MAPOC Meeting

January 2024

CT Department of Social Services

Agenda

- Justice-Involved 1115 Waiver Public Hearing
- Primary Care Access for Individuals with IDD

Justice-Involved 1115 Waiver Public Hearing

Justice-Involved (JI) Waiver
History and Background

There is a long-standing prohibition in Medicaid that precludes Medicaid reimbursement for services provided to incarcerated individuals. This is known as the “inmate exclusion."

In January 2023, California received approval from the Centers for Medicare and Medicaid Services (CMS) to waive the inmate exclusion rule with agreed-upon rules and procedures. In June 2023, Washington received approval for their waiver.

Currently, 18 states have submitted applications to CMS. California’s and Washington's have been approved.

In 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which required the U.S. Department of Health and Human Services to guide states on how to seek 1115 demonstration authority to waive the inmate exclusion to improve care transitions to the community for incarcerated individuals.

CMS has advised states to align JI waiver applications with what has already been authorized under the California and Washington models if states want an expedited review of their applications.

Connecticut's Waiver Application

- Connecticut will request waiver authority, via an amendment to the Substance Use Disorder 1115 Demonstration Waiver, to design and implement a "Reentry Demonstration" that provides:
  - Medicaid coverage for eligible individuals in the state correctional system, including all correctional centers (jails and courthouses), and correctional institutions (prisons), and juvenile and community residential centers.
    - Eligible individuals include those with behavioral health needs, including mental health disorders and substance use disorder (SUD), certain other health conditions, and detained youth.
    - Coverage period of up to **90 days** immediately prior to release from the correctional system.
  - An initial targeted benefit package to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services being implemented in subsequent phase-ins.

Demonstration Goals

- Consistent with CMS' goals as outlined in the April 17, 2023, State Medicaid Directors' letter, Connecticut's specific goals for the reentry demonstration are to:
  - Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
  - Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
  - Improve coordination and communication between correctional systems, Medicaid systems, including administrative services organizations, and community-based providers;
  - Increase investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
  - Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN);
  - Reduce deaths in the near-term post-release; and
  - Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Proposed Services

Three core services that must be operational at the start of the waiver:

- Transitional case management (pre- and post-release)
- Medication-assisted treatment (MAT) for substance use disorder
- 30-day supply of medications upon release

Additional services to be implemented in subsequent phase-ins:

- Physical and behavioral health clinical consultation
- Laboratory and radiology services
- Services by community health workers, to the extent covered under the Medicaid State Plan, including those with lived experience
- Family planning services, including contraceptives and other birth control
- Other services such as medications and medication administration; screening for common health conditions, such as blood pressure, diabetes, hepatitis C, and HIV; rehabilitative or preventive services, including those provided by community health workers; treatment for hepatitis C; and health-related social needs such as housing supports

Health-Related Social Needs (HRSN)

- CT is requesting to cover certain housing related services and supports for the justice-involved population upon reentry to the community:
  - One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture);
  - Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
  - Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention;
  - Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation

Target Population

Youth

- All detained youth (under age 19) who are Medicaid eligible – no demonstrated health care need is required

Adults

- Medicaid eligible
- Meet one of the following health care need criteria:
  - Mental Illness
  - Substance Use Disorder
  - Chronic Conditions/Significant Clinical Condition
  - Intellectual or Developmental Disability
  - Acquired Brain Injury, including Traumatic Brain Injury
  - HIV/AIDS
  - Pregnant/Postpartum

Services Are Needed

- Approximately 12,000 adults are released from correctional facilities each year
  - It is estimated that 85% of adults will meet the waiver's medical needs criteria
- Approximately 650 adolescents are released from juvenile and community residential centers per year
- In 2022, DOC data analysis* on the inmate population found:
  - 95.5% of the incarcerated population had at least one or more of the following:
    - A history of mental health disorders,
    - An active mental health disorder requiring treatment,
    - A history of substance use disorder, or
    - An active substance use problem requiring treatment.
  - 80.8% of the incarcerated population had either an active mental health disorder requiring treatment, or an active substance use disorder requiring treatment; 24.5% of the population had both.

