinuity in formula for penalty, comparing hospitals that face greater penalties to those that face smaller penalties

Implications: In this program for this population, "paying for value" appears to have improved patient care and decreased spending

a. Different studies examine different patient populations and use different empirical strategies. Here is a brief review of some recent evaluations. Note that the baseline readmission rate for the conditions initially targeted by the HRRP is acute myocardial infarction (AMI), heart failure, pneumonia, and nontarget conditions were 21.9%, 27.5%, 20.1%, and 18.4%, respectively, at hospitals later subject to financial penalties (source). So, a 2 percentage point reduction would correspond to roughly a 10 percent reduction. Gupta 2021: 1 percentage point reduction. Carey & Lin (2016): 1.8 – 2.9 percentage point reduction. Desai et al (2016). 0.5 to 0.9 percentage points. Ziedman (2018) finds a 30% reduction in readmissions for AMI, with no impacts on other conditions. For mortality and "gaming", see Gupta 2021.

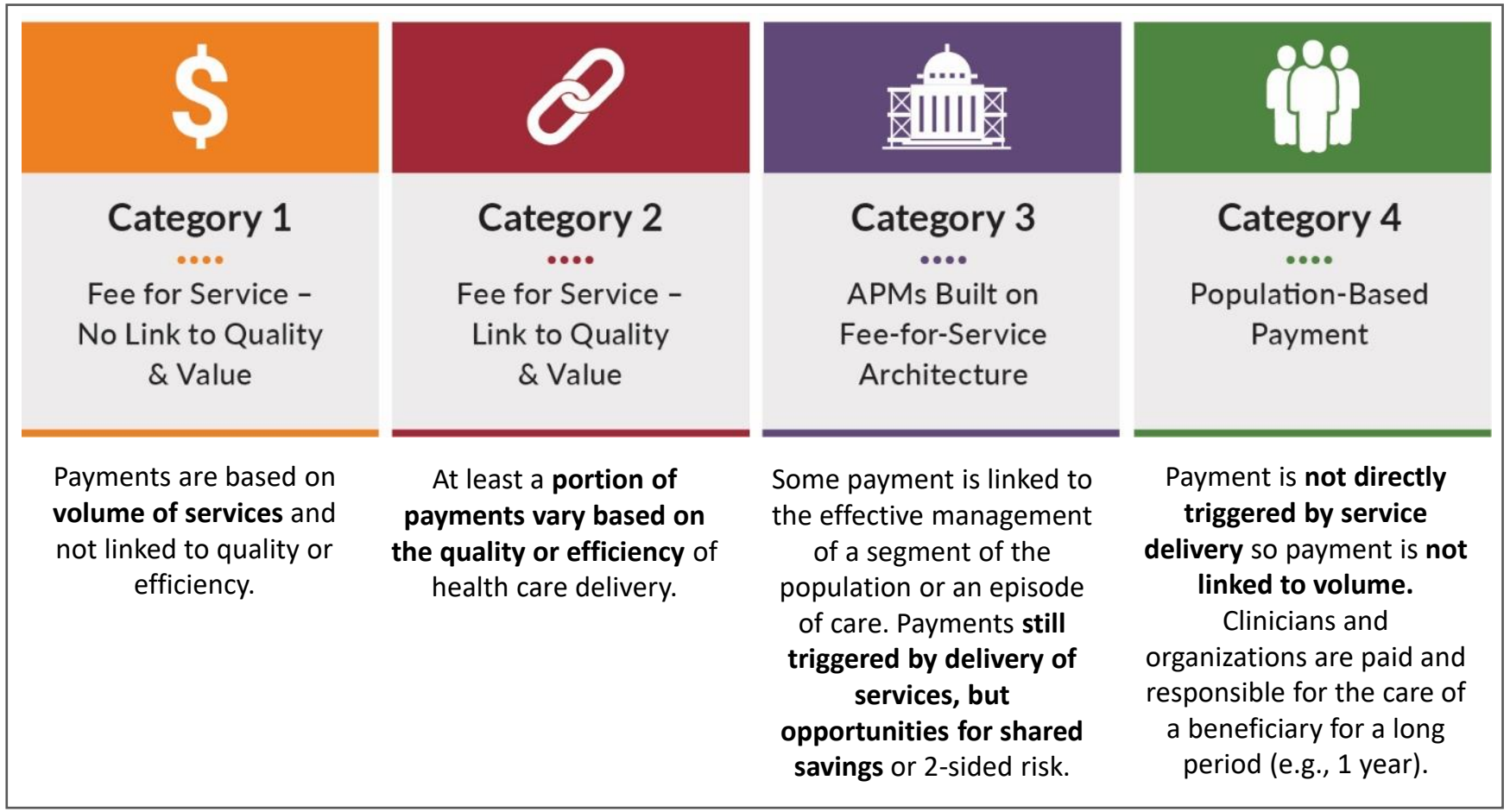
What kinds of payment models are considered VBP?

VBP models range from models that include some link to quality or value, to population-based payment models that pay per member, instead of per service.

The widely referenced **HCP-LAN Framework** categorizes payment models on a spectrum that moves from purely **volume-based payment** to more **value-based payment**.

Note: higher category does not necessarily mean "better"

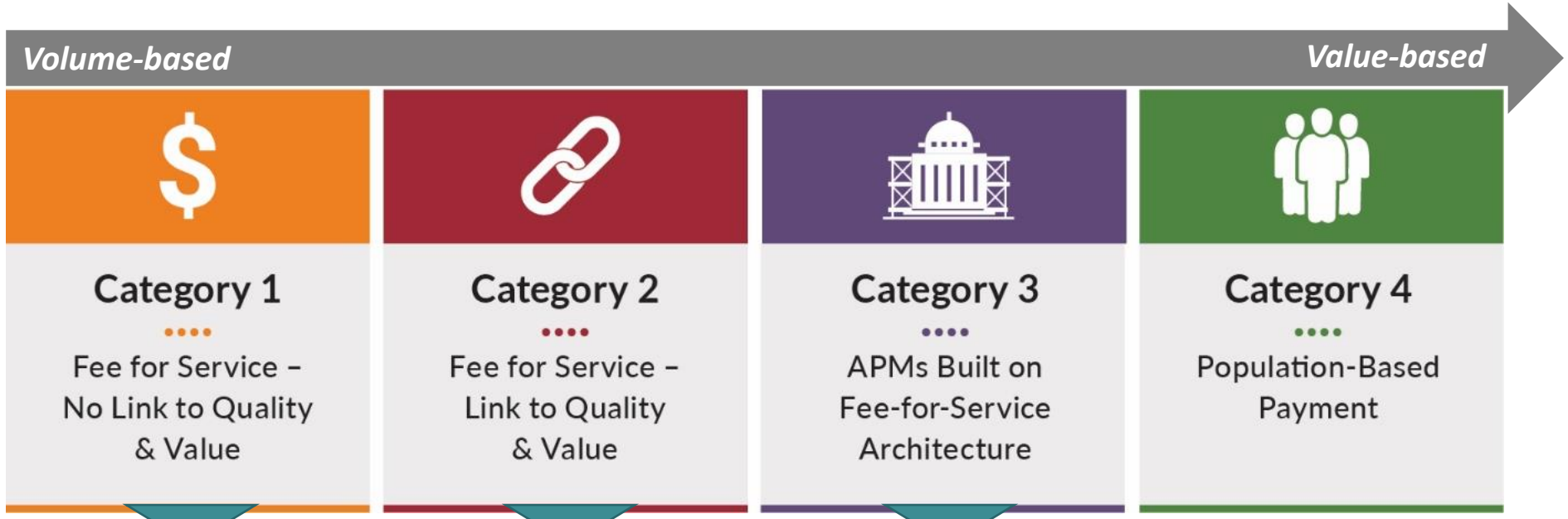
Degree of value-based



Source: Health Care Payment Learning & Action Network, APM Framework, 2017

CT DSS Payment Models

Where do ~~CT~~ DSS' provider payment models fall on the VBP spectrum now?



DSS Payment Models

- **Most HUSKY Payments**

- **PCMH**
- **Nursing home quality payment***
- **Home and Community-Based Service (HCBS) VBP**