**CT Sentencing Commission: Mental Health Disorders in CT's Incarcerated Population*

Waiver Application vs. Implementation Plan

- California received approval in January 2023 and plans to implement in November of 2024
- Washington received approval in June 2023 and has requested an extension on the submission of their implementation plan

Waiver Application Submission:

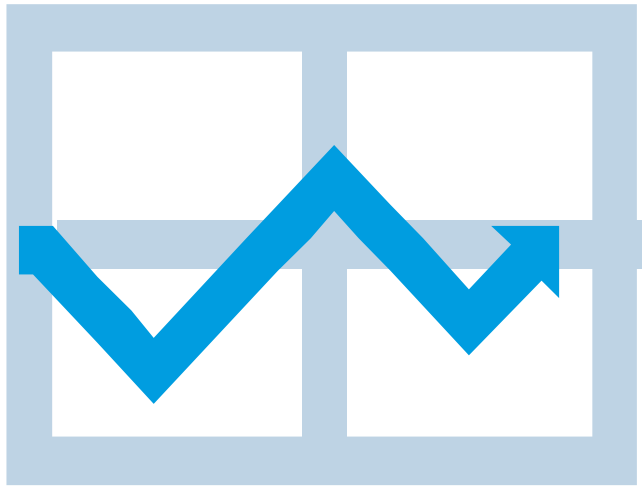
- This is step 1 of numerous steps to secure authority from CMS to implement these services
- Connecticut to submit the waiver application early 2024 to get in the queue as soon as possible

Implementation Plan:

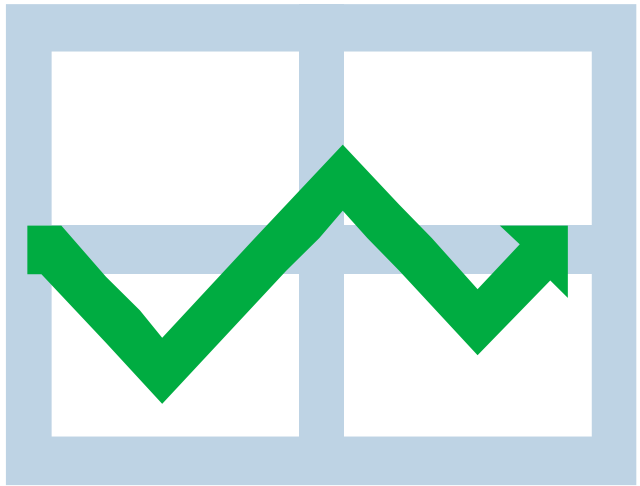
- CMS has at least 90 days to review the waiver application, but it is very likely that there will be extensions based on multiple questions that the state is likely to receive during the review process
- While the application is under review and after formal approval of the waiver, the state agencies will continue to conduct in-depth stakeholder meetings to inform the implementation plan
- The state will continue to seek stakeholder input after the submission of the state's application to CMS

Federal Budget Neutrality

- CMS requires 1115 demonstration waivers to be budget neutral to the federal government on a per member per month (PMPM) basis
- Under Reentry 1115 waivers, CMS allows states to treat service costs for residents of a correctional facility as if those costs were allowable under Medicaid (called hypothetical costs). The state is not liable for caseload growth for JI services, and is held to an aggregate cap for administration and HRSN.