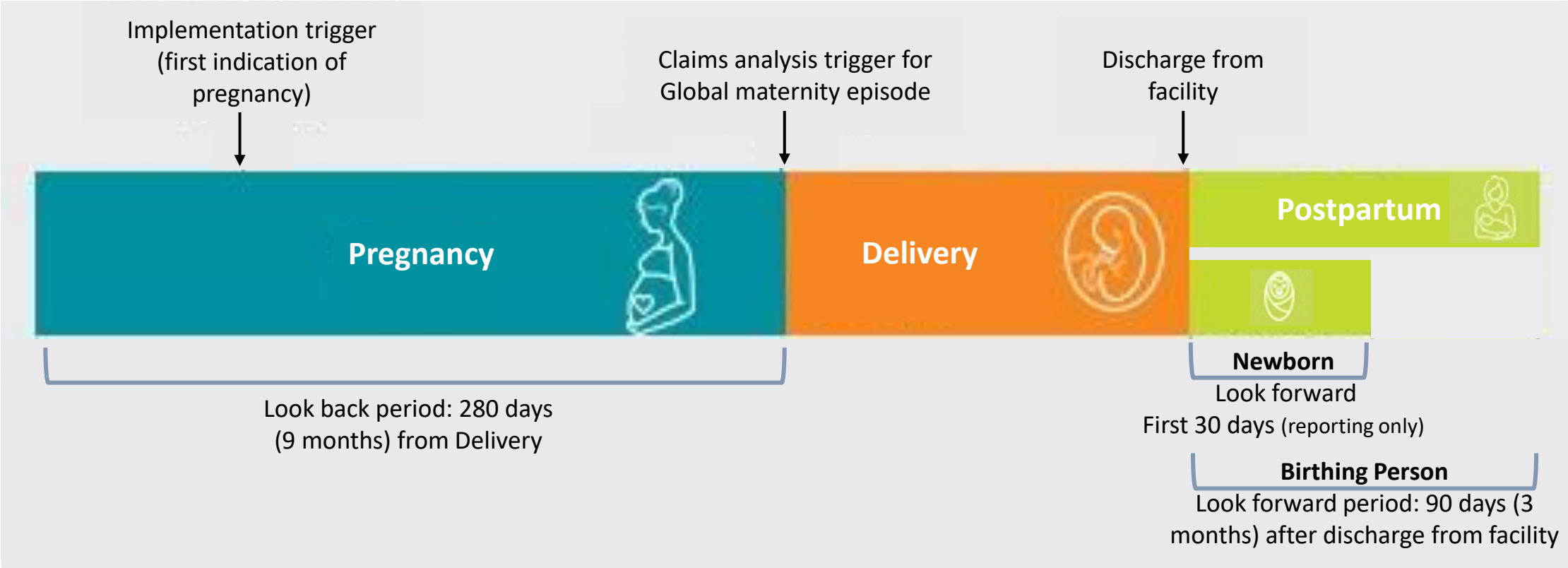
- **PCMH+**
- **Maternity bundle***

*** Indicates that slide is coming**

Source: Health Care Payment Learning & Action Network, APM Framework, 2017

Maternity Payment Bundle

From September 2022 MAPOC



Pregnancy:

- Monthly prenatal visits
- Routine ultrasound
- Blood testing
- Diabetes testing
- Genetic testing

- Doulas
- Care navigators
- Group education meetings
- Childhood education classes
- Preventive screenings (chlamydia, cervical cancer, etc.)

Labor and Birth:

- Vaginal or C-section delivery

Postpartum:

- Breastfeeding support
- Depression screening
- Contraception planning
- Ensuring link from labor and birth to primary and pediatric care providers occurs for birthing person and baby

From October 2022 MAPOC

Example: Value-based payment in nursing homes
Pressure ulcers

Clinical context

Pressure ulcers (bed sores) impact an estimated 2+ million people per year… and can cause severe pain…

…and, if hospitalized, can cost tens of thousands of extra dollars (source) and death

How homes can help

Strong evidence, via randomized control trials, that homes can take steps to reduce pressure ulcer incidence rate

JAMA Internal Medicine

Table 1. Intervention Effect and Quality of Supporting Randomized Controlled Trials (RCTs)

Strategy	Description of Preventive Interventions	Participant Population	No. of RCTs/ No. of Participants	Pressure Ulcers, RR (95% CI)[b]	Randomization[a]	Allocation Concealment[a]	Blinding of Outcome Assessment[a]	Source
1	Pressure redistribution foam (ie, cubed foams,[24,25] visco-elastic foam,[26] and high-density foams)[25-27] vs standard hospital mattresses	Medical, surgical, and rehabilitation patients	5/2016	0.40 (0.21-0.74)	4 RCTs	2 RCTs	None	McInnes et al[16]
2	Oral nutritional supplements (eg, daily drinks of 237 mL, 2 kcal/mL)[28] and standard hospital diet vs standard hospital diet	Elderly hospital patients	4/1224	0.85 (0.73-0.99)	4 RCTs	None	1 RCT	Stratton et al[17]
3	A hyperoxygenated fatty acid regimen for skin dryness, applied twice per day to the sacrum, trochanter, and heels (Mepentol; Laboratorios Bama-Geve SA, Barcelona, Spain) vs matched greasy placebo[22]	Patients from home care and/or geriatric centers	1/380	0.42 (0.22-0.80)	1 RCT	None	1 RCT	Reddy et al[12]
4	A foam cleanser combining an emollient, a water-repellent barrier, and a water-repellent deodorant (Clinisan; Shiloh Health Care, Oldham, England) vs soap and water for incontinence care[23]	Residents of long-term care sites	1/93	0.32 (0.13-0.82)	1 RCT	None	1 RCT	Hodgkinson et al[18]

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106015

HUSKY pays most* providers in one of four main ways

	(1). Provider fee schedule (most common)	(2). Cost-based (generally for institutions)	(3). Value based payments (small but growing)	(4). Grant based retrospective CPE claiming
Description	*Focus of today's presentation* HUSKY publishes a list of payments for each service and pays all providers who bill from that fee schedule accordingly	Creates provider-specific reimbursement based on a provider's costs	Pay providers based on the value (clinical and financial) they deliver to members	Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes
Example provider types	. Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.	Nursing homes	Maternity providers, starting 2023	DDS waiver providers
Advantages	. Follows Medicare . Simple . Creates incentives for providers to be financially efficient	. Matches reimbursement to costs, reducing costs . Avoids potential incentives to "cream or skim" healthier patients	. Gives providers incentives to improve quality and lower costs . Can encourage holistic treatment of disease	• Grant-based funding supports greater flexibility for providers • Agency / provider share responsibility for meeting federal claiming requirements.
Main disadvantages	. Little financial incentive to keep patients healthy . Could "overpay" some providers, paying more than costs	. Dulls incentives for providers to operate efficiently . Traditionally not linked to patient acuity	. Could potentially result in "stinting" or "cream skimming" if appropriate policies to mitigate are not in place	Delay in finalization and truing up expenditures for claiming purposes.

* There are some important provider types who are not paid according to these three buckets. For example, **Federally Qualified Health Centers (FQHCs)** are paid via the federally mandated prospective payment system (PPS). HUSKY pays our **hospitals** via an APR DRG system for inpatient services and an OPPS APC methodology for outpatient services.

HUSKY support for members with Autism Spectrum Disorder (ASD)

State Plan and Waiver Services

State Plan

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Entitlement
- Services limited through age 21
- Unable to access waiver services unless enrolled in waiver
- No cap on services
- Limited to services in the State Plan

Waiver

- Not an entitlement
- Lifespan (age 3 and up)
- Offer services that are not available under the State Plan
- Limits number of individuals served. Currently 219 individuals enrolled in waiver
- Can access State Plan services through age 21
- Annual $50,000 cap on services; average cost is far less

Overview of how HUSKY supports members with ASD: State Plan Services

Eligibility:
How people with ASD qualify for HUSKY

Individuals eligible for EPSDT services under Medicaid *under the age of 21* with an autism spectrum disorder diagnosis. Over 5,500 individuals have accessed ASD home-based services since 2015

ASD specific State Plan services

- Comprehensive evaluation
- Behavior assessment
- Home-based services
- Direct observation and direction (this allows the technician to receive real-time feedback from supervisor)

Non-ASD specific services

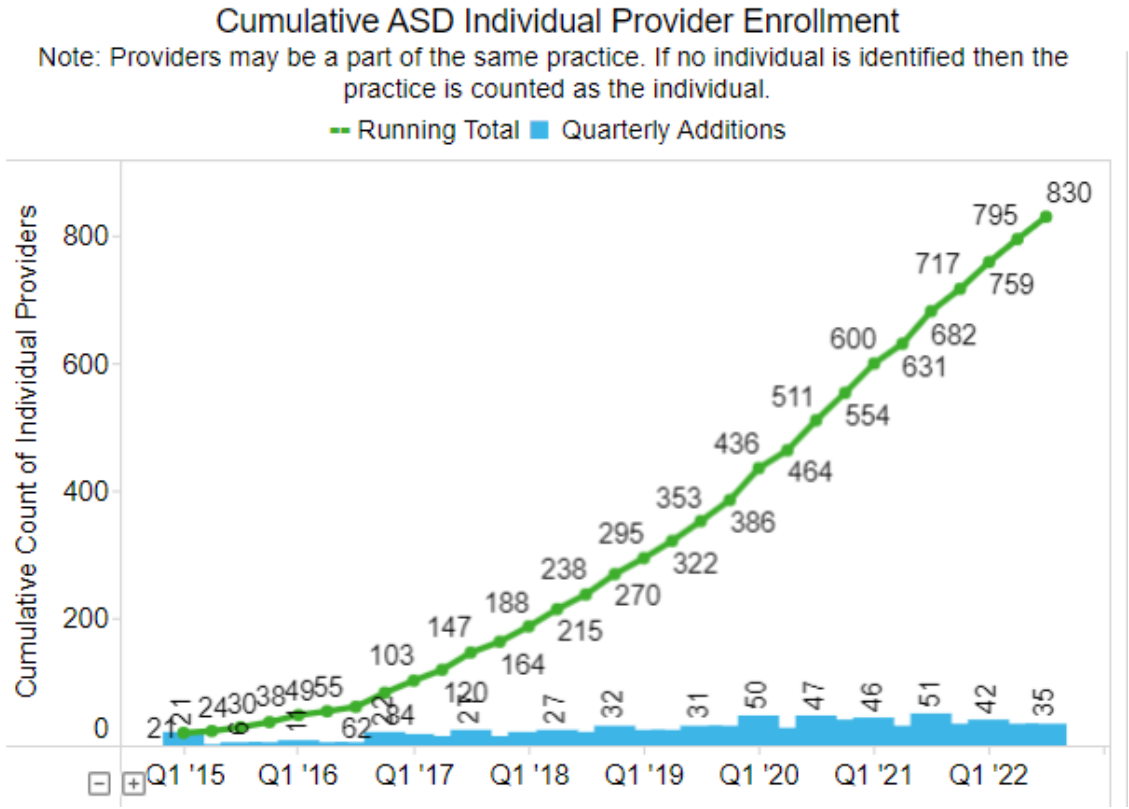
Individuals eligible for Medicaid who have been diagnosed with autism spectrum disorder are eligible for all Medicaid-covered services, if medically necessary. This includes, but is not be limited to, speech therapy, occupational therapy, physical therapy, transportation, and all other medical, behavioral health and oral health services.

Additional details: State Plan Services for ASD

- In 2015, DSS implemented ASD home-based services for youth under the age of 21 with autism spectrum disorder
- Beacon Health Options provides utilization management services for this service
- As of January 2023, over 5,500 youth have received services.
- Since 2015, Beacon Health has grown the provider network to over 800 ASD providers across the state
- Access to services has always been challenging based on the availability of licensed and experienced staff and the high demand for services

ASD Provider Enrollment as of 01/02/2023

750	185	889
individual providers have enrolled in Medicaid to provide ASD services.	unique practices (individuals or groups) have enrolled in Medicaid to provide ASD services.	providers are able to provide ASD treatment services.