Without Waiver Costs



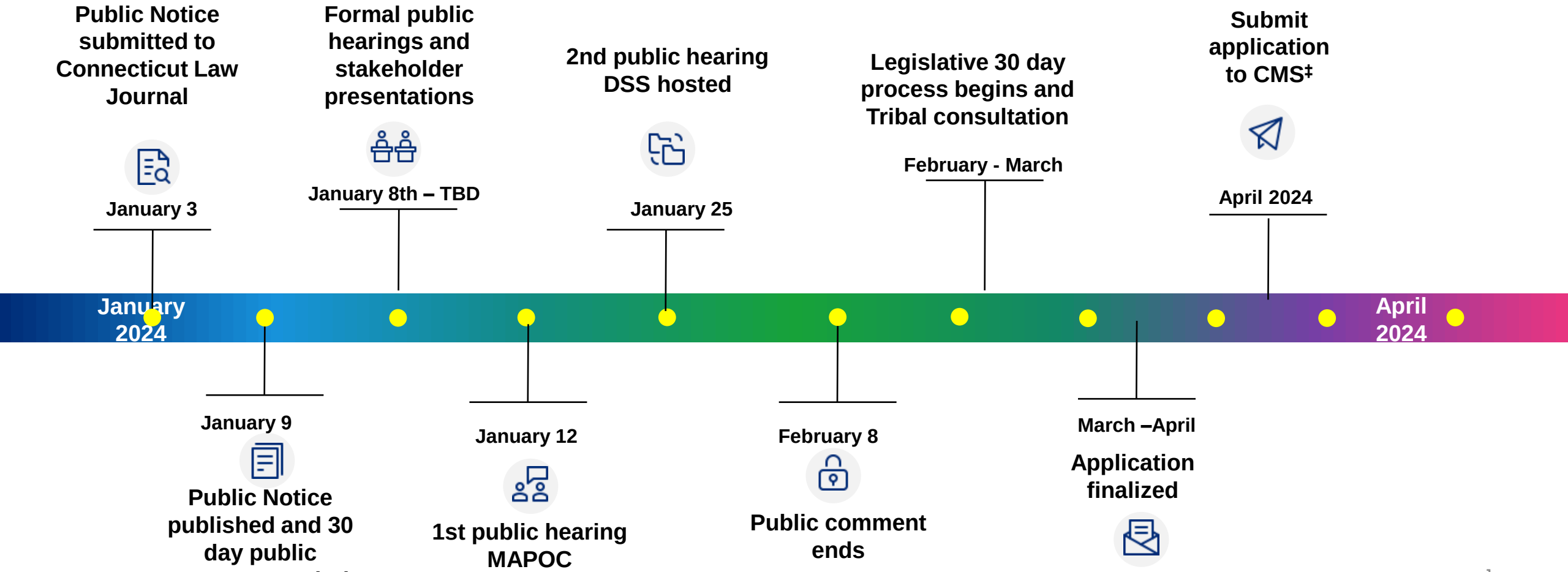
With Waiver Costs

Federal Budget Neutrality

- All 1115 Medicaid Demonstration waivers are required to be budget neutral to the federal government
  - Budget neutrality means the estimated federal costs under the waiver cannot exceed the estimated cost of the services without the waiver.
- How is this possible when we plan to spend more money, which means the federal government will ultimately spend more money on services?
  - Under the JI waiver, CMS allows states to consider JI costs as hypothetical – as if the state already had the waiver in place, – when establishing budget neutrality
- Simple example:
  - Assume the state is currently spending $10 million on transition care management services for the JI population through state-only funding
  - Under the waiver, those transition care management services become reimbursable under Medicaid, and thus the federal share of those costs is about $9 million (assuming HUSKY D federal reimbursement at 90%).
  - For budget neutrality purposes, CMS allows the state to include the $10 million as hypothetical costs, as if we had the waiver, and thus, for the purposes of budget neutrality, the $9 million in federal costs is under the $10 million threshold

CT's 1115 Justice-Involved Amendment – Potential Timeline for Early 2024 Submission

Currently, there are 18 pending JI applications with CMS. CMS has signaled they will prioritize these applications, especially if they align with California's and Washington's demonstrations.



Justice-Involved Waiver – Public Hearings and Public Comments

- Written comments are accepted from January 9, 2024, through February 8, 2024. Please send comments to: **CT-Justice-Involved-Waiver@ct.gov**

- Next virtual public hearing on January 25, 2024, to be hosted by DSS from 10am-12pm. For meeting link, please visit our dedicated justice-involved waiver website **1115 Justice-Involved Demonstration Waiver--Public Hearings and Public Comments (ct.gov)**

Primary Care Access for Individuals with IDD

How Does DSS Pay for Primary Care?

Most HUSKY Health primary care providers receive the majority of their revenue by submitting Evaluation and Management (E&M) codes.

E&M codes are a subset of the Current Procedural Terminology (CPT) codes used by healthcare providers to bill for patient encounters. They represent the process of evaluating a patient's health status and managing their care based on their diagnosis.