[History]: Home & Community Supports Waiver for Persons with Autism

The Home & Community Supports Waiver for Persons with Autism serves individuals with Autism through a 1915 (c) Medicaid waiver

- 2006 - legislation passed requiring the Department of Developmental Services (DDS) to establish a pilot program to provide supports and services to *adults* with autism. The pilot was established to fill a fill a gap in services for individuals with ASD who do not have an intellectual disability
- The pilot included a feasibility study on obtaining a Medicaid waiver to serve this population. The pilot originally served individuals with ASD over the age of 18 and was later opened to those age 3 through the lifespan
- 2007 - legislation passed creating the Division of ASD Services within DDS and provided authorization to seek a waiver
- 2012 - CMS approved Autism waiver.
- 2014 - CMS approved Early Childhood Autism waiver (sunsetted 2018 and Autism waiver amended to include children ages 3 and up.)
- 2016 - legislation moves Division of ASD Services from DDS to DSS. DSS, rather than DDS, became the lead agency for coordinating state agency functions that have responsibility for ASD services. Both waivers transition to DSS
- 2023 - most recent renewal of waiver
- In his FY 2024 and 2025 biennial budget, Governor proposed transferring lead agency responsibilities from DSS to OPM with Medicaid State Plan and waiver activities remaining at DSS

[Eligibility]: Home & Community Supports Waiver for Persons with Autism

The Home & Community Supports Waiver for Persons with Autism is *not* an entitlement; services and access to services under the waiver may be limited, based on available funding and program capacity.

To be eligible, individuals must meet the following:

- Have a primary diagnosis of Autism Spectrum Disorder
- Be at least 3 years of age
- Have a Full-Scale IQ score of 70 or higher as indicated on a test of intelligence
- Live in their own home or family home
- Have substantial limitations in at least two of the following: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living
- Have had functional impairments must diagnosed before age 22
- Be eligible for Medicaid (HUSKY A, C, or D)
- Have an impairment expected to continue indefinitely

[Services]: Home & Community Supports Waiver for Persons with Autism

List of services that HUSKY offers only to waiver participants

- Live-in companion
- Respite
- Assistive technology
- Clinical behavioral supports
- Community mentor
- Individual goods & services
- Interpreter
- Job coaching
- Non-medical transportation
- Emergency response System
- Nutrition
- Social skills group
- Specialized driving assessment
- Life skills coach

Members on waiver, who are under age 21 can access State Plan services.

[Process]: Home & Community Supports Waiver for Persons with Autism

	Step #1: Place on waitlist	Step #2. Wait for waiver slot	Step #3. Waiver slot becomes available	Step #4. Develop service plan	Step #5. Arrange services and ongoing monitoring
Involved parties	▪ Member and/or responsible party ▪ DDS	DSS Autism team	▪ Member and/or responsible party ▪ DSS case manager	▪ Member and/or responsible party ▪ DSS case manager ▪ All involved in member's personalized service plan	▪ Member and/or responsible party ▪ DSS case manager ▪ Providers ▪ Community party
Activities	1. Member and/or responsible party submits application to DDS for initial eligibility determination. 2. DDS determines if applicant meets diagnosis & IQ requirements 3. If requirements met, member placed on waitlist	1. DSS Autism team identifies the next members on the waiver waitlist and updates demographic information.	1. Universal assessment completed 2. Level of need completed 3. If clinically eligible and Medicaid eligible, enrolled in waiver	1. Identify member's goals 2. Develop person-centered service plan based upon level of need that is within annual service plan budget cap of $50,000.	1. Coordinate services with service providers. 2. Monitor services to ensure they meet member's needs. 3. Maintain consistent communication with member and responsible party.
Comment		▪ <21 & Medicaid eligible access State Plan services ▪ >21 & Medicaid eligible, access non-autism services	If not already completed, will need: 1. SSA disability determination 2. Medicaid eligibility determination	Needs reassessed annually. Services are often not reduced.	

Rebalancing

Overview: Community Options – Rebalancing Medicaid

Rationale

1. Consumers overwhelmingly wish to have **meaningful choice** in how they receive needed long-term services and supports (LTSS)
2. **Average per member per month costs** are less in the community
3. In Olmstead v. L.C., 527 U.S. 581 (1999), the Supreme Court held that title II prohibits the **unjustified segregation** of individuals with disabilities.
    1. Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities

Brief national history

1960s Medicaid – Required nursing home benefit

1970s Medicaid – Optional personal care assistance

1980s Medicaid – Optional 1915(c) waivers

1999 – Olmstead v. L.C 527 U.S.581

2005 – Deficit Reduction Act

Authorized Money Follows the Person

Optional 1915(i) benefit

2010 – ACA

New eligibility group under 1915(i)

Optional Community First Choice

Key achievements

Informed MACPAC report to Congress:

March 2022 Report to Congress on Medicaid and CHIP : MACPAC

Recognized for national leadership:

2020 Affordability and Access Winner Connecticut – The SCAN Foundation

Selected for NASHP best practice report:

Salom Teshale, Wendy Fox-Grage, Kitty Purington, (2022) "Paying Family Caregivers through Medicaid Consumer-Directed Programs: State Opportunities and Innovations"

Paying Family Caregivers through Medicaid Consumer-Directed Programs: State Opportunities and Innovations - NASHP

Selected for HUD best practice report:

Hiren Nisar, Dennis Okyere, Emily Brimsek, (2022) "Housing Search Assistance for Non-Elderly People with Disabilities: Draft Case Study of Connecticut's Medicaid Money Follows the Person Program." *Office of Policy Development and Research*

U.S. Department of Housing and Urban Development [Pending Publication]

Community Options: Primary Home and Community-Based (HCBS) Innovation Initiatives

	Operational			Pilot	In development		Operational redesign	
	My Place CT	**Community First Choice**	**Money Follows the Person Rebalancing Demonstration (MFP)**	**Value-Based Payment – HCBS**	**Supports at Home Option**	**Remote Live Community Hub**	**Connecticut Housing Engagement and Support Services**	**Universal Assessment**
Description	Web-based and Social Media project for information about long-term services and supports	Personal Care Attendant Services for people at institutional level of care	Transition from institution to community	Upside payments to HCBS providers who reach certain outcomes or goals	Long-term services and supports for people covered on the Medicare Savings Program	Local coordination of direct support, caregiver support and emergency back-up, integrated remote technology	Targeted Medicaid services to people who are homeless or homeless prior to nursing home stay coordinated with housing	Assessment tool used to determine an individual's needs used across multiple programs
Funding Primary	MFP	Medicaid	MFP	ARP 9817	American Rescue Plan Act Section 9817 (ARP-9817)	ARP 9817	Medicaid	Medicaid
Funding Secondary	None	MFP	Medicaid	Medicaid	None	Medicaid	MFP	MFP
Outcome: Improve Quality of Life	Increase access to information	Increase access to community supports	Increase % of people receiving HCBS relative to people receiving long-term services and supports	Increase member attainment of goals	Increase caregiver support for people with dementia	Increase independence	Decrease avoidable hospitalizations	Decrease disparity in budget allocation by member need
Evaluation	No	No	Yes	Yes	Yes	Yes	Yes	Yes

Community Options: Primary HCBS Innovation Initiatives

	Operational		Pilot		In development		Operational redesign	
	My Place CT	**Community First Choice**	**Money Follows the Person Rebalancing Demonstration (MFP)**	**Value-Based Payment – HCBS**	**Supports at Home Option**	**Remote Live Community Hub**	**Connecticut Housing Engagement and Support Services**	**Universal Assessment**
Description	Web-based and Social Media project for information about long-term services and supports	Personal Care Attendant Services for people at institutional level of care	Transition from institution to community	Upside payments to HCBS providers who reach certain outcomes or goals	Long-term services and supports for people covered on the Medicare Savings Program	Local coordination of direct support, caregiver support and emergency back-up, integrated remote technology	Targeted Medicaid services to people who are homeless or homeless prior to nursing home stay coordinated with housing	Assessment tool used to determine an individual's needs used across multiple programs
Funding Primary	MFP	Medicaid	MFP	ARP 9817	American Rescue Plan Act Section 9817 (ARP-9817)	ARP 9817	Medicaid	Medicaid
Funding Secondary	None	MFP	Medicaid	Medicaid	None	Medicaid	MFP	MFP
Outcome: Improve Quality of Life	Increase access to information	Increase access to community supports	Increase % of people receiving HCBS relative to people receiving long-term supports and services	Increase member attainment of goals	Increase caregiver support for people with dementia	Increase independence	Decrease avoidable hospitalizations	Decrease disparity in budget allocation by member need
Evaluation	No	No	Yes	Yes	Yes	Yes	Yes	Yes

Today's Focus

Money Follows the Person Rebalancing Demonstration

Money Follows the Person - overview

Federal Goals

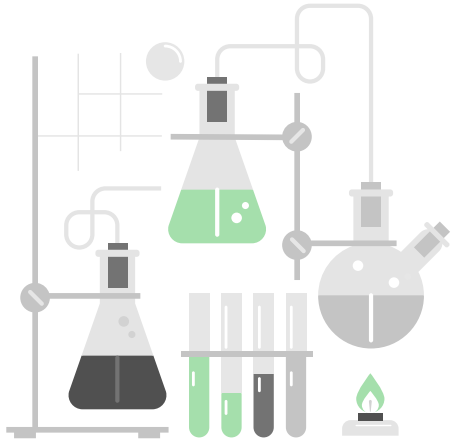
1. Increase home and community-based services (HCBS) and decrease institutionally-based services
2. Eliminate barriers that restrict people from receiving long-term services and supports in the settings of their choice
3. Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
4. Put procedures in place to provide quality assurance and improve HCBS