In primary care most providers bill CPT codes:

- **99212, 99213, 99214, 99215 (established)**
  and
- **99202, 99203, 99204, 99205 (new)**

Which CPT code or "level" is determined by:

- **Medical decision making (*MDM*)**

  or

- ***Time* Spent On Day of Encounter**

If billing off *MDM*:

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

If billing *off time*:

CPT	Established Patient Visit	CPT	New Patient Visit
99212	10-19 mins	99202	15-29 mins
99213	20-29 mins	99203	30-44 mins
99214	30-39 mins	99204	45-59 mins
99215	40-54 mins	99205	60-74 mins
Prolonged Visit Code			
99417	*Only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level service has been exceeded by 15 minutes.*		

Risk Adjustment for Individuals with IDD

In our existing PCMH+ program, clinical risk adjustment is utilized in a way that impacts provider payments and uses the following codes as part of the risk adjustment:

ICD-10 code	Code Description
F71	Moderate Intellectual Disabilities
F72	Severe Intellectual Disabilities
F73	Profound Intellectual Disabilities
F78	Other Intellectual Disabilities
F78.A	Other Genetic Related Intellectual Disabilities
F78.A1	SYNGAP1-related intellectual disability
F78.A9	Other genetic related intellectual disability
F79	Unspecified intellectual disabilities

Provider Utilization for Individuals with IDD

This comparison shows utilization patterns for adults and children with IDD compared against all adult and child members in calendar year 2022.

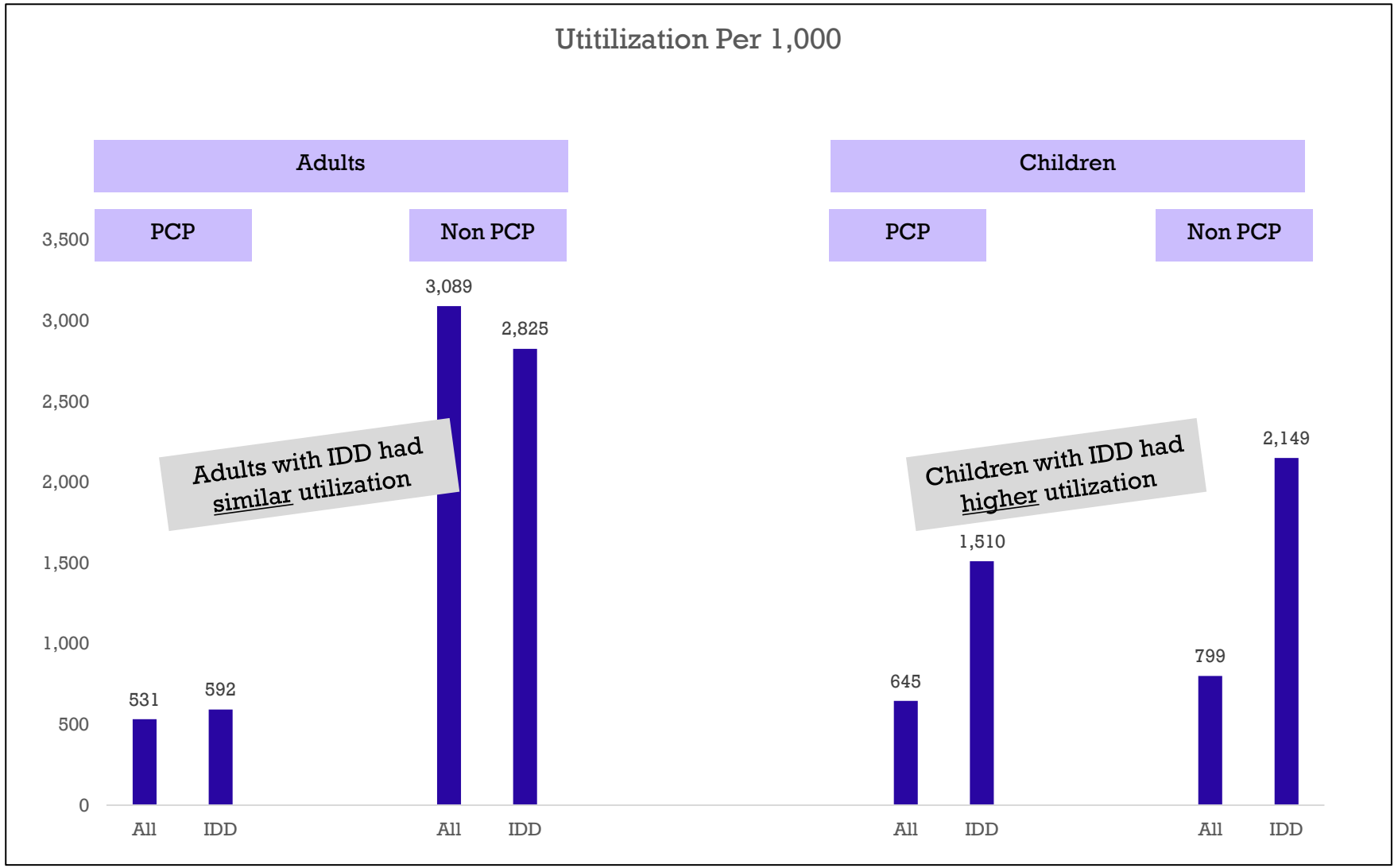
Utilization per 1000 of provider services between members with IDD and all members was similar in the adult population but was markedly higher in children with IDD compared to all members.