Brief history

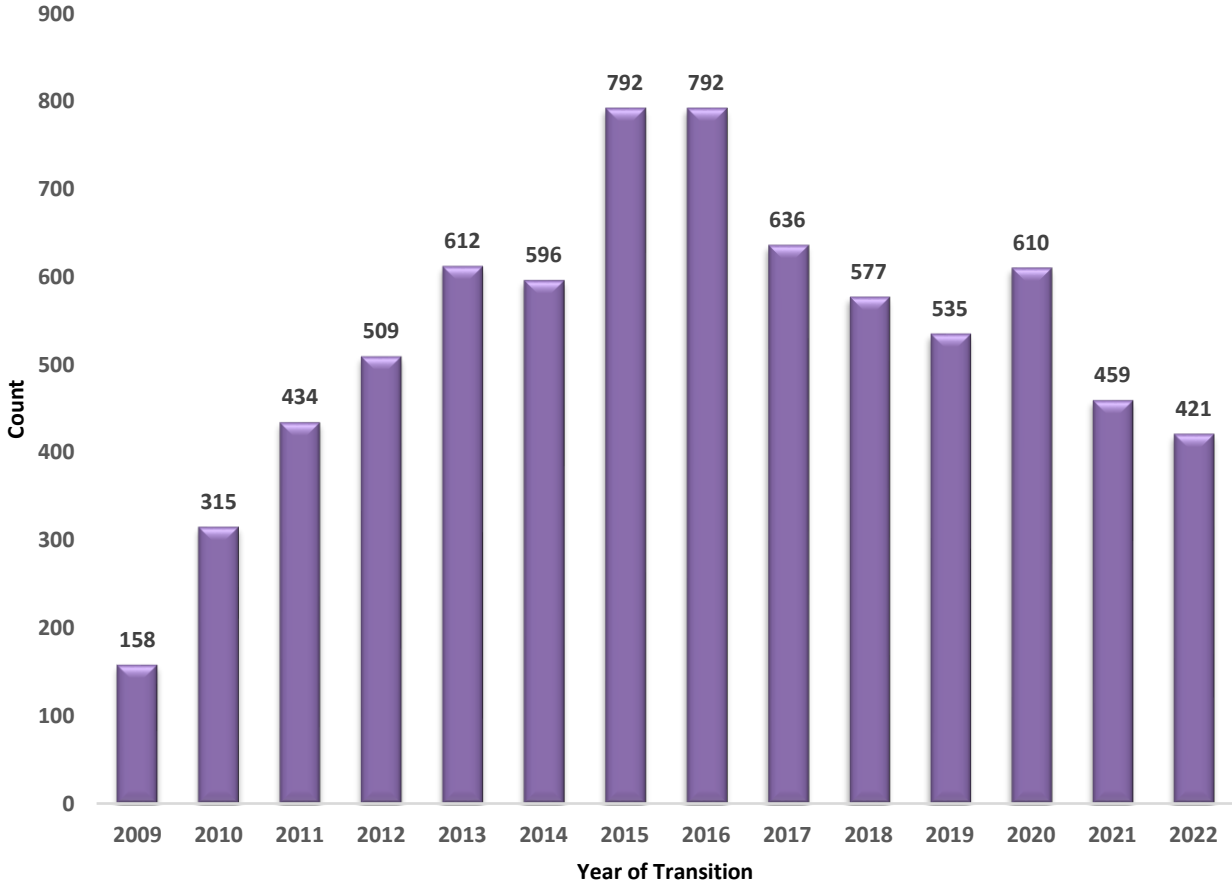
The Money Follows the Person Rebalancing Demonstration, created by Section 6071 of the Deficit Reduction Act of 2005, supports states' efforts to "rebalance" their long-term support systems so that individuals can choose where to live and receive services. States receive enhanced federal reimbursement. Connecticut was one of the first states to receive funding in 2007. Connecticut's initial goal was to transition 700 people from institutions to the community over 5 years. The goal was exceeded within 2 years of operation. **To date, Connecticut has transitioned over 7,000 people - more people per capita than any other state.**

Money Follows the Person Rebalancing Demonstration

***Over 7,000** People*
Transitioned to Community
From January 2009 - December 2022



Total Number of Transitions by Year



MFP is a 'laboratory' for analysis of gaps in the HCBS continuum that prevent people from having a choice to remain in or return to the community after a nursing home stay.

Claire's Story

As a child, Claire was diagnosed with Cerebral Palsy. For many years she lived in an apartment supported by the Department of Developmental Disabilities (DDS). In 2018, she became ill and was hospitalized. After hospitalization, she moved to a nursing home to continue rehabilitation. Unfortunately, rehabilitation did not go well for her. She remained in the nursing home long term and lost her apartment.

After transfer to a different nursing home, Claire's health and strength began to improve. Her DDS case manager told her about Money Follows the Person. Claire and her family were excited to know that a return to the community was once again possible.

Through MFP she received a new customized wheelchair and many other household goods such as toiletries, bedding, medical supplies/equipment, and groceries. In her new apartment, Claire and her roommate have a 24/7 PCA who helps them with activities of daily living activities and ensures that all their needs are met.