2022 (Members with IDD) Adult		2022 (All Members) Adult	
Category of Expenditure	**Util/1000**	**Category of Expenditure**	**Util/1000**
Physician Services – PCP	592	Physician Services – PCP	531
Physician Services – Non-PCP	2,825	Physician Services – Non-PCP	3,089

2022 (Members with IDD) Child		2022 (All Members) Child	
Category of Expenditure	**Util/1000**	**Category of Expenditure**	**Util/1000**
Physician Services – PCP	1,510	Physician Services – PCP	645
Physician Services – Non-PCP	2,149	Physician Services – Non-PCP	799

Source: CHNCT, Inc.

Utilization patterns from 2022 show that, for children, utilization is higher for members with IDD



What the data tells us

- Individuals with IDD and other disabilities face significant health disparities:
  - Higher rates of depression, heart disease, and diabetes compared to those without disabilities
  - Lower rates of preventive care like check-ups, blood pressure checks, and cancer screenings
- There are challenges for providers in delivering care to individuals with IDD due to structural, financial, and informational barriers, leading to inadequate patient-provider communication and access to care

Specialty Care Access for Children with Special Health Care Needs	There are significant access concerns to specialty care for children with special health care needs (CSHCN) - Winitzer 2012
U.S. Physician survey on care for individuals with significant disabilities	U.S. physicians report a lack of confidence in providing equal care to individuals with significant disabilities, potentially contributing to persistent healthcare disparities for this population - Iezzoni 2021
National Health Survey	Adults with intellectual and developmental disabilities have a higher likelihood of poor health and lower rates of health check-ups and preventive screenings - Havercamp 2015
Social Determinants impact on individuals with IDD	Social determinants have a significant impact on the health and health utilization of individuals with IDD – Friedman 2021 Adults with disabilities of any kind are more prone to face food insecurity compared to those without disabilities – Assi 2022

Key Structural Barriers to Care for People with Disabilities

In a 2022 Health Affairs study, researchers synthesized physician feedback and identified key structural barriers to care for people with disabilities, including:

(1) Limited time with patients	Participants repeatedly raised the issue of **limited time with patients** as a barrier to providing high-quality care to people with disabilities. *"**Seeing patients at a 15-minute clip is absolutely ridiculous**. To have someone say, well we're still going to see those patients with mild to moderate disability in those timeframes—it's just unreasonable and it's unacceptable to me."*
(2) Difficulties with coordination of care	Time constraints **impeded physicians' ability to coordinate care** with families of people with disabilities… *"Coordination of care becomes a huge challenge and barrier. Our institution is trying to get social workers in our office to do some of this legwork. There's financial and space constraints that limit that, too, but we're **looking for solutions to be able help coordinate care for these patients** with special needs because they are a unique population that require a unique set of interventions."*
(3) Electronic health record (EHR) data gaps	Participants also discussed **limitations of the electronic health record in documenting accommodation needs** from visit to visit. *"I would love to say we are more system-organized, but **I doubt there is any know-ahead that anybody with a disability is coming**. When they get there, we make do and try to accommodate as best as we can, but it would [be] a surprise to me if I knew they were coming, and I don't think the office manager knows, either."*

Source: Lagu, Tara et al. "I Am Not The Doctor For You: Physicians' Attitudes About Caring For People With Disabilities." *Health Affairs*, 41, 10, 2022, 1387-1395.

Policy Options to Address Key Structural Barriers

A range of strategies could help address these barriers, including:

Barrier	Policy Options	Examples
(1) Limited time with patients	• **Use prolonged service codes** to enable providers to bill for longer visits • **Restructure fee-for-service (FFS) payments** to risk adjust for disability status such that providers receive a higher FFS rate for members with disabilities. • **Restructure Medicaid payments to move away from FFS payments** made for distinct 15-min units towards more value-based payment methods, using a risk adjustment methodology that considers disability such that providers receive a higher rate for members with disabilities	• **Medicare** Physician Fee Schedule: includes an add-on code for Prolonged Office/Outpatient E/M Visits • **Medicare** Advantage: rates are adjusted for several risk factors including disability status using the Hierarchical Condition Category (HCC) risk adjustment model
(2) Difficulties with coordination of care	• **Introduce care coordination add-on payments** to enable providers to better coordinate care; consider risk adjusting payments such that providers receive a higher rate for members with disabilities	• **Comprehensive Primary Care Plus** (CMMI) & **Making Care Primary** (CMMI): Risk-adjusted per beneficiary per month payments to providers to support ongoing care management activities
(3) Electronic health record (EHR) data gaps	• **Support development and use of data infrastructure** with requirements and/or bonus payments tied to disability data collection and reporting	• **MassHealth** Primary Care ACO: bonus payments earned for health equity data collection and reporting, inclusive of member level disability information

Examples from Other States

States are using a range of delivery system and payment strategies to serve members with disabilities.

These programs leverage different waiver authorities, managed care vehicles, provider entities, and payment models. Examples may not be directly applicable to Connecticut – but provide some context for approaches other states are taking.

New York – Health Home/Care Coordination Organizations (HH/CCOs)
HH/CCOs provide care coordination across all service settings, under Section 1115 waiver authority (expanded to individuals with I/DD in July 2018); NY also operates two other programs for members with I/DD

- HH/CCOs receive a capitated rate in exchange for providing care coordination across all service settings
- HH/CCOs are controlled by a minimum of 51% nonprofit I/DD providers
- Goals of the waiver include establishing a more person-centered system, improving care coordination and service planning, enhancing access to HCBS, and establishing budget transparency

Arkansas – Provider-led Arkansas Shared Savings Entity (PASSE)
Provider-led entities with a global payment model, under Section 1915(b),(c) waiver authority (began in 2018)

- Providers of specialty and medical services partner with managed care organizations to form new business organizations, the PASSEs, which are at least 51% provider owned and serve individuals with I/DD and BH needs
- The global payment model includes both shared savings and incentive payments that are tied to reporting/achieving certain outcomes or quality measures; providers and MCOs share risk
- The premise of the PASSE model is that better case management and care coordination will minimize more costly acute services, such as emergency department visits, inpatient psychiatric stays, and hospitalizations

Source: "Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities." *ANCOR, January 2019*

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Tennessee - Employment and Community First (ECF) CHOICES program
Comprehensive service package for individuals with I/DD delivered through managed care, under Section 1115 waiver authority (began in 2016)

- Provides an integrated, comprehensive service package of physical, behavioral, and LTSS
- The state requires that all ECF providers have experience in integrated employment services and person-centered practices for people with I/DD
- Focus on advancing comprehensive workforce development goals, which are incentivized with payment incentives

Arizona – Arizona Long-Term Care System
Long-standing managed LTSS program with mandatory enrollment for individuals with I/DD, under Section 1115 waiver authority (began in 1989)

- The state Division of Developmental Disabilities (DDD) serves as the managing entity under a contract with the state Medicaid agency, and receives a monthly capitated rate for primary, acute, and LTSS for all individuals with I/DD
- Case management services are provided by DDD staff
- According to providers surveyed, the state has achieved savings through the bundling of LTSS and acute services under one entity, as well as by serving most people in the community as opposed to in an institutional setting

Source: "Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities." *ANCOR, January 2019*

DSS Primary Care Program Redesign

Reminder

Process	• DSS started a primary care evaluation process in early 2022 to systematically look at existing primary care systems including PCMH and PCMH+. • This process was presented out through MAPOC and involved data analysis and extensive focus groups with members, advocates, and providers. • That evaluation led to the identification of opportunities for improving the primary care system and advancing health and equity - which payment reform is a foundational component of.