Claire re**ports that she is happy and looking forward to what the future holds.**

MFP attempts to address some of the key barriers that members face when remaining or moving into the community

Key challenge faced by members	Example of how MFP helps
(1). Service gaps	Workforce recruitment Informal caregiver support
(2). Physical health	Informed Risk Agreement
(3). Mental health	Substance use disorder demonstration services Informal caregiver training related to dementia
(4). Housing	Monthly training for housing coordinators Access to the rental assistance program
(5). Member engagement	Quarterly professional development on engagement strategies
(6). Financial issues	Dedicated eligibility staff assigned to each person in Money Follows the Person

Note: key challenges are based on data collected by field staff on each individual who participates in Money Follows the Persaon

Value-Based Payment HCBS Providers

Initiative Funded under American Rescue Plan Act Section 9817

Value Based Payment, HCBS Providers - overview

Goals	Increase the number of people who receive services from a person-centered care team, guided by member's goals, with accountability for quality of service and choice of community services in lieu of institutionalization.
Context / Rationale	Members report that health care systems, including home and community-based service systems, are fragmented. Information is not shared across all providers and members occasionally receive conflicting guidance. A value-based payment for all providers, aligned with member goals, can incentivize a team-based delivery system and improve member experience.
What we're measuring	1. Reduce avoidable hospitalization 2. Reduce rate of hospital discharge to nursing home 3. Increase probability of return to community within 100 days of nursing home admission

Value Based Payment – HCBS Providers
Principles and Key Strategies

Principles

- Person-centered
- Equitable delivery of service
- Choice regarding where people receive long-term services and supports
- Fair - achievable for all providers

Key Strategies

- Team based culture – delivery reform guided by goal
- Value based payment based on rebalancing metrics – HCBS Measure Set
- Benchmark 'capacity building' glide path
  - Direct care worker training
  - Participating in Health Information Exchange
  - Learning collaboratives
    - Racial equity
    - Meaningful use of data

Value Based Payment – HCBS Providers Addressing Challenges in Existing System

	Challenges	HCBS VBP Design
Capacity	Lack of provider capacity to collect and use data	5% Quality Infrastructure Supplemental Payments
Standardization	Lack of standardized definition and measurement related to member (person-centered) goals	Implement training and measures National Committee for Quality Assurance (NCQA)
Data Sharing	Member data is not shared electronically across all healthcare systems	Member data shared across all providers who serve member within Connie
Measures	Lack of measures to ensure no disparity in delivery of service	Develop measure (Yale CORE) and integrate into outcome measures

HCBS VBP Roadmap

01 Milestone
State submits American Rescue Plan Act Spending Plan and receives approvals
Q4 2021

02 Milestone
CMS approval of benchmark methodology – 200 HCBS providers meet benchmarks
Q1 2022

03 Milestone
State submits VBP methodology – 200 providers continue to participate; 7200 direct care workers complete racial health equity training.
Q4 2022

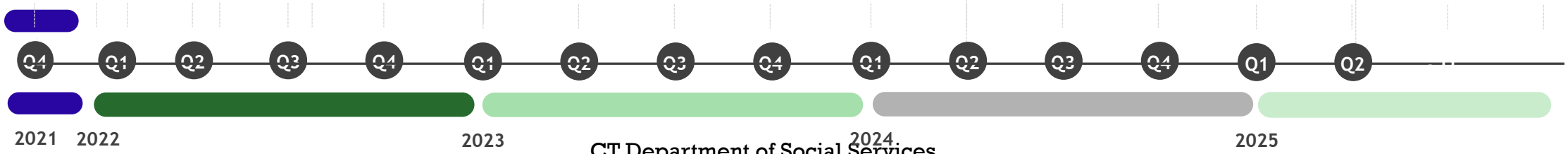
Today
New VBP methodology pending legislative hearing; HIE HCBS portal design completed; learning collaboratives begin
Q1 2023

04 Milestone
5% Quality Infrastructure payments begin
Q2 2023

05 Milestone
First outcome-based payment
Q2 2024

06 Milestone
Measure for racial health equity and person-centered goals implemented
04 2024

07 Milestone
VBP sustained beyond ARP 9817
Q3 2025



Community Options Partners for Design, Development and Implementation of Innovations

- Steering Committee
  - Self-advocates, advocates, Department of Mental Health and Addiction Services, Department of Aging and Disability Services, Department of Developmental Services, Connecticut Legal Rights, AARP, State Long-Term Care Ombudsman, Office of Policy and Management, ARC of CT, MS Society, etc.
- Providers
- Center on Aging – UCONN Health
- State Health Information Exchange – Connie
- National Committee for Quality Assurance (NCQA)
- Yale-New Haven Hospital Center for Outcomes Research and Evaluation (Yale CORE)

Program of All-Inclusive Care for the Elderly (PACE)

PACE - Program of All-Inclusive Care for the Elderly

- Medicare program for older adults and people over age 55 living with disabilities.
- Three-way partnership between the Federal government (Medicare), the State (Medicaid), and the PACE organization
  - Optional Medicaid State Plan Amendment
- Provides community-based care and medical services to people who otherwise need nursing home level of care.
- Benefits include, but are not limited to, all Medicaid and Medicare covered services, such as adult day care, dentistry, home care, and transportation.
- Providers receive monthly Medicare and Medicaid capitation payments for each enrollee.
- Operates in approximately 30 states
- Connecticut does not operate a PACE program but today we do have coordination activities in partnership with the 7 D-SNPs (Dual Eligible Special Need Plans) that operate in the state.

Note: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Office of Behavioral Health, Disability, and Aging Policy published this report that includes PACE in 2021:Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report | ASPE (hhs.gov)