Primary care payment reform can address key gaps in the primary care system – payment reform can improve access, quality, and member experience – and address marked disparities in member outcomes.

Goal	Opportunities	Volume-Based Payment	Value-Based Payment
Improve the biopsychosocial health and well-being of our members - especially for our most historically disadvantaged members and in a way that reduces inequities and racial disparities.	**(1) Identify and address health related social needs** **(2) Enhance care coordination through expanded care teams, inclusive of community and peer-based health workers** **(3) Ensure members have easy and timely access to care, including through technology enabled care options** **(4) Enhance the focus on measuring and addressing disparities in care**	**Low** → **High** Traditional fee-for-service (FFS) payment systems do not give providers the flexibility or incentives to address biopsychosocial member needs and identify and reduce disparities in care	Value-based payment models can give providers the flexibility and incentives to deliver high-value care that considers a member's full range of needs, with payments tied to reporting and performance goals around measuring and addressing disparities in care

Stakeholder Engagement

Reminder

Based on the 2022 evaluation, DSS outlined a Primary Care Program design plan which is being conducted in partnership with stakeholders, leveraging newly established and existing stakeholder engagement forums.

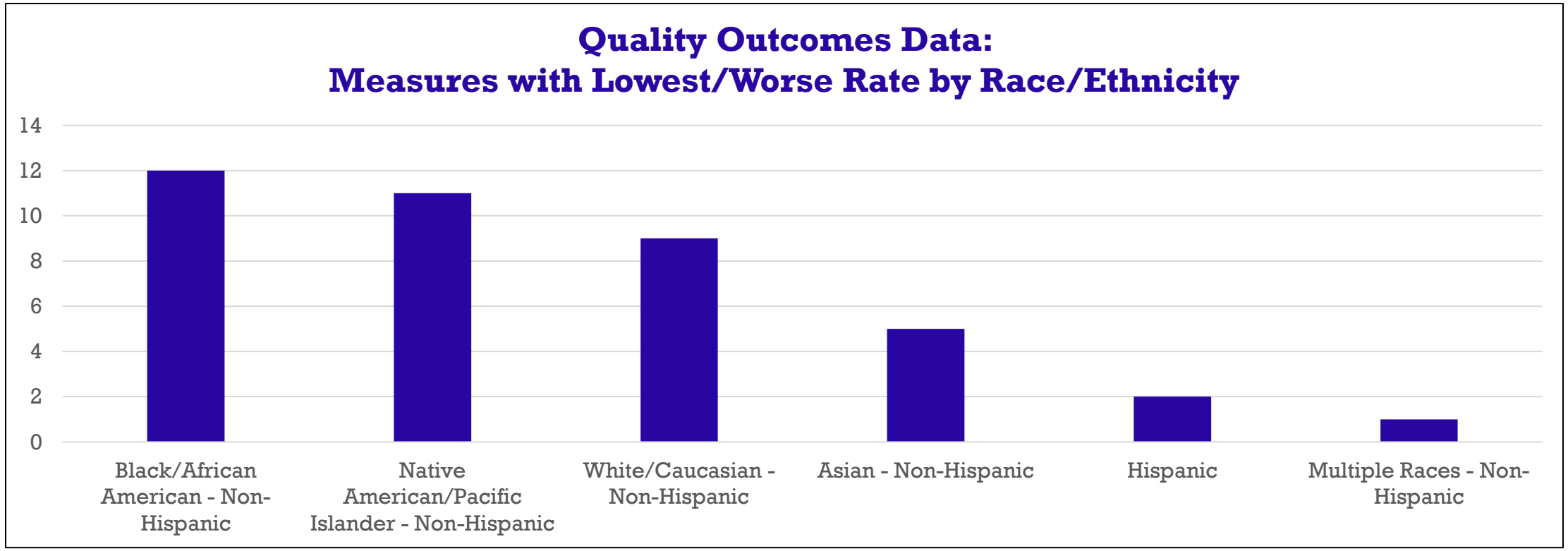
	Description	Participation	Meeting Cadence
MAPOC Care Management Committee	Ongoing updates to and engagement with MAPOC Care Management Committee	Existing forum	Established, every other month
Primary Care Program Advisory Committee (PCPAC)	Newly established committee that will serve as the primary program design advisory body	A diverse array of representatives, including providers, advocates, and state agency partners	Monthly
Primary Care Program Advisory FQHC Subcommittee	Newly established subcommittee that will advise on FQHC-specific program design topics	Representatives from each FQHC	Monthly, following PCPAC meetings
Non-FQHC Primary Care Provider Subcommittee	As needed forum for primary care provider engagement	Broad-based forum for Medicaid primary care providers	TBD, as needed
CHNCT Member Advisory Workgroup	As needed engagement with HUSKY members through existing member advisory workgroup	Existing forum	TBD, as needed

The Challenge Ahead of Us

- **Address disparities** in quality of care and member outcomes.
- **Ensure members have easy and timely access to care** and address the range of barriers that make it challenging for members to access care.
- **Enhance care coordination and team-based care** with a focus on integrating community health workers.
- **Improve chronic conditions management** with a focus on reducing unnecessary inpatient and ED utilization.
- **Invest more in primary care as a percent of total spend** with the intent to increase preventive care spending and decrease acute care spending.

Opportunity: Address disparities in quality of care and member outcomes.

Out of 40 total measures, Black/African American HUSKY members and Native American/Pacific Islander HUSKY members have the highest number of quality measures with the lowest or worse rate.



Source: CHNCT, Inc. – MY 2021 Summary of Health Measures by Race/Ethnicity (excluding Unknown)

The Essential Questions of Program Design

Care Delivery	What should primary care be doing to improve member health and well being?
Performance Measurement	What is the definition of success? How should this be measured?
Payment Model	How is primary care paid and incentivized for doing things that improve member health and well being?

Cross Cutting Equity Strategy: How do we reduce inequities and racial disparities?

Timeline for Primary Care Program Design

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – Feb 2024+***	***Mar – Dec 2024+***
✓ Establish advisory committee and FQHC subcommittee ✓ Review prior work with committees ✓ Respond to requests for additional starting point data and information ✓ Host listening sessions to understand priorities	❑ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including: ❑ Care delivery requirements ❑ Performance measurement ❑ Payment model ❑ Equity strategy	❑ Review key decision points in the development of program technical specifications and incorporate feedback ❑ Discuss key budget, authority, and program implementation model decisions

Committee Input On Care Delivery Priorities

Primary Care Program Goal

Improve the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members and in a way that reduces inequities and racial disparities.

Care Delivery Priorities	Chronic Condition & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in **management of chronic conditions.** Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.	**Care is easily accessible and prompt,** using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is **accessible to persons with disabilities** and is **culturally and linguistically competent.**	The practice team **screens patients** for social risk factors, is knowledgeable about community resources, and **facilitates a referral to address the member's need.**	The practice team **utilizes patient information** in conjunction **with data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform **targeted quality and equity improvement activity,** including design and implementation of quality improvement plans.	Care delivery **is team-based,** with the practice team consisting of a **range of clinicians and non-clinicians,** working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.

Note: Definitions of success align directly with OHS' Core Function Expectations of Primary Care Practice Teams; except for the definition associated with HRSN Screening & Community Supports, which has been updated based on committee feedback

Appendix

- Winizker, et al, Disability and Health Journal, 5: 26-33, 2012.
- Iezzoni, et al, Health Affairs, Feb;40(2):297-306 2021
- Havercamp and Scott, Disability Health Journal, Apr;8(2):165-72 2015
- Friedman, Disability and Health Journal, Jan(41)1:100964 2021
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- Connecticut Council on Developmental Disabilities, "Developmental Disabilities and Access to Care Resource Sheet," [Accessed: June 5, 2023], available at: https://portal.ct.gov/-/media/CTCDD/Content/Developmental-disabilities-and-access-to-care-resource-sheet-5-31-2023-copy.pdf.